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AN EXPLORATION OF THE IMPACT OF SOCIAL SUPPORT AND ASSERTIVENESS ON THE PSYCHOLOGICAL WELL-BEING OF PUERTO RICAN WOMEN IN NEW YORK CITY

by

JOANNE ROLON

A dissertation submitted to the Graduate Faculty in Psychology in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York.

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Abstract

AN EXPLORATION OF THE IMPACT OF SOCIAL SUPPORT AND ASSERTIVENESS ON THE PSYCHOLOGICAL WELL-BEING OF PUERTO RICAN WOMEN IN NEW YORK CITY

by

Joanne Rolon

Advisor: Professor Sue Rosenberg Zalk

This study, conducted with a sample of 90 Puerto Rican Women in New York City, systematically studied the impact of perceived social support, assertiveness, and sociodemographic factors on psychological well-being. A review of the literature suggested strong associations between factors as well as a causal model relating perceived social support from family and friends, assertiveness, level of education, personal income, proportion of time on the U.S. mainland, and overall symptomatology (including depressive and somatization domains). A questionnaire (available in English and Spanish) containing sociodemographic questions and measures of assertiveness, perceived social support, and a symptom checklist was administered. Path analysis results based on an alternative model indicated that level of education strongly affects personal level of income which in turn affects somatization. Proportion of time on the U.S. mainland also had a direct affect on somatization. Correlational analyses supported a number of hypotheses. Assertiveness and perceived social support from family and friends correlated negatively with depressive symptomatology. Level of education and perceived social support from family correlated negatively with overall symptomatology.

Level of education also correlated negatively with somatization. Level of income was found to be positively correlated with level of education and negatively correlated with somatic symptoms. Overall results have implications for clinicians, researchers, and public policymakers.

Dedication

To my mother, father, and sister with love and gratitude.

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Chapter 1

INTRODUCTION

The inclusion of women's mental health issues as part of the National Institute of Mental Health research agenda (Russo, 1990) and the continuous finding that women suffer depression at twice the rate of men (Delgado, 1997) points to the urgent need for research that addresses the plight of women nationwide. The urgency of this need becomes evident when one reviews the findings from the American Psychological Association (APA) Task Force report on Women and Depression (McGrath, et al., 1990). The APA Task Force sought to explore how depression might be related to women's social roles, personality and psychological characteristics, reproductive events, and life circumstances; namely, victimization and poverty. One of the findings outlined by the Task Force is the need for researchers to study women from a biopsychosocial perspective because several economic, social, biological, and emotional factors put women at a very high risk for depression. Another finding is that depression is related to certain cognitive and personality styles such as pessimism and passivity, respectively. Marriage was also found to confer a greater protective advantage on men than on women. The Task Force referred to poverty as the "pathway to depression" that has implications for women and children who make up 75% of the U.S. poverty population (annual income of $5,776 or less) (U.S. Census Bureau, 1987). Relevant to this is the finding that 43.9% of the Hispanic families headed by women were poor (U.S. Census Bureau, 1987). The Task Force also found that mothers of young children are at high risk for depression and that more depression has been reported in cases where there are

more children in the home.

More recent findings regarding poverty rates, particularly on Hispanics (including Puerto Ricans), based on the March 1994 Current Population Survey (CPS, 1995) conducted by the Bureau of the Census, U.S. Department of Commerce, continue to suggest a need for concern about poverty and its possible implications for women's mental health. In 1993, four in ten Hispanic children were living below the federal poverty level as compared with one in eight non-Hispanic White children. The poverty rate for Puerto Rican children was 54%, over three times the poverty rate (13.6%) for non-Hispanic White children. Similarly, while the poverty rate of non-Hispanic White families was below 8 percent in 1993, the poverty rate of Puerto Rican families, in the same year, was the highest of all Hispanic groups at 35 percent (CPS, 1995). The APA Task force found that poverty is a major risk factor for disorders such as depression.

While the Task Force found that women, in general, are more likely than men to suffer from depression, Delgado (1997) noted that Hispanic women report twice as many depressive symptoms than non-Hispanic women. A nationwide survey on women's health (as cited in Delgado, 1997) revealed that over 50% of the Hispanic women reported that they had suffered from severe depression. Eckenrode (1983), in a review of the research, emphasizes that the well-documented association between disadvantaged social positions (e.g., low SES, women, etc.) and increased risk of psychological disorders provides the rationale for including sociodemographic factors in the design of any study on women and mental health.

Russo (1990) points out that "research should consider the effects of the multiple

characteristics that distinguish subgroups of women, e.g., age, marital status, race / ethnicity, sexual orientation, socioeconomic status, and parental status"(p. 372). Special populations such as ethnic minority women, lesbians, female adolescents, women who are substance abusers, professional women, women who have been physically abused, and elderly women, have been identified as groups among those that are especially at high risk for depression (McGrath, et al., 1990). Vasquez (1994) notes that Hispanic women, as a group, are at a high risk for mental health problems.

The APA Task Force notes that there is a need for research on the accessibility of coping resources and on the support networks for subgroups of women who may be at risk for depression (McGrath, et al., 1990). Studies conducted with Puerto Rican women as well as with women in general have revealed that symptomatology is related to a lack of or inadequate family support (cited in Leavy, 1983).

Clearly, research on women and mental health ought to consider sociodemographic factors, parental status, sexual orientation, personal dispositions or psychological characteristics, as well as more contextual factors such as social support or social networks resources.

There is an urgent need for research in the area of women and mental health, especially with minorities such as Puerto Rican women who have, increasingly, become a socially and economically disadvantaged subgroup of the general female population. Approximately 42% of all Puerto Rican families were headed by females in 1980 and over 80% of these lived below the poverty level (USBC, 1983; Delgado, 1987). More recent census data estimates revealed that, in March of 1994, 44% of Puerto Rican

families were headed by females. Therefore, one can no longer view the Puerto Rican woman solely as the "wife at home" in what has been historically known as a patriarchical Hispanic family system. The Puerto Rican female population is a heterogeneous one. The APA Task Force, reporting on the research by Amaro, et al. (1987), reported that even though Hispanic women are overrepresented among lower socioeconomic classes and younger ages, their living arrangements are inconsistent with the gender stereotypes of Hispanic women. "One in seven Hispanic women over age 15 was separated or divorced in 1981, and more than one out of two had no husband present" (p. 77). Similarly, one cannot ignore the increasing number of professional Puerto Rican women who do not fit the well documented stereotype of "wife at home." Changes in role expectations and changing economic and social conditions have clearly impacted upon the traditional Puerto Rican family. These changes challenge the Puerto Rican family structure and cultural expectations and changing conditions have been shown to be sources of stress.

Research that identifies factors that may impact on the psychological well-being of Puerto Rican women has been cited in the social science literature (e.g., Garcia & Zea, 1997; Rivera-Arzola. & Ramos-Grenier, 1997; Alarcon & Foulks, 1995; Comas-Diaz & Greene, 1994; Vasquez, 1994; Canino & Canino, 1993; Inclan, 1979; Amaro, et al., 1987; Towns-Miranda, 1985; Soto, 1979, 1983; Torres-Matrullo, 1974). Past epidemiological and individual clinical researchers of the Puerto Rican population have made an attempt to examine the relationship among factors such as marital status, total household and personal income levels, socioeconomic status, level of education, sex-role

attitudes, and symptomatology. General studies as well as studies focused on Puerto Rican women have found that factors such as socioeconomic status and income level predict symptomatology (Hollingshead & Redlich, 1958; Soto, 1979, 1983).

Amaro and Russo (1987), in their paper on Hispanic women and mental health research, point out that an understanding of women's mental health requires an examination of the interaction of a broad range of factors that include psychological, social, and cultural variables. The research proposed here will study the interrelationships of assertiveness and social support and the impact these and other factors may have on the psychological well-being of a diverse sample of Puerto Rican women in New York City. Similar to the APA Task Force findings, studies conducted on mainland Puerto Ricans in both psychiatric and non-psychiatric settings have also revealed that rates of depressive symptomatology are higher amongst the women than the men (Canino, G.J., et al., 1987). Vasquez (1994) also cites research data that suggests that depression is more prevalent among Hispanic women than their male counterparts.

Statement of the Problem

Two factors that may be highly relevant to Puerto Rican women are 'social support' and 'assertiveness.' Changing economic and social conditions in the United States have influenced the traditional Puerto Rican family system. Puerto Ricans have traditionally relied primarily on the nuclear and the extended patriarchical family system for support. Changes have also challenged the cultural role expectation of passivity amongst Puerto Rican females.

Concepts such as 'social support' and 'assertiveness' are examples of contextual

and personality variables that have not received as much consideration as other factors in studies relevant to the psychological well-being of Puerto Rican women. In fact, the study of the interaction of these two factors, assertiveness and social support, has been relatively absent from research studies conducted with the general population (Elliott & Gramling, 1990). "Data collected . . . in an urban setting provide evidence that personal assertiveness significantly augments specific types of social relationships to predict psychological symptoms under stressful conditions" (p. 427). The potential impact that "social support" might have on the psychological well-being of Puerto Ricans cannot be overlooked given the historical importance of the family social system in Puerto Rican culture. The increasing number of Puerto Rican female heads of households in a changing American society as well as the impact that American norms have had on the structure of the traditional tightly-knit Puerto Rican family, raises questions about both the sources and the nature of 'social support' among Puerto Rican females in contemporary times. Similarly, the study of personality variables such as 'assertiveness' among Puerto Rican women in contemporary times is equally relevant given that women are decreasingly being raised and socialized in traditional, patriarchical Puerto Rican families. Traditionally, the gender role socialization of Puerto Rican women has encouraged the inhibition of aggression and assertiveness (Soto, 1979; Comas-Diaz & Duncan, 1985). This inhibition, i.e. passivity, has been linked to psychosomatic symptoms and depressive symptomatology (Wolf, 1952; Rothenberg, 1964; Soto, 1979, 1983; McGrath, et al., 1990). The relevancy of the two factors cited above, also raises the question of whether assertiveness interacts with social support, and if so, what impact

do these two factors have on the psychological well-being of Puerto Rican women.

An exploration of a broad range of factors that might predict symptomatology or well-being should also include factors such as level of education and socioeconomic status. These have been found to be important variables contributing to levels of symptomatology among Puerto Rican women (Towns-Miranda, 1985; Inclan, 1979; Soto, 1979, 1983). Canino and Canino (1993) cite past epidemiological data on Puerto Rican women in New York City whereby the women who reported less education and lower incomes were also more likely to report greater symptomatology than men or those in higher socioeconomic brackets.

Researchers have made an attempt to examine factors that might predict psychological well-being among Puerto Rican women. However, contextual variables such as 'social support' have not been widely examined among Puerto Rican females in New York City. The problem is that both personality and contextual variables need to be examined systematically if one is to get a better understanding of the factors that might be linked to the psychological well-being of Puerto Rican women. This is the focus of the study proposed here. First, however, one must have some understanding of the traditional Puerto Rican family system and its gender-role socialization patterns in order to understand the possible impact that these factors might have on Puerto Rican females in New York City.

Chapter 2

LITERATURE REVIEW

The Traditional Puerto Rican Family / Culture

In 1917, an Act of Congress made it possible for Puerto Ricans to become citizens of the United States and move to the states without immigration restrictions. In his review of the literature, Delgado (1987) notes that the early migration patterns of Puerto Ricans, i.e. those who came to the United States between 1900 and 1945 and those who arrived during the Great Migration (1946-1964), generally involved poor and working-class individuals. However, Delgado (1987) characterizes the more recent migration pattern as one of Puerto Rican professionals who are leaving the island in times of recession in hopes of finding employment. Thus, Puerto Ricans on the mainland represent a very diverse group and not all Puerto Rican migrants can be presumed to be poor people who lack psychosocial resources (e.g. social support, education) to handle changes incurred in moving to the United States (Dressler & Bernal, 1982).

Many Puerto Ricans who came to the United States during the early migration wave, that is, many who are now considered first generation Puerto Ricans, arrived with traditional gender role values embedded in a patriarchical family structure (Stycos, 1955; Torres-Matrullo, 1976; Soto, 1979). The gender roles among Puerto Ricans are strictly differentiated, from a historical point of view (Torres-Matrullo, 1974, 1976): the male is expected to be the ultimate authority in his family, while the female is expected to be submissive, never questioning the authority of the male (Stycos, 1955; Wagenheim, 1970; Fitzpatrick, 1971). There was an expectation on the part of Puerto Rican women,

who migrated to the United States, that they be "self-sacrificing, chaste, restricted to the home, dependent, and respectful to the male" (Torres-Matrullo, 1976, p. 710). The term "marianismo" has been used to define the Hispanic woman's social role (Gil & Vazquez, 1996). Marianismo has been defined as passive suffering like the Virgin Mary (Ghali, 1982; Stevens, 1973). Gil and Vazquez (1996) point out that self-sacrifice, passivity, and submission to male authority are among the chief dictates of marianismo and that the principles of dependency and passivity are transmitted through the process of socialization. Thus, the traditional cultural and gender role socialization of Puerto Rican women encourages the inhibition of aggression and assertiveness (Soto, 1979; Comas-Diaz & Duncan, 1985). Cultural values such as "dignity" and "hospitality" have also been linked to the inhibition of assertiveness and aggression among Puerto Ricans, in general (Steward. 1956; Rand, 1958; Rothenberg, 1964; Soto, 1979).

The above depicts some of the gender role norms and values of the traditional Puerto Rican family. In her study on gender role traditionalism, assertiveness, and symptomatology among Puerto Rican women on the mainland, Soto (1979) found first generation women (born in Puerto Rico) to be less assertive and second generation women (born in the United States) to be significantly more assertive as well as less gender role traditional. She also found that 'age of arrival,' of Puerto Rican women who had migrated to the U.S., was a more adequate variable in accounting for differences than generation. Puerto Rican women in Soto's study who arrived in the U.S. at an early age were more likely to be better educated, less traditional, more assertive, and less symptomatic than subjects who were older upon arrival.

Assertiveness and Mental Health

According to Wolpe (1982), "assertive behavior is the appropriate expression of any emotion other than anxiety toward another person" (p. 118). Elliott and Gramling (1990), in their review of the literature, note that assertiveness has been traditionally defined as the effective communication of one's thoughts and feelings in an interpersonal situation, with respect for the thoughts and feelings of others. Comas-Diaz and Duncan (1985), in their paper on the use of assertiveness training with Puerto Rican women, write that, according to Rimm and Masters (1979), assertive behavior manifests itself in the expression of a wide range of personal feelings, attitudes, opinions and behaviors in a manner that is direct, effective and appropriate.

The expression or inhibition of assertiveness is a phenomenon based on differential socialization patterns. Block (1973), who has written on the sexual development of Americans, notes that "little boys are. . .taught to control the expression of feelings and affects, while assertion and extension of self are abetted. Little girls are. . .taught to control aggression, including assertion and extension, while. . .encouraged to regard the inner, familial world as the proper sphere of their interest" (p. 515).

Wolpe (1982) notes that suppression of the outward expression of feelings may result in prolonged inner turmoil which may in turn generate psychosomatic symptoms. Wolpe (1971) has also hypothesized that depression is a consequence of prolonged and inhibited anxiety.

There is evidence that assertiveness is significantly negatively correlated with anxiety (Gay et al., 1975). Culkin and Perrotto (1985) cite studies that confirm an

inverse relationship between depression and assertiveness.

Wolpe and Lazarus (1976) were one of the first to report case studies of the use of assertion training in the treatment of depression. Research studies have also been conducted to assess the effectiveness of assertion training as a treatment modality. Sanchez, V.C., Lewinsohn, P.M., and Larson, D.W. (1980) found that depressed outpatients who were assigned to an assertion training group reported feeling less depressed and more assertiveness than patients who had been assigned to a traditional psychotherapy group. In a study of assertiveness training with low-income Puerto Rican women, Comas-Diaz and Duncan (1985) found that the assertiveness scores of the training group were significantly higher than those of the no-training group, regardless of level of education.

Various instruments have been designed to measure assertive behaviors in different situations. Wolpe and Lazarus (1966) made early attempts to assess assertiveness amongst patients and developed a questionnaire for clinical use. Lawrence (1970) developed the Lawrence Assertive Inventory (LAI) with 112 items that included descriptions of real-life situations drawn from Wolpe and Lazarus (1966) and other sources. Responses to these situations were developed by asking introductory psychology students what they would do in each situation (Rich & Schroeder, 1976). McFall and Lillesand (1971) developed the Conflict Resolution Inventory (CRI) to assess one's level of assertiveness, the ability to refuse unreasonable requests, among college students. Rathus (1973) also used an undergraduate population and developed the Rathus Assertiveness Scale, a 30 item rating scale based on Wolpe's (1969) and Wolpe

and Lazarus' (1966) situations and selected items from the Allport (1928) and Guilford and Zimmerman (1956) scales. Galassi, DeLo, Galassi, and Bastien (1974) developed the College Self-Expression Scale (CSES), a 50 item inventory to measure assertiveness among college students. The items for the CSES were primarily based on the work of Lazarus (1971), Wolpe (1969), and Wolpe and Lazarus (1966).

Gay, Hollandsworth, and Galassi (1975) developed the Adult Self-Expression Scale (ASES), a 48 item, self-report measure of assertiveness for use with the general adult population. Adult age individuals were used in the standardization of the ASES as opposed to the college age populations used in the development of the instruments cited earlier. The ASES will be used in this proposed research because it is appropriate for use with a general adult population and because it has been used successfully with Puerto Rican women in research and in assertiveness training projects (Soto, 1979; Comas-Diaz & Duncan, 1985).

Assertiveness and Puerto Ricans

For Puerto Ricans, the relative lack of assertiveness is not only a phenomenon that is based on differential socialization patterns (Gil & Vazquez, 1996; Torres-Matrullo, 1974, 1976; Soto & Shaver, 1982) but one that is also, according to Rothenberg (1965), embedded in the cultural values of "hospitality" and "dignity." Rothenberg (1965), who writes on Puerto Rican psychiatric patients and on the general Puerto Rican population, notes that these cultural values or ideals "may embody suppression and repression of assertiveness and aggressiveness, the need to preserve an appearance of outward dignity and calm at the expense of inner psychological needs. . .Socially, direct

assertiveness is frowned upon. For example, if people drop in unexpectedly at one's home and one has plans for the evening, such as going to the theater, one is expected to cancel one's plans without a word. The outward show of hospitality is maintained" (p. 966).

Comas-Diaz and Duncan (1985), who write on their assertiveness training program with mainland Puerto Rican women, spell out certain traditional Puerto Rican values, norms, and codes of behavior that discourage assertive responses among women. One is the concept of respect (respeto) which prescribes obedience and respect towards authority figures, parents, relatives, the elderly, husbands and others. Another cultural value is the concept of familism. Familism favors a supported family network (nuclear and extended) which fosters loyalty, interdependency, reciprocity, and cooperation over competition (Comas-Diaz & Duncan, 1985; Sabogal, et al., 1987). A third barrier to assertive behaviors by Puerto Rican women, as outlined by Comas-Diaz and Duncan (1985), can be found in the traditional differentiation of gender roles, in the two codes of behaviors, namely, "machismo" and "marianismo." Machismo sanctions the domination of males over females and it often manifests itself in the unreasonable restrictions that are placed on the freedom of movement of women (Stevens, 1973). Marianismo, or the martyr complex, is a code of behavior whereby the woman is expected to be self-sacrificing for the sake of her children and to accept her husband's extramarital affairs in order to preserve his macho role (Comas-Diaz & Duncan, 1985). According to marianismo, women are also expected to be spiritually superior to men for enduring the suffering inflicted by them (Stevens, 1973). Comas-Diaz and Duncan (1985) note that

cultural factors such as respect, familism, and machismo / marianismo mitigate against assertive behavior and that it is not uncommon for Puerto Rican women to manifest psychosomatic symptoms such as 'ataques' or nervous states, headaches, or other pains or indirect manipulations in interpersonal situations due to the impediment of direct expression of thoughts and feelings or assertiveness. In their review of the literature, Canino and Canino (1993) note that for the past 30 years, the 'ataque' or the 'ataque de nervios' (nerve attacks), a form of somatization, has been described as a culturally defined syndrome typical of Puerto Ricans and other Hispanic groups. Rivera-Arzola and Ramos-Grenier (1997) point out that the 'ataques de nervios' is an intense emotional response which is manifested physically and may include trembling, shortness of breath, and heart palpitations. Rivera-Arzola and Ramos-Grenier further point out that Puerto Rican cultural values, such as 'respeto' (respect), 'humildad' (humility), and the concept of 'marianismo,' discourage assertiveness and that these cultural values influence the ways in which women express their feelings and that as a result some women may be manifesting distress indirectly through somatization or through the 'ataque'. Rivera-Arzola and Ramos-Grenier emphasize that the 'ataque de nervios' appears to be a 'culture-specific' way of expressing distress rather than a purely pathological one.

Soto's (1979) research on Puerto Rican women in New York City revealed that gender role traditional women had the most difficulty asserting themselves in public situations and with friends. The more assertive Puerto Rican women were more likely to be highly educated as well as members of a higher SES bracket. She also found that the women who were less traditional were also better educated and second generation Puerto

Ricans. Soto (1983) notes that the significant relationship found between education and traditionalism suggests that the American education system exposes the Puerto Rican woman to less strict gender role values and to the American norm of assertiveness. Gil and Vazquez (1996) note that the increasing number of Hispanic women in North America who are heads of households, divorcees, and professional women, for example, suggest that more women are challenging the marianista ideology which encourages passivity and discourages assertiveness.

Assertiveness, as measured by RAS and the ASES, has been found to be negatively correlated with depression and other symptoms scores, as measured by the scales such the Inventory to Diagnose Depression, the Beck Depression Inventory, the General Severity Index (Elliott & Gramling, 1990) and the Symptom Checklist 90 (Soto, 1979; Soto & Shaver, 1982). These findings suggest that low levels of assertiveness among Puerto Rican women may manifest itself in depression and psychosomatic symptoms.

Social Support

The concept of social support has received a great deal of attention in the research literature. The notion of supportive social relationships has been viewed as important to the maintenance of psychological well-being and physical health (Cobb, 1976; Gottlieb, 1981; Eckenrode, 1983). Cohen and Wills (1985) note that past studies have revealed a positive relationship between social support and mental health outcomes. However, Thoits (1982) points out that the pioneering research in the area of social support reveals a great deal of inconsistencies, an inadequate theory base, differing

results, and measurement problems. A consensus on the definition of social support has not been reached, making the study of social support very difficult (Heitzmann & Kaplan, 1988). However, even though ". . .definitions vary, most include both tangible components (e.g. financial assistance and physical aid) and intangible components (e.g. encouragement and guidance)" (Heitzmann & Kaplan, 1988, p. 75). House (1981) has defined social support as "an interpersonal transaction involving one or more of the following: emotional concern (liking, love, empathy); instrumental aid (goods or services); information (about the environment); or appraisal (information relevant to self-evaluation)" (p. 39). Heitzmann and Kaplan (1988), in their review on methods for measuring social support, indicate that existing definitions of social support express the multidimensional aspect of the concept. Barrera (1986) notes that in spite of the existing diversity of ways in which social support is conceptualized and measured, social support concepts and their operationalizations can be divided into three broad categories: namely; social embeddedness (connections that individuals have with others in their social environments / social network), perceived social support (an individual's cognitive appraisal of being connected with others), and enacted support (behavioral descriptions of support / frequency of help). Sarason, Sarason, and Pierce (1990), in their contemporary review of social support, cite Dunkel-Schetter and Bennett (1990) who recommend a need for more precise concepts and narrower models of social support because of a lack of clarity in the way social support has been conceptualized. Dunkel-Schetter and Bennett offer a conceptual framework that makes distinctions among social integration (the existence of social relationships), social network (the structure of social

relationships), and social support (the function of social relationships which is further characterized by whether support is available - perceived support - or whether it is activated in interpersonal transactions - received support). Dunkel-Schetter and Bennett add that measures of support have been developed to operationalize perceived support including the widely used Perceived Support Scales for Family and Friends (PSS-Fa, PSS-Fr; Procidano & Heller, 1983), which are two separate, 20 item scales that are used to measure the extent to which an individual appraises or perceives that family and friends fulfill his or her needs for support, information, and feedback. The Perceived Support Scales for Family and Friends (PSS-Fa, PSS-Fr; Procidano & Heller, 1983) will be used in this proposed research project. Dunkel-Schetter and Bennett (1990) note that researchers have pointed out that the 'perception of available support' influences general health and well-being and has a greater main effect on health than specific support transactions. One reason reported in the literature is that the main effects of support on health may operate through a psychological or cognitive pathway rather than through a transactional process (Sarason, Sarason, & Pierce, 1990). In their literature review on social support, Cohen and Wills (1985), address two different models or conceptualizations of social support, each of which represents a distinct process through which social support may affect well-being. The "buffering" model of social support proposes that support buffers or protects persons from stress. The "main effect" model of social support proposes that social resources are bound to have a beneficial effect regardless of whether or not persons are under stress. The main effect model postulates that an increase in social support results in an increase in well-being, irrespective of

stress levels (Cohen & Wills, 1985; Cutrona, 1984; Elliott & Gramling, 1990). In their recent review of the social support literature, Procidano and Smith (1997) write that although some studies confirm the "buffering" model, there is relatively more evidence that social support contributes directly to well-being and that it is inversely related to symptomatology. Dunkel-Schetter and Bennett (1990) suggest that received support (such as frequency of support behaviors or amount of support received) is more likely to have buffer effects and that available or perceived support is more likely to have a main effect on health. The research proposed here predicts that social support will have a main effect on psychological well-being.

Sarason, Shearin, Pierce, and Sarason (1987) emphasize a conceptualization of social support based on an individual's perception that they are loved and valued by persons who would provide them with assistance if necessary as opposed to a conceptualization based on the actual receipt of support (as cited in Heitzmann & Kaplan, 1988). Sarason, Sarason, and Pierce (1990), in their comprehensive review of research and theories on social support, address three major conceptions of social support: the network model, the received support model, and the perceived support model. However, Sarason, Sarason, and Pierce emphasize the importance of the perceived support model as evidenced by highly consistent findings that it is perceived social support that is most closely related to health outcomes They also point out the importance of an awareness and an understanding of the cultural context in which an individual perceives support from others. Procidano and Smith (1997) note that cultural values, such as 'familism' in Hispanic culture, prescribe expectations that influence the

interpersonal relationships and transactions amongst the members of a specific group and that experiences and participation in one's cultural group is bound to impact upon the perceptions of support provisions.

Social Support and Mental Health

The importance of studying the relationship between social support and psychological disorders became increasingly evident when the President's Commission on Mental Health (1978) recommended the need for greater research into the relationship among social support, mental health, and stress. Roberts and Gotlib (1997) cite evidence that suggests that vulnerability to depression is associated with inadequate perceived social support. Leavy's (1983) literature review on research done on social support and psychological disorders consistently revealed that a lack of support was associated with symptomatology. Leavy cites studies where low levels of social support were found to be associated with depressive symptomatology, high trait anxiety, test anxiety, and maladjustment amongst poor inner city children. Leavy (1983) also cites the classic Brown et al. (1975) study whereby among women the crucial variable mediating negative life changes and clinical depression was an intimate confidant, i.e. boyfriend or spouse. The Brown et al. study revealed that women who lacked an intimate confidant and who were experiencing life stressors were almost ten times more likely to experience serious depression than those who had a confidant. Subsequent studies of depression in men and women (cited in Leavy's review) also revealed that a confiding relationship correlated with lower levels of depression even when the confidant was of the same sex.

Studies on social support suggest that it is the quality of the support that is more

important for psychological health and well-being than the mere existence of a spouse / confidant or the quantity of support that is available to an individual (reported in Leavy, 1983). Heller, Dusenbury, and Swindle (1986) emphasize that it is an individual's appraisal or perception of being cared for and valued by significant others that is health protective and most important for well-being.

Social Support and Puerto Ricans

A greater understanding of Puerto Rican social support systems requires a cultural framework. Cultural definitions of male and female roles influence patterns of social interaction and support (Sanchez-Ayendez, 1988). Cultural values may also determine the nature and sources of social support systems. Several social science researchers and theoreticians of Puerto Rican and Hispanic support systems point to the important role of the nuclear and extended family. The notion that Puerto Ricans have traditionally turned to family support systems in times of need is well documented (Rogler & Hollingshead, 1965; Fitzpatrick, 1971; Mizio, 1974; Delgado & Humm-Delgado, 1982; Rogler, 1983; Delgado, 1987; Sanchez-Ayendez, 1988; De La Rosa, 1988). However, while a great number of studies on Hispanics have focused on the interaction of variables such as education level, income, gender, and age, for example, few have systematically examined the relationship between social support among Puerto Ricans and psychological well-being (De La Rosa, 1988). Nevertheless, social scientists have made noteworthy contributions to the literature by analyzing and writing about the social support systems of Puerto Ricans and other Hispanic groups. An overview of some of this literature may shed light on what one might predict about the social support

experience of Puerto Rican women.

In a study of the social network characteristics of 100 Puerto Rican migrant spouse pairs and 100 pairs of their adult married children, Rogler and Procidano (1986) found that women in both generations of Puerto Rican families (mothers and daughters) had significantly more family members incorporated into the network than men. They also found that education was not statistically related to the number of family members incorporated into the network and that this was true for both generations and for men and women.

Sanchez-Ayendez (1988), in her ethnographic study of the social support networks of 16 low-income, elderly Puerto Rican women living in Boston found that the family played one main supportive role for the women interviewed. She also found that the friendships were determined along sex lines. None of the elderly women interviewed named one male friend. The women mentioned only female friends. Sanchez-Ayendez, whose aim was to explore the influence of cultural meanings on patterns of social interaction and support, attributed that latter finding to the cultural definitions of male and female roles. The definitions, based on traditional Hispanic culture, tend to influence the exchanges or patterns of social interaction within the social network. Sanchez-Ayendez noted that the low-income, elderly Puerto Rican women in her study expressed mistrust about males based upon the notion of machismo and the expectation that there is a high probability that males will make advances to prove their virility. Even though this study is based on a very small sample (16 subjects), one that does not allow one to generalize the results to the entire population at large, her findings have

implications for attitudes among the elderly, recent immigrants, but do not suggest those of women who either arrived on the mainland as children or were born and raised in the United States.

Baker (1977) writes about 'natural support systems,' which include family and friendship groups, informal care-givers, and other systems which exclude the professional care-giving systems of the community (as cited in Delgado and Humm-Delgado, 1982). Delgado (1987) makes a distinction between natural support systems or natural helping networks that do not rely on human service agencies and formal systems or resources provided by public or private human service agencies.

The framework provided by Delgado (1987), which is based on the work of Delgado and Humm-Delgado (1982) with Puerto Ricans, consists of four major categories, which include the extended family and close family friends; folk healers; religious groups; and merchants and social clubs. The natural support systems of Puerto Ricans address certain emotional, financial, and psychological needs. Delgado and Humm-Delgado (1982) view the natural supports systems as a source of strength, as resources that Puerto Ricans can turn to for help. However, the particular combination of the four natural support systems that are bound to be used by any individual will be unique to that individual. These natural support systems may not be operating in the lives of all Puerto Ricans. Delgado (1987) suggests that it is possible that Puerto Ricans of a higher socioeconomic level and degree of acculturation may make greater use of formal systems or institutions.

De La Rosa (1988) conducted a systematic study that examined the relationship

between support from natural support systems and stress and emotional problems, substance abuse, and family problems among Puerto Ricans. De La Rosa cites past research literature that suggests that Puerto Ricans who receive strong support from their natural support systems are better able to cope with stress and less likely to experience emotional or physical problems than those who receive little or no support. However, De La Rosa points out that few studies have been designed to systematically test whether available natural support systems are in fact a source of strength for Puerto Ricans and that few studies have examined the relationship between natural support systems and the well-being of Hispanics. Like Delgado and Humm-Delgado (1982), De La Rosa (1988) used Baker's (1977) definition of natural support systems. In his study, a questionnaire was administered to 200 Puerto Ricans. The questionnaire was divided into three parts. The first part asked for socioeconomic and demographic information. In the second part, an inventory was administered to measure the concept of strength of support received by Puerto Ricans from their natural support systems. Finally, the third part of the questionnaire consisted of a measurement of a level of stress and a measurement of the incidents of emotional problems, substance abuse, and family problems. De La Rosa used a stepwise multiple regression model to analyze the relative strength of the independent variables in predicting both the absence or presence of symptoms of stress and the incidence of emotional, substance abuse, or family problems. Strength of support was found to be the variable most highly correlated to symptoms of stress. In other words, when all of the other independent variables were accounted for, the higher the level of support received from natural support systems, the lower the symptoms of

stress. Yearly income was the second variable most highly correlated to symptoms of stress. Thus, when other independent variables were accounted for, an increase in income resulted in a decrease in symptoms of stress. Similarly, strength of support and yearly income predicted the incidence of emotional, substance abuse, and family problems. An analysis of the background characteristics of the Puerto Rican sample "seems to suggest that those who receive strong support from their support systems are better able to handle stressful situations and less likely to become ill, regardless of their socioeconomic status, age, gender, health status, or marital status" (De La Rosa, 1988, p. 187).

De La Rosa (1988) points out that his research findings support both the conceptual framework put forth by Delgado and Humm-Delgado (1982) and provide empirical evidence that the support Puerto Ricans receive from their natural support systems is the most important variable in determining level of stress and incidence of emotional, substance abuse, and family problems.

Garrison's (1978) study on the support networks of schizophrenic and non-schizophrenic Puerto Rican-born women revealed that the most severely disturbed women had few or no friends and family members in their networks whereas the non-clinical women had numerous supports which included spouse, friends, and family. She also found that the more adaptive subjects had a significant number of family resources whereas the most disturbed subjects relied mostly on nonfamily members.

Sabogal, et al. (1987) examined the effects of acculturation on attitudes towards the family in 452 Hispanics compared to 227 white nonHispanics. They explored three

dimensions of "familism," one of the most important values in Puerto Rican culture and in other Hispanic cultures, as well (Mizio, 1974; Moore, 1970). Sabogal, et al. (1987) describe familism as including an individual's identification and attachment with his or her nuclear and extended family. Familism also values loyalty, interdependence and reciprocity (Comas-Diaz & Duncan, 1985; Sabogal, et al., 1987). The three dimensions of familism studied by Sabogal, et al. (1987) were: family obligations, perceived support from the family, and family as referents. Familial obligations were defined as the person's perceived obligation to provide material and emotional support to extended family members. Perceived support from the family referred to the perception of family members as reliable providers of help and support to solve problems. Finally, the family as referents factors dealt with relatives as behavioral and attitudinal referents. Results indicated that the familial obligations and family as referents factors tended to decrease with an increase in the level of acculturation for the different Hispanic subgroups in the sample. The perceived support from family factor seemed to be the central core of familism since it was not affected by acculturation, place of birth, generation, or place of growing up. Sabogal, et al. speculate that this finding may be a result of Hispanic cultural characteristics that emphasize mutual help and interdependence among family members. Another one of their findings was that the attitudes of Hispanics with high levels of acculturation were more familistic than those of white nonHispanics. Sabogal, et al. conclude that this finding supports Keefe's (1980) argument that acculturated Hispanic families do not resemble white nonHispanic families.

Clearly then, the Hispanic woman's link to her family must be viewed from a

cultural perspective and not from a Caucasian perspective whereby one's link to family members in adulthood may be construed as a sign of dependence as opposed to healthy adaptation. Mizio (1974) stresses that family ties among Puerto Ricans should not be considered pathological since the family is, in contrast to the American family, an extended family system. The intimate relationships in this system are both highly valued and a source of pride and security for Puerto Ricans. In her paper on Hispanic women and mental health providers, Vasquez (1994) also cautions against the strict imposition of the majority culture's value system on Hispanic women and the assumption that the absence of certain values suggests pathology.

The Puerto Rican family has been viewed as a supportive, help-giving system where the rendering and receiving of help is an integral component of familial bonds (Rogler & Hollingshead,1975). Rogler (1983) emphasizes, however, that this view cannot be generalized to all Puerto Rican families given the increasing problems that are besetting Puerto Ricans in New York City, such as the rapid increase of single-parent households and the rising number of divorces. In reference to supportive networks that have been cited as important in traditional Hispanic culture, Rogler (1983) points out that very little is known about the vitality of the family, friends, neighbors, and compadres (god parents) as help-giving systems among Puerto Ricans in the New York City area.

Social Support, Assertiveness

And

Other Individual Characteristics

As Predictors of Psychological Distress

The extent to which individual differences may influence the relationship between social support and psychological well-being has been addressed as a research question by numerous social scientists. Some research has provided evidence suggesting that social support has a direct effect on psychological well-being and that certain individual characteristics may interact with or influence social support. Newcomb and Keefe (1997) write that, empirically and theoretically, personality has been linked to social support and that personality variables such as shyness, introversion, sociability, self-esteem, and assertiveness, have consistently been correlated with perceived social support. Duckitt (1984) suggests that findings such as these lend support to an interactionist approach in research, one that integrates person and context variables for the prediction of psychological well-being. Procidano and Smith (1997) also report that both there has been increasing evidence that personality traits are associated with perceived social support and that research models have suggested that individual differences in personality traits influence perceived social support.

Elliott and Gramling (1990) took into account person and context variables in predicting psychological symptoms under stressful conditions. In their research of personal assertiveness and the effects of social support among urban college students, they noted the relative absence of research that has examined the interaction between

interpersonal variables and social support. The authors describe personal assertiveness as an interpersonal variable that, from a theoretical standpoint, is vital for effective social support exchanges. Elliott and Gramling note that one would expect assertive individuals who are, for example, experiencing high levels of stress, to exhibit effective interpersonal behaviors in the social support process, particularly since assertiveness encompasses effective communication of one's thoughts and feelings as well as appropriate requests for assistance from others.

Elliott and Gramling (1990) conducted two separate studies with college students in an urban setting. The studies sought to examine "the relationship of assertiveness to social support in predicting depression and distress under stressful and general conditions. . .The major findings indicate(d) that, in general, assertiveness. . .augment(ed) the beneficial effects of specific social relationships" (p. 433). The results of the first study revealed that assertiveness and social support were significantly negatively correlated with depression scores. Similarly, assertiveness was significantly negatively correlated with the depressive behavior and distress measures used in the second study as were most of the social support subscales. There was also a strong positive correlation between stress level and the depressive / distress measures used in both studies. Roberts and Gotlib (1997) cite evidence suggesting that vulnerability to depression is associated with personality as well as inadequate perceived social support. Procidano and Smith (1997) note that personality traits such as 'extroversion,' have been linked to perceived social support, suggesting that extroverts, who may experience relatively more comfort in interpersonal situations than introverts, are more likely to

perceive support from others than those who are not extroverted.

Duckitt (1984) also conducted a study with college students in an attempt to examine the influence of six personality factors (i.e., anxiety, extroversion, critical independence, sensitivity, shrewdness, inhibition) on the relationship between social support and symptoms of psychological distress. The results revealed that "only one of the six personality factors considered, extroversion, showed a significant interaction with social support in the prediction of distress" (p. 1202). Specifically, the results suggested that extroverts experienced less psychological distress at higher levels of social support but more psychological strain at lower levels of social support.

Eckenrode (1983) conducted a study with 308 women users of a neighborhood health center in an attempt to explore the role of certain individual-level characteristics as constraints in the mobilization of social supports. Specifically, the individual characteristics examined were dispositional variables such as locus of control and help-seeking beliefs, as well as sociodemographic variables which included level of education, income, age, and ethnicity (the latter defined as English versus Spanish-speaking). Eckenrode sought to explore factors or variables that could either inhibit or facilitate the social support mobilization process in times of stress. Results, based on a series of multiple regression analyses used to explore the prediction of support mobilization, indicated that the two dispositional variables, internal locus of control and positive beliefs in the benefits of help-seeking, were associated with more support mobilization, independent from the number of potential supports available. However, the number of potential supports (i.e., friends and family members one could count on)

was significantly associated with support mobilization. Level of education showed a direct, positive relationship to support mobilization. Tests for interaction between each of the remaining independent variables revealed that the number of potential supports, internal locus of control and positive help-seeking beliefs had a greater impact on support mobilization for persons with higher education, higher incomes or from English-speaking (versus Spanish-speaking) backgrounds. Procidano and Smith (1997) write that, by definition, personality traits reflect behavior patterns that are less likely to vary across situations than perceived social support, which is more likely to vary in response to changing life events. Procidano and Smith further point out that one may find that perceived support, which has been found to mediate stress, may mediate the personality's contribution to adjustment outcomes.

Studies and theoretical writings such as those cited in this section support the inclusion of person and contextual variables such as social support and assertiveness in designing a predictive model of psychological well-being.

Women, Sociodemographic Characteristics, and Mental Health

The extensive documentation in the literature of the positive association between disadvantaged social positions (e.g., low SES, women, etc.) and the increased risk of psychological disorders provides the rationale for including sociodemographic factors in the design of any study on women and mental health (e.g., Eckenrode, 1983; Belle, 1990). Belle (1990) reports that the association between poverty and mental health is not

surprising when one considers that poverty imposes considerable stress on individuals and families while also attacking many potential sources of social support.

Higher levels of socioeconomic status have been found to be related to lower levels of symptomatology (Hollingshead & Redlich, 1958). The education levels from the Hollingshead's (1977) Four Factor Index of Social Status (FFISS) will be used in this study to determine its association with psychological distress.

Level of education has also been found to be related to symptomatology. Researchers report that an inverse relationship between prevalence of depressive symptoms or current major depression and education level has been reported in most research done with Caucasian and Hispanic populations (See Canino, et al., 1987).

The importance of taking an interdisciplinary approach, that includes social, economic, and emotional factors, when researching women and mental health has been reported by the APA Task Force on Women and Depression (McGrath, et al., 1990). This approach allows one to sort out predictors of psychological well-being. It is also important to control for sociodemographic variables in order to sort out possible psychosocial correlates of symptomatology. In their study, of 499 women, on the relationship between demographic variables, psychosocial variables (which included social support), and depressive symptomatology, Warren and McEachren (1983) found that high depression scores were associated with lower social support. They also found that high depression scores were correlated with variables that included lower education, younger age, and lower family income. However, they found that the psychosocial variables (which included social support) examined in the study accounted for a greater

percentage of the depression variance.

This study will incorporate sociodemographic variables given the implications of these factors for symptom levels as well as the need for statistically controlling the effects of these variables in sorting out other predictors of symptomatology.

Hispanics (Puerto Rican) Women, Sociodemographic Characteristics, and Mental Health

Vasquez (1994) cites literature that outlines various sociodemographic factors (e.g., educational attainment, generation, income, employment) which are relevant to Hispanic mental health.

In their paper on "Hispanic Women and Mental Health," Amaro and Russo (1987) address certain demographic and socioeconomic factors and the implications these have for the mental health outcomes of Hispanic women. They point out that the social and economic contexts that shape the realities of contemporary Hispanic women's lives need to be understood if one seeks to further understand the mental health issues of this population. In this paper, Amaro and Russo, point out that even though many Hispanic women may fall in low income and education brackets, it is important to recognize that 13% of Hispanic women (over 1 in 10) have a professional or managerial employment status (Bureau of the Census, 1985b). More census data from the Current Population Survey (CPS, 1995) estimates that 16% of Hispanic women are employed in managerial and professional specialized occupations as compared with 31% of non-Hispanic White females. In their study on "Family and Work Predictors of Psychological Well-Being among Hispanic Women Professionals," Amaro et al., (1987) pointed out that more needs to be known about the factors that are associated with mental health outcomes for

the highly educated and relatively affluent segment of the Hispanic female population. Findings from Amaro and Russo (1987), Amaro, et al., (1987), and others on demographic and socioeconomic data pertaining to the mental health of Hispanic (Puerto Rican) women are cited below.

A factor, whose association with psychological disorders is well established, is income (Belle, 1990; Amaro & Russo, 1987). Amaro and Russo (1987) report that in 1984, Hispanic women earned less (annual income of $5,830) than women overall (annual income of $6,949) and that Puerto Rican women had the lowest annual income ($4,985) as compared to other persons of Spanish origin (as cited in Escutia & Prieto, 1986). They also report that in 1984, 25.2% of Hispanic families lived below the poverty level as compared with 9.1% of Anglo families. Of these Hispanic families, Puerto Rican families were found to be the poorest, with 42% of them falling below the poverty line (Bureau of the Census, 1985b). According to March 1994 Current Population Survey estimates, Puerto Rican families were still found to have the highest poverty rate (35%) of all Hispanic groups. In their study on Hispanic female professionals, Amaro, et al. (1987) found that women who reported fewer psychological distress symptoms were more likely to have a higher income.

Amaro and Russo (1987) also cite data on the educational attainment of Hispanics. They reported that, in 1985, the median years of education was 12.7 for nonHispanic women 25 years of age and older compared with 11.5 years for Hispanic women and 11.2 for Puerto Rican women (Bureau of the Census, 1985b). Amaro and Russo (1987) note that education is an important factor in mental health outcomes;

education has been described as a significant preventative against depression. Torres-Matrullo (1974), in her study on Puerto Rican women in the U.S., found a significant differences in psychopathology among women with different levels of education. The more educated women scored consistently lower on all psychopathology scales. More recent data raise concerns about levels of education amongst Hispanics and its implications for mental health outcomes. Vasquez (1994) writes that the educational attainment rates amongst Hispanics remain at low levels and that a 1991 report generated by the American College Testing Service indicated that Hispanics had the lowest educational attainment rates when compared to other groups. Data on the education attainment found that, in 1994, only 3% of Hispanic adults had obtained an advanced degree while 31% had less than a 9th grade education. The association between education and income is also noteworthy. Data on the 1993 educational attainment (from less than the 9th grade through the doctorate degree level) of Hispanics revealed that median earnings of Hispanic females increased with higher levels of education (CPS,1995).

On female heads of households, Amaro and Russo (1987) write that in 1984. 23% of Hispanic females were headed by women, compared with 12.8% of Anglo families and that of these Hispanic families, Puerto Ricans had the highest proportion (44%) of families headed by women. They also reported that Hispanic families headed by women were more likely (53.4%) to fall below the poverty line than their Caucasian counterparts (27.1%) (Bureau of the Census, 1985a, 1985b). Subsequent 1993 census estimates indicate that Hispanic families are more than twice as likely than non-Hispanic families

to be living below the poverty level (CPS,1995).

On marital status, the APA Task Force on Women and Depression (McGrath, et al., 1990) reported that marriage was found to confer a greater advantage on men than on women. In their study with highly educated, high income Hispanic women, Amaro, et al. (1987) found that "marital status was not significantly associated with distress symptomatology (but that). . .having a spouse who was perceived as supportive was associated with lower stress in balancing family and wife roles" (p. 518). McGrath et al. (1990) cites literature that has reported that unhappily married women experience more depressive symptoms than their unmarried or happily married counterparts.

Amaro et al. (1987) report findings (from Ross & Huber, 1985; Ross, Mirowsky, & Huber, 1983) that the presence of "young children in the home has been associated with both an increase and decrease in depression depending on the level of economic hardship. If economic hardship is controlled, presence of children has been. . .associated with decreased levels of depression " (p. 518). No relationship was found between having children and psychological distress symptoms among highly educated, high income Hispanic women studied by Amaro, et al., (1987).

Amaro and Russo (1987) conclude that data on Hispanic women show that they are overrepresented among lower socioeconomic classes and younger ages and that this can put Hispanic women at risk for psychological disorders.

In their review of the literature, Alarcon and Foulks (1995) write that distress amongst Puerto Ricans, in socially disadvantaged positions, may manifest itself in the form of somatization.

Proposed Research

The purpose of this study is to explore the impact that social support, assertiveness, demographic and socioeconomic factors may have on the psychological well-being of a sample of Puerto Rican women in New York City. Given that Puerto Rican women are not homogeneous, that individual differences are bound to influence study results, demographic and sociodemographic variables will be both analyzed and controlled for in this proposed research. 'Age of arrival,' to the U.S. mainland data will also be collected to assess the possible effects of early versus later socialization on the mainland. 'Age of arrival' has been found to be a more adequate variable in accounting for differences than data on whether Puerto Rican women are first generation (born in Puerto Rico) or second generation women (born on the U.S. mainland) (Soto, 1979). Data on the proportion of time spent on the U.S. mainland will also be collected to assess whether or not 'actual' time spent on the mainland has an effect on symptomatology. These variables along with the personal and contextual factors of focus in this study: namely, assertiveness and social support, will be examined in order to gain a better understanding of predictors of psychological well-being among a sample of New York City Puerto Rican women. The major hypotheses to be tested in this proposed research will follow. The outcome measure (the Symptom Checklist, SCL-90-R), utilized to analyze the dependent variable of symptomatology, will generate three scores for the purposes of this research study. Overall symptomatology will be determined by the SCL-90R Global Severity Index (GSI) and scores from both the SCL-90-R's depressive and somatic symptoms domains will be generated as well.

Major Hypotheses

**Level of education is mediated by personal yearly income in negatively affecting symptomatology.

**Level of education is mediated by assertiveness in affecting symptomatology.

**Proportion of time on the U.S. mainland is mediated by assertiveness in negatively affecting symptomatology.

**Assertiveness is mediated by perceived social support in negatively affecting symptomatology.

a.Assertiveness will be positively related to perceived social support for friends.

b.Assertiveness will be negatively related to perceived social support for family.

**Assertiveness will be negatively related to symptomatology.

**Perceived social support will be negatively related to symptomatology.

** Income will be negatively related to symptomatology.

**Education is mediated by Income in affecting symptomatology.

Proposed Conceptual Model of Symptomatology

Based on the research previously cited in the literature, a path analysis model (see Figure 1) has been proposed to analyze the direct and indirect effects of exogenous variables (e.g., education, income) on endogenous variables (e.g., overall symptomatology). The relationships between variables, to be analyzed by the model, are listed in the 'major hypotheses' section. Overall symptomatology (a total score based on the Global Severity Index of the SCL90-R), Depression (a SCL90-R subdomain), and Somatization (a SCL90-R subdomain) will be tested in the model in separate analyses.

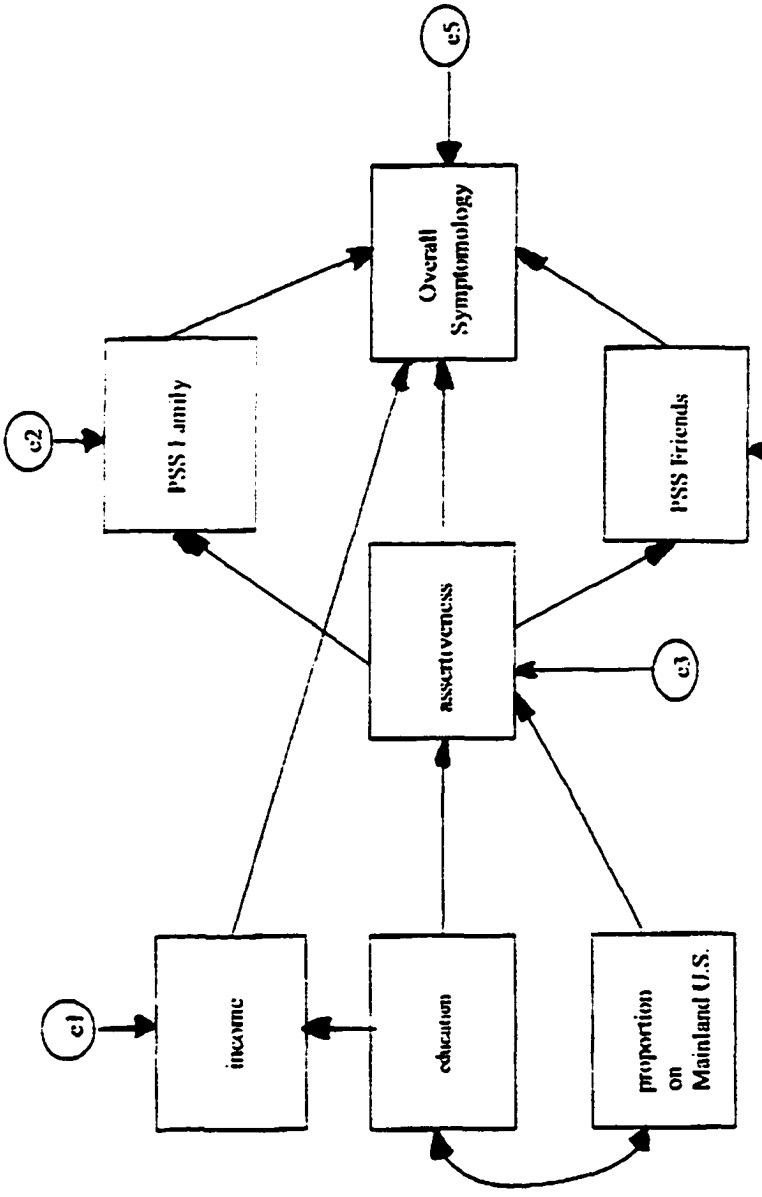


Figure 1

Conceptual Model of Symptomatology

Chapter 3

METHOD

Participants

Ninety Puerto Rican women from the New York City metropolitan area participated in the study. Efforts were made to recruit volunteers from different age groups, education levels, and social classes in an attempt to obtain variability across all of the factors that were being examined. The mean age of all participants was 36.167 years (range; 18-55) and the median age was 35 years. Levels of education ranged from less than an 8th grade education to the graduate school level and the median level of education was 'some college.' Most of the participants (N=79) were born on the U.S. mainland. The mean income (N=73) was $27,650. Table 1 presents the major demographic variables on all participants.

Procedure

Participants were recruited from various organizations, agencies, and businesses in the New York metropolitan area. Organizations servicing the Puerto Rican community, such as the Puerto Rican Association for Community Affairs (PRACA), were contacted and names and phone numbers of those who agreed to be contacted for such purposes were obtained. Efforts were also made to locate participants who reside in different New York City boroughs. Directors or department heads of the organizations who were contacted for permission to recruit Puerto Rican female participants, were informed of the nature and the goals of the study as were the participants. Once participants were contacted over the telephone, they were read a prepared statement (in

Table 1

Major Demographic Characteristics of the Sample

N=90

Age Range 18-55 Years N=90

Mean = 36.167

Median = 35

Place of Birth N=90

Puerto Rico = 9 subjects

United States = 79 subjects

Other = 2 subjects

Y- (Personal Annual) Income N=90

Mean= $27.650

Median= $23,000

Valid Cases = 73

Missing Data = 17

Level of Education N=90

1)8th Grade of Less = 5.6%(5)

2)9 Grade = 2.2%(2)

3)Some High Sch. = 13.3%(12)

4)High Sch./Vocational = 22.2%(20)

5)Some College = 27.8%(25)

6)College Degree = 16.7%(15)

7)Grad Degree =12.2%(11)

Employment Status N=90

Currently employed =66.7%(60)

Not employed =30.0%(27)

Temporarily out of work=3.3%(3)

either English or Spanish) explaining the purpose of the study and they were told that their participation was voluntary, confidential, anonymous (See Appendix B). Once a participant agreed to be a part of the study, a questionnaire (available in English and Spanish) (See Appendix A) and a consent form, also available in English and Spanish (See Appendix C) was mailed with a stamped, return envelope that had the researcher's home address but no participant identifying data. Since the response rate by mail was less than 25%, arrangements had to made to drop off batches of the questionnaires at agency locations whereby the questionnaires were then distributed in a manner that ensured confidentiality and anonymity. The prepared statement, which explained the purpose of the study and that was used with subjects who were contacted by telephone, was then attached to the questionnaire. All parties contacted, including the participants, were informed that participation in the study was voluntary, confidential, anonymous, and that there would be no consequences or penalty as a result of not participating in this study.

Instruments

Data was systematically collected by having each subject fill out a questionnaire available to all subjects in either English or Spanish. The questionnaires consisted of background information and demographic questions as well as scales to measure perceived social support (PSS), assertiveness (ASES), and symptomatology (SCL-90-R).

Perceived Social Support Scales (PSS)

The Perceived Social Support Scales (PSS) consist of two separate 20 item scales, the Perceived Social Support Scale for Family (PSS-Fa) and the Perceived Social Support

Scale for Friends (PSS-Fr), developed by Procidano and Heller (1983). Each scale is used to measure the extent to which an individual appraises or perceives that friends and family fulfill his or her needs for support, information, and feedback. Test-retest reliability for the PSS has been estimated to be .83 with reliability estimates based on a sample of 222 undergraduate students. Both the PSS-Fr and the PSS-Fa scales have been found to be homogeneous measures with internal consistency coefficients (Cronbach's alpha) of .88 and .90, respectively. Evidence for construct validity lies in findings that PSS-Fa and PSS-Fr are better predictors of psychiatric symptomatology than characteristics of support networks or life events (Heitzmann & Kaplan, 1988). PSS-Fr and PSS-Fa have both been found to be inversely related to distress symptoms and psychopathology with the relationship stronger for PSS-Fa (Procidano & Heller, 1983). Procidano and Heller (1983) note that the distinction between family support and friend support is an important one since different populations may benefit from family or friend support to different extents and at different points in time. Perception of family support seems to be stable and not influenced by temporary changes in attitudes (Procidano & Heller, 1983). In their review of methods for measuring social support, Heitzmann and Kaplan (1988) report that the two scales of PSS appear to be quite psychometrically adequate and that the scales assess the most crucial aspect of the construct, the perception of social support.

Each PSS scale, the PSS-Fa and the PSS-Fr, consists of 20 items with a YES-NO-DON'T KNOW answer format. The PSS was chosen for this research study because it is psychometrically sound, it assesses the perception of social support which has been

found to be more closely related to health outcomes, and because the use of the PSS-Fa (Perceived Social Support Scale for Family) subscale seems adequate for use with Puerto Ricans, a culture which has traditionally placed much importance on the family and the extended family unit.

The Adult Self-Expression Scale (ASES)

The Adult Self-Expression Scale (ASES) is a 48 item self-report assertiveness measure developed by Gay, et al. (1975). The ASES measures a wide range of assertive behaviors and interpersonal situations in which different types of assertive behaviors typically occur. The ASES measures interpersonal situations involving parents and authority figures. The scale also measures assertive behaviors such as expression of opinions, positive feelings, anger, and refusal of unreasonable requests (Gay, et al., 1975). Each of the 48 items is scored from 0 to 4, with an "almost always" to "never or rarely" answer format.

High test-retest reliability has been found with 2 week and 5 week test-retest reliability coefficients at .88 and .91, respectively. The ASES was also found to have moderate to high construct validity as determined by correlations with scales from the Adjective Checklist and by a discriminant analysis procedure. Concurrent validity was also established for the ASES (Gay, et al., 1975).

The ASES was used in this research study because it is deemed adequate for use with adults, found to be psychometrically adequate, and has been used successfully with Puerto Rican women (e.g., Soto, 1979; Comas-Diaz & Duncan, 1985).

Symptom Checklist-90-R (Revised) (SCL-90-R)

The SCL-90-R (Derogatis, 1983) is a 90 item symptom inventory and it is a revised version of the SCL-90 (Derogatis, 1977; Derogatis & Cleary, 1977; Derogatis, et al., 1976). It is a 5-point Likert type scale where a high score is indicative of symptomatology. The SCL-90-R measures nine areas of symptomatology and three global indices of distress. It is a measure of current psychological symptom status and not a measure of personality, except for describing types. The nine symptom dimensions are: somatization, obsessive-compulsive symptoms, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. The three global indices of distress are: Global Severity Index (GSI), the Positive Symptom Distress Index (PSDI), and the Positive Symptom Total (PST). Each item on the SCL-90-R is scored 0 to 4 with an answer format ranging from "not at all" to "extremely."

The Symptom Checklist is widely used and has been demonstrated to be a valuable clinical instrument with sound psychometric properties. High validity has been established for the symptom constructs of the SCL-90-R (Derogatis & Cleary, 1977). Internal consistency coefficients for the nine scales of the SCL-90-R range from a low of .77 for psychoticism to a high of .90 for depression (Derogatis, et al., 1976). Test-retest reliability is adequate with coefficients fluctuating between .80 and .90 (Derogatis, et al., 1971, 1972).

The SCL-90-R (Derogatis, 1983) was used in this research study due to its sound psychometric properties and its widespread use with Puerto Rican female populations (e.g., Soto, 1979; Inclan, 1979) and general populations as well. This measure is deemed

appropriate given the noted manifestation of psychosomatic and depressive symptoms amongst Hispanics. Final analyses with the SCL-90-R measure included the Global Severity Index (GSI) of overall symptomatology as well as the Somatization and Depressive Symptoms dimensions, as outcome (dependent) variables.

Sociodemographic Data

The sociodemographic data that was collected included information on level of income, level of education, age, marital status, parental status, place of birth, proportion of time spent living in the United States, and age of arrival to the U.S. mainland.

The FFISS (Hollingshead, 1977) was used in this research study to assess socioeconomic status because of its widespread use with Hispanic and general populations. Level of education was assessed using the FFISS (Hollingshead, 1977) categories and then compiled into 7 categories ranging from 1 to 7 (See Table 1) for the purposes of conducting the proposed statistical analyses. Only the education portion of the FFISS was utilized in the final analyses because spousal educational and occupational data was not collected for the purposes of this research study. Other personal history questions were incorporated into the questionnaire to gather additional relevant sociodemographic data on the sample of Puerto Ricans subjects participating in this study. The questionnaires, which were available in English and Spanish, appear in Appendix A.

Data Analysis

The proposed research model was tested using a path analysis. Three separate path analyses were conducted to include the SCL-90R Global Severity Index and the

SCL90-R Depression and Somatic Symptoms domains as endogenous variables. Additional statistics including Pearson product-moment correlational analyses were used to examine relationships between the variables of interest. 'Age of arrival' to the mainland, which was assessed in years, with a value of zero for those born on the U.S. mainland, which was to be analyzed with the 'Proportion of time spent on the U.S. mainland,' had to be omitted from the analyses since, due to uncontrollable factors in sampling, approximately 88% of the women who participated in this study were born on the U.S. mainland and this resulted in minimal variability. However, analyses with 'Proportion of time' or actual time spent on the U.S. mainland were conducted. Proportion of time spent on the U.S. mainland was analyzed whether or not the participant was born in Puerto Rico or on the U.S. mainland or moved back to Puerto Rico for a few years and in turn returned back to the U.S. mainland. Proportion of time spent on the U.S. mainland was calculated with the following formula:

$$\text{Proportion of time spent on the U.S.} = \frac{(\text{Age now} - \text{Age to the U.S.}) - (\text{Time spent in P.R.})}{\text{Age now}}$$

Descriptive statistics for the study variables are presented in Table 2. In addition to means and standard deviations, the table also lists the 'actual' range of scores for this sample as well as the range of scores that were possible.

Table 2

Descriptive Statistics for the Study Variables

Variable	M	SD	N	Range of Scores	PossibleRange
Somatization	.73	.64	90	0-3.33	0-4
GSI	.75	.54	90	0-2.77	0-4
Depression	.96	.73	90	0-2.92	0-4
PropTinUS	.94	.12	88	.53-1.00	0-1
Education	4.63	1.55	90	1-7	1-7
PSS-Fr	14.01	4.79	90	0-20	0-20
PSS-Fa	14.61	5.06	90	1-20	0-20
ASES	140.31	22.01	90	89-192	0-192
Y-Income	27.649.95	22,784.59	73	1050-150,000	0-

Chapter 4

RESULTS

Research Sample

As indicated earlier, the major demographic characteristics of the sample are outlined in Table 1. The sample of women, which includes women of all levels of education and income levels recruited from different sources in New York City, consisted primarily of participants who were born and raised in the United States.

Correlation Analyses

In order to test the correlational prediction of each hypothesis, Pearson product-moment correlations were performed. All of the variables were treated as continuous variables. The significant correlations appear in Table 3.

Overall results revealed significant correlations, at the $p<.05$, $p<.01$, and $p<.001$ level, between variables in support of a number of hypotheses. Results supported the following hypotheses in the directions originally predicted:

**Level of Assertiveness was found to be negatively correlated with depressive symptomatology ($r=-.249$, $p<.05$). Subjects who reported higher levels of assertiveness, reported fewer depressive symptoms.

**Level of Education was found to be negatively correlated with overall symptomatology (Global Severity Index, GSI) ($r=-.253$, $p<.05$) and somatic symptoms ($r=-.389$, $p<.001$). Subjects who reported higher levels of education also reported fewer somatic symptoms and overall symptomatology (GSI).

** Personal Yearly Income or Y-Income level was found to be positively

Table 3

Significant Correlation Coefficients

Variable	1	2	3	4	5	6	7	8	9
1.ASES	1.00	*-.249	----	----	----	----	----	----	----
2.DEPRESS		1.00	----	----	----	*-.266	----	----	*-.236
3.EDUCATION			1.00	*-.253	----	----	***-.389	***.551	----
4.GSI				1.00	----	*-.225	----	----	----
5.PROPTUS					1.00	----	**-.298	----	----
6.PSS-Fa						1.00	----	----	----
7.SOMATIC							1.00	**.-309	----
8.Y-INCOME								1.00	----
9.PSS-Fr									1.00

* p<.05; **p<.01; ***p,.001

ASES=Adult Self-Expression Scale

DEPRESS=SCL90-R Depression Domain

GSI=Global Severity Index of the SCL90-R

PROPTUS=Proportion of time spent on the U.S. mainland

PSS-Fa=Perceived Social Support from Family

SOMATIC=SCL90-R Somatic Domain

Y-INCOME=Personal Yearly Income

PSS-Fr=Perceived Social Support from Friends

correlated with level of education (r=.551, p<.001). Subjects who reported higher personal yearly incomes or Y-Income levels were also more likely to report higher levels of education.

**Personal income level was found to be negatively correlated with somatic symptoms (r=-.309, p<.01).

**Perceived social support was found to be negatively correlated with depressive symptomatology. Subjects who reported greater perceived social support from both family (PSS-Fa) and friends (PSS-Fr) also reported fewer depressive symptoms (r=-.266, p<.05; r=-.236, p<.05, respectively). Perceived social support from family (PSS-Fa) was also found to be significantly negatively correlated with overall symptomatology (GSI) (r=-.225, p<.05).

An additional finding revealed that proportion of time spent on the U.S. mainland was negatively correlated with somatization (r=-.298, p<.01). Subjects who reported a greater proportion of time spent on the U.S. mainland also reported fewer somatic symptoms.

Path Analysis

The causal model proposed for this research was examined by path analysis, a technique that interprets linear relationships among a set of variables and where a causal order is hypothesized. Path analysis assumes that causation is unidirectional and that errors are uncorrelated. In path analysis diagrams, proposed causality is represented by straight arrows. Curved arrows are used to represent the correlation between two variables, not causality. Figure 2 illustrates the original proposed model, the estimated

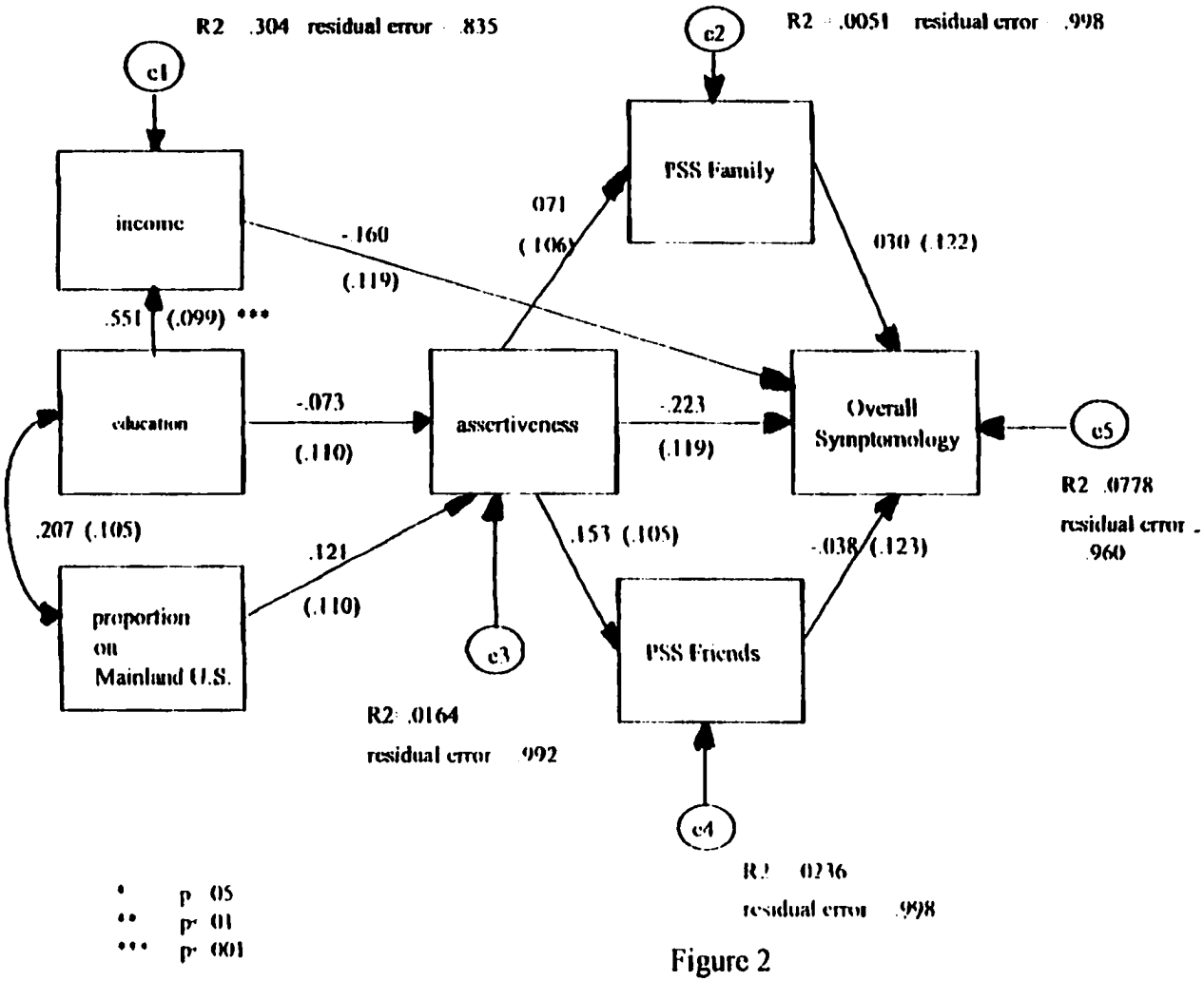
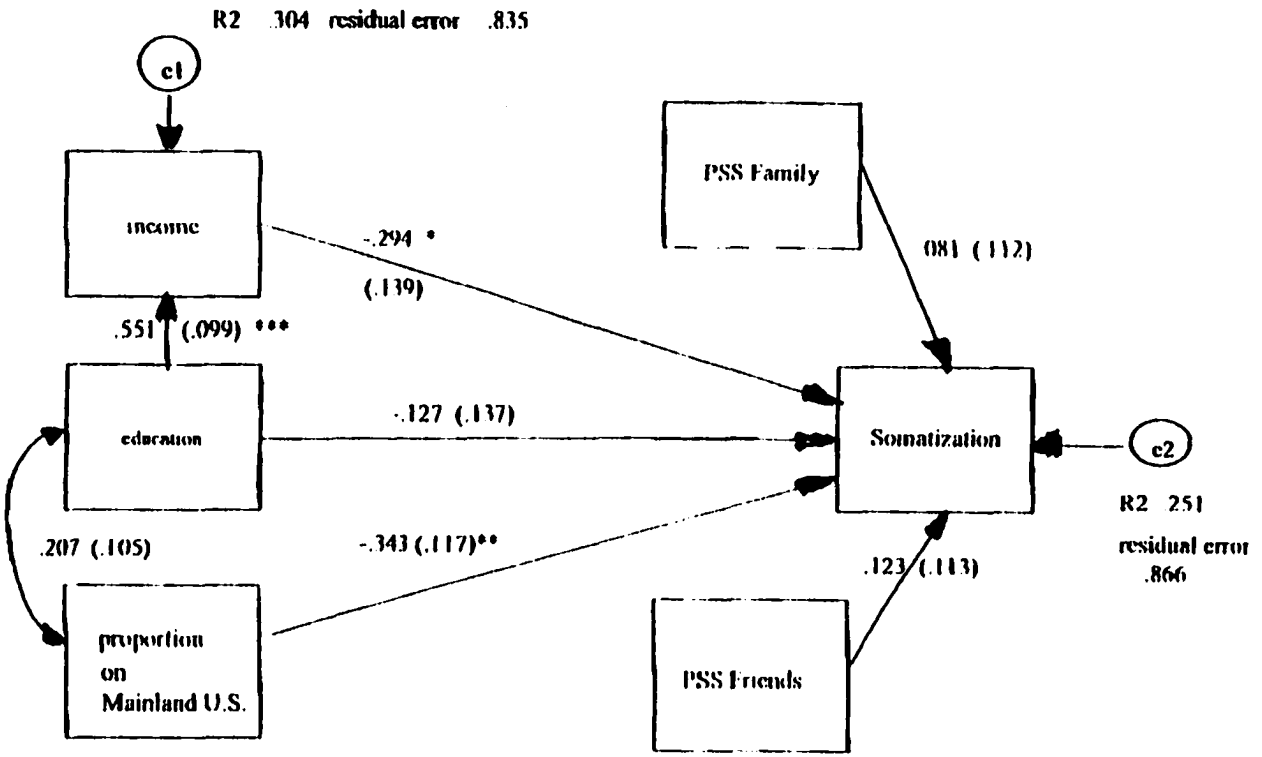


Figure 2

Path Analysis of Conceptual Model of Symptomatology

coefficients associated with each causal path, and the standard errors of the coefficients in parentheses. The original model, with overall symptomatology (GSI), including separate analyses with the depressive and somatization domains, as the final endogenous variable, did not yield statistically significant paths except for level of education, which was found to have a strong direct affect (r=.551, p<.001) on personal yearly income. Results also revealed that proportion of time spent in the U.S. and level of education accounted for less than 2% ($R2$=.0164) of the variance in the level of assertiveness. Similarly, this original model only explained approximately 8% ($R2$=.0778) of the total variance.

Results cited earlier from the correlational analyses conducted revealed highly significant correlation coefficients for a number of variables. Somatization was found to be highy correlated with level of education, level of income, and proportion of time on the U.S. mainland. These correlations suggested an alternative model as illustrated in Figure 3, with the somatic symptoms domain as the final endogenous variable and levels of education and income as exogenous variables, but without assertiveness included in the model since level of education and proportion of time on the U.S. mainland, in the original model, had only accounted for less than 2% of the variance in level of assertiveness. In this alternative causal model, education powerfully and directly affects personal yearly income (r=.551, p<.001) which finally affects somatic symptoms (r=.-294, p<.01). Proportion of time in the U.S. was also found to have a direct effect on somatic symptoms (r=.-343, p<.01). This simplified, alternative model accounts for approximately 25% ($R2$=.251) of the total variance, relatively more than the original



* p < .05
** p < .01
*** p < .001

Figure 3

Path Analysis of Alternative Conceptual Model of Symptomatology

model which only explained approximately 8% (R^2=.078) of the total variance and therefore increases the explanatory power of the model.

Chapter 5

DISCUSSION

General Discussion and Clinical/Research Implications

This study proposed here was based on previous studies conducted on Hispanic women and women, in general, as well as classic and current findings in the field of mental health. The American Psychological Association (APA) Task Force report on Women and Depression (McGrath, et al., 1990) stated the need for researchers to study women from a biopsychosocial perspective because several economic, social, biological, and emotional factors put women at a very high risk for depression. Another APA Task Force finding indicated that depression is related to certain cognitive and personality styles such as pessimism and passivity, respectively. Given such findings, an attempt was made here to systematically study certain factors, including, sociodemographic variables , level of assertiveness, and perceived social support amongst a sample of Puerto Rican women living in the N.Y.C. area and their implications for overall symptomatology, depression, and somatization. A review of the literature revealed that the Adult Self-Expression (ASES), the Perceived Social Support Scales (PSS-Fa, PSS-Fr; for family and friends, respectively), and the Symptom Checklist-90-R (SCL-90-R) were psychometrically adequate measures that had also been widely utilized in research with Puerto Rican women and Hispanics, in general.

A questionnaire, available in English and Spanish, with demographic questions and the selected measures (ASES, PSS, SCL-90-R) was administered to 90 Puerto Rican women in the New York City metropolitan area. Eighty-four of the 90 participants

(93.3%) chose to complete the English version of the questionnaire while the remaining six participants (6.7%) filled out the Spanish version. Major findings were outlined in Table 2, Table 3 and Figure 3.

The data supported a number of the hypotheses, as predicted. Traditionally, the gender role socialization of Puerto Rican women has encouraged the inhibition of assertiveness (Soto, 1979; Comas-Diaz & Duncan, 1985; Gil & Vazquez, 1996) and this inhibition has been linked to depressive symptomatology (Wolf, 1952; Rothenberg, 1964; Soto, 1979, 1983; Culkin & Perritto, 1985; McGrath, et al., 1990). Results based on this sample revealed significant associations between level of reported assertiveness and depressive symptomatology. The Puerto Rican women in the study who reported higher levels of assertiveness also reported less depressive symptoms. However, it is worthy to note that some of the questions from the assertiveness scale (ASES) reflect the Hispanic cultural value of 'respeto' or respect towards one's parents and that responses to such questions may not necessarily suggest pathology. In addition, it is worthy to note that the mean score (see Table 2) on the assertiveness scale, for this entire sample, suggests that, overall, the women in this study revealed a high level of assertiveness. This result and the standard deviation suggest relatively little variability and this may partially explain why the variance accounted for by assertiveness in the original conceptual model, tested by path analysis, was less than 2%. Nonetheless, assertiveness was found to be significantly correlated to depressive symptomatology and assertiveness, as it relates to 'marianismo' in Hispanic culture, is a variable that merits further study as well as remedies and interventions for healthier outcomes.

Assertiveness training, as conducted by mental health clinicians, Sanchez, Lewinsohn, and Larson (1980) and Comas-Diaz and Duncan (1985), resulted in reports of lessened levels of depressive symptoms and higher levels of assertiveness regardless of education, respectively. Mental health clinicians, who work with Puerto Rican and other Hispanic female clients in their practices, can have a positive impact on their clients by addressing unhealthy aspects of the marianista code of behavior (Gil & Vazquez, 1996), which encourages passivity and discourages assertiveness. Clinical work which results in fostering assertiveness skills and support-seeking strategies are some ways in which clinicians can contribute to the empowerment of Hispanic women (Vasquez, 1994).

Past research has found that both education and income levels are both negatively associated with psychological disorders (Amaro & Russo, 1987; Belle, 1990). Torres-Matrullo (1974), in her study on Puerto Rican women in the U.S., found that the more educated women scored consistently lower on all psychopathology scales. Puerto Rican women, in this study, who reported a lower level of education were more likely to report greater overall symptomatology and somatization but the effect of education on somatization was mediated by level of income. Similarly, Puerto Rican women who reported lower personal annual incomes were also more likely to report greater somatic symptoms. Puerto Rican participants who reported higher levels of education also reported higher levels of personal yearly income. These findings raise serious concerns, particularly, when one examines recent census (CPS, 1995) estimates on educational attainment, which reveal that in 1994, 31% of Hispanic adults had less than a 9th grade

education. Equally concerning is the finding that Puerto Rican families still have the highest poverty rate (35%) of all Hispanic groups (CPS, 1995). This data and the study findings suggest the need for viable programs that will break the cycle of poverty and provide greater opportunities for Puerto Rican women to obtain higher levels of education as well as job opportunities that will lead to higher earning potentials.

Past research done on social support and psychological disorders has consistently revealed that a lack of support is associated with symptomatology (Leavy, 1983). Studies on social support suggest that it is the quality of support that is more important for psychological health and well-being than the mere existence of a spouse/confidant or the quantity of support that is available to an individual (Leavy, 1983). Sarason, Sarason, and Pierce (1990), in their comprehensive review of research and theories on social support, emphasize the importance of 'perceived' social support as evidenced by highly consistent findings that the perception of social support is what is most closely related to mental health outcomes. The importance of the role of the nuclear and extended family has been documented by numerous social science researchers and theoreticians of Puerto Rican and Hispanic support systems. However, few have systematically examined the relationship between 'perceived' social support from one's family and mental health outcomes amongst Puerto Rican women. Similarly, less is known about the perception of social support from one's friends and its impact on the psychological well-being of Puerto Rican women.

A major contribution of this research was the systematic study of perceived social support from family and friends amongst Puerto Rican women living in New York City.

This study revealed that Puerto Rican women who reported lower perceived social support from family and friends also reported greater depressive symptomatology. Those who reported less perceived social support from family also reported greater overall symptomatology. These findings suggest that in spite of changing social and economic conditions and changing role expectations that have impacted upon and challenged the traditional Puerto Rican family structure, the family still influences mental health outcomes. The women in this study who appraised or perceived that their family and friends fulfilled their needs for support, information, and feedback, were less likely to report depressive symptomatology. One would expect the perceived social support from friends to take on greater importance, amongst Puerto Rican women, given the increasing number of Puerto Rican female heads of households (CPS, 1995) and changing living arrangements that are inconsistent with the gender stereotypes of Hispanic women (Amaro, et al., 1987).

Path analyses conducted with overall symptomatology, (GSI -Global Severity Index-SCL-90-R), depression (SCL-90-R domain), and somatization (SCL-90-R subscale) as endogenous variables, in the original model proposed, did not result in significant causal pathways or sufficient variance contributing to the explanatory power of the model except for level of education, which was found to have a strong direct effect on personal yearly income. This latter finding is consistent with past reports and with 1993 data on the educational attainment of Hispanics, which revealed that the median earnings of Hispanic females increased with higher levels of education (CPS, 1995).

An alternative path analysis model revealed a causal pathway whereby education

strongly affects personal yearly income which in turn affects somatic symptoms. Amaro and Russo (1987) noted that education is an important factor in mental health outcomes. In her study with Puerto Rican women in the United States, Torres-Matrullo (1974) found significant differences in psychopathology among women with different levels of education. Similar to the correlational findings of the research conducted here, the more educated women were in her study, the lower they scored on all psychopathology scales. However, the alternative path analysis model and additional path analyses revealed that education did not have a direct effect on somatization, that its effect on somatization was indirect, i.e., mediated by income. Level of income did have a direct effect on somatization and this finding is highly consistent with the well-established association between income and psychological distress cited in the literature (Belle, 1990). The APA Task Force (McGrath, et al., 1990) also found that poverty is a major risk factor for psychological disorders. In their study on Hispanic female professionals, Amaro, et al. (1987) found that women who reported fewer psychological distress symptoms were more likely to have a higher income.

Findings based on the alternative model suggest that the Puerto Rican women in disadvantaged social positions in this study are more likely to express psychological distress, in the form of somatization, than those in higher income brackets. In their review of the literature, Canino and Canino (1993) note that for the past 30 years, 'ataques de nervios' (nerve attacks), a form of somatization, have been described as a 'culturally defined' syndrome, typically found amongst Puerto Ricans and other Hispanic groups. Canino and Canino cite past epidemiological data, on Puerto Rican adults,

which suggests that somatization or 'ataques de nervios' (nerve attacks) were more prevalent among women over 40, with low education, and from low socioeconomic backgrounds but approximately two-thirds of these women also met the criteria for either an anxiety or depressive disorder. Canino and Canino note that these findings raised some question about the 'ataque' as an expression of distress and suggested the possibility that the 'ataque' syndrome may also be a cultural idiom used by Puerto Ricans to describe depression and anxiety.

The alternative path analysis model did not yield statistically significant paths nor did it account for sufficient variance when depression and overall symptomatology were entered into the model as endogenous variables. However, the alternative path analysis model did yield significant paths and had greater explanatory power when somatization was entered into model. There may be a number of reasons for this finding. This result suggests that perhaps the alternative model is a better model to test for somatization, particularly given that past findings have linked income and education levels with somatization. In this research, income had a direct affect on somatization while the effect of education on somatization was indirect through income. Secondly, the alternative model may have yielded significant results because somatization, particularly the 'ataque,' is salient in Hispanic populations and is a culturally specified form of symptom expression (Canino & Canino, 1993; Rivera-Arzola & Ramos-Grenier, 1997). Canino and Canino point out that given the frequency of reported somatic symptoms within the Puerto Rican population, clinicians need to consider the possible impact that cultural values may have on symptom expression. Rivera-Arzola and Ramos-Grenier

(1997) note that Puerto Rican cultural values and traditions, which discourage assertiveness, may in turn influence the way symptoms are manifested and that somatization, including 'ataques,' appear to reflect a culture-specific response to distress rather than a purely pathological one.

Results indicated that the greater the proportion of time a woman spent on the United States mainland, the less likely she was to report psychosomatic symptoms and this finding was statistically significant, suggesting some form of adaptation as the time spent on the U.S. mainland increases. Soto (1979) looked at 'age of arrival' to the U.S. mainland and found that it was a more adequate variable in accounting for differences than looking at first generation (women born in Puerto Rico) and second generation of Puerto Rican women (women born on the U.S. mainland). Age of arrival data was collected here, however, approximately 88% of the women studied were born on the U.S. mainland and therefore, 'age of arrival' could not be adequately analyzed. A future study with greater variability in both the 'age of arrival' and 'proportion of time spent on the U.S. mainland' factors might explain a greater portion of the variance in a similar model. Nonetheless, the variance accounted for by the alternative model greatly increased the explanatory power of the model as compared with the original model. However, both models left a portion of the variance unaccounted for and possible explanations for this will be discussed later, in the 'limitations of the study' section.

The APA Task Force (1990) emphasized not only the need for future research on women that examines women's personality and psychological characteristics and poverty, but studies that systematically examine women's life circumstances, including

victimization, social roles, reproductive events, and other biological factors, all of which may put a women at high risk for depression. Clearly, numerous exogenous variables aside from those examined here, which included level of education and income, may be mediating factors or variables directly affecting overall symptomatology, depression, and somatization.

Overall results suggest that greater economic and educational opportunities as well as assertiveness training programs for Puerto Rican women and other Hispanic women would be highly beneficial but these may not suffice. Discrimination, faced by mainland Puerto Rican women can, for instance, affect educational and employment opportunities (Comas-Diaz & Duncan, 1985). The Puerto Rican woman can experience psychological distress as an ethnic minority. In their study on highly educated, higher income professional Hispanic women, Amaro et al. (1987) found that discrimination, as experienced by these women, was related to distress symptoms. Padilla and Ruiz (1973) note that Hispanics "experience a great deal of stress, related to poor communication skills in English, the poverty cycle, and acculturation to a society that appears prejudicial, hostile, and rejecting (p.467) (as cited in Comas-Diaz & Duncan, 1985)." Rivera-Arzola and Ramos-Grenier (1997) point out that Puerto Rican women are at great risk for health and mental health problems, not only due to a high poverty rate, but to stress from prejudice, discrimination, and emigration as well as language-related barriers. Vasquez (1994) also notes that the recurrence of racist events can result in depression, anxiety, and post-traumatic stress disorders. Clearly, the possible impact that the experience of discrimination may have on mental health outcomes cannot be overlooked.

Distress resulting from the process of acculturation, which was not directly assessed here with traditional measures, is also a factor that might be explored systematically in future studies along with 'age of arrival' to the U.S. mainland and the 'proportion of time' spent on the U.S. mainland. Acculturation has been recognized as an important construct that has implications for mental health outcomes. Past research with Hispanics, involving the use of established acculturation measures, has rendered useful information. However, in her article based on a recent conference on acculturation, a conference partly sponsored by the American Psychological Association, Azar (1999) writes that research findings from the past two decades have been limited by problems in the way acculturation has been conceptualized and measured. Most commonly used measures of acculturation have been based on a traditional, linear model (Azar, 1999). Rogler, Cortes, and Malgady (1991) note that the use of a linear, single continuum model of acculturation yields limited information in research, in that, this model assumes that as one's acculturation to American culture increases, one's identification with one's own culture decreases. Clearly, this is not always the case since a person can be highly acculturated to American culture while being strongly identified with his or her own culture (as cited in Garcia & Zea, 1997). As contemporary researchers move towards reconceptualizing acculturation as a more complex and multidimensional construct, rather than a linear one, the measurement of both the risk factors as well as the health protective aspects of acculturation will become possible (Azar, 1999) and its contribution to any study of Hispanic women, along with other factors indicated so far, will be greatly optimized. Clinicians Gil and Vazquez (1996) address the issues of acculturation and

Hispanic traditions and write about the psychotherapeutic benefit of moving away from the self-defeating aspects of 'marianismo,' towards a more empowered self that holds on to one's traditions in a healthy manner.

Limitations of the Study

One of the limitations of this research, which may have affected overall results, is sampling bias. The procedure for recruiting Puerto Rican women for this study was done in a confidential and anonymous manner and no identifying data was linked to any of the participants. While this procedure may have resulted in greater reliability in that participants may have felt more comfortable about responding to questions in an open, honest manner, the procedure did not make it possible for the researcher to monitor the data and insure greater variability in certain sociodemographic factors. In addition, the Puerto Rican women were originally recruited from persons active in the Puerto Rican community. Consequently, approximately 67% of the women were currently employed; close to 88% of the participants were born and raised on the U.S. mainland; approximately 57% of the sample had some college or greater education; and about 93% (84 out of the 90) of the women filled out the English version as opposed to the Spanish version (suggesting some undetermined level of acculturation). In addition, while the March 1994 census estimates (CPS, 1995) indicated that the median income of Puerto Rican families, in 1993, was $19,700, the median personal yearly income, i.e., the income reported by the participants (73 out of the 90) as being their own, was $23.000. This data suggest that this group of women was not a representative sample of the entire population nor did this sample represent the segment of the Puerto Rican population that

has minimal education and an exceedingly high poverty rate.

The demographics of this sample, as previously noted, may have influenced overall results. An examination of the standard deviations (see Table 2) suggest little variability and the mean scores revealed that the Puerto Rican women in this study evidenced a high level of assertiveness, low levels of overall symptomatology, depression, and somatization, and relatively high levels of perceived social support from family and friends. While these results are encouraging, these results may partially explain why the original conceptual model, when tested by path analysis, did not yield significant results, why assertiveness accounted for less than 2% of the variance, and why the original model had minimal explanatory power.

Another reason as to why both the original and alternative models left some of the total variance unaccounted for is that numerous factors, besides those examined here and beyond the scope of this dissertation research, may have a direct or indirect affect on symptomatology.

An additional limitation of the study may have been related to the number of subjects; a greater number of subjects may have resulted in greater variability and the original model, with assertiveness entered into the model, may have accounted for a greater amount of the total variance. Another possible limitation of the study is that Puerto Rican women, who were already very assertive and who were experiencing relatively less distress in their lives, may have been more likely to complete the study questionnaire.

In spite of biases that may have been linked to the sampling procedure, overall

results from this sample of Puerto Rican women offered rich and informative data that have important clinical and research implications.

Additional Directions for Future Research

This study revealed the importance of numerous variables, such as assertiveness which traditionally has been contraindicated by 'marianismo', perceived support from one's family and friends, level of education, and personal income, and their implications for mental health outcomes. Additional contributions to the literature on Puerto Rican women and mental health may be possible with a much larger-scale study, one with a greater number of subjects and greater variability in sociodemographic factors. The inclusion of a clinical control group would also render more informative results. A future study should encompass a cultural, socio-economic, and psychosocial perspective and include an assessment of victimization and discrimination if the goal is to learn more about why some Puerto Rican women develop psychological distress while others are able to adapt and persevere similar life circumstances on the U.S. mainland. Health-related and biological factors might also have important implications for depression and other forms of symptomatology and these variables, along with psychosocial and environmental factors, should also be addressed in future studies with Puerto Rican women and women, in general. Information obtained from such research can be very beneficial to health practitioners and clinicians who work with Hispanics in the mental health field as well as public policymakers and those involved in developing programs for Hispanics.

Appendix A

Questionnaires

(English and Spanish Versions)

SURVEY OF PUERTO RICAN WOMEN IN NEW YORK CITY
(ENGLISH VERSION)

REMINDER: Your Responses are Confidential! Do not write your name on the Questionnaire.

1. Your Age_____

2. Place of Birth
   1. Mainland United States
   2. Puerto Rico
   3. Other Location (Specify)_____

3. If you were born in the Mainland United States (or other location) but you have lived in Puerto Rico:
   1. How old were you when you moved to Puerto Rico:
      a. Age_____
      How old were you when you moved back to the United States:
      b. Age_____
   2. Not applicable, I have not lived in Puerto Rico

4. If you were born in Puerto Rico, how old were you when you moved to the Mainland United States?
   1. Your Age_____
   2. Not applicable, I was born in the Mainland United States (or other location)

5. Where do you feel you were primarily raised?
   1. Mainland United States
   2. Puerto Rico
   3. Other Location (Specify)_____

6. How long have you lived in the Mainland United States?_____

7. Are you heterosexual?
   1. Yes
   2. No_____

8. Current Marital Status
   1. Single
   2. Married
   3. Separated
   4. Divorced
   5. Widowed

9.Do you live with your spouse / boyfriend / partner?

1.Yes_____
2.No_____
3.Not applicable, I do not have a spouse / boyfriend / partner.

10.Do you live alone?

1.Yes_____
2.No_____
a.If no, how many people, counting yourself, live in your household?____
b.What are their relationships to you (For example: my husband, 2 sons...)
_____

11.Do you have children?

1.Yes_____
a.If yes, how many children do you have?_____
b.What are their ages?_____
2.No_____

12.Aside from any time spent alone, Who do you spend most of your free time with? (Select one answer only):

1.Spouse / Boyfriend / Partner_____
2.Parents / Relatives_____
3.Friends_____
4.Co-workers_____
5.Other (Specify)_____

13.Do you work?

1.Yes_____
a.Specify occupation_____
2.No_____
3.I am only out of work temporarily. My occupation has been_____

14.What is the highest level of education that you have completed?

1.Less than eighth grade_____
2.Eighth grade_____
3.Ninth grade_____
4.Some High School (10th or 11th grade)_____
5.High School diploma or equivalent (e.g. GED)_____
6.Vocational training completed (Specify)_____
7.Some college (at least one year)_____
8.College degree_____
9.Graduate School (Indicate highest degree)_____

15.Where does most of your family live?

1.Mainland United States_____

2.Puerto Rico_____

3.Other Location (Specify)_____

16.Approximately, what is your annual income?__$_____per year

17.Do you receive public assistance?

1.Yes_____

2.No_____

18.If others in your household work or receive public assistance, approximately, what is the total annual income in your household (include your income in this total)?:

__$_____per year

19.Comments:

This section will get information on the way you express yourself. Circle the number which shows how you generally express yourself in the situations described. If a particular situation does not apply to you, answer as you think you might respond in that situation. Your answer should not reflect how you think you ought to act or how you would like to act, but how you really do act. Work quickly. Your first answer is usually the best.

	Almost Always OR Always	Usually	Sometimes	Seldom OR Rarely	Never
1. Do you ignore it when someone pushes in front of you in a line?	1	2	3	4	5
2. Do you find it difficult to ask a friend to do you a favor?	1	2	3	4	5
3. If your boss or supervisor makes what you consider to be an unreasonable request, do you have difficulty saying "no"?	1	2	3	4	5
4. Are you reluctant to speak to an attractive person of the opposite sex?	1	2	3	4	5
5. Is it difficult for you to refuse unreasonable requests from your parents?	1	2	3	4	5
6. Do you find it difficult to accept compliments from your boss or supervisor?	1	2	3	4	5
7. Do you express your negative feelings to others when appropriate?	1	2	3	4	5
8. Do you freely volunteer information or opinions in discussions with people whom you do not know very well?	1	2	3	4	5
9. If there was a public figure whom you greatly admired and respected at a large social gathering, would make an effort to introduce yourself?	1	2	3	4	5

10. How often do you openly express justified feelings of anger to your parents?	1	2	3	4	5
11. If you have a friend of whom your parents do not approve, do you make an effort to get them to know one another better?	1	2	3	4	5
12. If you were watching a TV program in which you were interested and a close relative was disturbing you, would you ask them to be quiet?	1	2	3	4	5
13. Do you play an important part in deciding how you and your friends spend leisure time together?	1	2	3	4	5
14. If you are angry at your spouse / boyfriend or girlfriend, is it difficult for you to tell him or her?	1	2	3	4	5
15. If a friend who is supposed to pick you up for an important engagement calls 15 minutes before he(she) is supposed to be there and says that he cannot make it, do you express your annoyance?	1	2	3	4	5
16. If you approve of something your parents do, do you express your approval?	1	2	3	4	5
17. If in a rush you stop by a super-market to pick up a few items, would you ask to go before someone in the checkout line?	1	2	3	4	5
18. Do you find it difficult to refuse the requests of others?	1	2	3	4	5

19. If your boss or supervisor expresses opinions with which you strongly disagree, do you venture to state your own point of view?	1	2	3	4	5
20. If you have a close friend whom your spouse/boyfriend or girlfriend dislikes and constantly criticizes, would you inform them that you disagree and tell them of your friend's assets?	1	2	3	4	5
21. Do you find it difficult to ask favors of others?	1	2	3	4	5
22. If food which was not to your satisfaction was served in a good restaurant, would you bring it to the waiter's attention?	1	2	3	4	5
23. Do you tend to drag out your apologies?	1	2	3	4	5
24. When necessary, do you find it difficult to ask favors of your parents?	1	2	3	4	5
25. Do you insist that others do their fair share of the work?	1	2	3	4	5
26. Do you have difficulty saying no to salesmen?	1	2	3	4	5
27. Are you reluctant to speak up in a discussion with a small group of friends?	1	2	3	4	5
28. Do you express anger or annoyance to your boss or supervisor when it is justified?	1	2	3	4	5
29. Do you compliment and praise others?	1	2	3	4	5

30. Do you have difficulty asking a close friend to do an important favor even though it will cause them some inconvenience?	1	2	3	4	5
31. If a close relative makes what you consider to be an unreasonable request, do you have difficulty saying no?	1	2	3	4	5
32. If your boss or supervisor makes a statement that you consider untrue, do you question it aloud?	1	2	3	4	5
33. If you find yourself becoming fond of a friend, do you have difficulty expressing these feelings to that person?	1	2	3	4	5
34. Do you have difficulty exchanging a purchase with which you are dissatisfied?	1	2	3	4	5
35. If someone in authority interrupts you in the middle of an important conversation, do you request that the person wait until you have finished?	1	2	3	4	5
36. If a person of the opposite sex whom you have been wanting to meet directs attention to you at a party, do you take the initiative in beginning the conversation?	1	2	3	4	5
37. Do you hesitate to express resentment to a person who has unjustifiably criticized you?	1	2	3	4	5
38. If your parents wanted you to come home for a weekend visit and you had made important plans, would you change your plans?	1	2	3	4	5

39. Are you reluctant to speak up in a discussion or debate?	1	2	3	4	5
40. If a friend who has borrowed $5.00 from you seems to have forgotten about it, is it difficult for you to remind this person?	1	2	3	4	5
41. If your boss or supervisor teases you to the point that it is no longer fun, do you have difficulty expressing your displeasure?	1	2	3	4	5
42. If your spouse/boyfriend or girlfriend is blatantly unfair, do you find it difficult to say something about it to them?	1	2	3	4	5
43. If a clerk in a store waits on someone who has come in after you when you are in a rush, do you call his attention to the matter?	1	2	3	4	5
44. If you lived in an apartment and the landlord failed to make certain repairs after it had been brought to his attention, would you insist on it?	1	2	3	4	5
45. Do you find it difficult to ask your boss or supervisor to let you off early?	1	2	3	4	5
46. Do you have difficulty verbally expressing love and affection to your spouse/boyfriend or girlfriend?	1	2	3	4	5
47. Do you readily express your opinions to others?	1	2	3	4	5
48. If a friend makes what you consider to be an unreasonable request, are you able to refuse?	1	2	3	4	5

The statements which follow refer to feelings and experiences which occur to most people at one time or another in their relationships with their families. For each statement there are three possible answers: Yes, No, Don't know. Please circle the answer you choose for each item.

Circle One

Yes No Don't know 1. My family gives me the moral support I need

Yes No Don't know 2. I get good ideas about how to do things from my family

Yes No Don't know 3. Most other people are closer to their family than I am

Yes No Don't know 4. When I confide in the members of my family who are closest to me, I get the idea that it makes them uncomfortable.

Yes No Don't know 5. My family enjoys hearing about what I think

Yes No Don't know 6. Members of my family share many of my interests

Yes No Don't know 7. Certain members of my family come to me when they have problems or need advice

Yes No Don't know 8. I rely on my family for emotional support

Yes No Don't know 9. There is a member of my family I could go to if I were just feeling down, without feeling funny about it later

Yes No Don't know 10. My family and I are very open about what we think about things

Yes No Don't know 11. My family is sensitive to my personal needs

Yes No Don't know 12. Members of my family come to me for emotional support

Yes No Don't know 13. Members of my family are good at helping me solve problems

Yes No Don't know 14. I have a deep sharing relationship with a number of members of my family

Yes No Don't know 15. Members of my family get good ideas about how to do things or make things from me

Yes No Don't know 16. When I confide in members of my family, it makes me uncomfortable

Yes No Don't know 17. Members of my family seek me out for companionship

Yes No Don't know 18. I think that my family feels that I'm good at helping them solve problems

Yes No Don't know 19. I don't have a relationship with a member of my family that is as close as other people's relationships with family members

Yes No Don't know 20. I wish my family were very much different

The statements which follow refer to feelings and experiences which occur to most people at one time or another in their relationships with friends. For each statement there are three possible answers: Yes, No, Don't know. Please circle the answer you choose for each item.

Circle One

Yes No Don't know 1. My friends give me the moral support I need

Yes No Don't know 2. Most other people are closer to their friends than I am

Yes No Don't know 3. My friends enjoy hearing about what I think

Yes No Don't know 4. Certain friends come to me when they have problems or need advice

Yes No Don't know 5. I rely on my friends for emotional support

Yes No Don't know 6. If I felt that one or more of my friends were upset with me, I'd just keep it to myself

Yes No Don't know 7. I feel that I'm on the fringe in my circle of friends

Yes No Don't know 8. There is a friend I could go to if I were just feeling down, without feeling funny about it later

Yes No Don't know 9. My friends and I are very open about what we think about things

Yes No Don't know 10. My friends are sensitive to my personal needs

Yes No Don't know 11. My friends come to me for emotional support

Yes No Don't know 12. My friends are good at helping me solve problems

Yes No Don't know 13. I have a deep sharing relationship with a number of friends

Yes No Don't know 14. My friends get good ideas about how to do things or make things from me

Yes No Don't know 15. When I confide in friends, it makes me uncomfortable

Yes No Don't know 16. My friends seek me out for companionship

Yes No Don't know 17. I think that my friends feels that I'm good at helping them solve problems

Yes No Don't know 18. I don't have a relationship with a friend that is as intimate as other people's relationships with friends

Yes No Don't know 19. I've recently gotten a good idea about how to do something from a friend

Yes No Don't know 20. I wish my friends were much different

Below is a list of problems and complaints that people sometimes have. Please read each one carefully. After you have done so, please circle the number that best describes HOW MUCH THAT PROBLEM HAS BOTHERED OR DISTRESSED YOU DURING THE PAST FEW MONTHS INCLUDING TODAY. Circle only one response for each problem. Please do not skip any items.

	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
1. Headaches	1	2	3	4	5
2. Nervousness or shakiness inside	1	2	3	4	5
3. Unwanted thoughts, words or ideas that won't leave your mind	1	2	3	4	5
4. Faintness or dizziness	1	2	3	4	5
5. Loss of sexual interest or pleasure	1	2	3	4	5
6. Feeling critical of others	1	2	3	4	5
7. The idea that someone else can control your thoughts	1	2	3	4	5
8. Feeling others are to blame for most of your troubles	1	2	3	4	5
9. Trouble remembering things	1	2	3	4	5
10. Worried about sloppiness or carelessness	1	2	3	4	5
11. Feeling easily annoyed or irritated	1	2	3	4	5
12. Pains in heart or chest	1	2	3	4	5
13. Feeling afraid in open spaces or on the streets	1	2	3	4	5
14. Feeling low in energy or slowed down	1	2	3	4	5

15. Thoughts of ending your life	1	2	3	4	5
16. Hearing voices that other people do not hear	1	2	3	4	5
17. Trembling	1	2	3	4	5
18. Feeling that most people cannot be trusted	1	2	3	4	5
19. Poor appetite	1	2	3	4	5
20. Crying easily	1	2	3	4	5
21. Feeling shy or uneasy with the opposite sex	1	2	3	4	5
22. Feeling of being trapped or caught	1	2	3	4	5
23. Suddenly scared for no reason	1	2	3	4	5
24. Temper outbursts that you could not control	1	2	3	4	5
25. Feeling afraid to go out of your house alone	1	2	3	4	5
26. Blaming yourself for things	1	2	3	4	5
27. Pains in lower back	1	2	3	4	5
28. Feeling blocked in getting things done	1	2	3	4	5
29. Feeling lonely	1	2	3	4	5
30. Feeling blue	1	2	3	4	5
31. Worrying too much about things	1	2	3	4	5
32. Feeling no interest in things	1	2	3	4	5

33. Feeling tearful	1	2	3	4	5
34. Your feelings being easily hurt	1	2	3	4	5
35. Other people being aware of your private thoughts	1	2	3	4	5
36. Feeling others do not understand you or are unsympathetic	1	2	3	4	5
37. Feeling that people are unfriendly or dislike you	1	2	3	4	5
38. Having to do things very slowly to insure correctness	1	2	3	4	5
39. Heart pounding or racing	1	2	3	4	5
40. Nausea or upset stomach	1	2	3	4	5
41. Feeling inferior to others	1	2	3	4	5
42. Soreness of your muscles	1	2	3	4	5
43. Feeling that you are watched or talked about by others	1	2	3	4	5
44. Trouble falling asleep	1	2	3	4	5
45. Having to check and double check what you do	1	2	3	4	5
46. Difficulty making decisions	1	2	3	4	5
47. Feeling afraid to travel on buses, subways or trains	1	2	3	4	5
48. Trouble getting your breath	1	2	3	4	5
49. Hot or cold spells	1	2	3	4	5

50. Having to avoid certain things, places or activities because they frighten you	1	2	3	4	5
51. Your mind going blank	1	2	3	4	5
52. Numbness or tingling in parts of your body	1	2	3	4	5
53. A lump in your throat	1	2	3	4	5
54. Feeling hopeless about the future	1	2	3	4	5
55. Trouble concentrating	1	2	3	4	5
56. Feeling weak in parts of your body	1	2	3	4	5
57. Feeling tense or keyed up	1	2	3	4	5
58. Heavy feelings in your arms and legs	1	2	3	4	5
59. Thoughts of death or dying	1	2	3	4	5
60. Overeating	1	2	3	4	5
61. Feeling uneasy when people are watching or talking to you	1	2	3	4	5
62. Having thoughts that are not your own	1	2	3	4	5
63. Having urges to beat, injure or harm someone	1	2	3	4	5
64. Awakening in the early morning	1	2	3	4	5
65. Having to repeat the same actions such as touching, counting, washing	1	2	3	4	5

66. Sleep that is restless or disturbed	1	2	3	4	5
67. Having urges to break or smash things	1	2	3	4	5
68. Having ideas or beliefs that others do not share	1	2	3	4	5
69. Feeling very self-conscious with others	1	2	3	4	5
70. Feeling uneasy in crowds, such as shopping or at a movie	1	2	3	4	5
71. Feeling everything is an effort	1	2	3	4	5
72. Spells of terror or panic	1	2	3	4	5
73. Feeling uncomfortable about eating or drinking in public	1	2	3	4	5
74. Getting into frequent arguments	1	2	3	4	5
75. Feeling nervous when you are left alone	1	2	3	4	5
76. Others not giving you proper credit for your achievements	1	2	3	4	5
77. Feeling lonely even when you are with people	1	2	3	4	5
78. Feeling so restless you couldn't sit still	1	2	3	4	5
79. Feelings of worthlessness	1	2	3	4	5
80. Feeling that familiar things are strange or unreal	1	2	3	4	5
81. Shouting or throwing things	1	2	3	4	5

82. Feeling afraid you will faint in public	1	2	3	4	5
83. Feeling that people will take advantage of you if you let them	1	2	3	4	5
84. Having thoughts about sex that bother you a lot	1	2	3	4	5
85. The idea that you should be punished for your sins	1	2	3	4	5
86. Feeling pushed to get things done	1	2	3	4	5
87. The idea that something serious is wrong with your body	1	2	3	4	5
88. Never feeling close to another person	1	2	3	4	5
89. Feelings of guilt	1	2	3	4	5
90. The idea that something is wrong with your mind	1	2	3	4	5

INFORME SOBRE LA MUJER PUERTORRIQUENA VIVIENDO EN LA CUIDAD
DE
NUEVA YORK
(SPANISH VERSION)

RECUERDE: Sus Respuestas son Confidencial! No escriba su nombre en el Cuestionario.

1.Su Edad_____

2.Sitio de Nacimiento
1.Estados Unidos
2.Puerto Rico
3.Otro Lugar (Especifique)_____

3.Si nacio en los Estados Unidos (o otro lugar) pero ha vivido en Puerto Rico:
1.Que edad tenia usted cuando se mudo a Puerto Rico:
a.Su Edad_____
Que edad tenia usted cuando se mudo de nuevo a los Estados Unidos:
b.Su Edad_____
2.Esto no me aplica porque no he vivido en Puerto Rico

4.Si nacio en Puerto Rico, cuantos anos tenia usted cuando se mudo a los Estados Unidos?
1.Su Edad_____
2.Esto no me aplica porque naci en los Estados Unidos (o otro lugar)

5.Donde considera que fue criada?
1.Estados Unidos
2.Puerto Rico
3.Otro Lugar (Especifique)_____

6.Cuanto tiempo tiene usted viviendo en los Estados Unidos?_____

7.Eres Heterosexual?
1.Yes
2.No

8.Actualmente, cual es su estado marital?
1.Soltera
2.Casada
3.Separada
4.Divorciada
5.Viuda

9.Vive usted con su esposo / novio / companera?

1.Si_____
2.No____
3.Esto no me aplica porque no tengo esposo / novio / companera

10.Vive usted sola?

1.Si_____
2.No_____
a.Si contesto No, cuantas personas, contando usted misma, viven en su casa?_____
b.Que relacion tienen ellos con usted(Por ejemplo: mi esposo, 2 hijos(as))
_____

11.Tiene usted hijo (s) / hija (s)?

1.Si_____
a.Cuantos hijo (s) / hija (s) tiene usted?_____
b.Cuantos anos tiene cada nino (a)?_____
2.No_____

12.Ademas de tiempo que pase sola, Con quien pasa la mayor parte de su tiempo libre? (Escoja una respuesta solamente):

1.Esposo / Novio / Companera_____
2.Padres / Familia_____
3.Amistades_____
4.Trabajadores de su lugar de trabajo_____
5.Otras Personas (Especifique)_____

13.Usted trabaja?

1.Si_____
a.Especifique su ocupacion_____
2.No_____
3.Estoy temporariamente sin trabajo. Mi ocupacion ha sido:_____

14.Cual es el grado mas alto de educacion que usted ha completado?

1.Menos de octavo grado_____
2.Octavo grado_____
3.Noveno grado_____
4.Un tiempo en la escuela secundaria (grado 10 o 11)_____
5.Diploma de la escuela secundaria o equivalente (por ejemplo, GED)_____
6.Escuela vocacional (Especifique)_____
7.Un tiempo en la universidad (por lo menos un ano)_____
8.Diploma de la universidad_____
9.Escuela graduada (Indique el diploma mas alto)_____

15.Donde vive la mayoria de su familia?

1.Estados Unidos_____
2.Puerto Rico_____
3.Otro Lugar (Especifique)_____

16.Aproximadamente, cual es su ingreso anual?__$_____al ano

17.Recibe asistencia publica?

1.Si_____
2.No_____

18.Si otras personas en su casa trabajan o reciben asistencia publica, cual es el ingreso total anual de su casa (incluya su ingreso en este total)?:

__$_____al ano

19.Comentarios:

Esta seccion sera para obtener informacion acerca de su manera de expresarse. Circule el numero que mejor le corresponde a la manera en que generalmente usted se expresa. Si la situacion particular no le aplica, conteste como usted cree que respondera bajo esa situacion. Su contestacion no debe reflejar como usted cree que debe actuar, sino como en realidad usted actuaria. Trabaje rapido, su primera respuesta usualmente es la mejor.

	Casi siempre O Siempre	Ordinariamente	A veces	Rara vez	Nunca O Por rareza
1. ¿Ignora cuando una persona la empuja y se pasa frente a usted en una fila?	1	2	3	4	5
2. ¿Se le hace dificil pedir un favor a un(a) amigo(a)?	1	2	3	4	5
3. ¿Si su jefe o supervisor le pide un favor que no considera razonable se le hace dificil decirle que "no"?	1	2	3	4	5
4. ¿Se le hace dificil hablar con una persona atractiva del sexo opuesto?	1	2	3	4	5
5. ¿Se le hace dificil rechazar demandas que no son razonables de sus padres?	1	2	3	4	5
6. ¿Se le hace dificil aceptar complementos de su jefe o supervisor?	1	2	3	4	5
7. ¿Expresa sus sentimientos negativos hacia otros cuando es apropriado?	1	2	3	4	5
8. ¿Expresa libre y voluntariamente informacion y opiniones en discusiones con gente que no conoce muy bien?	1	2	3	4	5
9. ¿Si en una reunion social se encuentra una figura publica muy admirada y respetada, haria el esfuerzo de presentarse usted misma?	1	2	3	4	5

10. ¿Cuantas veces ha expresado abiertamente a sus padres un enojo que usted cree justificado?	1	2	3	4	5
11. ¿Si tiene un amigo(a) del cual sus padres no aprueban, hace el esfuerzo para que se conozcan mejor?	1	2	3	4	5
12. ¿Si esta viendo un programa de television del cual esta muy interesada, y un pariente cercano la esta pertubando, le pediria que se callara?	1	2	3	4	5
13. ¿Toma papel importante en tomar decisiones a como pasaran ratos libres usted y sus amistades?	1	2	3	4	5
14. ¿Si usted se enoja con su esposo(a) /novio(a), se le hace dificil decirlo?	1	2	3	4	5
15. ¿Si la persona con quien tiene cita llama quince minutos antes de lo que se supone que la recoga y dice que no puede ir, le expresaria su molestia?	1	2	3	4	5
16. ¿Si aprueba de algo que sus padres hacen, se lo expresa?	1	2	3	4	5
17. ¿Si estando de prisa, hace parada en un colmado para comprar algunos articulos, pediria poder adelantarse en la fila para pagar?	1	2	3	4	5
18. ¿Se le hace dificil rechazar los pedidos de otros?	1	2	3	4	5
19. ¿Si su jefe o supervisor expresa opiniones de las cuales no esta de acuerdo, se atreveria dejarle saber su punto de vista?	1	2	3	4	5

20. ¿Si tiene un amigo(a) intimo(a) que le desagrada a su esposo/novio o esposa/ novia y al cual el(ella) critica, le informa que no esta de acuerdo y le dice de los atributos personales de su amigo(a)?	1	2	3	4	5
21. ¿Se le hace dificil pedir favores a otros?	1	2	3	4	5
22. ¿Si no le satisface la comida que le sirven en un buen restaurante, le llama la atencion al mozo?	1	2	3	4	5
23. ¿Tiende usted a elaborar demasiado para excusarse?	1	2	3	4	5
24. ¿Se le hace dificil pedir favores a sus padres cuando es necesario?	1	2	3	4	5
25. ¿Insiste usted a que otros hagan la parte del trabajo que le corresponde?	1	2	3	4	5
26. ¿Se le hace dificil decir que "no" a los vendedores?	1	2	3	4	5
27. ¿Se le hace dificil participar en discusiones en grupos pegueños de amistades?	1	2	3	4	5
28. ¿Le demuestra coraje o molestia a su jefe o supervisor cuando es justificado?	1	2	3	4	5
29. ¿Le da complementos y alaba a otros?	1	2	3	4	5
30. ¿Se le hace dificil pedirle a un amigo(a) intimo(a) un favor aunque le sea inconviniente?	1	2	3	4	5
31. ¿Si un amigo(a) intimo(a) le pide un favor que usted no considera razonable se le hace dificil decir que no?	1	2	3	4	5

32. ¿Si su jefe o supervisor hace una declaracion que usted considera no es cierta, lo cuestionaria en voz alta?	1	2	3	4	5
33. ¿Si encuentra que le esta cojiendo cariño a una amistad, se le hace dificil expresarle estos sentimientos a esa persona?	1	2	3	4	5
34. ¿Se le hace dificil devolver mercancia que ha comprado y con la cual no esta satisfecha?	1	2	3	4	5
35. ¿Si alguien con authoridad la interrumpe en el medio de una conversacion importante, le pediria usted a esa persona que espere hasta que usted haya terminado?	1	2	3	4	5
36. ¿Si una persona del sexo opuesto, el cual usted ha estado deseando conocer le presta atencion en una fiesta, iniciaria usted la conversacion?	1	2	3	4	5
37. ¿Vacilaria en expresar resentimiento a una persona que le critica injustificadamente?	1	2	3	4	5
38. ¿Si sus padres quieren que usted los visite en el fin de semana y usted ya tiene otro compromisio importante, cambiaria sus planes?	1	2	3	4	5
39. ¿Esta usted poco dispuesta para tomar parte en una discusion o debate?	1	2	3	4	5
40. ¿Si un amigo o amiga le ha cogido prestado cinco pesos, y parece que se le ha olvidado, se le hace dificil recordarle a esa persona?	1	2	3	4	5

41. ¿Si su jefe o supervisor le bromea hasta el punto que ya no es una broma, se le hace dificil expresarle su disgusto?	1	2	3	4	5
42. ¿Si su esposo(a)/novio(a) es obviamente injusto con usted, se le hace dificil decirselo?	1	2	3	4	5
43. ¿Si estando usted de prisa el dependiente de una tienda le sirve a una persona quien ha llegado despues de usted, le llama usted la atencion?	1	2	3	4	5
44. ¿Si vive en un apartmento y el dueño fallo en arreglar ciertas reparaciones despues de haberle llamado esto a su atencion, insistiria usted en ello?	1	2	3	4	5
45. ¿Se le hace dificil pedir a su jefe o supervisor que le deje salir temprano?	1	2	3	4	5
46. ¿Tiene dificultad en expresar verbalmente amor y afecto a su esposo(a)/novio(a)?	1	2	3	4	5
47. ¿Expresa usted rapidamente sus opiniones a otros?	1	2	3	4	5
48. ¿Si su amigo le pide also que no considera razonable, puede usted rechazarlo?	1	2	3	4	5

Las declaraciones que sigen se refieren a los sentimientos y a las experiencias que les occuren a las mayores de personas en un momento o en otro en sus relaciones con sus familias. Para cada declaracion, hay tres respuestas que son posibles: Si, No, No Se. Circule, por favor, su respuesta para cada declaracion.

Circule Uno

Si No No Se 1. Mi familia me da el apoyo moral que necesito

Si No No Se 2. Mi familia me da ideas buenas sobre como hacer las cosas

Si No No Se 3. La mayoria de las personas son mas apegada a sus familias que yo

Si No No Se 4. Cuando confio en miembros de mi familia, me creo que se sienten incomodos

Si No No Se 5. Mi familia le gusta escuchar lo que pienso

Si No No Se 6. Miembros de mi familia estan de acuerdo con muchas de mis intereses

Si No No Se 7. Ciertos miembros de mi familia vienen a donde mi cuando tienen problemas o necesitan consejos

Si No No Se 8. Yo cuento con mi familia para el apoyo emocional

Si No No Se 9. Hay un miembro de mi familia con quien puedo acercarme si me siento triste, sin sentirme rara mas tarde

Si No No Se 10. Mi familia y yo somos muy abierto sobre lo que pensamos de las cosas

Si No No Se 11. Mi familia es sensitiva a mis necesidades personales

Si No No Se 12. Miembros de mi familia vienen a donde mi para el apoyo emocional

Si No No Se 13. Miembros de mi familia saben como ayudarme a resolver problemas

Si No No Se 14. Tengo una relacion profunda con unos cuantos miembros de mi familia

Si No No Se 15. Miembros de mi familia consigen ideas buenos de mi sobre como hacer las cosas o como construir las cosas

Si No No Se 16. Cuando confio en miembros de mi familia, me siento incomoda

Si No No Se 17. Miembros de mi familia me buscan para el companerismo

Si No No Se 18. Creo que mi familia se siente bien de que se como ayudarlos a resolver problemas

Si No No Se 19. No soy tan apegaga a ningun miembro de mi familia como otros son con miembros de sus familias.

Si No No Se 20. Quisiera que mi familia fuera mucho mas diferente

Las declaraciones que sigen se refieren a los sentimientos y a las experiencias que les occuren a las mayores de personas en un momento o en otro en sus relaciones con sus amistades. Para cada declaracion, hay tres respuestas que son posibles: Si, No, No Se. Circule, por favor, su respuesta para cada declaracion.

Circule Uno

Si No No Se 1. Mis amistades me dan el apoyo moral que necesito

Si No No Se 2. La mayoria de las personas son mas apegada a sus amistades que yo

Si No No Se 3. Mis amistades les gusta escuchar lo que pienso

Si No No Se 4. Ciertas amistades vienen a donde mi cuando tienen problemas o necesitan consejos

Si No No Se 5. Yo cuento con mis amistades para el apoyo emocional

Si No No Se 6. Si sintiera que una o mas de mis amistades estuvieran de mal humor conmigo, me lo guardaria

Si No No Se 7. Siento que yo estoy en la periferia de mi circulo de amistades

Si No No Se 8. Hay una amistad con quien puedo acercarme si me siento triste, sin sentirme rara mas tarde

Si No No Se 9. Mis amistades y yo somos muy abierto sobre lo que pensamos de las cosas

Si No No Se 10. Mis amistades son sensitiva a mis necesidades personales

Si No No Se 11. Mis amistades vienen a donde mi para el apoyo emocional

Si No No Se 12. Mis amistades saben como ayudarme a resolver problemas

Si No No Se 13. Tengo una amistad profunda con unas cuantas de mis amistades

Si No No Se 14. Mis amistades obtienen ideas buenas de mi sobre como hacer las cosas o como construir las cosas

Si No No Se 15. Cuando confio en mis amistades, me siento incomoda

Si No No Se 16. Mis amistades me buscan para el companerismo

Si No No Se 17. Creo que mis amistades se siente bien de que se como ayudarlos a resolver problemas

Si No No Se 18. No soy tan apegaga a ninguna amistad como otros son con sus amistades.

Si No No Se 19. Recientemente, he recibido de una amistad una idea buena de como hacer algo

Si No No Se 20. Quisiera que mis amistades fueran mucho mas diferente

Mas adelante, se presenta una lista de problemas y quejas que las personas tienen algunas veces. Favor de leer cada una cuidadosamente. Luego de leer cada una, por favor circule el numero que mejor describa CUANTA MOLESTIA ESE PROBLEMA TE HA CAUSADO EN LOS ULTIMOS MESES, INCLUYENDO HOY. Circule uno de los numeros y no saltes u omitas ninguna de las aseveraciones.

	NADA	UN POCO	MODERADAMENTE	BASTANTE	EXTREMADA-MENTE
1. Dolores de cabeza	1	2	3	4	5
2. Nerviosidad o temblores por dentro	1	2	3	4	5
3. Pensamientos desagradables constantes que no se van de tu mente	1	2	3	4	5
4. Desmayos o desvanecimientos	1	2	3	4	5
5. Falta de interes o placer en el sexo	1	2	3	4	5
6. Criticar a otros	1	2	3	4	5
7. La idea de que alguien puede controlar tus pensamientos	1	2	3	4	5
8. Sentir que otros tienen la culpa de tus problemas	1	2	3	4	5
9. Tener problemas recordando cosas	1	2	3	4	5
10. Preocuparte por descuidos y chapucerias	1	2	3	4	5
11. Sentirte molesta o irritada facilmente	1	2	3	4	5
12. Dolores en el corazon o en el pecho	1	2	3	4	5
13. Sentirte asustada en espacios abiertos o en la calle	1	2	3	4	5

14. Sentirte con poca energia o lenta	1	2	3	4	5
15. Pensamientos relacionados con ponerle fin a tu vida	1	2	3	4	5
16. Escuchar voces que otras personas no escuchan	1	2	3	4	5
17. Temblores	1	2	3	4	5
18. Sentir que no puedes confiar en otras personas	1	2	3	4	5
19. Poco apetito	1	2	3	4	5
20. Llorar con facilidad	1	2	3	4	5
21. Sentirte timida o incomoda con personas del sexo opuesto	1	2	3	4	5
22. Sentirte atrapada o capturada	1	2	3	4	5
23. Asustarte repentinamente sin ningun motivo o razon	1	2	3	4	5
24. Arranques de coraje que no puedes controlar	1	2	3	4	5
25. Sentirte temerosa de salir de tu casa sola	1	2	3	4	5
26. Culparte a ti misma por cosas	1	2	3	4	5
27. Dolores de espalda	1	2	3	4	5
28. Sentirte bloqueado cuando tienes que tener cosas hechas	1	2	3	4	5
29. Sentirte sola	1	2	3	4	5
30. Sentirte melancolica	1	2	3	4	5

31. Preocuparte demasiado por las cosas	1	2	3	4	5
32. No sentir interes en las cosas	1	2	3	4	5
33. Sentirte atemorizado	1	2	3	4	5
34. Sentir que otros pueden herir tus sentimientos facilmente	1	2	3	4	5
35. El hecho de que otras personas se den cuenta de tus pensamientos	1	2	3	4	5
36. Sentir que otros no te entienden o que son indiferentes contigo	1	2	3	4	5
37. Sentir que las personas no son amigables contigo o que tu no les gusta	1	2	3	4	5
38. Tener que hacer las cosas lentamente para asegurarte que estan correctas	1	2	3	4	5
39. Aceleramientos o latidos violentos del corazon	1	2	3	4	5
40. Nauseas o malestar estomacal	1	2	3	4	5
41. Sentirte inferior a los demas	1	2	3	4	5
42. Dolores musculares	1	2	3	4	5
43. Sentir que otros te observan o hablan de ti	1	2	3	4	5
44. Problemas en quedarte dormida	1	2	3	4	5
45. Tener que comprobar y re-comprobar lo que haces	1	2	3	4	5
46. Dificultad en tomar decisiones	1	2	3	4	5

47. Sentir miedo de viajar en guaguas, subterraneos o trenes	1	2	3	4	5
48. Problemas al respirar o al coger aliento	1	2	3	4	5
49. Ataques de frio o calor	1	2	3	4	5
50. Tener que evitar ciertas cosas, lugares o actividades porque te atemorizan	1	2	3	4	5
51. Momentos en que la mente se te queda en blanco	1	2	3	4	5
52. Adormecimiento o picazon en algunas partes del cuelpo	1	2	3	4	5
53. Un nudo en la garganta	1	2	3	4	5
54. Sentirte sin esperanzas con respecto al futuro	1	2	3	4	5
55. Problemas de concentracion	1	2	3	4	5
56. Sentir debilidad en ciertas partes del cuelpo	1	2	3	4	5
57. Sentirte tensa o agitada	1	2	3	4	5
58. Sentir los brazos o las piernas pesadas	1	2	3	4	5
59. Pensamientos de muerte o sentir que te estas muriendo	1	2	3	4	5
60. Comer en exceso	1	2	3	4	5
61. Sentirte incomoda cuando las personas te miran o hablan de ti	1	2	3	4	5
62. Tener pensamientos que no son tuyos	1	2	3	4	5

63. Deseos de pegar, lastimar o herir a alguien	1	2	3	4	5
64. Despertarte temprano en la manana	1	2	3	4	5
65. Tener que repetir las mismas acciones de tocar, contar o lavar	1	2	3	4	5
66. Sueno perturbado o insomnio	1	2	3	4	5
67. Tener deseos de romper o aplastar cosas	1	2	3	4	5
68. Tener ideas o creencias que otros no comparten	1	2	3	4	5
69. Sentirte muy cohibido con los demas	1	2	3	4	5
70. Sentirte incomodo entre grupos de gente como hay en las tiendas o el cine	1	2	3	4	5
71. Sentir que todo es un esfuerzo (que todo requiere esfuerzo)	1	2	3	4	5
72. Ataques de terror o panico	1	2	3	4	5
73. Sentirte incomoda al comer o beber en publico	1	2	3	4	5
74. Entrar en discusiones frequentemente	1	2	3	4	5
75. Sentirte nerviosa cuando te dejan sola	1	2	3	4	5
76. No recibir reconocimiento de otras personas por tus logros	1	2	3	4	5
77. Sentirte sola aun cuando estas con otras personas	1	2	3	4	5

78. Sentirte tan intranquila que no te puedes estar quieta	1	2	3	4	5
79. Sentirte inutil	1	2	3	4	5
80. Sentir que also malo te va a pasar	1	2	3	4	5
81. Gritar o tirar cosas	1	2	3	4	5
82. Sentir miedo de desmayarte en publico	1	2	3	4	5
83. Sentir que las personas se van a aprovechar de ti si tu los dejas	1	2	3	4	5
84. Tener pensamientos del sexo que te molestan mucho	1	2	3	4	5
85. La idea de que tu debes ser castigada por tus pecados	1	2	3	4	5
86. Sentir que tienes que hacer las cosas	1	2	3	4	5
87. La idea de que algo serio anda mal en tu cuerpo	1	2	3	4	5
88. Nunca sentirte cerca a otra persona	1	2	3	4	5
89. Sentimientos de culpa	1	2	3	4	5
90. La idea de que algo anda mal en tu mente	1	2	3	4	5

Appendix B

Instructions to Participants

(English and Spanish Versions)

The Graduate School of the City University of New York
33 West 42nd Street
New York, New York 10036

Thank you for agreeing to participate in this research study of Puerto Rican women in New York City. I have attached a questionnaire (English/Spanish) which will take about 45 minutes to complete. As I mentioned over the telephone, I, Joanne Rolon, am a doctoral student in Clinical Psychology who is interested in studying a variety of factors such as, social support, years in the U.S. mainland, and education, and its effect on the emotional health of Puerto Rican women. Participation in this study is confidential, voluntary and anonymous since the questionnaire will not have any identifying information. Your return of the completed questionnaire in the enclosed stamped, addressed return envelope indicates that you have consented to participate in this study. If you do not wish to participate in this study, do not fill out the questionnaire and do not return the questionnaire. There will be no penalty or consequences as a result of not participating in this study. The overall goal of this research is to generate information for public policy and help implement programs that address the needs of Latina women.

The Graduate School of the City University of New York
33 West 42nd Street
New York, New York 10036

Le quiero dar las gracias por estar de acuerdo con su participacion en este estudio de mujeres Puertorriquenas que viven en la Cuidad de Nueva York. Le he mandado un cuestionario (Ingles/Espanol) que le tomara como 45 minutos para completar. Como le mencione por el telefono, yo, Joanne Rolon, estoy estudiando para mi doctorado en Psicologia Clinica y estoy interesada en estudiar una variedad de factores como, por ejemplo, el apoyo social, anos en los Estados Unidos, y el nivel de educacion, y los efectos que factores como estos pueden tener en la salud emocional de las mujeres Puertorriquenas. Su participacion en este estudio es confidencial, voluntario, y anonimo porque el cuestionario no tendra ninguna informacion de identificacion. Si usted devuelve este cuestionario en el sobre con sello que esta incluido, esto indicara que usted ha dado su consentimiento para participar en este estudio. Si usted no desea participar en este estudio, no llene este cuestionario ni lo devuelva. Usted no sera penalizada y no hay consequencias si usted decide que no va a participar en este estudio. En general, el objetivo de este estudio es para conseguir informacion que puede contribuir a la realizacion de programas dirigidos a las necesidades de las mujeres Latinas.

Appendix C

Consent Forms

(English and Spanish Versions)

Study on Characteristics and Emotional Health Problems
of
Puerto Rican Women Living in N.Y.C.

Statement on Informed Consent

I give, Joanne Rolon from the CUNY Graduate School, consent to be a subject and participate in the study on characteristics and emotional health problems of Puerto Rican women living in New York City. The study has been fully explained to me. I understand that my responses will be kept confidential and anonymous and that the questionnaire will have no identifying information. I also understand that my participation is voluntary and that I can withdraw from the study at anytime without penalty.

_____ _____

Signature of Subject Date

_____

Principal Investigator

Estudio sobre Las Caracteristicas y Problemas de la Salud Emocional de Puertorriquenas que Viven en La Cuidad de Nueva York

Declaracion de Consentimiento Informado

Le doy, a Joanne Rolon del CUNY Graduate School, consentimiento para ser subjeto y participar en el estudio de las caracteristicas y problemas de la salud emocional de Puertorriquenas que viven en la Cuidad de Nueva York. Me han dado una explicacion completa sobre este estudio. Entiendo que mis respuestas permaneceran confidencial y anonimo y que el cuestionario no tendra ninguna informacion de identificacion. Tambien entiendo que mi participacion es voluntaria y que puedo retirarme del estudio en cualquier momento sin ser penalizada.

_____ _____

Firma del Subjeto Fecha

_____

Investigadora Principal

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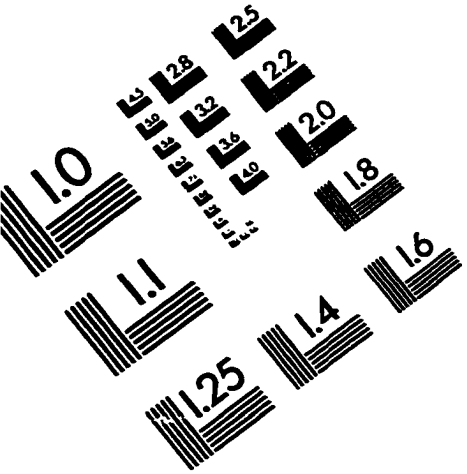
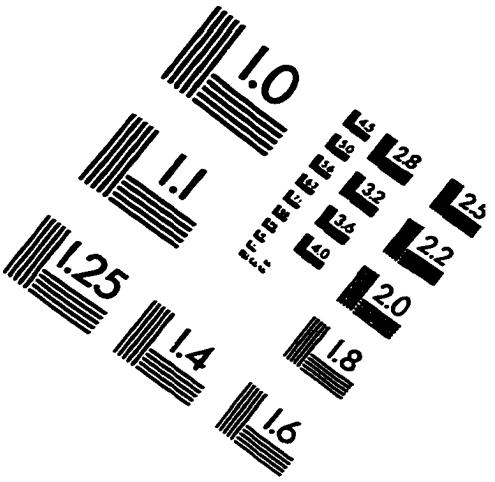
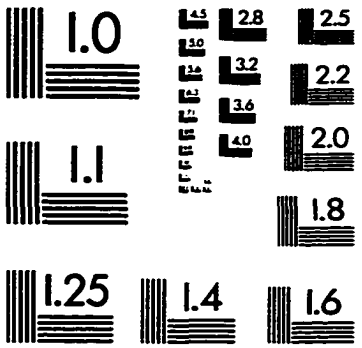
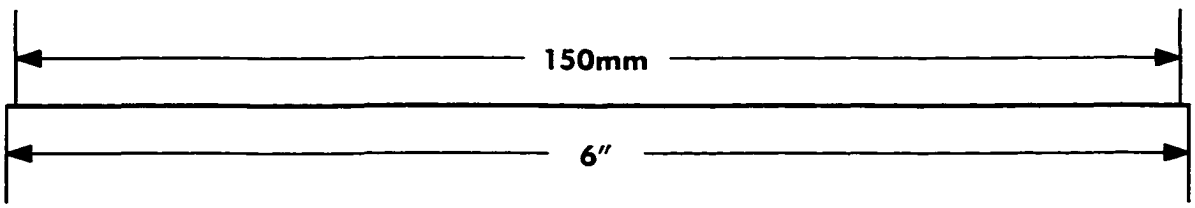
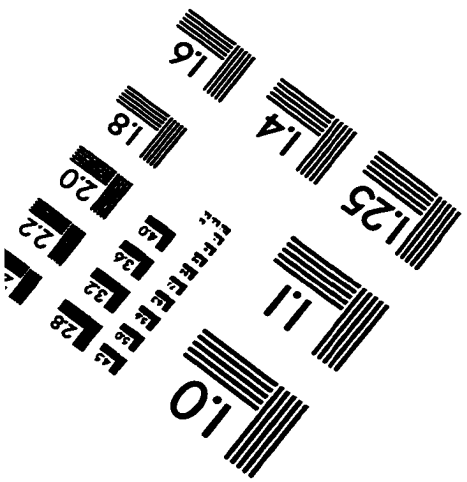
IMAGE EVALUATION TEST TARGET (QA-3)

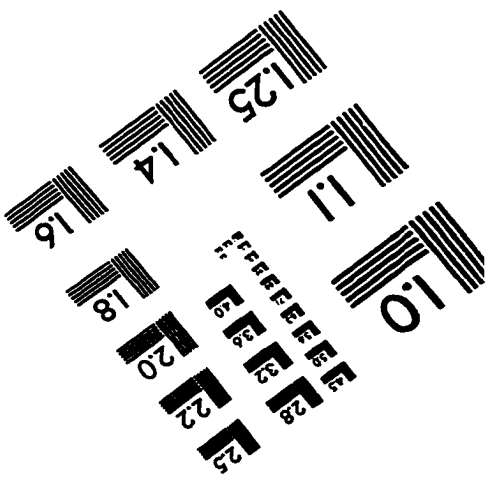












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