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A

The Relation of Interviewer Ethnic, Cultural, and Interpersonal Characteristics to Patient Dropout

BY
Lorna Myers

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.

1999

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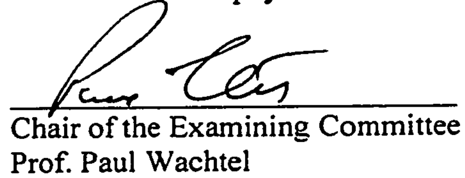

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Abstract

THE RELATION OF INTERVIEWER ETHNIC, CULTURAL AND INTERPERSONAL CHARACTERISTICS TO PATIENT DROPOUT

by

Lorna Myers

Adviser: Professor Paul Wachtel

Through the participation of twenty-three bilingual clinicians and one hundred and twelve Hispanic (Caribbean, South and Central American) psychiatric patients, this study investigated five hypotheses regarding dropout and number of missed sessions in the assessment phase. It was proposed that a match between clinician and patient on a more superficial level of acculturation would not correlate to dropout or missed sessions, while a match on a deeper level of acculturation would correlate to outcome. It was also proposed that higher clinician scores of nurturance would correlate to lower dropout rates and missed sessions while higher rates of clinician dominance would correlate to higher dropout rates and/or missed sessions. Lastly, it was suggested that clinicians with low empathy ratings by the patients would correlate to more dropouts and missed sessions.

The instruments used to measure the constructs of interest were the Bidimensional Acculturation Scale, the Hispanic Features Measure, the Barrett-Lennard Relationship Inventory, and the Interpersonal Adjectives Scale. Patient dropout and number of missed sessions were determined through the medical charts kept in the clinic. Correlational and multiple regression analyses were conducted in order to evaluate the hypotheses. Significant negative correlations were found between empathy ratings of the clinicians by the patients and both dropout rates and number of missed sessions. A

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significant negative correlation between clinician self-rated dominance and patient ratings of clinician empathy was also detected. However, the results of correlational and multiple regression analyses indicated that match on superficial or deeper levels of acculturation, and clinician dominance and nurturance were not significantly correlated to dropout and/or missed sessions.

The significant negative correlation between clinician empathy ratings and assessment phase outcome, combined with the absence of significant correlations between all other variables offers relevant information about Hispanic psychiatric patients and their clinicians. It suggests that with Hispanic psychiatric patients, once providing bilingual clinicians has controlled for the language variable, the perception of having an empathic clinician outweighs cultural match and certain interpersonal characteristics of the clinician.

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Para mis padres, Adela Escudero y George Myers,quienes me dieron la oportunidad de crecer en un ambiente bilingüe y diverso

To my parents, Adela Escudero and George Myers, who gave me the opportunity of growing up in a bilingual and diverse setting

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There are so many people to whom I am grateful for the support and encouragement they gave my project and me that it is difficult to know where to start. I think it is only right to begin with those who were the actual participants, the 112 patients and 23 clinicians who volunteered their time and effort to answer numerous questionnaires and scales. I would then like to thank Dr. A.J. Franklin who really helped me take a very amorphous idea for a dissertation project and mold and shape it into an approved proposal over the course of a year. I will also always remember Dr. Paul Wachtel who read version after version of the dissertation, patiently helping me to polish it, while always encouraging me onward. I would also like to give thanks to Dr. Carmen Vazquez who from the start supported the plan to conduct this project at Bellevue Hospital and was invaluable in navigating the IRB process. I am especially grateful to Dr. Yvette Caro who for two years consistently supported my research endeavors in the clinic of which she is unit chief. I would also like to say thank you once again to two great research assistants, Sharoly Gonzalez and Martha Gimenez, who allowed me to continue collecting data while I was a full-time intern. I am grateful to Mark Glassman for his invaluable advice on statistics and for the stimulating discussions we had about the results. I also want to formally thank my parents for the tremendous emotional and financial support with which they provided me throughout and particularly during some especially rough stretches. I thank my brother and sister-in –law for their help with actual parts of the data collection and for the many books that they ordered for me over the Internet.

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CHAPTER ONE: INTRODUCTION:

This study proposes to examine a series of factors that may play a role in Hispanic patients' decision to prematurely terminate the psychological intake process. Variables obtained from both interviewers and patients include ethnicity, level of acculturation, and adherence to Hispanic values. Variables that correspond only to the therapists include interpersonal qualities (measure of dominance and nurturance), as well as patients' assessment of the relationship that was established with the interviewer during the first interview. The intake process for these cases will then be monitored to determine the outcome (e.g. dropout vs. completion).

The original idea for this study stemmed from numerous reports of Hispanic patients' significantly elevated dropout rate after initial interviews, and the under-utilization of psychological treatments that then followed (Karno & Edgerton, 1969; Kline, L., 1969; Abad, V., Ramos, J., & Boyce, E., 1974; Kahn & Heiman, 1978; Acosta, F.X., 1980; Acosta, F.X., Evans, L., Yamamoto, J., & Skilbeck, W., 1983; Dworkin, R. & Adams, G, 1987; Mohl, P., Martinez, D., Ticknor, C., & Appleby, J., 1989; Rogler & Cortes, 1993; Ruiz, P., 1995). This under-utilization is especially intriguing when considered alongside studies that report a high prevalence of psychiatric disorders in the Hispanic-American population (Kessler, et al., 1994--in Miranda, Azocar, Organista, Munoz, & Lieberman, 1996; Sue et. al., 1994; Ruiz, P., 1995).

The present study was then designed with the general objective of contributing a measure of understanding to the apparently paradoxical nature of

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mental disorders and access to mental health treatment by the Hispanic population.

More specifically, this project was designed to examine the first contact between patient and mental health professional, the intake phase. During this preliminary stage, the manifest objective is the assessment of the patient. However, at the same time that the interviewer is performing this assessment, on an interpersonal level, patient and interviewer are interacting and engaging, or failing to engage one another. Multiple interpersonal and personal factors can intervene and interact during this first juncture, resulting in the development of a bond between interviewer and patient, or in the premature miscarriage of the relationship. This study will focus on some of these factors. Thus, a number of therapist and patient factors that are hypothesized to be involved in Hispanic patients' decision to complete or to prematurely terminate the psychological intake process will be investigated.

It is important to keep in mind that although completing an intake offers no guarantees that the patient will continue in treatment, discontinuing it prematurely assures that the patient will not be receiving treatment in the near future.

Since this project will be conducted with a Hispanic sample, particular attention is being paid to a number of suggested guidelines for performing research with Hispanic populations (Alviredez, J., Azocar, F., & Miranda, J., 1996; Dworkin, R. and Adams, G., 1987; Marin G. & VanOss- Marin, B., 1991; Miranda, J, 1996). Thus, attention to language usage, as well as to the patients'

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ethnicity, migration history, and level of acculturation are being factored into the design of this project.

For practical reasons, this particular study involves the exclusive examination of Spanish-speaking interview dyads. This was decided given that a large percentage of Hispanics in this country are either monolingual Spanish-speakers or bilinguals for whom Spanish is a primary language. For these patients, interviews performed in English could lead to the language variable overshadowing all other variables (Marcos, L., 1976; Marcos, L. and Alpert M., 1976; Marcos L. and Urcuyo L., 1979).

RATIONALE:

There are multiple levels of significance to this study, the most outstanding of which has to do with the contribution that this study will make to the virtually nonexistent field of outcome research in mental health services with Hispanic patients.

Although the United States has 27 million Hispanics (US Bureau of the Census, 1994), and the National Comorbidity Survey (Kessler, et al., 1994) found that Hispanics had a higher prevalence of current affective disorders and active comorbidity (three or more) disorders than non-Hispanic Whites, psychotherapy studies with Hispanic populations are still very limited. In fact, "a recent meta-analytic review of all psychotherapy studies conducted in the United States with Hispanic participants in the 20 year period starting in 1970 identified only 135 such studies (Miranda, Azocar, Organista, Munoz, & Lieberman, 1996).

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[However], of the 123 studies that could be located by the reviewer, 28 were single-case reports, 27 were single-group, preassessment-postassessment (pre-post) comparisons, and 48 were nonexperimental designs, included no quantitative data, or were primarily theoretical in nature." Of the remaining 20 reports, 11 were studies of children or adolescents with behavioral or drug problems. A critical analysis through a computerized literature search for the past three years on Hispanic mental health care studies, conducted by Mezzich, Ruiz, and Muñoz (1999), revealed that only 3% of all studies involved the evalution of treatment outcome.

Research of this population is also needed, particularly in the case of Hispanic immigrants, because it has been hypothesized that the stress of migration and acculturation, combined with the lower SES of most of these immigrants, plays a role in the development of mental health disorders (Potter, Rogler, & Moscicki, 1995; Salgado de Snyder, 1994). Epidemiological studies have repeatedly indicated that socioeconomic status is inversely related to mental health problems (Schwabb & Schwabb, 1982; Adler, et. al., 1994). Specifically depression and hostility have shown the most consistent relationship with both socioeconomic status (SES) and physical health outcomes. It has also been suggested that the association between SES and health may result from exposure to stress. Given that the rapidly growing Hispanic population is exposed in its majority to a number of the risk factors for mental and physical disorders that have been mentioned above, it becomes apparent that this is a strategically important group on which to focus future mental health service research.

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Because minorities are underrepresented in psychotherapy studies, psychiatrists/psychologists are having to plan, develop, and implement public services while lacking empirical data on the populations they are targeting. Information on this population is also absent as evidenced by the Report to the President's Commission on Mental Health (Special Populations Subtask Panel on the Mental Health of Hispanic Americans, 1978). This report concluded that the field of "Hispanic mental health research lacked a programmatic plan, and that the methodological and analytic quality of research needed to be improved" (Sue et al., 1994).

To rectify the under-representation of minorities in clinical research, the NIH has issued strict guidelines requiring, as of 1994, that women and members of minority populations be included in all research funded by the NIH (Hohmann, A., 1996b).

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PURPOSE OF STUDY:

The underlying purpose of this study is to improve mental health services for Hispanics residing in the United States. Primarily, completing the intake and, in that manner, gaining access to treatment, increases the probability of producing a decrease in the prevalence of emotional disorders in the Hispanic population through the use of mental health facilities. Long range implications of this study's findings will allow clinics that work with a Hispanic patient pool to more accurately identify prospective mental health workers better suited to work with this population. It may also provide guidelines (e.g. concerning the importance of certain modes of interaction with certain patients) for training programs that are offered to current staff members.

The short-term objective of this study is to discriminate specific factors that may contribute to Hispanics' compliance or noncompliance with the intake process. In order to do this, special emphasis is placed on certain constructs including ethnicity, acculturation, interpersonal qualities, and values.

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CHAPTER TWO: LITERATURE DOMAINS:

In order to carry out this project an extensive review of the literature, comprising four literature domains, was conducted. These included 1) studies on dropout in psychotherapy outcome research; 2) research on client and therapist variables in psychotherapy as they relate to assessment and treatment dropout; 3) race, ethnicity and culture as they relate to Latin Americans; and 4) cultural diversity and therapy.

To begin with, adequate outcome research with Hispanic patients requires familiarity with and the adoption of current validated measures and guidelines of general psychotherapy research. Subsequently, the existing outcome literature that focuses on dropout is used as a foundation which provides information on what has already been studied and what still needs to be studied in this respect. Increased precision within the field of outcome research is obtained by shifting the focus towards patient and therapist characteristics as they affect outcome. Of the characteristics reviewed, these include not only certain interpersonal qualities of therapists but also ethnicity and cultural variables of therapists and patients, since part of the therapist sample and all of the patient sample is Hispanic. However, in order to assess cultural and ethnic variables, the underlying concept of Hispanic culture, race, and acculturation must be carefully analyzed and defined. Lastly, a review of the Hispanic cross-cultural therapy literature provides a framework of information and recommendations that have been suggested for consideration when working with this population, as well as a basis

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from which the *universality* of our psychological theories and assumptions can be questioned.

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GENERAL COMMENTS ON PSYCHOTHERAPY OUTCOME RESEARCH:

A principal area of assessment in clinical psychology involves the evaluation of interventions. Within the branch of psychotherapeutic assessment, as its name suggests, studies have focused almost exclusively on psychotherapy process and outcome. On the other hand, intakes, which precede the therapy phase, have been the object of very few research projects.

Criteria for evaluating therapy are numerous. They have included measures of the significance of the clinical change experienced by patients, as well as the proportion of patients who improved, the durability of the improvements, and the impact this improvement has had on significant others (Bordin, E., 1986; Docherty, J, & Streeter, M., 1996, Gendlin, E., 1986). Criteria for evaluating the efficiency and cost of interventions have included assessment of the duration of the treatment, costs of professional expertise, client costs, and other analyses (Kazdin, 1992).

Psychotherapy research has grown tremendously over the decades. Among its primary contributions is the assessment of major therapeutic approaches (e.g. psychodynamic, behavioral, cognitive-behavioral, and experiential, among others). Another growing area of investigation has focused on the diverse ingredients of therapeutic efficacy, including client and therapist variables (Bergin, A. and Garfield, S., 1994; Orlinsky, D., 1994).

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One of the fundamental objectives of this form of research has been to provide information about factors that might be related to successful and unsuccessful therapeutic interventions (Elliot, R & Morrow-Bradley, C., 1994). One of the many ways in which therapeutic success and failure have been defined involves completion or premature termination of the therapeutic process on the patient's part. Among the variables that have been related to either of these two outcomes are some patient variables, some therapist variables, and/or an interaction of both. However, the use of samples that have already traversed waiting lists, intakes, sometimes more waiting lists, and exposure to two or more mental health professionals (e.g. phone screener, intake interviewer, therapist) may affect the correlations these variables are thought to present. It is the premise of this study that widening the scope to include the preliminary assessment process will provide a much wider pool of prospective clients from which additional information about patient, interviewer, and interactional variables as they relate to premature termination will be obtained. In addition, because incomplete intakes and/or refusal of therapy are extremely pervasive and troubling problems that clinical practitioners encounter regularly, this study stands to offer necessary information regarding a crucial clinical issue. Only a few outcome researchers have directed their attention to intake outcome (Raynes & Warren, 1971; Sue, McKinney, & Allen, 1976; Kahn & Heiman, 1978; Phillips & Fagan, 1982—in Barrett-Lennard, G., 1986). Their findings and others will be discussed in this section.

PREMATURE TERMINATION OF INTAKES AND THERAPY

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Definition of therapy dropouts and rejecters :

Garfield (1994) proposes that the definition of dropout is "one who has been accepted for psychotherapy, who actually has at least one session of therapy, and who discontinues treatment on his or her own initiative by failing to come for any future arranged visits with the therapist." On the other hand, individuals who never show up for their first therapy appointment can be considered rejecters or refusers of therapy. For the purposes of this study, individuals who do not complete the intake process (three interviews) will be defined as intake dropouts. An additional point that one must keep in mind is that not all early therapy terminators are necessarily treatment failures. While early intake terminators do seem to indicate some sort of failure the process, since no actual treatment has yet been provided we do not have data regarding the impact of the uncompleted therapeutic contact (e.g. whether the patient did not follow up because s/he felt better).

Dropout from Intake:

It is surprising that intakes have not been the object of more research activity since statistics show that approximately 40-50% of prospective clients are being lost after this first contact (Sue, et al., 1976). An exception to this trend is a recent study of 96 patients at the time of their initial screening interviews (Mohl, Martinez, Ticknor, Huang, & Cordell, 1989). It was observed that those patients who dropped out early liked the clinician less, felt less liked and respected, experienced a weaker helping alliance, and viewed the interviewer as more passive and psychotherapy as less potent than did the ones who remained. Also,

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Brill and Storrow (1960) speculated that intake interviewers often had less positive feelings for lower-class patients than for patients who occupied their own class and saw them as less treatable through insight-oriented psychotherapy. Such attitudes were thought to be associated with the lower-class patients' abandonment of psychological treatment.

Refusal of therapy after completing an intake:

Several studies have reported significant percentages of patients who complete the intake process, yet afterwards do not follow through with the recommendation of treatment. Sue, McKinney, & Allen (1976) reported that out of 2,551 cases drawn from 17 community mental health facilities, 40.8% of the cases failed to return after the intake interview. Additionally, a report of 2,922 students seen at a university counseling center over a period of 8 years indicated that almost 49% failed to come to the first therapy session (Phillips & Fagan, 1982—in Barrett-Lennard, G., 1986). The fact that in the Sue et al. study the intake only involved one interview before referral to therapy gives rise to questioning whether these statistics represent actual therapy refusal or might have been an intake dropout.

Explanations of therapy refusal: Organizational variables

Raynes & Warren (1971a) suggest that when faced with numerous demands from the community for psychiatric care, combined with an inadequate supply of personnel, many psychiatric clinics defend themselves by putting up institutional barriers. These include long waiting lists, extended intakes, fees, and strict criteria for patients who are selected. Raynes & Warren (1971b) found that

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extensive waiting lists were correlated with refusal of therapy after the fifteenth day.

Other organizational variables that may also be related to patient refusal of treatment involve structural incongruities between the characteristics of patients of Hispanic culture and those of the mental health system. Ellmer and Olbrisch (1983) have pointed out how including the cultural component can add to researcher's understanding of client satisfaction. This viewpoint assumes Hispanics are seeking professional help, but are rebuffed by the way in which mental health care is organized. Hispanic patients are thought to encounter numerous obstacles to obtaining treatment. A number of these are (a) biased staff who overdiagnose and lack empathy (Arroyo, 1996; Ruiz, 1995; Rogler, Cortez & Malgady, 1991; Abad, 1974); (b) staff who are not Spanish-speaking and/or bicultural (Padilla, Ruiz & Alvarez 1975; Kline et al., 1980; Marcos, 1988; Rogler, et al., 1991; Guarnaccia & Rodriguez, 1996); (c) SES differences between the Hispanic patient and therapist (Evans, 1984; Ruiz, 1995); and (d) interference in the accessibility to mental health services as a result of the therapists' values (Padilla et al., 1975, 1989; Szapocznik, J., Scopetta, M., Aranalde, M. & Kurtines, W., 1978; Gorkin, 1986; Comas-Diaz, L., 1988; Marcos, 1988). Supporting evidence for culturally congruent facilities has been provided by Rodriguez (1986) who demonstrated a link between providing bilingual/bicultural professional staff and the increase in Hispanic clients in a study of a community mental health center located in a predominantly Puerto Rican area of the South Bronx. Acosta et al. (1983) also demonstrated the utility of a pretherapy

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preparation program for low-income Hispanic, Black, and White patients. Patients who had been exposed to an orientation program were more knowledgeable and positive in their attitudes towards therapy.

Therapy dropout:

Proportionally a much greater amount of research has focused on the problem of therapy dropouts or premature terminators. Findings on the extensiveness of therapy discontinuation are alarming, especially for therapists who favor long-term treatment modalities. Garfield & Kurz (1952) found that out of 560 patients who were offered and who accepted treatment at a VA Outpatient Clinic, approximately two-thirds received less than ten sessions. Along the same line, Sue et al. (1976) found that 23% of the cases dropped out after the first therapy session, and 69.6% ended before the tenth session. An analysis of a representative number of investigations carried out between the late 40's and 80's (Garfield, 1994) showed that "a majority of the clinics have terminated or lost half of their therapy clients before the eighth interview." Additional studies that have focused on urban mental health clinics have reported even higher dropout rates. One of these studies, (Fiester & Rudestam, 1975) reported that 37 to 45 % of their adult outpatients dropped out after the first or second session.

Researchers trying to offer explanations for therapy dropout have approached this problem from different directions, focusing, among other things, on patient, therapist, or interactional variables.

The effect of patient-therapist interaction on outcome (McCullough, et al., 1991), and on outcome as it relates to experiences while interacting during the

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initial phase of treatment (Saltzman, C., Luetgert, M.J., Roth, C.H., Creaser, J., & Howard, L., 1976) have been studied. Baekeland & Lundwall (1975) found fifteen factors that were predictive of psychotherapy dropout. Of these, social isolation on the patient's part, therapist attitudes and behaviors, and discrepancies between patient and therapist treatment expectations were found to be predictive in 100% of the studies that were reviewed. Pekarik and Wierzbicki (1986) found that there was a strong correlation between a patient's expected and actual treatment duration.

Lastly, as concerns intake dropout and explanations for it, because studies have not focused on intakes other than to measure dropout rates, no specific explanations have yet been offered. For the purpose of this study, it will be necessary to analyze and extrapolate certain variables and explanations from psychotherapy dropout studies.

Psychotherapy research with culturally diverse populations:

Specifically related to psychotherapy research with minority patients, Sue et al. (1994) state that there is evidence that ethnic minority groups are experiencing significant mental health problems, but also that significant controversy exists over the effectiveness of traditional psychotherapeutic approaches for members of ethnic minorities. This controversy persists partially because until recently most psychotherapy research studies did not include representative numbers of minority participants. However, it also persists because a number of the psychotherapy studies that have included minorities have been

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lacking in scientific rigor (Beutler, L., Brown, M., Crothers, L., Booker, K., & Seabrook, M.K., 1996).

The two principal questions that are posed by these authors are: 1) "What evidence is there for the efficacy of psychotherapy [with minority clients]? and 2) What are the conditions that promote effectiveness [in psychotherapy with minorities]? An additional question that Sue and co-authors consider important is: What client, therapist, and situational circumstances are associated with positive treatment outcomes and with the progress of psychotherapy? The third question has been partially addressed by preliminary research involving client characteristics such as acculturation and preferences, and therapist characteristics, such as ethnicity and therapeutic style, and situational variables such as treatment setting. However, these studies have assessed single factors only, rather than interactions between therapist and client variables (Garfield, 1994).

Recruitment and retention of psychotherapy research participants:

A common explanation for the limited number of minorities in psychotherapy studies has been that it is extremely hard to recruit and retain this population in this type of study. It has been suggested that this difficulty can be overcome if attention is paid to the three following factors: (a) recruitment and retention of ethnic minority individuals in research, (b) the adaptation and administration of culturally and linguistically sensitive measures and interventions, and (c) a conceptualization of ethnicity that furthers knowledge about the role of ethnic factors in psychological processes (this is discussed in more detail in the following domain).

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Recruitment of Hispanics has traditionally been a problem because psychotherapy studies generally recruit from psychiatric outpatient facilities. It has been found that poor and ethnic minority populations are underrepresented in these settings. Other obstacles that ethnic minorities face include: lack of insurance, time, child-care, and transportation. Access to this population can also be significantly improved if services and measures are provided in Spanish, and culturally sensitive strategies for recruiting and retaining Hispanics in treatment outcome studies are developed (Miranda, J., 1996).

CLIENT AND THERAPIST CHARACTERISTICS

Explanations of therapy refusal: Patient variables

Socioeconomic Status:

A few studies (Albronda, H., Dean, R., & Starkweather, J, 1964; Kraft Goin, M., Yamamoto, J, & Silverman, J., 1965) have sought to find correlations between the socioeconomic position of the patient and refusal of treatment. Rosenthal & Frank (1958) found a significant relationship between the clients' incomes and acceptance of treatment, as well as between acceptance and rated level of motivation. Yamamoto & Goin (1966) also found a significant correlation between a client not keeping his/her initial appointment and lower socioeconomic class.

Race/Ethnicity:

Raynes & Warren (1971a) reported that patients who were least likely to attend therapy were African-American men, 40 years old or younger, followed by African American women. Others reported that patient's ethnicity was a

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significant variable in psychotherapy refusal (Mohl, P, Martinez, D., & Appleby, J., 1989). However, the overlap that frequently occurs between lower socioeconomic status and race or ethnicity obscures the significance of these findings. In addition, given that these studies assessed race and ethnicity on a superficial level, (often only through self-definition), the significance of these findings is unclear. So, although some correlations between social class and/or race/ethnicity and therapy refusal have been found, these results in no way adequately explain the number of dropouts from intakes or therapy refusals that regularly occur. Explanations for Hispanic patient high attrition rates include low levels of acculturation, and lack of knowledge about the therapeutic process (Acosta, F.X., Evans, L., Yamamoto, J., & Skilbeck, W., 1983; Rogler, 1996).

Other General Explanations:

Other hypotheses that have been suggested include: insufficient motivation for therapy, fear of discovering that one suffers from a severe mental disturbance, a reluctance to acknowledge that one needs help, stigmas associated with consulting a mental health professional, and a significant change in one's life situation that makes therapy unnecessary.

Although a number of explanations have been provided, few conclusive findings are available. Their absence is even more evident in the general area of intake dropout, and in the specific area of Hispanic intake dropout and therapy refusal.

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Therapy dropout: Patient Factors

A variety of client attributes in relation to outcome and continuation in treatment have been subject to research, including social class, personality, diagnosis, age, sex, ethnicity, intelligence, and length of disturbance.

Socioeconomic Status:

Many explanations linking therapy dropout to patient characteristics have been offered. However not all suggested variables have proven significant.

One of the most predictive variables is patient socioeconomic status. A clear linear and negative correlation has been found between social class and premature terminations (Pilkonis, Imber, Lewis, & Rubinsky, 1984; Bergin & Garfield, 1981). A study of duration of treatment in a barrio-neighborhood mental health service (Kahn & Heiman, 1978) offered a striking illustration of the above. In this setting, where the clinic population was composed largely of lower socioeconomic Mexican-Americans, 75% of the cases came only for one session, 15% for 2 sessions, and only 10% for 3 or more sessions.

Patient, Age, and Diagnosis:

Studies that have sought associations between patient gender, age, and diagnosis and dropout have not found any clear associations between any of these factors (Bowman, D. G., 1993; Garfield, 1994; Malloy, 1981).

Education:

This variable is highly correlated with social class, yet has been evaluated separately in relation to duration of treatment. Most studies have reported a positive relation between education and length of stay, but others have not. In a

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study by Dubrin & Zastowny (1988) lower status occupations and less education were correlated significantly with prematurely terminating therapy.

Race/Ethnicity:

The effect of ethnic match in therapy with Hispanic patients remains uncertain. One analogue study (Acosta, F.X. & Sheehan, J., 1976) reported that Mexican American participants attributed more skill, understanding, trustworthiness, and attractiveness to the Anglo professional than to the Mexican American professional. However, after reviewing literature on race matching, Atkinson (1983) concluded that Hispanics did not seem to show a preference for therapist race or a race effect on therapy process variables, such as perceived therapist credibility, perceived therapist effectiveness, and client verbal behavior. A few years later Atkinson, Poston, Furlong, & Mercado, (1989) found that three fourths of the Mexican American students in their sample *preferred* an ethnically similar therapist to an ethnically dissimilar therapist when given a choice.

In relation to both SES and racial match, Carkhuff & Pierce (1967) found that patients most similar to their therapists in race and social class tended to engage in more and deeper self-exploration.

Regardless, questionable definitions and operationalizations of race and ethnicity undermine many of the results that have been obtained up to now (Zuckerman, 1990; Betancourt & Regeser Lopez, 1993). Future studies need to pay greater attention to the operationalization of these terms, going beyond the use of nominal categories, moving towards the underlying factors that make up that category.

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Acculturation:

A number of studies have looked at the relationship between acculturation levels and mental health (Caetano, 1987; Cortes, 1994; Cuellar & Roberts, 1997). However, no studies were found to have assessed the relationship between acculturation level and therapy dropout.

Values:

Though a number of articles have broached the issue of Hispanic values (Abad et al., 1974; Szapocznik, J., Scopetta, M., Aranalde, M. & Kurtines, W., 1978; Triandis, Marin, Lisansky & Betancourt, 1984; Marin & Triandis, 1985; Javier & Yusseff, 1995; Ruiz, 1995; Marin and VanOss Marin, 1991), none have compared therapist and Hispanic patient values. Nor have they looked at the effects that this match or mismatch has on therapy outcome.

Client preference studies of Hispanic-Americans have explored up to now the relationship between client ethnicity and acculturation, and ratings of therapists of similar and different ethnicities and therapeutic styles. Regarding the importance of therapist ethnicity, it is necessary to keep in mind that these studies have measured client preference, rather than actual dyads in which the ethnicity of the therapist was varied. Until now, the results of these studies have indicated no conclusive evidence in favor or against an ethnically similar therapist. Nonetheless, the fact that the majority of them have been based on a judgment method (by which participants are asked to evaluate or rate therapists who are similar in all characteristics except ethnicity), rather than on actual therapy experiences, undermines these results. Researchers have found that more relevant

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than ethnic similarity alone in the therapeutic process are acculturation and cultural commitment of the Hispanic rater, attitudinal match between rater and therapist, and therapist style (Sue et. al., 1994).

Studies have also varied greatly in the manner by which they have operationalized cultural variables. It often has been assumed that ethnic affiliation is an adequate representation of cultural variation. However it is important to understand that ethnic and cultural differences are not equivalent.

Language:

It is now estimated that Spanish is used by more than 14.5 million people in this country. While this is so, according to the American Psychiatric Biographical Directory (1989), the number of psychiatrists who can communicate in Spanish in the United States is limited.

Beginning in the 70's, a series of studies (Marcos, 1976, 1988, 1994; Marcos & Alpert, 1976; Marcos & Urcuyo, 1979; Perez Foster, 1992; Pitta, Marcos, & Alpert, 1978) consistently showed the significance of language in psychotherapy with Hispanic patients. The phenomena of translation in assessment, bilingualism in psychotherapy, uses of language as an emotional barrier, the implications of language switching, and so forth were also analyzed (Guttfreund, D., 1990; Marcos, L., 1994; Rozensky, R.H. & Gomez, M.Y., 1983).

It is now understood that insufficient language familiarity and usage can be a fundamental obstacle for a smooth establishment of rapport and the ensuing treatment. When therapy is conducted in the patient's second language, the patient often encounters important impediments in expressing him/herself fully.

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Bilinguals often appear less willing to talk and more emotionally withdrawn. They also present as deficient in the cognitive sphere.

In addition, upon finding themselves in an alien culture and language, Hispanic patients often tend to behave in a self-effacing manner. Patients have also admitted that in interviews conducted in their secondary language they are concerned that they will be seen as less intelligent, less friendly, and less self-confident.

Direct misinterpretation of the therapist by the patient may also occur when therapy is conducted in a language that is not the patient's primary tongue. It has been underscored that it is especially important for monolingual English clinicians be aware that their paralinguistic signals may not be meaningful to patients who are from a different cultural background.

The therapist can also misinterpret the Hispanic patient. Kline et al. (1980) reported that whereas Spanish-speaking patients interviewed by an English-speaking interviewer together with an interpreter reported feeling understood and helped and wanting to return, nonetheless, the interviewers reported that the patients felt less understood and helped, and did not want to return to the clinic.

Based on these conclusions, it seems clear that psychotherapy with monolingual Hispanic patients is unlikely to be successful unless a Spanish-speaking therapist is provided. It also appears that therapy with a bilingual Hispanic patient may be enhanced with a bilingual therapist. However,

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insufficient bilingual psychotherapists limit the possibility of offering bilingual therapy to many Hispanic patients.

Therapy dropout**: *****Therapist variables:***

A number of therapist variables are considered to be intricately associated with or predictive of psychotherapy outcome. Beutler et al. (1994) offer three important observations: "1) In statistical analysis, magnitude of benefit is more closely related to the identity of the therapist than with the type of psychotherapy that the therapist practices, 2) some therapists in all therapeutic approaches produce consistently more positive effects than others; and 3) some therapists produce consistently negative effects." Other authors (Wampold et. al., 1997) have conducted meta-analyses of outcome studies revealing that the efficacy of bona fide psychological treatments is relatively equivalent. These findings seem to suggest that other variables, including perhaps therapist effects, may be accounting for some of the differences in treatment outcome.

However, regardless of how true these observations may be, efforts to identify the therapist attributes that may explain these systematic variations have often been unproductive. This may be explained by the fact that the therapist does not exist alone, but rather in interaction with the patient, the particular situation, and the type of therapy practiced. As a result of this, the need for psychotherapy studies that attempt to include both therapist and patient variables becomes evident.

Smith & Glass' (1977) findings and Landman & Dawes (1982) review add support for a shift towards studying particular therapist variables. These indicated

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that nearly 400 controlled evaluations of psychotherapy and counseling showed no difference in effectiveness between types of therapy. This finding suggested that other more sensitive variables, including therapist characteristics, might be involved in the variations observed in treatment outcome.

In addition, Luborsky, L, McLellan, T, Woody, G., O'Brien, C., & Auerbach, A. (1985), Luborsky, et al. (1986, 1987) reported finding that the major component of effectiveness in psychotherapy was the personality of the therapist, particularly the ability to form "a warm and supportive relationship." They concluded that the therapist's personal qualities probably exerted their main influence on an ability to form a helping alliance. And then, since the helping alliance measure was most highly correlated with outcome, the therapist's ability to form this alliance seemed to play a fundamental role in determining his/her effectiveness.

Luborsky, Auerbach, Chandler, Cohen & Bachrach (1971) reviewed existing quantitative research on factors that influenced outcome, and concluded that significant therapist variables included: experience, attitude and interest patterns, empathy, and similarity of patient and therapist. Truax et al. (1966) have underscored the effect of therapist warmth and empathy.

Age:

Age is often confounded by therapist's years of experience. Inconsistent results have been obtained by studies that have assessed the effect of the therapist's age on therapy outcome. Some studies (Beutler, L., Machado, P., & Allsteter, Neufeldt, S., 1994; Thompson, Gallagher, & Breckenridge, 1987) have

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reported successful treatments when the therapist is younger than the patient is. Others (Weisz, Weiss, Alicke, & Klotz, 1987) reported positive results when the therapist was older. However, other studies have indicated that age similarity is also associated with positive therapeutic outcome (Luborsky, Crits-Cristoph, Alexander, Margolis, & Cohen, 1983). Thus, further exploration of the effect of therapist age is necessary.

Therapist expertise and skill:

In a study where 30 of 134 students refused therapy after completing intake, client satisfaction and perceptions of therapist trustworthiness and expertness were related to continuation ((Kokotovic & Tracey, 1987). Luborsky, Auerbach, Chandler, Cohen & Bachrach (1971) found that level of experience and skill were significant factors for psychotherapy outcome. O'Malley, S, Foley, S., Watkins, J, Sotsky, S., Imber, S., & Elkin, I. (1988) made a similar finding in their study of interpersonal therapy of depression.

Gender:

More research on therapy outcome as a function of therapist-client gender-matching is also needed because up to now, the significance of this variable remains unclear.

Some interesting results regarding the effect of gender matching with Hispanic patients have been reported by Levine and Franco (1981). In an analogue study, the sex and ethnicity of a questionnaire administrator affected Hispanic student response rates in that Hispanic women disclosed most when the administrator was also female, and Hispanic men disclosed most when the

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administrator was not only female, but also Hispanic. Gender matching may be a weightier variable with Hispanic patients, given the strict manner in which gender roles are defined in that culture (Abad et al., 1974; Gil & Vazquez, 1996).

Race/Ethnicity:

Despite many counselors being well-intentioned and in possession of strong humanistic values, Ridley (1995), as well as others (e.g., Brody, C., 1987; Carter, R., 1995; Hunt, P, 1987; Martin, T., 1993; Yamamoto, J. James, Q., Bloombaum, M., & Hattem, J., 1967) contend that racial factors, are very present in psychotherapy. In relation to ethnic match, a series of studies (Arroyo, 1996; Babad, Bernieri, & Rosenthal, 1989) have measured the signs and effects of therapist ethnic bias. In Arroyo's analogue study, therapists who were shown either a white or Hispanic patient tended to report less empathy, poorer prognosis, and to associate greater blunted affect with the Hispanic patient. If one considers these findings in light of Shapiro's (1974) conclusions that a therapist's positive feelings toward clients and their positive prognoses for treatment are related to continuation, Hispanic patients' high dropout rates may begin to be clearer.

However, the shape and magnitude of the impact race and ethnicity play in a therapeutic dyad still remains unclear. There are probably countless reasons for this, among them, the intangibility of concepts such as race, ethnicity, and bias, as well as the pragmatic difficulties of studying bias and racism in our fellow therapists. Lopez (1989) suggests as a solution to the lack of empirical studies and/or contradictory findings that have plagued psychotherapist bias studies that certain conceptual limitations, particularly a restricted definition of bias and of a

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biased clinician be tackled. He proposes that the definition of biased clinical judgments be broadened to include overpathologizing/minimizing and over and underdiagnosing. Following these guidelines, Lopez found, after reviewing a significant number of psychotherapy studies, that bias was most consistently evident with the mentally retarded and lower SES members. He also found evidence of race bias with diagnostic judgments.

Sanchez & Mohl (1991) noticed individual differences between caseloads of residents in their study. They stated that "Although working with more acculturated and more educated patients facilitates empathy and understanding in therapists, because of therapists' different *personal characteristics* it is possible some still feel uncomfortable with Mexican Americans. Some residents working at the therapy service at the time of this study never saw a Mexican-American patient, whereas other residents followed the course of several Mexican-Americans at the same time."

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Values:

Although it is obvious that therapists, like all people adhere to values, there is a commonly held belief among clinical psychologists that when working as therapists they are objective and neutral. Value judgments and personal beliefs are to be kept at a minimum, and there is an expectation that specific prejudices be completely absent. However, therapists **do** make value judgments, and the consequences of working without being aware of these values and of the effects that they have on our choice of action can disturb the therapeutic relationship.

Values, assumptions, and practices are closely connected. The assumptions therapists make about people are influenced by their values. If self-determination is highly valued, the therapist will probably assume that in order to be psychologically healthy, people should behave autonomously. These ideas in turn will influence his/her interventions. Research efforts and therapy will be directed at promoting independence (Prilleltensky, 1997). Despite the coherence of this argument, studies of therapists' and patients' values as they relate to therapy outcome have not been overly abundant (Welkowitz, J., Cohen, J., & Ortmeyer, D., 1967; Pettit, Pettit, & Welkowitz, 1974; Lafferty, Beutler & Crago, 1989; Walsh, 1995).

With regards to therapists' values in psychotherapy, Rogler, Malgady & Rodriguez, (1989) comment that the diagnostician's own set of values and theoretical orientation prescribe an outlook that molds the evaluation of a patient's disclosures. Depending on a clinician's general and culture-specific values and orientation, a wide degree of latitude could be induced into the

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diagnosis rendered about a given patient. However, since there are no definite measures of Hispanic values in existence, no empirical studies involving Hispanic values and outcome have been conducted.

Relationship Skills:

The focus on therapists' interpersonal variables can be traced back to Rogers' (1957) therapeutic triad of nonpossessive warmth, empathy, and genuineness, or to Sullivan's (1953) underscoring of a therapist's social style alongside her/his clinical skill. Indeed, a number of studies (Lafferty, Beutler & Crago, 1989) have associated higher levels of empathic understanding to positive therapeutic outcome. Rudy, McLemore & Gorsuch, (1985) also reported that patients were more satisfied when they perceived their therapists as "warm and freeing." This therapist variable could prove to be of even greater significance with Hispanic patients given the collectivistic and allocentric characteristics of this population.

Therapist Behavior:

Patterson & Forgatch (1985) reported that therapists' facilitative and supportive behaviors were followed by a decrease in patients' noncompliance, while teaching and confronting behaviors were followed by an increase in patient noncompliance.

Interpersonal style:

The effect of therapist style in Hispanic psychotherapy has been examined in the last years. Preliminary evidence supports the claim that Hispanics prefer a

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directive counseling style to a nondirective style (Ponce & Atkinson, 1989; Pomales and Williams, 1989).

However, in many of these studies, the definition of therapist styles was not consistent. In an attempt to increase consistency, other studies (Cherbosque, 1987; Folensbee, Draguns & Danish, 1986) have focused on discrete units within the session. The first reporting the positive effect of lesser amounts of therapist self-disclosure, the second reporting the positive effects of therapist affective responses versus closed questioning.

RACE, ETHNICITY, AND CULTURE

When referring to Hispanics often there is a tendency to blend together all Spanish-speaking peoples, as if they constituted one homogenous mass, while glossing over the multiple differences among and within their subgroups. Though it is true that all share a common language and a Spanish heritage, as well as a general set of cultural values, which are based on cooperation and mutual aid, there are also many significant differences. It is important to note that although for the sake of brevity, the term Hispanic is used, Hispanic culture can manifest itself in numerous ways, and varies according to different countries, regions, socioeconomic, political and historical circumstances.

Dissimilarities between Hispanic-American groups are partially a result of the different types of migrations and political ideologies held by these migrant groups. Often they also differ in nationality, geographic origins, educational backgrounds, socioeconomic levels, and religious beliefs. The following demographics of Hispanics in the US begin to exhibit some of these differences.

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Hispanic Demographics:

The growth in numbers of the Hispanic population through immigration and procreation exceeds that of any other group in the United States. According to the U.S. Bureau of the Census of 1990 (US Bureau of the Census, 1994) Hispanics make up about 8.6% of the United States population. It is estimated however that this percentage may be even greater since many undocumented Hispanic immigrants and all Puerto Ricans living in the Commonwealth of Puerto Rico were not included in the Census (Malgady, R., 1994a).

Hispanics vary in their national background, with 63% being of Mexican origin, 11% of Puerto Rican origin, and 5% of Cuban origin. Fourteen percent are from Central and South America and 7% were classified as "Other" Hispanics. Hispanics make up more than 12% of the New York State population, and 24% of the New York City population.

Regarding age, Mexicans, Puerto Ricans, Central Americans, and South Americans (median = 24 to 28 years old) are considerably younger than Cubans (median = 39 years old), and "Other" Hispanics (median = 31 years old).

Cuban families are smaller in size (median = 2.81 persons) than non-Hispanic families (median = 3.13 persons). Central and South American (median = 3.81 persons) and Mexican families (median = 4.06 persons) are the largest.

With regard specifically to Puerto Ricans, (US Bureau of Census, 1991)), their rate of single female-headed families is more than double (43%) Cuban and Mexican rates (19%), and one and a half times the rate of "Other" Hispanics (27%) and Central and South Americans (26%).

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Educationally, Cubans (61%), Central and South Americans (60%), and other Hispanics (71%) are the most likely to complete high school or above. This is still below the non-Hispanic rate of 80%. Mexicans and Puerto Ricans are the least likely to complete high school or more (44% and 58%, respectively).

Unemployment rates for Mexicans and Puerto Ricans run 4% higher than the rate for non-Hispanics, Cubans, and other Hispanics. Striking differences between groups are also apparent. Whereas non-Hispanic men are most likely to be engaged in management and professional jobs (27%), only Cuban men follow this trend (26%). The remaining Hispanic groups are far more likely to be employed as operators, and laborers. In contrast, most Hispanic women, excluding Central and South American women, are most likely to be employed in technical, sales, and administrative support positions, similar in this respect to non-Hispanic women.

Median household incomes of all Hispanic groups are less than that of non-Hispanic households ($30.5K). Cuban ($26K) and other Hispanic ($25.5K) median household incomes are the highest, followed by Central and South Americans ($23.5K), Mexicans ($22.5K), and then Puerto Ricans ($16K). Hispanic families that are below the poverty level differ according to ethnicity. Thus, only 17% of Cubans (compared to 12 % of non-Hispanics) are below the poverty level, as compared to 41% of Puerto Ricans (Rogler, Malgady & Rodriguez, 1989).

An additional change in the global economy and its impact on the U.S. labor market has significant implications for today's new immigrants from Latin

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American countries. They confront a steady decline of industries such as garment manufacturing, which have traditionally provided unskilled, entry-level jobs to newly arrived populations in the United states. Thus, these more recent immigrant groups cannot follow the kind of labor market insertion open to earlier European groups- a significant historical difference that is often overlooked when comparing the integration of turn-of-the-century immigrants with those arriving today (Gurak, D.T. & Rogler, L.H., 1983; Torres, A., 1995).

Culture:

The notion that all Latin Americans share a history and culture can be traced back to the writings of Simon Bolivar through which he attempted to create a unified country out of the disparate Spanish colonies. This notion has continued in various nationalistic movements throughout Latin America. Yet at the conceptual level, this definition is problematic.

The concept of culture can be approached from a multitude of directions, including ethnic identity, language, material signs and symbols, events and celebrations, and values. Social status, age, gender, and acculturation can mediate culture.

Culture is both a product of group values, norms, and experiences, and of individual adaptations and life experiences. "Recent views see it as a person's cultural inheritance of ideas, values, feelings, ways of relating, and behaviors, but also look at social transformations, social conflicts, power relations, and migrations as influencing culture" (Guarnaccia, 1996). It is not static but rather an ever-evolving entity.

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Rohner (1984) proposed as a definition of culture a "highly variable systems of meanings" which are "learned," and "shared by an identifiable segment of a population." The construct of culture would include not only physical elements (e.g. buildings, utensils, etc.), but also less tangible elements (e.g. values, norms, beliefs, roles, etc.). Culture could be understood to cover a gamut of human characteristics, including diverse roles, communication patterns, affective meaning systems, individualism-collectivism, spirituality, religiosity, self and other stereotypes, and so forth.

Hispanic Culture:

A major contribution to Hispanic culture was the introduction of Catholicism and concrete forms of linear thinking. The major Native-American contribution to the *mestizoization* process was that of a general philosophical way of life in which all matter in the universe had a place as an integral factor in an interconnected universe. This philosophy was based on a nonlinear way of thinking (Morones p. & Mikawa, J., 1992).

This ideology, combined with African influences, places a greater emphasis on Nature and endorses a oneness with Nature as opposed to the fragmentation and compartimentalization of phenomena, which occurs in Western scientific thought. As a result of this, health is perceived as the maintenance of oneness in a dynamic system that includes God, the family, the community and oneself (Kreisman, J., 1975).

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Several authors (Betancourt & Regeser Lopez, 1993; Davidson, L., 1988; Kinzie, 1978; Korchin, S., 1980; Lillard, A., 1998; Rendon, M., 1974; Sue, S., 1981, 1988; Sue S. & Zane, N., 1987; Sue, S., Zane, N., & Young, K., 1994; Yamamoto, J, James, & Palley, N., 1968) have questioned the cross cultural generalizability of a number of psychological theories. However, as Betancourt & Regeser Lopez said "the study of culture and related variables pretty much still occupies a secondary position in American (mainstream) psychology." This is particularly surprising in a country that has been and continues to be built by migrants who originate from very diverse cultures. However, efforts are being made to widen the focus of psychological research. Increasingly, it is becoming apparent that only by studying other ethnicities and classes can theoretical and empirical gaps in mainstream psychology, which resulted from focusing almost exclusively on middle class whites, be filled.

With the objective of studying culture, it has been recommended that it be defined in terms of psychologically relevant elements, such as roles and values, through which it can be measured. Then, by incorporating the conceptualization and measurement of specific cultural elements, the comparative study of national, ethnic or cultural groups is more likely to contribute more to the understanding of the role of culture and acculturation than other types of comparative studies.

However, attempts at atomizing culture have also received criticism. One of these critics, Malgady (1994b), states:

When culture is atomized into selective lists of customary values (e.g. Democratic vs. Republican), expected sex roles (e.g. female submissiveness vs. male-female equality)...

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individuals' cultural profiles as native members of the same community will register many, if not all possible, permutations of these traits' values. Hence, the concept of culture becomes superfluous... As one atomizes the essential defining (necessary and sufficient) properties of any concept, such as the concept of culture, the distinctions between concepts are easily blurred.

He goes on to say that any attempt to narrow down subgroups into discrete traits, does violence to the essential nature of the concept of culture in its philosophical and anthropological sense.

In conclusion, he states that "little cultural fine tuning may be necessary for mental health services that have been demonstrated to be effective with one or another Hispanic group." He also proposes "sensitivity to the language, racial, and broad cultural traits of Hispanic culture in general is probably sufficient, although this speculation has not been empirically tested."

Although the above certainly sounds convincing from a philosophical and anthropological perspective, it does not as much from a more practical perspective. This is because in the psychological realm, these speculations will not remain in the abstract, but will have a direct effect on treatment of patients. It is necessary to have a slightly higher degree of certainty that the countless differences in nationalities, social classes, histories, and so forth that Hispanics present are irrelevant. However, Malgady's point is well taken in that it is necessary to guard against dividing subgroups to such an extent that the concepts that are being studied cease to be meaningful. Consequently, a valuable compromise between these two positions involves analyzing the generalities of Hispanic culture and its components and then using this analysis as a foundation for discussing some of the specific differences within the culture.

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Ethnicity:

Culture also manifests itself through ethnic identities, nationality, and language. Ethnicity is defined as a person's membership in a group with a specific national or religious identity (Carter, 1995).

Any attempt at defining Hispanic ethnicity, much like that of any other group's ethnicity is a highly complex undertaking. This is primarily because ethnic identities are not crystallized structures. They shift over time and probably more so when in interaction with other cultural groups (Smith, T., 1980). In addition, one person may have more than one ethnic identity, "each of which may be invoked (voluntarily or involuntarily) in different social situations" (Harwood, 1994).

Hispanic ethnicity, like other ethnicities, has changing political, economical, social, and cultural meanings and values. Thus, for some, Hispanic ethnicity is representative of a welfare-ridden, AIDS-ridden, teenage pregnancy-ridden, drug-ridden, dropout-ridden group -- consequently Hispanics, defined as such, become a social problem (Fitzpatrick, J.P., 1996). While increasingly, from the perspective of businessmen, advertisers, and politicians the term Hispanic ethnicity identifies a lucrative market segment, and a powerful voting block (Oboler, 1995).

The shape and strength of a person's ethnic identity is affected by the receptivity to external influences that is present in the host society and by length of exposure to the host environment. Furthermore, educational level and age at arrival into the host nation have a major and independent effect upon the ethnic

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identity of the immigrant. Arrival at a younger age restricts past social experiences in the native country, thus leading to an ethnic identity that is less firmly established. Concomitantly, higher levels of education tend to weaken the ethnic identity since it provides for a stronger exposure to alternative values and lifestyles. This is true whether the education was received in the country of origin or the host country.

As could be expected, the ethnic identity of the second-generation individuals is less accentuated than the ethnic identity of the first-generation migrants. Gonzalez (1997) found that when interviewing blue-collar mainly third-generation Hispanics in New Mexico, participants could not provide an elaborated ideological conception of separateness from others, and a clear ethnic identity. They tended to be uncertain when asked questions about labels, and to define Spanish-Americans as what they were not ("A person who's not Anglo, or not Indian, or not Black") rather than as what they were.

However, while second and third generation Hispanics experience a change in their ethnic identities, the American identity is also undergoing a change of its own as a result of prolonged and growing contact with Hispanics and other ethnic groups. From this perspective, the bilingual education debate and English Only movements can be seen as raising two issues that concern ethnic identity. The first concerns the role that language is playing in constructing or affirming the identity of the Hispanic ethnic group. The second concerns the role that Spanish language is playing in constructing a different representation of what constitutes an American identity (Oboler, 1995).

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Phinney (1996) attempts to introduce some clarity into this difficult task of defining ethnic identity. She proposes ethnicity be divided into three aspects: 1) cultural norms and values, 2) strength, salience, and meaning of ethnic identity, and 3) the experiences and attitudes associated with minority status.

With reference to cultural norms and values, Phinney proposes measures of specific cultural attributes (dependence, interdependence, strength of family affiliation, maintenance of interpersonal harmony, etc.), rather than simply using general cultural terms.

As regards ethnic identity, Phinney defines it as “a complex cluster of factors that define the extent and type of involvement with one’s ethnic groups.” Ethnic identity can vary between same ethnic group members, and even within an individual over time.

Regarding ethnicity as a minority status, Phinney refers to the important association between one’s situation and experiences in society and one’s ethnic identity. She speaks of many ethnic minorities’ experience of duality, in which they feel partly Black, for example, and partly American.

In conclusion, it is not sufficient to haphazardly include ethnicity in research with ethnic minority persons, it must be adequately operationalized and measured for it to be a meaningful contribution to ethnic minority research.

***Labels (Hispanic/ Hispanic)*:**

The labeling of groups of people has followed a complicated historical process both in Latin America and in the United States. Often these terms have

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been used indiscriminately, or one or another has been used preferentially for political reasons.

Phillip Gonzalez (1997) defines ethnic labels as elaborations of one's ethnicity based on a definition of the group's cultural content and notions, an interpretation of the group's history, and a politicized perspective on the relation between the group's interests and those of the greater society. This interpretation places the focus of the ethnic identity in the person and involves a self-definition. It leaves out the significant influence that definitions provided by other ethnic groups have on a particular group's ethnic identity.

Popular reasoning about the origin of the term Hispanic usually locates it within the legacy of the Spanish conquest and colonization of the New World. This seems reasonable given that Spanish colonial rule lasted for over three centuries, which is certainly long enough for the social, ethnic, linguistic, racial, and national experiences of the populations of Latin America and the Caribbean to establish a homogenous heritage. Oboler (1995) suggests that the definition and uses of the term Hispanic in the United States cannot be found in its Spanish colonial heritage or even in Latin American antecedent debates. Instead, its meaning and social value must be found through exploring the specific context of the US society that fostered the emergence of this ethnic label as an ideological construct.

Particularly in the years following the Civil War, imagined boundaries of inclusion and exclusion in the national community were institutionalized through legalized segregationist practices and customs in relation to previously enslaved

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African Americans. The American ethnic identity was constructed as white, Protestant, and Anglo Saxon, despite the presence not only of nonAnglo Saxon and Catholic Europeans, but also of native Americans and African Americans, as well as Asians, Caribbeans, and Latin Americans of varying classes, races, and national origins.

In spite of legal rights, Puerto Ricans and Mexican-Americans have remained largely unacknowledged as fellow citizens of Americans throughout much of the twentieth century. Exclusion from full rights of citizenship has reinforced the *public* perception of Chicanos, like that of Puerto Ricans, as outside of the boundaries of the popular image of the national community. This explains, for example, Mexican Americans' treatment by US officials, who, at various times throughout the twentieth century, felt no qualms in deporting them at will, regardless of their US citizenship and length of time in this country (Oboler, 1995).

Particularly between 1965 and the mid-seventies, large sectors of Chicanos and Puerto Ricans mobilized in different ways in response to the specific local and regional needs of their communities (e.g. The Young Lords Party, La Raza Unida Party). Internal differences notwithstanding, the various movements of the period reexamined their histories and roots and embraced in different forms and to different extents the cultural nationalistic values, symbols, myths, and traditions of their communities. In so doing, by the mid-1970s Mexican Americans/Chicanos and Puerto Ricans had managed to establish their respective identities, and their presence was acknowledged in the "national community."

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Yet precisely at this point in time, the homogenizing term Hispanic emerges. Through it, the racial, class, gender, and ideological differences within their respective communities were de-emphasized. At the same time, it served the purpose of obscuring the specific historical roots of each group's respective experiences in the United States. So, under the pretext of strengthening awareness of "ethnic diversity" within the "national community," ethnic diversity was instead blurred and erased. Precisely when these groups were emphasizing their distinctiveness and indigenous Latin American roots, a shift towards their Spanish-European heritage and toward homogenization was made.

Acculturation

Exposure to a host culture leads to diverse levels of acculturation. Acculturation has been defined as the "product of culture learning due to contacts between two or more groups" (Beery, 1980). It is the process of adaptation or assimilation by an ethnic or racial group to a host culture (Dana, 1996). Acculturation has been operationalized as measurable by one or more of the following: length of stay in the United States, place of education, generational history, Spanish surname, language usage and proficiency, ethnicity, degree of loyalty toward culture of origin, and by scores on psychometrically developed scales of acculturation (Rogler, Cortez & Malgady, 1991). It is a process of change, both attitudinal (e.g. of values and beliefs) and behavioral (e.g. language usage), undergone by individuals who live in a multicultural society.

According to Beery (1980) there are six areas of psychological functioning where acculturation has a direct effect: language, cognitive styles, personality,

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identity, attitudes, and acculturative stress. This process can result in a variety of outcomes including: a) separation from one's original culture and assimilation of the host culture, b) an integration of and comfort within both cultures - biculturality, c) and marginalization - a rejection by and of the host culture.

Three levels of changes due to the acculturation process have been described. The first includes the acquisition of facts that belong to the new culture and sometimes loss of facts that are part of one's cultural history or tradition (e.g. names of historical figures, national anthem, etc.). The second, the acquisition of visible social behaviors that are appropriate in the new culture and sometimes loss of visible social behaviors from the original culture (e.g. language preference and usage, ethnicity of spouse and friends, etc.). The third, at a deeper level, the acquisition of norms and values stemming from the new culture and sometimes loss of traditional cultural norms and values (Marin, 1992).

Harwood (1994) points out very eloquently the complexities involved in conceptualizing and studying traditional culture and American acculturation. He explains this partly by indicating the widespread influence that the US has had on the rest of the world.

> People in remote parts of the contemporary world, in both rural and urban settings, learn "American" cultural standards from U.S.-made television programs (see, for example, Kottak, 1990, on a study of urban and rural Brazil). Cosmopolitan health care facilities, medicines (van der Geest & Whyte, 1988, 1989), processed food, mass-produced clothing, and other manufactured goods have penetrated to all parts of the globe. In addition, the worldwide spread of factory work has challenged community values, time orientations, and family structures in ways

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similar to those already observable in industrialized nations. Compared to earlier periods, too, proportionately fewer immigrants arrive today without prior exposure to English...

In short, compared to earlier times, many contemporary immigrants have already acquired cosmopolitan cultural orientations in their countries of origin and have internalized them, not as alien accretions or "American" ways, but as part of their own culture.

The complex nature of acculturation increases exponentially when one considers that the penetration of American culture has not occurred evenly in all countries, or across all social classes within the same country. It becomes more complicated when one looks at the cultural and educational differences that already preexisted between persons of the same ethnicity.

In addition, acculturation seems to be affected by a migrant's status (e.g. refugee, voluntary migration), timing, place of arrival, age, and gender (Rogler, Cortez & Malgady, 1991; Cortez, 1994).

Based on the above, it becomes apparent that it would be inaccurate to assume that a particular ethnic group is internally homogenous, as well as to assume that this same ethnic group is necessarily culturally distant from American culture.

Unaware of these complexities, anthropological studies interested in measuring acculturation or assimilation of indigenous populations first conceptualized acculturation according to a linear model. Further advances led to the measurement of separate dimensions of traditionality and acculturation. Over the past years, a significant number of measures of acculturation have been created. Many of them have been specifically designed for use with certain ethnic groups (Szapocznik, J., Scopetta, M.A., Kurtines, W. & Aranalde, 1978; Marin, G

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& Gamba, M., 1996). For Mexican Americans, the Cultural Life Style Inventory (CLSI), Acculturation Rating Scale for Mexican-Americans (ARSMA), Bicultural/Multicultural Experience Inventory (B/MEI), and Measure of Acculturation- (MOC) have been developed. For Cuban-Americans, the Bicultural Involvement Questionnaire (BIQ) has been developed.

However, several major criticisms have been leveled at many of the existing measures. These criticisms have pointed to the inadequate assessment of the diversity within ethnic groups and of their acculturation process (Harwood, 1994; Rogler, Cortez & Malgady, 1991). Betancourt & Regeser Lopez (1993) as well as Phinney (1996) have stated that these measures primarily assess more superficial aspects of acculturation (e.g. behaviors and birthplace) and only represent indirect measures of cultural values. Others (Marin, 1992, Rogler et al., 1991) have pointed out that most published acculturation scales for Hispanics are based on acculturation as a uni-dimensional process or produce scores that are uni-dimensional in nature. In addition, the high levels of internal consistency reliability reported have been criticized because this reliability is achieved at the expense of content validity. It is achieved through a reduction of the process of acculturation to acquisition of the host society's language. Although proficiency in the host society's language is instrumental to acculturation, this process also encompasses adherence to values, interpersonal relations, food preferences, child rearing practices, and other elements of culture (Cortez, 1994) which are not included in most measures. As a result a call has been made for acculturation

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measures to move beyond language items, to include other factors that are more proximal representatives of acculturation.

In addition, it has been pointed out that measures of acculturation have produced a series of contradictory results, which contribute to creating a veil of confusion around this variable. For example, some studies support the hypothesis that increased acculturation is related to stress (Torres-Matrullo, 1976; Warheit, Vega, Auth & Meinhardt, 1985), while others say that achieving biculturalism is conducive to mental health (Ortiz & Arce, 1984; Szapocznik, Kurtines & Fernandez, 1980).

However, the solution is not to eliminate the existing measures of acculturation. The solution is not to replace them with simplified self-judgments either. Ignoring or continuing to inaccurately measure this variable may obscure important intragroup differences and produce inconsistent and irrelevant findings that will only further impede understanding Hispanics.

In fact, certain measurements at the intermediate level of acculturation (e.g. language, behavior) seem to have produced reliable and valid instruments. Acculturation levels, assessed with these measurements, have been associated with Hispanic mental health status, levels of social support, social deviancy, alcoholism, and drug use, political and social attitudes, health behaviors, etc.

It is, however, necessary to be aware that these instruments are tapping a less central aspect of the acculturation process and, therefore, are not the most valid possible measurements of all levels of a person's acculturation. It is important to be aware that at best these are indirect measures of values and

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beliefs. And because of that, it cannot be assumed, just because an individual has a low acculturation score on one of these measures, that he/she is more likely to adhere to traditional cultural values regarding such variables as sex role orientations and collectivism-individualism (Betancourt & Regeser Lopez, 1993). Such a use of the instrument attempts to indirectly assess a level of acculturation for which it has not been designed.

The next step that needs to be taken involves enhancing the existing intermediate level measures by adding assessments of deeper levels of acculturation (e.g. measures of Hispanic values and attitudes). Only with multilevel measurements can a more accurate approximation of an evaluation of acculturation be made.

***Hispanic values*:**

Javier & Yusseff (1995) make the contention that "morality, although assumed to have universal values, is intimately influenced in its development by culture/ethnicity."

Yet even within a culture, important variations occur over time in terms of the values to which persons adhere. Latin Americans are not an exception to this rule. Many of the traditional Hispanic values derive from traditional rural cultures of Latin America. However, urbanization, industrialization, and migration have modified many traditional Hispanic values a great deal.

Despite the variations found in Hispanic culture, some studies (Szapocznik, Scopetta, Aranalde & Kurtines, 1978; Triandis, Marin, Lisansky & Betancourt, 1984) have found commonalties between Hispanics on a general

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moral structure. They have also found that Hispanics as a group can be differentiated from non-Hispanics as a group on these moral or social elements.

Among the values shared by most Hispanics are respeto (respect), dignidad (dignity), familismo, simpatia, confianza, and personalismo. Familism is the strong identification with and attachment to nuclear and extended families and strong feelings of loyalty, reciprocity and solidarity among the members. Confianza is the degree of closeness necessary for intimate disclosures to be possible.

Triandis, Bontempo & Villareal, (1988) have described allocentrism and idiocentrism as psychological equivalents of the social constructs of collectivism and individualism. They have found Hispanic culture to be more collectivist in nature and Hispanics to be more allocentric when compared to representatives from more individualistic societies.

Three basic Hispanic characteristics are respeto, simpatia and interdependence. These are very opposite from the key norms of the Anglo cultural tradition, which seems based primarily on economic success and independence (Szapocznik, 1994).

Linearity in social relations ties into respeto, which is the backbone of the Hispanic moral structure. Not only does this concept underscore the worth of the individual, it also requires special treatment of adults who occupy positions of authority and of elders. Conflicts between Hispanic parents and children often arise around the respeto concept in the US as a result of the differential rates of acculturation between generations.

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As a collectivist culture, Hispanics place a greater emphasis on interdependence and thus the opinion that others have of someone carries a lot of weight. Because of this, shame and other mechanisms of social control ((e.g. religion) are used more than other internal mechanisms, such as guilt. However, as in all cultures, both types of control are used to a degree. Withdrawal of the family's love is a powerful negative reinforcer. Similarly, the negative consequences of the community's disapproval, the acquisition of a bad reputation among the "vecinos" (neighbors), faces the person with the risk of becoming an outcast.

Personalismo is also an outgrowth of a collectivist culture. It is the inclination to relate to and trust people rather than institutions, to dislike formal, impersonal structures. It is associated with preferring services that emphasize flexibility and human contact, while minimizing rigid bureaucracy.

Gender differences are also represented in moral expectations. Women and men are guided by a different and somewhat contradictory moral code. Women are expected to maintain a virginal attitude with regard to sexual behavior, to be submissive, and deferential to men, and to suffer infidelity in silence. They are supposed to do all of this because they are "spiritually superior to men, and therefore capable of enduring all suffering inflicted by men," (Stevens, 1973). These attitudes represent what has been called Marianismo. Based on this, they are trained to believe they are ultimately responsible for maintaining the integrity of the family. As a consequence of the gender expectations for men, which require high levels of sexual activity, women must

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always be watched over, can never be alone with a man, must avoid talking about sex, or even looking into a man's eyes. Based on machismo, men are expected to conquer as many women as possible, but in their role as father they are expected to care for their family. (Abad, 1974).

Triandis, Marin, Lisansky & Betancourt (1984) have studied simpatia (the need for behavior that promotes smooth and pleasant social relationships), a cultural script that is characteristic of Hispanics. The results of three of their studies, which assessed simpatia in Hispanic and non-Hispanic groups, provided proof that Hispanics are in fact more likely than non-Hispanics to expect high frequencies of positive social behaviors and low frequencies of negative social behaviors. Marin (1992) also suggests that a number of Hispanic cultural values (e.g. respeto, linearity, etc.) serve the purpose of encouraging positive interpersonal relationships and of discouraging negative, competitive, and assertive interactions.

Race:

Race is highly variable in Latin America, ranging from white to Mestizo to black. Originally, race was used to refer to biological factors, and more specifically to physical appearance. However, over time, and particularly in the US, race has acquired a fundamental social meaning by which these biological differences, through stereotyping, have become associated with status assignment within the social system.

Race has become a sociopolitical designation in which individuals are assigned to a particular racial group based on presumed biological characteristics,

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or even in some cases, based on language usage. Thus, despite the racial heterogeneity of Hispanics as a group, not infrequently, they are classified as a racial group. This generates serious confusions between the concepts of ethnicity and race.

Carter (1995) dedicates the first part of his book to defining race, ethnicity, and cultural identities and to tracing the presence and effects of race in US culture in general, and in psychotherapy, in particular. However, despite his efforts to provide clarification, a degree of confusion persists around the meanings of these terms and how they differ from the classification of visible ethnic groups.

Defining ethnicity and race in Hispanics is difficult because visible racial characteristics, as well as specific cultural, socio-economic and historical traits are extremely varied in this group. In order to understand the complexity of ethnicity and race in Hispanics living in the US, it is necessary to trace the historical roots of the ideas of race and culture back to Latin America.

Distinctions between Christians and pagans were quickly erased by the relatively quick conversion of the indigenous populations. However, as these religious grounds for separation disappeared, colonial master-slave relations were superimposed on a racial order that became increasingly diversified through both miscegenation and the introduction of the slave trade from Africa.

As a result of extensive racial mixtures throughout the colonies, racial classifications and social status evolved into a hierarchical arrangement. The resulting racial system led to whiter skin being directly related to higher social status and honor, while darker skin was associated both with the physical work of

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slaves and the indigenous populations, and with the shame of those who were conquered. This extreme color consciousness was then integrated into a complex legal and social system which affected marriages, taxes, residential settlements, and so forth (Skidmore, T., 1995).

Aline Helg et al. (1995) explore the difficult dilemma that race posed in diverse Latin countries which from the middle of last century aspired to grow closer to Europe and the US. These authors sustain that several Latin countries were faced with the difficult reality that in order to approach these nations they had to adopt certain pseudo scientific theories of White racial superiority while at the same time their societies were composed of a heterogeneous mix of races.

However, with the passage of time, deep changes occurred in the social organization of many of these same Latin American countries. Over time, social hierarchy became defined primarily by class and not as much by race. This is not to say that ethnicity, nationality, race, and language are not socially and culturally significant in Latin America. Yet it does point to a different way of stratifying groups from the one used in the US, which involves *primarily,* though not exclusively, race over social position.

These diverse kinds of classifications differentially affect people's sense of self and of belonging, their position in society, while simultaneously defining and legitimizing (or in some instances limiting) their political rights and social obligations- and hence their national and cultural identities both at home and abroad. In reference to the significance of class in Latin America, Gimenez (1988) states: "Nationality is not as important in determining patterns of

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association and participation in the host society as social class... Middle and upper-middle class immigrants are more likely to share the values of the dominant classes including class, racial, and ethnic prejudices."

Considering what has been put forth above with regards to Hispanics, the importance of paying greater attention to cultural elements than to race per se becomes evident as they may prove more significant in understanding behavioral differences which until now were associated with racial groupings.

CULTURAL DIVERSITY AND THERAPY:

Rogler, Malgady, Constantino & Blumenthal (1987) have proposed that two events which took place in the sixties brought the need for culturally sensitive mental health services for the economically disadvantaged minority populations to the fore. The first of these two events was the rise of the civil rights movement when Blacks and other minorities demanded that the institutional structure of American society become more responsive to them. The second occurred when President Johnson's Great Society programs were created, and when community mental health programs were developed. Once mental health services were opened to economically disadvantaged populations, traditional institutional frameworks and therapies proved deficient.

Simply reducing the cost of therapy and making it available did not actually expose many lower class patients to psychological treatment (Aponte, H., 1994). It was suggested that clinicians continued to use judgments for appropriateness for therapy that led to a lower proportion of patients in the lower classes being seen as suitable for psychotherapy than in the upper classes (Brill &

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Storrow, 1960). An association between race and dropouts from treatment was also made. Lief and co-authors (1961) reported a surprisingly low dropout rate in their clinic compared to a study conducted at a different clinic. They speculated: "since the dropout rate was twice as high among Negroes as among whites in the Phipps Clinic, our low percentage of Negro patients is probably a factor in our results." They went on to point out the social class issue suggesting that that factor might have been interacting with the racial factor.

The resulting conclusion from both these studies was that the existing treatments were unsuitable and nonbeneficial for lower class and non white patients. Thus Brill and Storrow state that " the present methods of individual therapy... are methods which were designed for use between people who belong to the same social class and who share in common a large number of assumptions." Lief and his co-authors go further, stating: "It is becoming clearer and clearer that there must be many techniques of treatment because no one treatment will be suitable for the entire range of psychological patterns present in the population... Our hands are tied by wasteful attempts to apply analytically oriented therapy to all types of people with all kinds of problems. Let us keep the analytically oriented therapy for Class 2 and Class 3 patients... and devise newer methods more appropriate for class 4 and 5 patients." A decade later, Raynes (1971) found again that the distinguishing feature of patients who failed to attend a psychiatric clinic after referral was that they were Black men or women. Sue and co-authors (1976) reported that among 17 community mental health centers that they studied, patients who were most likely to terminate prematurely were,

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among other variables, members of ethnic groups who had low educational backgrounds. However, some contradictory reports are appearing more recently. In 1989, Mohl et al. reported that among those variables that were found to be significant in psychotherapy refusal was ethnicity. However, more recently a longitudinal study (Sanchez & Mohl, 1992) reported that Mexican Americans currently seem to be utilizing mental health services in proportion to their representation in the community. Preselection of patients may play a role in these higher numbers, though, given that, in this particular clinic, they had to call at least two times, fill out a preregistration form, keep a screening appointment with an Anglo-American staff member, and then have psychotherapy recommended before they began treatment. It was reported in this study that approximately 45% of those who called were eventually assigned a therapist (almost all of whom were Anglo-Americans). In addition the Mexican-American sample had gone beyond high school and no mention of acculturation or language was made.

Lloyd Rogler (1989 & 1994) has actively tackled the problem of Hispanic under-representation in mental health services and research in the US, focusing not only on the pathways that lead patients to seek services, but also on dropout. Rogler (1996) has concluded after reviewing numerous studies that: 1) Hispanic patients are less likely to reach mental health services, 2) are less likely to be retained in the facilities they reach, 3) are more likely to be misdiagnosed, and 4) are less likely to receive adequate treatment. He, among others (Gonzalez, F., 1995; Lefley, H., 1984; Malgady, R., 1994a; Oppenheimer, M., 1992; Sager, C., Brayboy, T., & Waxenberg, B., 1972) has suggested that certain factors must be

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present for the mental health system to be adequate for the needs of Hispanics. To begin with, the therapists should be bilingual and preferably ethnically matched. Second, the facility should present ethnic-specific characteristics, such as ethnically matched literature and décor. Third, it should be organized to address a full range of problems. However, with reference to the need of hiring ethnically matched therapists, Dworkin & Adams (1987) report an interesting if disconcerting finding that requires further analysis. They found that, opposite to what they had hypothesized, ethnically matched case mangers appeared to be related to lower retention of Hispanic patients.

Rogler has also pointed out the significance of patients' acculturation level and knowledge of the therapeutic process in dropout. Regarding treatment modalities, he has indicated that many Hispanics do not meet the criteria for insight oriented therapy because they are not relatively free from external chaos and are not motivated to remain in prolonged treatment. Because of this, it has been suggested that treatment modalities for Hispanics should shift away from insight-oriented treatments to more ecologically oriented and active therapies. Others have proposed alternative treatment modalities, including group (Masnik, R; Olarte, S., & Rosen, A., 1980; McKinley, V., 1987; Simoni & Perez, 1995) and social action models (Paster, V., 1986), along with therapies adapted to specific ethnicities (Sanchez, E. & Mohl, P., 1991).

Alternative explanations for Hispanic under-utilization of mental health services have been provided. The alternative resource theory points to the existence of alternative sources of mental health care (e.g. strong family support

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system, espiritismo). The cultural barrier theory points to the existence of Hispanic cultural values and beliefs that act as impediments to the use of mental health facilities. These include underutilization as a result of insufficient *confianza* (trust), or due to *verguenza* and *orgullo,* (shame and pride), or as a result of a fatalistic attitude. Another explanation involves institutional barriers, a matter that has been discussed in a previous section.

In relation to Hispanic patients' resistance, noncompliance, and treatment failures, a number of articles have offered other speculative and descriptive explanations.

Primarily, mention has been made that from the outset of therapy with Hispanic patients there may be fundamental divergences between the patient and the therapist based on clashing ideologies and values. Hispanic patients may feel that many of their values are challenged and endangered from within the traditional psychotherapeutic perspective (Marcos, L., 1988; Ruiz, P., 1995).

Resistance has also been thought to stem from confusion about the implications of the changes called for in treatment. When a change in behavior or attitude is called for in the treatment process, the Hispanic patients can often misunderstand this, feeling that they are being pushed to become Americanized. They may also confuse changes needed for maladaptive behaviors as being acculturation changes.

Because of the separation that exists between Western medical and psychological treatments and the symptoms addressed, some Hispanics may become confused regarding which services they seek. Expressing emotional

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problems in conjunction with physical complaints is common given that this coincides with the Mestizo viewpoint described by Morones and Mikawa (1992). To ignore this mind-body association may result in patients not reaching the treatments they need.

Erratic attendance (noncompliance) is often interpreted as resistance. However, this resistance can also be understood as often evolving from a cultural prohibition against talking to outsiders about personal or familial problems. The differences between disclosure in therapy and bochinche (gossip) may not be evident to the patient. To overcome the taboo that one should never discuss personal affairs with strangers, patients often attempt to incorporate the therapist into their family or clan network by inquiring about the therapist's personal background or introducing him/her to numerous family members in the waiting room, for example.

An additional factor that sometimes contributes to noncompliance may have to do with a learned suspiciousness of human service agencies.

Minrath (1985) suggests that white therapists should examine their underlying prejudicial beliefs and attitudes. She delineates several unconscious reasons Whites may want to work with minority populations, reasons that, if gone unexamined, could impede therapeutic progress. In addition, clinicians overwhelmed by white guilt often wonder about their own contribution to oppression and may become so anxious and preoccupied when treating the urban poor that their work suffers.

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Inversely, clinicians of minority status may over-identify with patients of their own cultural background and consequently may lose the necessary objectivity for effective therapeutic interventions. The therapist may fail to explore the meanings of events for their patients and assume that their issues are similar to their own.

Bernard (1953) stated "If an analyst has insufficiently analyzed his own unconscious material pertaining to his own group membership and those of others, he and his patients may be insufficiently protected from the interference of a variety of positive and negative countertransferential reactions stimulated by the ethnic, religious and racial elements that are present in the situation, the patient's personality, and in the specific content of the patient's material."

The result of these and other ethnic minority writings has been to provide support for novel treatment modalities, some explanations for minorities' behaviors vis a vis therapy, and new frameworks for research.

CONCLUSION:

Considering the almost complete absence of research on intakes, particularly intake dropout, this is a promising and unexplored area of research. The somewhat unclear findings as relates to certain patient and therapist variables (e.g. patient's ethnicity, acculturation, SES, education, and values, along with therapist's age, race, ethnicity, and values) leave open ground for their application to both intake and psychotherapy research endeavors. This is an especially relevant topic considering the alarmingly high rate of premature terminations of minorities during intakes.

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Specifically, with respect to Hispanic patients, the complexities of adequately defining race, culture, and ethnicity, and the labels that are applied to them, are multiple. Undoubtedly, simplified self-judgments or nominal categories can no longer be used, either for scientific purposes, or for ethical reasons. However, this also faces the researcher with the difficult task of tightrope walking between a homogenizing trend on the one hand, and an atomizing one on the other (Malgady, 1994). For empirical purposes one is pulled towards using discrete units that are more amenable to measurement. Thus culture is conceived of as values, cultural scripts, and roles. Acculturation is conceptualized at intermediate (language based) and deeper (values, cultural scripts, and roles) levels, while important variables of nationality, migration history, race, and specific elements of ethnicity need also to be considered.

Finally, cross-cultural/ethnic minority psychotherapy has not only questioned the universality premise that has pervaded psychology, but also has provided a foundation for doing not only therapy but also research with Hispanics.

The form that this study has taken is based on the above literature review. Thus, among the therapist and patient variables that were collected are SES, age, education, ethnicity, acculturation, values, and interpersonal styles for the first, and SES, age, education, ethnicity, and values for the second. Providing all patients with fluent Spanish-speaking interviewers eliminated difficulties stemming from language barriers.

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Lastly, the complexities discussed above in measuring culture, acculturation, and ethnicity have been factored into the study design. Consequently, these concepts will be distinguished and measured with a series of measures and at multiple levels.

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STATEMENT OF HYPOTHESES:

1) Dyads that are matched on Acculturation will not be significantly related to more or less premature terminations.

2) Dyads that are not matched on Hispanic values will be significantly related to more premature terminations.

3) Dyads that are not matched on ethnicity will be significantly related to more premature terminations.

4) High interviewers' dominance scores will be significantly related to premature terminations.

5) Low interviewer nurturance scores will be significantly related to premature termination.

6) Interviewers with low ratings on empathy will be significantly related to premature termination.

7) Dyads that are matched on Acculturation will not be significantly related to number of missed sessions.

8) Dyads that are not matched on Hispanic values will be significantly related to number of missed sessions.

9) Dyads that are not matched on ethnicity will be significantly related to number of missed sessions.

10) High interviewers' dominance scores will be significantly related to number of missed sessions.

11) Low interviewer nurturance scores will be significantly related to number of missed sessions.

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12) Interviewers with low ratings on empathy will be significantly related to number of missed sessions.

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CHAPTER THREE: METHOD:

Description of Research Site:

The recruitment of patient-participants will take place at Bellevue Hospital Outpatient Department- Bilingual Treatment Program (BTP). This is a clinic designed to treat only Hispanic patients, so it is an ideal setting to obtain a good representation of this ethnic group. Almost all patients have Medicaid coverage, which solves any difficulties around fees. Medicaid provides subway tokens for each visit, which solves the transportation cost problem. Child-care is provided by the hospital for the duration of the visit.

Initial screenings are held on four days a week at this clinic. Two patients are scheduled on each of these days. In total, the patient meets three times with the intake interviewer. This three-interview model allows dropout to be monitored. It also facilitates assessing the effect of interviewer and client characteristics in the initial contact, before being transferred to a psychotherapist.

Description of study population:

Participants: Given that approximately 90% of Hispanic patients who consult the clinic where this study will be conducted are female, only female participants will form part of this project. The age of the participants ranges from 21-70. SES was determined with greater precision during the study using the Hollingshead's Four Factor Index of Social Position (1958). However what was known at the outset of the study was that almost all patients had qualified for Medicaid, which assured a maximum income of less than $300 per month. Patients were Caribbean (Puerto Rican, Dominican, and Cuban), as well as Central and South

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American. Almost all participants were exclusively Spanish-speaking or primarily Spanish-speaking. As regards presenting problems, most of these patients presented anxious/depressive symptoms and most of them were eventually diagnosed with depressive and/or anxious disorders.

Participants who were excluded were: Minors and persons above the age of 70, and those patients who presented severe symptoms such as: suicidal ideation, homicidal ideation, substance abuse, psychosis, and other psychiatric disorders that usually warrant immediate referral to the emergency room for acute management. Intakes that were prematurely terminated by the interviewer after the first meeting due to geographic or other extra-clinical reasons were also excluded from the study.

All interviewers in the study were Spanish-speaking. All had approximately the same amount of clinical experience (two to six years). Interviewers who were not fluent in Spanish were excluded.

Participant Recruitment Methods:

All patient-participants were recruited from the Bilingual Treatment Program, which receives over 250 referrals of Hispanic (primarily women) patients in one year. Informed consent was obtained immediately after the first screening session. This consent was provided in Spanish and was read out loud to the patient because many were unable to read.

A brief description of the questionnaires that would be administered was offered to the patients once they completed the first screening interview. The patients' acceptance to participate in the study was facilitated through the

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provision of a bilingual/bicultural researcher who administered the measures. In addition, all measures were made available in Spanish.

The recruitment of interviewers also took place at the BTP from a pool of psychology externs and interns, social workers, and psychiatry residents.

Procedure:

Both patient and interviewer were administered a demographic questionnaire, the Bidimensional Acculturation Scale (BAS), and the Hispanic Features Measure. Interviewers were also asked to complete the Interpersonal Adjectives Scale (IAS). Patients were asked to complete the Relationship Inventory (RI), rating the interviewer on empathy.

Patients had all four measures administered to them once they completed their first intake interview. Because many of the patients seen at the BTP are not fully literate, a bilingual interviewer read the questionnaires to them. Completion of these questionnaires took between 30 to 45 minutes.

Interviewers were asked to fill out the packet of questionnaires during the first weeks of the academic year. Completion of these questionnaires took no longer than 45 minutes.

Compliance rates (i.e. missed or canceled appointments) and premature termination was reviewed through patient charts.

Confidentiality:

Assigning each participant an identification number that replaced personal names insured the confidentiality of interviewers and patients. All results will be reported as group results; no individual's results will be reported.

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Materials and Instruments

The instruments used to measure the constructs of interest are:
1) a demographic questionnaire; 2) the Multigroup Ethnic Measure (Phinney, 1992); 3) the Bidimensional Acculturation Scale for Hispanics (Marin & Gamba, 1996); 4) the Interpersonal Adjectives Scales (Wiggins, 1995); 5) Hispanic Features Measure (designed for this study), and 6) the Barrett-Lennard Relationship Inventory (Barrett-Lennard, 1962).

1) **Demographic Questionnaire**: A brief demographic questionnaire was used to obtain relevant descriptive information. The format for this questionnaire was based on a longer version developed by Quiñones (1996). It was administered to both patient and interviewer. Items on this measure include age, marital status, educational and work information, racial (white, Black, Asian, native/indigenous) and ethnic background, self ethnic identification, birthplace, years in the United States, age of arrival to the US, and, specifically for the interviewers, information on their multicultural education, and experience with Hispanic patients.

2) **The Bidimensional Acculturation Scale for Hispanics (BAS**): (Marin G & Gamba, R., 1996) Marin and Gamba developed the BAS in the effort to overcome the numerous shortcomings that prior acculturation scales presented. Primarily, their objective was to develop a measure that did not conceptualize acculturation as a uni-dimensional process in which one moves from a Hispanic

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pole to a non-Hispanic pole, and one dimension is lost as the other is gained. In addition, given that few acculturation scales have used data-reduction techniques, these authors planned to develop the BAS utilizing these techniques to psychometrically derive the scales that would form part of it.

The BAS consists of 24 items (12 for the Hispanic cultural domain, 12 for the English cultural domain) that make up three language-related factor subscales. One subscale is labeled Language Use and includes six items (three for each domain) measuring frequency of use of English and Spanish when speaking and when thinking. A second language-related subscale that is labeled Linguistic Proficiency includes twelve items (six for each domain) dealing with how well the respondent speaks, reads, understands, and writes English and Spanish. A third language-related subscale is composed of six items (three for each domain) dealing with the frequency with which the respondents use English and Spanish language electronic media (radio, television, and music). This subscale is labeled Electronic Media. These items are answered using a 4-point Likert-type scale with scores ranging from 4 (almost always) to 1 (almost never) for items 1 through 6 and items 19 through 24, and 4 (very well) to 1 (very poorly) for items 7 through 18.

The BAS was developed and validated by surveying a random sample of 254 adult Hispanics (24% born in Mexico and 52.8% born in Central America). The majority of the respondents were born outside of the United States (79.5%) with a large proportion having arrived within the five years prior to the survey (19.7%). The majority of the respondents (79.9%) were classified as first

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generation Hispanics (i.e. born outside of the United States), 17.3 % were classified as second generation Hispanics (i.e. born in the United States to foreign-born parents), and 2.8% were third generation or higher. The average length of residence in the United States was 15.9 years. The mean age for the sample was 37.3 years. In general women (M=38.3) were slightly older than men (M=36.1 years). The average formal education years were 10.4.

The survey was performed using the Mitofski-Waksberg method for random digit dialing (Waksberg, 1978, cited in Marin & Gamba, 1996). A household was considered to be eligible if those answering the telephone self-identified as Hispanics or identified the majority of residents in the household as such. Within a given household, the respondent was selected by asking for the Hispanic member who most recently celebrated a birthday and was between the ages of 18 and 65 years. Trained bilingual and bicultural interviewers of both genders conducted interviews.

The initial 60 items given to the respondents were obtained through a review of the literature that led to the identification of 30 acculturative changes that could be present in an acculturating Hispanic. The responses of the participants to each of the 60 items were then submitted to factor analytic procedures to identify equivalent factor scales. The resulting factor scales were submitted to validation procedures to assess their effectiveness in measuring acculturation for the whole sample and for Mexican Americans and Central Americans separately. The responses to the 4-point Likert type questions were considered as interval data in order to conduct the various statistical analyses.

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The responses were subjected to principal components factor analysis with oblique rotations and separately for language-related items and for items dealing with social behaviors. The results of the factor analyses were used to identify factor subscales that would make up the acculturation scale. Generally, items were chosen to form part of a particular subscale if they loaded higher than .45 on a given factor and had low loadings on all other factors. An additional criterion of inclusion was that an item had to load in one same factor, regardless of its cultural domain (Hispanic or non-Hispanic). Finally, factor subscales had to have at least three items per cultural domain that met the above requirements to be considered for further analyses.

From the forty language-related items, three language-related factor subscales emerged. From the twenty social items, most did not meet the criteria chosen for the creation of scales. Only the Celebrations subscale emerged from the factor analysis, but since this subscale showed poor validity coefficients, it was not included in the final version of the BAS.

Regarding internal consistency, all of the subscales showed very high internal consistency (range of alpha = .97 for linguistic Proficiency for Non-Hispanic Domain to alpha = .60 for the Celebrations subscale for the Hispanic domain). Overall, once again, the lowest alpha coefficients were found for the Celebration subscales (alpha = .65 for the non-Hispanic domain and alpha = .60 for the Hispanic domain). Among the language-related subscales, the lowest internal consistency was found for the Electronic Media subscales (alpha = .83 for the non-Hispanic domain and alpha =.81 for the Hispanic domain). The

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combined score of the four subscales also showed high internal consistency for the Hispanic domain (alpha = .87) and for the non-Hispanic domain (alpha = .94).

The various subscales and composite scales were validated by correlating them with criteria (generation status, length of residence in the US, amount of formal education, age of arrival in the US, proportion of respondent's life in the US, ethnic self-identification, and correlation with the acculturation score obtained through the Short Acculturation Scale for Hispanics) previously used by researchers developing other acculturation scales (Cuellar, I. & Roberts, R., 1997; Marin et al., 1987; Szapocznik, Kurtines & Fernandez, 1978).

All of the language-based subscales showed high correlations with the various validating correlates with the exception of the correlations in the Electronic Media subscales. The Celebrations subscale showed fairly low correlations with the various validating correlates of acculturation, particularly for the Hispanic domain subscale (Marin & Gamba, 1996).

3) The Interpersonal Adjective Scales (IAS): (Wiggins, 1995) The IAS will be administered to the interviewer, not to the patient. The IAS is a self-report instrument designed to measure two dimensions of interpersonal transactions: Dominance and Nurturance. The IAS consists of a test booklet with a list of 64 adjectives that are descriptive of interpersonal interactions. Using an eight-place Likert-type format, respondents rate how accurately each word describes them as individuals, with 8 corresponding to extremely accurate and 1 to extremely inaccurate. IAS responses yield scores on eight interpersonal variables that are placed on an interpersonal circumplex with Dominance and Nurturance as the

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primary axes. The IAS also measures the respondent's interpersonal type and intensity of type.

The IAS was developed based on approximately 1700 terms for significant human tendencies that were selected by Goldberg (1977). A preliminary taxonomy of Goldberg's list resulted in the identification of eight major domains (interpersonal, character, temperament, etc.). Approximately 800 adjectives were classified within the interpersonal category and were then used as the pool from which the IAS was constructed (Wiggins, 1979).

Items from the interpersonal domain were then further classified into the 16 categories of interpersonal behavior described by Leary (1957). Expert raters coincided in the distribution of 567 items across these 16 categories. Item analyses were conducted using a college student sample that had been administered the 1700 adjectives from Goldberg's (1977) list in self-report format. Preliminary clusters of the 16 interpersonal categories were constructed from these data, and the individual items were evaluated for circumplex properties. However, it was found that the Leary system did not conform well to this model, and as a result, the original theoretical model was revised, and the 1700 adjectives were reevaluated with reference to the 16 genuinely bipolar clusters. A number of circumplex-based item selection procedures were examined in the course of deriving a final set of eight 16-item interpersonal adjective scales (Wiggins, 1995).

A computer program was then written that identified and selected single items in terms of estimated location within the interpersonal circumplex. Its

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Angular Location (displacement from the horizontal LOV axis) and its communality give the location of an item in interpersonal space from the center of the circle. Communality refers to the strength of association between the item and the two axes of the system.

The final version of the scale is made up of interpersonal adjectives that are distributed continuously around the circumplex from 0 to 359 (Angular Location). The interpersonal circle has been partitioned into eight sectors, and sets of eight items of relatively high communality values were selected to form scales located at the center of each sector.

Internal consistency coefficients for the eight IAS scales were calculated using the Cronbach coefficient alpha. The two samples used were a college student sample that included participants from recent research samples, and an adult sample, made up of an employment selection sample, a longitudinal sample, and a volunteer sample. The reliability coefficients were similar for both samples, with only the Unassuming-Ingenuous scale below the .80 benchmark.

More detailed information on circumplexity was obtained through a factor matrix, in which it was evident that the distance of the obtained locations from the expected locations is very small (only 3). In addition, summing the squared factor loadings and then dividing them by the total number of variables (8) yielded the proportion of variance accounted for by the DOM (35.6%) and LOV (35.5%) factors. Together, the two factors accounted for 71% of the covariance among the IAS scales.

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Finally, the residual correlation matrix indicated that the differences between the obtained correlation matrix and the estimated population correlation matrix were small (their absolute mean value = .04).

4) The Barrett-Lennard Relationship Inventory (RI): (Barrett-Lennard, 1962)

The Barrett-Lennard Relationship Inventory (RI) has been in existence for over more than thirty-five years. Based on Carl Roger's (1957) classic conception of the necessary conditions of therapy, in 1959 Barrett-Lennard constructed a 72-item inventory. The primary objective of this measure was to assess therapeutic or helping relationships. Although it was applied successfully to several studies (Barrett-Lennard, 1962; Berlin, 1960; Clark & Culbert, 1965) several considerations prompted further revisions, which led to the development of the current 64 item form. The primary considerations aimed: 1) to broaden the applicability of the RI to significant nontherapy relationships, 2) to adequately reflect theoretical refinements of the concepts of unconditionality and congruence, which had occurred since the original development of the RI, 3) to subject all items to item analysis, 4) to achieve a balance of positive to negative items within each of the four scales, thus further offsetting certain response bias possibilities. A fifth scale called the willingness to be known scale was eliminated primarily because it was not predictive of therapy outcome. In addition, a simpler more experiential language was introduced for some of the more complex or abstract items. The 64-item revision was finally lithographed in 1964 and since then, no major changes to its OS and MO forms have been made by Barrett-Lennard (1978).

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The RI is a questionnaire research instrument that was designed to measure the following four variables: empathic understanding, congruence, level of regard, and unconditionality of regard. Each variable is assessed by sixteen items (eight of which are worded positively and eight of which are worded negatively).

Parallel forms of the RI require the respondent to focus (i) on the other person's response within their relationship (other toward self, or OS forms) and/or (ii) on his or her response to that other (myself to the other, or MO form). An example of an OS question is she cares for me. An example of an MO question is I feel that I am genuinely myself with him.

Each item is answered on a six-step anchored scale (+3, +2, +1, -1, -2, -3), with numerically coded answers ranging from +3 (Yes, I strongly feel that it is true) to -3 (No, I strongly feel that it is not true). They are treated as an interval scale.

Originally, Barrett-Lennard conceptualized this answer system as providing three affirmative and three negative responses (Barrett-Lennard, 1962). He still supports this and proposes that from this viewpoint there is a qualitative difference between, on the one hand, discriminating something as true or probably true, and on the other, deciding that probably something *is* true or probably it is *not* true.

He cites a strong precedent in the California E Scale (Adorno, Frenkel-Brunswik, Levinson, & Sanford, 1950) both for the basic approach (the yes-no

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scheme) and the specific form (use of the same "+" and "-" answers, applied to six categories in two symmetrical groups).

The rationale for excluding a neutral, midpoint category is partly that it could be used by respondents to avoid committing to a reluctant (but real) yes or no answer or, simply, to dispose of the task more easily when a yes or no answer was not immediately clear. However, Barrett-Lennard reasons that it is plausible to infer an implicit, although unused, equally true and untrue middle category, for which the answer code would be zero. He goes on to consider that if it were included it would not require a change in the present number codes, while it would also make all adjacent categories equidistant by literal interpretation of the codes.

The important issue of when to administer the RI must also be considered. Barrett-Lennard originally chose to administer his measure after five therapy interviews to assure a "safe minimum" amount of contact between therapist and patient that would then allow the RI to be completed based on *experience* in *that* relationship (Barrett-Lennard, 1962). However, in retrospect, Barrett-Lennard (1986) believes that he may have "erred a little on the conservative side [since] in most counseling and therapy research by other investigators using the RI, the inventory data have been gathered earlier. In fact, many have administered the RI after only one interview, or, in *analogue studies*, after 30, 20, 15, or even 6 to 10 minutes' contact or observation (Alvarado, 1976/77; Brauer, 1979/80; Brown, 1980/81; Brown & Calia, 1968; Feldstein, 1982; Fretz, Corn, Tuemmler, & Bellet, 1979; Goldfarb, 1978; Mann & Murphy, 1975; McKitrick & Gelso, 1978;

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Melchior, 1980/81; and Seay & Altekruse, 1979)." He contends, however, that such "early" gathering of data necessarily yields results that have a very different meaning than those obtained after several complete therapy interviews. He also states that "after a single interview in therapy, situation-related expectancy and participant characteristics plausibly still would play a major part in the perceptions of responding participants." Nevertheless, a personal communication with Barrett-Lennard regarding the applicability of the RI specifically after one intake session lent support to the decision of using this measure for this project. The following is an extract from a personal communication with Barrett-Lennard: "As far as I can tell, the RI would be applicable in the context you describe, although it is designed to measure qualities in an experienced *relationship,* and after only one contact I think the respondent has, in effect to fill in 'gaps' in directly pertinent experience, on the basis of expectation--which implies that answers may say as much about the respondent as the interviewer. This might not matter in the sense that their picture would still represent their sense of the other's understanding and attitude, which could be predictive as you anticipate."

Use of this measure in a small pilot study provided the actual experience of administering it after one screening interview. Participants had the most difficulty answering the unconditionality items. Based on this, these items (# 7,15, 23, 31, 39, 47, 51, 59, 3, 11, 19, 27, 35, 43, 55, 63) have been removed from the final version of the RI that was used for this project.

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Level of regard and congruence items were administered but were not analyzed, since the focus of this study is primarily on the patient's sense of having been empathetically understood.

Empathic Understanding: The definition of empathy used by Barrett-Lennard is:

Qualitatively, empathic understanding is (A1) an *active process* of *desiring to know* (B1) *the full present and changing awareness of another person*, and (A2) *of reaching out to receive* (B2) *the other's communication and meaning.* This involves (C1) *translating his words and signs into experienced meaning* which(C2) *matches at least those aspects of his awareness that are most important to him at the moment.* All this (D) *is an experiencing of the consciousness "behind another's outward communication* but (E) *with continuous awareness that this consciousness is originating and proceeding in the other* (Barrett-Lennard, 1962, 1981a, 1981b). Elements A1 and A2 imply an active and purposeful engagement with the other (e.g. he/she wants to understand how I see things). B1 and B2 signal that this engagement is directed to the communication, experiencing, and (felt) meanings of the other (e.g. he/she realizes what I mean even when I have difficulty in saying it). C1 and C2 indicate that this engagement unfolds through an accurate experiential grasp of that which has priority or centrality for the other (e.g. He/she may understand my words, but he/she doesn't see the way I feel). D reveals that the process can also go beyond "experiential grasp" to a kind of coexperiencing of features of the other's inner consciousness (e.g. He/she does not realize how sensitive I am about some of the things we

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discuss). E underscores that this coexperiencing occurs within a clear frame of awareness that the point of reference is the *other person's* consciousness, not one's own (e.g. When I am hurt or upset, he/she can recognize my feelings exactly without becoming upset him/herself).

Validity:

Content validity of the measure was obtained through the procedures listed below. In the original development of the instrument, and in later revisions each of the defined interpersonal variables which it was designed to sample were carefully sampled. Direct checks on the effectiveness of these operationalizations involved appraisal of the items by five judges. The judges were asked to classify each statement as a positive, negative or neutral/irrelevant expression of the theoretically described variable. All items which were included in the final version of the measure met the criterion of being classified in the same way by all judges, except for one item which received a single neutral classification (Barrett-Lennard, 1962). In preparing the 64-item revision, three investigators well acquainted with the Inventory and its theoretical orientation were asked to review and comment on the draft selection and wording, given detailed item analysis information as well as theoretical grounding and purposes of the revision. In addition, the draft-revision was used in a research pilot-study with a group of participants who came from counseling and mental health-related professions. These participants were also asked to provide direct feedback on the instrument itself. All of this feedback was largely confirmatory though some critical

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comments and suggestions were also made. These responses were put to use in refining the exact sampling and form of the items (Barrett-Lennard, 1978).

Construct validity was obtained through the positive results of a number of independent predictive studies that looked at the association between the RI-assessed relationship conditions and therapy outcome. In relation to this, Gurman (1977) concluded after extensively reviewing research on this area, "there exists substantial, if not overwhelming evidence in support of the hypothesized relationship between patient-perceived therapeutic conditions and outcome in individual psychotherapy and counseling."

Further refinement of the measure included separately applying the same item-analysis procedure to five samples of data. Two of these samples were from Barrett-Lennard's original study with the RI (Barrett-Lennard, 1962). A third sample was provided by a group of Auburn University students enrolled in an introductory psychology course. They were asked to pick any long-standing relationship, and to use the OS form, thus reporting the other person's response to them. A fourth set of data, obtained with MO forms, was provided by a group of graduate teachers at Auburn, also taking an introductory course in the university. The fifth sample of data was drawn from Hollenbeck's study in which he obtained separate father and mother relationship descriptions (using the 72-item version of the RI) from 50 male and 50 female students in the University of Wisconsin (Hollenbeck, 1965).

The sample of scale scores was divided at the median, and the means of the scores falling into the "upper" half-sample and into the "lower" half-sample

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were determined. The difference between these two half-sample (scale score) means was divided by the number of items used in arriving at the scale scores. This resulted in the average contribution per item to this difference. The actual contribution of each individual item to this difference was then determined by calculating the mean rating or score for each separate item, within each half sample, and then taking the actual difference between the pairs of item means thus obtained for each item. Each item had a directly comparable Item Discrimination Index value, with a mean of unity (+1) for all items in any scale. This transformation was carried out for each set of obtained item difference scores, to achieve inter-sample comparability. Items that were weak or inconsistent contributors to their scale were modified, or omitted.

Reliability:

Adequate reliability was originally obtained from split-half analysis applied to Client and Therapist RI data, and from test-retest correlations for a sample of family and friend relationships. In each analysis and on every scale, reliability coefficients exceeded .80, except for one scale (willing to be known) which was later omitted. In each sample, mean reliabilities across the five component scales were .85 or above.

The review by Gurman (1977) includes the principal published cumulation of internal and test-retest reliability of RI scales based on data from a substantial range of contexts and investigators. Fifteen respondent samples from the work of 12 investigators or collaborating pairs generated the data for internal reliability assessment using split-half and alpha coefficient methods. Results from differing

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RI revisions, from several groups additional to the therapy-relationship majority, and from naturalistic and analogue studies, are included together. Five of the samples used nonEnglish translations/revisions of the RI. In 11 cases, separate reliabilities for all four of the primary scale variables are presented. The means of coefficients cumulated by Gurman are for regard .91, empathy .84, unconditionality .74, and congruence .88. Only one of the fifty coefficients listed is below .67. Sixty percent were .87 or above.

The test-retest reliabilities listed (Gurman, 1977) are based on ten samples, yielding 45 scale and total score coefficients, which range from .61 to .95. There is more evenness across the four scales than in the case of internal consistency, with means of coefficients varying only from .80 (for unconditionality) to .85 (for congruence). The extremes in test-retest intervals were 12 days and 12 months. Taking all the relevant evidence, in view of the heterogeneity of sources, methodologies and specific RI forms, the consistency and levels of obtained reliability are excellent.

5) Hispanic Features Measure:

The plan to create a Hispanic features measure came about partly after considering the critiques that have been leveled at the existing acculturation measures. The objective was to produce a measure of cultural adherence that extended beyond language-based items, achieving a subtler level, which included values and cultural scripts. The first step in this project involved searching general literature on values (Rokeach, M., 1979) and on Hispanic culture and its components (Griffith, J.D., Joe, G.W., Chtham, L.R., & Simpson, D.D., 1998;

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Lopez, S. & Hernandez, P., 1987; Ruiz, P., 1994; Szapocznik, J., Scopetta, M., Aranalde, & Kurtines, W., 1978). The Rokeach Values Scale was not selected for the study for several reasons. The primary reason was that because of its general nature it did not to touch upon certain social components that are associated with Hispanic culture. Secondly, the items' application to the participants' lives was complicated precisely because the values were presented in an abstract, de-contextualized manner. In third place, the need for participants to be literate and to be able to juggle tens of adjectives made this measure difficult to use with this study's pool of patients.

Based on the cross-cultural readings, six items that represented a series of Hispanic values along with a specific Hispanic cultural script were combined (familism, simpatia1, simpatia2, respeto, simpatia3, personalismo) into a first draft. Answers were provided on a four-point Likert-type scale ranging from 1 not at all true to 4 very true. The exact wording was discussed with three native Spanish-speakers as a first attempt in assuring that the items provided accurate reflections of the variables while remaining comprehensible to the population for which they were designed.

Then, four bilingual/bicultural psychologists who served as judges provided content validity by directly assessing the accuracy of the operational translations. The judges were asked to identify which Hispanic value or cultural script each statement represented. They were also given the option of finding them nonrepresentative of these same values. All items met the criterion of being classified in the same way by all four judges.

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The next step involved assessing whether this measure could actually differentiate between a Hispanic and non-Hispanic sample. The measure was administered to Hispanic and Anglo women whose ages ranged from 18 to 65 years. Ethnicity was assessed through a three-generational ethnicity self-report on the part of the participants (e.g. self, mother, father, paternal and maternal grandparents).

Non-Hispanic scores were obtained from a patient sample in the Northeast, and from several samples of church-goers, staff from two schools, and various professionals in the South. In total, 37 Non-Hispanic participants were recruited. As regards SES (based on Hollingshead's index of social position for which 1 = lowest/ 5 = highest), 14% were Level 1, 19% were level 2, 33% were level 3, 17% were level 4, and 19% were level 5. Hispanic scores were obtained from service personnel (maids, gardeners, and janitors) and varied professionals. In total, 52 Hispanic participants were recruited. As regards SES, 27% were level 1, 17% were level 2, 21% were level 3, 21% were level 4, and 13% were level 5.

All non-Hispanic participants (37 in total) were third generation, United States citizens. Hispanics (52 in total) were, but for the exception of two, all born in Latin America or had arrived in the United States as children.

Reliability and validity analyses were run on the responses given by the 89 participants. Reliability was analyzed by calculating the correlation coefficients of the six items that constituted the measure. The results were disappointing (alpha = 0.0151-- see Table I). Upon closer examination of the correlations between each item, it became apparent that two items in particular (both of which

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were meant to assess "simpatia," labeled simp 2 and simp 3) were correlating negatively with the other items. After removing them, leaving four items in total, the correlation coefficient improved somewhat (alpha = 0.4241-- see Table II). However low internal consistency of the measure was still evident.

An analysis of the validity of the measure was then conducted by using T-tests (See Table III) to compare the means of two independent groups (Hispanics and non-Hispanics). Two items (simp 2 and 3) presented results that were different from those of the remaining items. Simp 2 provided a slightly higher mean for the non-Hispanic group than for the Hispanic group (non-Hispanic mean = 2.7027/ Hispanic mean = 2.2500) and simp 3 displayed no difference between the means of both groups (p = 0.030). These T-Test results along with the above negative correlations of these same two items with the other items led to the decision of significantly modifying their wording in the final version. The results of the other four items indicated that Hispanic means differed significantly from Non-Hispanic means. The probability that these means could have differed to this extent by chance is extremely low (Family: p = 0.000, Simp1: p = 0.000, Respeto: p = 0.000, and Personalismo: p = 0.008).

The results of the above reliability and validity analyses are disconcerting at first. Since all items were designed to assess a level of Hispanic culture one would expect that if one item is strongly endorsed all others would also be endorsed and vice versa. However, this did not occur. Individual differences in the endorsement of items came through regardless of ethnicity. Some values were consistently favored over other values. This could be understood as providing

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support for those who oppose the concept of Hispanic culture as a separate and measurable entity, given the numerous differences that exist within Hispanic groups and the overlap that can occur between all cultures (especially in times of mass media and accessible international travel). However, these results could also be seen as reflecting the natural internal inconsistency found in any cultural value-set (related to the existence of individual differences within and among cultures), while not completely obliterating all notions of culture and cultural diversity. Support is lent to this hypothesis by the results of the validity analyses that indicate that although internal consistency is lacking in the scores, a detectable and significant difference between Hispanics as a group and non-Hispanics as a group is apparent.

After reviewing these results, a decision was made to re-work the items that had not proven to be sensitive measures and to add six other items that tapped into Marianismo and to the original values targeted by the first version of the scale. Items 5, 8, and 11 were reversed to guard against response set.

This new 12-item scale was then administered to all the Hispanic patients in the study (n = 112), to a few other patients in the clinic (n = 9) and to all the intake workers (n = 23) who participated in the study. A total of 121 patients and 23 therapists were asked to fill out this scale.

The final version of the scale (see page 131-135) includes items of familismo (three items), simpatia (three items), respeto (one item), personalismo (two items), and marianismo (three items). Once again, a four point Likert scale ranging from: 1 not at all true to 4 very true was used.

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Reliability and validity analyses were run on the responses given by the 121 patient and clinician participants. Reliability of the patient scores was analyzed by calculating the correlation coefficients of the twelve items that constituted the measure. The results were better than for the first six item measure now presenting a moderate positive correlation (alpha = 0.5567-- see Table IV). However, internal consistency is still limited. Upon closer examination of the correlations between each item, it became apparent that three items presented a weak negative correlation with the other items. This is an indication that the selected items are still not coherently representing the construct they are expected to measure.

Reliability of the clinician scores was also analyzed by calculating the correlation coefficients of the twelve items. The results were disappointing indicating a weak negative correlation (alpha = -.1835--- see Table V). Internal consistency was very low with five items correlating negatively with the other items and all other items presenting low correlation coefficients.

A validity analysis of the measure was performed by comparing the patient scores on this measure to the Bidimensional Acculturation Scale (BAS). The hypothesis was that if the Hispanic Features Measure were a valid measure of acculturation, it would be positively correlated with the Spanish domain score and negatively correlated with the English domain score. The results indicated that the measure presents a moderately negative correlation (r = -.3690, p = .000) with the English domain scores of the BAS. It presented a positive but low correlation (r = .1802, p = .057) to the Spanish domain.

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A validity analysis of the measure was then performed by comparing the clinician scores on this measure to the BAS. The hypothesis was again that if the Hispanic Features Measure were a valid measure of acculturation it would be positively correlated with the Spanish domain score and negatively correlated to the English domain score. The results were exactly opposite to what was predicted. The correlation to the English domain was positive ($r = .2252$, $p > .05$) and the correlation to the Spanish domain was negative ($r = -.2951$, $p > .05$).

A third analysis of the measure was then performed using socio-economic status (SES) of the patients and their scores on this measure. The results indicated that there is a moderately negative correlation ($r = -.3970$, $p < .001$) between SES and scores obtained on this measure. In other words, patients with lower SES tended to score higher or endorse more items on the scale.

When this same analysis was made of the clinician scores and their SES, the results also showed a negative tendency ($r = -.1641$), or rather, a lower SES correlated with a higher score. However, this correlation was not significant ($p > .05$).

The results of the above reliability and validity analyses require some discussion. All items were designed to assess adherence to Hispanic cultural features. However, not all items seem to do this. Internal consistency is moderate within the patient sample, and extremely low within the clinician sample. As regards the patient sample, one possible explanation for this moderate internal consistency has to do with the number of years the participants have lived in the United States. This sample of patients has been in the United States a mean

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of 17.8 years. Although many of them may not have acquired linguistic competence over those years, they have probably been exposed to the non Hispanic culture in one way or another. This suggests that although language competence and usage may be a good sign of acculturation, it may not be tapping into other forms in which the host culture is influencing the immigrant. With this, what is being suggested is that it may be possible to not master the dominant language of a country and yet to adapt and adopt beliefs and values of the country of residence. In this case, linguistic competence and usage might actually be measuring one visible aspect of acculturation while other nuances of acculturation are not being detected. As for the clinicians, they are uniformly bicultural based on their acculturation scores and the years they have spent in the US and in a non Hispanic educational system. It seems possible that they may be providing fluctuating endorsements of the different items on the Hispanic Features measure as a result of this.

While the above speculations about acculturation may be on the right track, it is still evident that English language competence and usage along with exposure to the English media increases the chances the immigrant has to become familiar with the host culture. The moderately negative correlation between the English domain of the BAS and the Hispanic Features scores corroborate this. Spelled out, this correlation means that patients who reported speaking less English and being exposed less to English media tended to endorse the Hispanic Feature items more. Spanish mastery and exposure were not as strongly correlated to the Hispanic Features measure. This would seem to indicate that

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language mastery is not just a sign of acculturation but also a medium for acculturation. Not being able to communicate in the host language imposes a limit on transcultural interactions, as a result of which traditional Hispanic values may remain more intact.

One additional factor that correlated with this measure is socio-economic status (SES). Results showed that lower SES respondents tended to score higher on the Hispanic features measure. This seems to indicate that the items in this measure which were designed to assess traditional Hispanic values coincide with lower social status values.

In conclusion, the administration of the Hispanic Features Scale as part of this study shows that this measure tends to correlate negatively with socio-economic status (education and occupation) and with English competence and usage. When administered to the highly bicultural clinicians, who were pretty uniformly distributed on upper middle and upper socio-economic status, the measure provided evidence of very low internal consistency and no significant correlations with socio-economic status. This measure will require further adjustment and more precise definitions of its items before it is again administered. In its present state any conclusions based on this measure must be at the least tentative.

8) Chart records: Compliance rates and premature terminations were recorded in patient hospital charts. These charts were checked periodically, approximately one month after the first screening session.

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Data Analysis:

The analytic objective in this study involves attempting to identify predictors/correlates of failure in the screening process for psychotherapy. Failure is operationally defined in two different ways. The first of these is a simple dichotomous variable, completed the screening process versus did not complete the screening process. The second operationalization is a continuous variable that is a simple count of the number of sessions missed or canceled by the patient.

The set of predictor, or independent, variables is composed of a number of measures. Two of these measures are discrepancy scores that indicate the degree of difference between the patient and the interviewer in the areas of 1) acculturation and 2) adherence to Hispanic values. For each of these areas, the degree of fit, or more accurately lack of fit between patient and interviewer will be operationalized using the Euclidean distance metric commonly used in cluster analysis. More specifically, the square root of the sum of the squared differences between the scores of patient and interviewer across the subscales in each area will be used to operationally define the lack of fit between patient and therapist. This measure ranges from 0 implying no lack of fit to some upper limit defined by the maximum possible discrepancy between patient and therapist across the score profile of each area. The other independent variables are two scores corresponding to the dominance and nurturance dimensions of the Interpersonal Adjective Scales, the empathy subscale of the Barrett-Lennard Inventory, a

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measure of how the patient perceives the interviewer, and ethnic match and nonmatch between patients and clinicians.

Given these measures, the first analysis to be conducted will involve the use of logistic regression analysis (chi square model) to predict the dichotomous outcome-- successful versus unsuccessful completion of the screening process. The set of independent variables outlined above will constitute the predictor set in this analysis. The second analysis involving the continuous outcome measure, number of missed and canceled sessions, will again be predicted using the same set of predictor variables. Here, however, the analytic strategy will shift from the use of logistic regression, which is appropriate for categoric outcomes, to the use of multiple regression analysis that is appropriate for continuous outcomes.

In each of these analyses, the overall goodness of fit of the prediction model will be evaluated via the use of a pseudo R^2 in the first analysis and the conventional R^2 in the second, along with the conventional statistical significance tests associated with these models. Assuming that the models do significantly predict the outcome measures, the net relationship of each predictor to each outcome will also be assessed using the odds ratios in the logistic regression analysis and standardized partial regression coefficients, i.e., beta weights, in the multiple regression analysis. The magnitude, direction, and statistical significance of each of these net relationships will be reported and discussed.

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CHAPTER FOUR: RESULTS

Demographic Information:

Sample demographics:

Patient and intake workers' demographic information, including age, ethnicity, race, marital status, and socio-economic status (SES), foreign or US born, and years living in the US was collected. The two participant samples varied on many aspects including ethnicity, race, socio-economic status, and age. As regards ethnicity, nearly two-thirds of the patient participants were Caribbean (Dominican and Puerto Rican) and one third were from Central or South America. The intake worker sample was made up of Anglo and African-Americans (21.7%), South or Central Americans (34.8%), and Caribbeans (43.5%), including Dominicans, Puerto Ricans, and Cubans.

As regards race nearly the entire patient sample self-identified as White/Hispanic (98.3%). The intake workers sample was evenly split as White/non-Hispanic (47.8%) and White/Hispanic (47.8%). There was one intake worker of African-American origin.

As regards socio-economic status (SES), because of some skewing in the patient sample due to one outlier, the median is reported instead of the mean. The median social position for the patient sample was a one (out of five--one being the

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lowest level), while intake workers had a mean social position of 3.83 out of five (upper middle level).

As regards marital status, 25% of patients were single, 30.4 % were married or living with someone, 31.3% were separated or divorced, and 12.5% were widowed. 60.9% of the clinicians were single, 34.8% were married, and 4.3% were widowed.

As regards age, the mean patient age was 45.52, while the mean intake worker age was 31.91.

Nearly the entire patient sample was born outside of the US (96.4%). As regards years of living in the United States, the patient sample had lived a mean of 17.8 years in the US, while intake workers had lived a mean of 14.63 years in the US.

The scores obtained by the patient sample indicated that the patients were generally unacculturated to the English domain ($\bar{x} = 1.82$, SD = .75) and highly acculturated to the Spanish domain ($\bar{x} = 3.45$, SD = .40). The scores obtained by the intake worker sample indicated that they were acculturated both in the Spanish ($\bar{x} = 3.03$, SD = .52) and English domains ($\bar{x} = 3.63$, SD = .44), with slightly higher scores in the English domain. This suggests that the intake workers tended to be bicultural, while the patients remained predominantly monocultural (Spanish) regardless of the years they have lived in the US.

The scores obtained by the patient sample on the Hispanic features measure indicated a moderate adherence to Hispanic values/features ($\bar{x}= 2.69$, SD

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= .45). The scores obtained by the intake workers on this same measure indicated a lesser adherence to Hispanic values/features ($\bar{x}$ = 2.0, SD = .24).

The intake worker sample tended in general to assess themselves as more nurturant ($\bar{x}$= 1.70, SD = .85, out of -.26 to 3.5) and less dominant ($\bar{x}$= .16, SD = .99, out of –1.9 to 1.9).

The patient sample tended to assess their intake workers as moderately empathic ($\bar{x}$= 25.21 out of a total of 48 points, SD = 10.84).

Patient dropout from the intake phase that lasts three sessions was 33.9% with a total of 66.1% who completed the intake process and were admitted into the clinic. Out of a minimum of zero missed sessions to a maximum of 2 missed sessions, patients missed a mean of .65 (SD = .79) sessions.

Correlational analyses:

The independent variables of the study included discrepancy scores between the patient and clinician samples on acculturation and adherence to Hispanic values, as well as ethnic match or mismatch between clinician and patient, clinician dominance and nurturance, and clinicians' empathy as perceived by the patient. The dependent variables included patient dropout and number of missed sessions.

A chi-square model was used to determine whether the six independent variables just noted were predictors of intake dropout. This correlational model was chosen because dropout is a dichotomous (yes/no) variable. The results

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indicated that when combined in the same equation, the six independent variables were significant predictors of number of patient dropouts ($x^2 = 54.637$, $df = 6, p < .01$.

Hypothesis I: Hypothesis I stated that intake dyads that were matched on acculturation would not show less dropouts. This was stated because the measure used is based almost exclusively on language usage and competence. It was believed that a discrepancy on language competence between patient and clinician would not be related to dropout. This hypothesis would be confirmed by the absence of a correlation between the magnitude of discrepancy between patient and intake workers' scores on the Bidimensional Acculturation Scale (BAS) and dropout. This hypothesis was confirmed. The results obtained from the chi square model indicated that there was no significant correlation between patient and intake worker acculturation discrepancy and dropout. (partial $R = .0000$, $p > .05$—see Table VI).

Hypothesis II: Hypothesis II stated that intake dyads that are matched on adherence to Hispanic values as measured by the Hispanic Features measure would be correlated to more dropouts. This hypothesis would be confirmed by a significant positive correlation between the magnitude of discrepancy between patient and intake workers' scores on the Hispanic Features Scale and dropout. This hypothesis was not confirmed. The results obtained from the chi square model indicated that there was no significant correlation between patient and intake worker discrepancy on adherence to Hispanic values discrepancy and dropout (partial $R = .0000$, $p > .05$—see Table VI).

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Hypothesis III: Hypothesis III stated that ethnically mismatched dyads would be significantly correlated to greater number of dropouts. This hypothesis would be confirmed by a significant positive correlation between ethnic mismatch and dropout. This hypothesis was not confirmed. The results obtained from the chi square model indicated that there was no significant correlation between ethnic match or mismatch and dropout (partial $R = .0000$, $p > .05$).

Hypothesis IV: Hypothesis IV stated that high interviewer dominance scores on the Interpersonal Adjectives Scale (IAS) would be related to greater numbers of dropouts. This hypothesis would be confirmed by a significant positive correlation between dominance scores and dropout. This hypothesis was not confirmed. The results obtained from the chi square model indicated that there was no significant correlation between intake workers' dominance scores and dropout (partial $R = .0000$, $p > .05$—see Table VI).

Hypothesis V: Hypothesis V stated that higher interviewer nurturance scores on the IAS would be related to lesser numbers of dropouts. This hypothesis would be confirmed by a significant negative correlation between nurturance scores and lower dropout numbers. This hypothesis was not confirmed. The results obtained from the chi square model indicated that there was no significant correlation between intake workers' nurturance scores and dropout (partial $R = .0000$, $p > .05$—see Table VI).

Hypothesis VI: Hypothesis VI stated that lower empathy ratings on the Barrett-Lennard Relationship Inventory (RI) would be related to higher dropout numbers. This hypothesis would be confirmed by a significant negative

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correlation between empathy ratings and dropout numbers. This hypothesis was confirmed. The results obtained from the chi square model indicated that there is a significant and moderately strong negative correlation between patients' perception that their intake worker was empathic and dropout rates (partial R = -.3474, $p < .01$ — see Table VI).

Multiple regression analyses:

A multiple regression analysis was used to test the correlation between the set of independent variables (discrepancy scores of acculturation and Hispanic values, ethnic match or mismatch, intake workers' dominance and nurturance and perceived clinician empathy) and the number of missed sessions. Multiple regression could be used because the number of missed sessions is a continuous variable. The results indicated that when taken as a set, the independent variables are significant predictors of number of sessions missed by intake patients. These six variables could explain 25 % of the variance in the analysis when combined ($R^2 = .24799$, $F = 5.71594$, $df = 6$, $p < .00001$—see Table VII).

Hypothesis VII: Hypothesis VII stated that intake dyads that are matched on acculturation would not be correlated to more missed sessions. This hypothesis would be confirmed by the absence of a correlation between the magnitude of discrepancy between patient and intake workers' scores on the BAS and missed sessions. This hypothesis was confirmed. The results obtained through a multiple regression analysis indicated that there is no significant

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correlation between discrepancy of patients and intake workers' acculturation and number of missed sessions (r = .039, p > .05-- see Table VII).

Hypothesis VIII: Hypothesis VIII stated that intake dyads that are less well matched on adherence to Hispanic values would evidence more missed sessions. This hypothesis would be confirmed by a significant positive correlation between the magnitude of discrepancy between patient and intake workers' scores on the Hispanic Features Scale and missed sessions. This hypothesis was not confirmed. The results obtained through a multiple regression analysis indicated that there is no significant correlation between discrepancy between patient and intake workers' Hispanic features scores and number of missed sessions (r = .131, p > .05-- see Table VII).

Hypothesis IX: Hypothesis IX stated that intake dyads that were not matched on ethnicity would be correlated with more missed sessions. This hypothesis would be confirmed by a significant positive correlation between ethnic mismatch and number of missed sessions. This hypothesis was not confirmed. The results obtained through a multiple regression analysis indicated that there is no significant correlation between ethnic match or mismatch and number of missed sessions (r = .0142, p = .882—see Table VII).

Hypothesis X: Hypothesis X stated that high interviewer dominance scores on the IAS would be correlated with a greater number of missed sessions. This hypothesis would be confirmed by a significant positive correlation between higher dominance scores and missed sessions. The results obtained through a Pearson correlation of this individual variable indicated that therapist dominance

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is positively correlated with number of missed sessions (r = .398, p = .000). However, a multiple regression analysis indicated that there was no significant correlation between intake workers' dominance scores and missed sessions (Beta = .185367, p > .05). It can be noted however that therapist dominance has the second highest Beta weight (Beta = .185367) after empathy (Beta = -.362433—see Table VII). A second look at the Pearson correlations also revealed a significant negative correlation (r = -.666, p = .000) between intake workers' dominance scores and perceived empathy of the intake worker by the patient (See Table VII). This seems to indicate that higher self-ratings of dominance by intake workers correlate negatively with ratings of empathy by patients.

Hypothesis XI: Hypothesis XI stated that higher interviewer nurturance scores on the IAS would be related to fewer missed sessions. This hypothesis would be confirmed by a significant negative correlation between nurturance scores and number of missed sessions. This hypothesis was not confirmed. The results obtained through a multiple regression analysis indicated that there was no significant correlation between intake workers' nurturance scores and numbers of missed sessions (r = .022, p > .05—see Table VII).

Hypothesis XII: Hypothesis XII stated that lower empathy ratings on the Barrett-Lennard Relationship Inventory (RI) would be related to a higher number of missed sessions. This hypothesis would be confirmed by a significant negative correlation between empathy ratings and number of missed sessions. This hypothesis was confirmed. The results obtained through a Pearson correlation indicated that there is a significant negative correlation (r = -.460, p = .000)

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between patients' perception that their intake worker was empathic and number of missed sessions. A multiple regression analysis then also indicated that there is a significant negative correlation (Beta = -.362433, p = .0029—see Table VII) between patients' perception that their intake worker was empathic and number of missed sessions.

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CHAPTER FIVE: DISCUSSION OF RESULTS

The hypotheses relating five of the independent variables (discrepancy between patient and intake workers' acculturation; discrepancy in adherence to Hispanic values; ethnic match/mismatch between clinician and patient; and therapist dominance and nurturance) was related to patient dropout from intake were not corroborated by the results. However, the sixth hypothesis -- that perceived intake worker empathy by the patient was related to patient dropout from intake -- was strongly corroborated by the results. There was a significant negative correlation between the two variables, indicating that there tends to be less dropout when the patient reports feeling more empathy from the intake worker.

The hypotheses that number of missed sessions was related to therapist nurturance, to discrepancy between patient and intake workers' acculturation and adherence to Hispanic values, ethnic match/mismatch between clinician and patient ethnicity were not corroborated by the results. However, the fifth hypothesis, suggesting that intake workers' self-assessed dominance was related to number of missed sessions, was corroborated. A significant positive correlation between intake workers' dominance and number of missed intake sessions was found. The sixth hypothesis, that intake workers' perceived empathy was related to the number of missed sessions, was also corroborated. A significant negative correlation between empathy ratings and number of missed sessions was found. In addition a significant negative correlation was found

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between these two variables (empathy rating and dominance), suggesting that intake workers who rated themselves as more dominant also tended to be rated by their patients as less empathic. When these variables were analyzed using multivariate techniques, the results showed only one significant correlation, a significant negative correlation between empathy ratings and number of missed sessions. This suggests that the predictive value of clinician empathy ratings by patients overshadows any of the other variables, including clinicians' dominance.

Several authors (Malgady, R., 1994; Oppenheimer, M., 1992; Rogler, L.H., Malgady, R.G., Constantino, G. & Blumenthal, R., 1987; Ruiz, P., 1995) have suggested that cultural and ethnic match between patients and clinicians is a necessary factor for the retention and successful treatment of minority and, more specifically, Hispanic patients. The results of this study did not support these speculations. The study was designed so that a language barrier between patients and clinicians did not overshadow other variables. All clinician participants were fluent in both English and Spanish. Several other factors could explain the results obtained.

It is possible that whether the clinician is able to communicate in the patient's dominant language may be more critical than whether s/he is from the same country or is similar to the patient in acculturation levels. This may be particularly true in these initial and time-limited contacts.

Second, discrepancies in patient/clinician intermediate level acculturation might not be related to patient noncompliance because such discrepancies coincide with the patient's expectations. It would be improbable that a clinician

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who works in a major city hospital and speaks both languages would not be exposed to the English/American culture. Actually, it is not uncommon for patients to look to the clinician as a cultural and linguistic guide within the system.

As regards the nonsignificant relation between patient and clinician Hispanic values discrepancy scores and intake outcome, these results should be interpreted cautiously due to the statistical fragility that characterizes this measure. It is, however, also possible that because contact is limited to three sessions, discrepancies between deeper cultural variables would not be evident to the patients and would then not influence outcome.

Clinician empathy (Lafferty, P., Beutler, H. & Crago, M., 1985; McLemore & Gorsuch, 1985; Rogers, C.R., 1957; Sullivan, H.S., 1953; Truax, C. et al., 1966) has consistently been mentioned as a significant factor in therapy success. It can be hypothesized that particularly within the Hispanic culture, which tends to encourage positive and non confrontational interactions (Triandis, H., Marin, G., Lisansky, J., Betancourt, H., 1984), an “empathic” attitude on the clinician’s part might be critical in the success of the intervention. Confirming this expectation, this factor proved to be highly predictive of both patient dropout and missed sessions. In fact, out of the five factors that were included in the study, it was the only one that was significantly related to these two intake outcomes. However, while this confirms that perceived empathy is a good predictor of patient compliance/noncompliance with intakes, it is still unclear what leads the clinician to be perceived as empathic or not empathic.

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The literature (Elkin, 1999; Garfield, 1997; Lambert & Okiishi, 1997; Luborsky, Auerbach, Chandler, Cohen, & Bachrac, 1971; Luborsky, et al., 1987; Luborsky, McLellan, Diguer, Woody, & Seligman, 1997; Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1971) has emphasized the relevance of therapist characteristics on therapy outcome. Therapist expertise, age, SES, education, behavior, and expectations have all been mentioned as probably being relevant in therapy outcome. Specifically, Patterson & Forgatch (1985) reported that therapists' supportive behaviors were followed by a decrease in patients' noncompliance, while confronting behaviors were followed by an increase in patient noncompliance. The present study focused on clinician nurturance and dominance as they related to intake outcome. The results did not corroborate that clinician nurturance is related to noncompliance. They did, however, provide some interesting, if partial, corroboration of the relation between clinician dominance and number of missed sessions. When the dominance variable was looked at alongside the empathy variable, additional information for an interpretation of the observed outcome was provided. It seems that those clinicians who self rated themselves as possessing dominant traits, many of which might be considered assertive traits, tended to be rated by their patients as less empathic. A cultural interpretation suggests that these clinicians' and patients' interactions may stem from very different behavioral norms and suppositions. From the simpatia cultural script, assertiveness may be perceived as unempathic given the strong tendency in Hispanic culture against negative and competitive interactions. From the more acculturated clinician's perspective, assertiveness

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within their professional role may be appropriate and positive. The interaction of these two differing behavioral norms may clash and lead to the patient making an interpretation of the clinician's behavior that is very different from what the clinician thinks he/she is communicating. This finding alludes to the relevance in work with Hispanic patients of the interpersonal characteristic of dominance. It suggests that there may be a relation between the clinician's characteristics and behavior and the patient's perception of being empathetically understood. Based on this, future studies might aim to further discriminate interpersonal characteristics and focus on specific clinician behaviors that within the Hispanic culture might be interpreted as nonempathic.

Limitations of the study and recommendations for future research:

The current study presented limitations that need to be considered. First, the patient participants in this study were homogenous in many of their demographic characteristics. The patient sample was almost uniformly from a very low socio-economic status, unemployed, and born outside of the United States. A more diverse sample probably would have presented different types of relationships and interactions with the clinician variables. However, focusing on a lower class, inner city, Hispanic population was interesting because this is precisely the population that has been cited in the literature as being the hardest to retain in mental health centers.

Secondly, an associated effect of the first limitation is that the patient sample was strikingly uniform on the intermediate acculturation measure (BAS). As a result, there was limited opportunity to see how variations in acculturation

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might relate to outcome. For example, would bicultural patients or patients who are more acculturated in English than Spanish produce different results? In addition, the second acculturation measure (Hispanic Features Measure) was demonstrated to have moderate to poor reliability and variable validity depending on the sample to which it was administered. Scores on this measure must then be cautiously interpreted and add uncertain information about deeper-level acculturation.

A third and perhaps weightier limitation of the study is that this sample was recruited exclusively from one clinic that is especially culturally sensitive to the Hispanic population it serves. In fact this clinic showed a much lower dropout rate (approximately 30%) from intake than many other reported dropout rates from other clinics that serve lower income, minority populations ((Kahn & Heiman, 1978). Individual ethnicity and acculturation differences between the patient and clinician may be outweighed by the predominantly Hispanic nature of the clinic.

A fourth limitation is that the above mentioned clinic is staffed by clinicians who are not just fluent in Spanish, but who have themselves often sought out this clinic to work with a Hispanic patient population. This could explain why discrepancy scores of acculturation and adherence to Hispanic values/features were not significant. In fact, the clinician scores on each of these measures provided evidence of biculturalism. Based on this, it is possible that the discrepancy scores in this particular sample of clinicians and patients may be

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much lower than those of other clinicians and Hispanic patient samples in general mental health clinics.

A fifth limitation of the study is that although patients interact primarily with the intake worker, they also have contact with the secretary, the psychiatrist, the research interviewer, all of whom speak Spanish and are of Hispanic origin. Thus the patient has been exposed to other clinic staff who may also have affected their experience of the clinic. In a related vein, a number of patients have a strong attachment to the Bellevue institution and/or to the medical doctor who made the referral to psychiatry. These external factors might interact with the patient's decision to comply or not with the evaluation process in ways that this study did not expect.

Lastly, the sole recruitment of Hispanic patients limits what can be said about Hispanic patients as they compare to non Hispanic patients. A new line of research might compare Hispanic and non Hispanic groups on these same variables to see if different cultural/ethnic groups demonstrate similar correlations of perceived empathy and clinician dominance with outcome. As this study stands now, no comparisons can be made outside of this sample.

Summary:

This study investigated twelve hypotheses which stated that Hispanic patients dropout or number of missed sessions would be correlated with ethnic match, discrepancy between patient and clinician adherence to Hispanic values; clinician dominance and nurturance and perceived clinician empathy. The results of correlational analyses indicated that discrepancy scores between patient and

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clinician acculturation and adherence to Hispanic values, ethnic match within the dyad, as well as measures of clinician nurturance, were not significantly correlated with dropout or missed sessions. The results of the first step of the multiple regression analysis (Pearson correlation) indicated a significant positive correlation between clinician dominance and number of missed sessions. This same analysis also indicated a significant negative correlation between perceived clinician empathy and number of missed sessions. There was also a strong negative correlation between self reported clinician dominance and perceived clinician empathy. This suggested that clinicians who rated themselves as more dominant seemed to be perceived by their patients as less empathic. The results of the second step of the multiple regression analysis indicated that perceived clinician empathy was the only significant predictor variable of missed sessions.

It was concluded that perceived clinician empathy by the patient is predictive of patient dropout and number of missed sessions. The strong negative correlation between clinician dominance and perceived clinician empathy points to future direction for outcome research.

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First draft of the Hispanic Features Measure

Table I: Correlation matrix of six Hispanic features

	familismo	simpatia1	Simpatia2	Respeto	simpatia3	Personalis
Familismo	1.0000					
Simpatia1	.0430	1.0000				
Simpatia2	-.2419	.0781	1.0000			
Respeto	.2060	.1609	-.2224	1.0000		
Simpatia3	-.0476	-.1223	-.1491	-.0123	1.0000	
Personalis	.1144	.0907	-.2541	.3289	.1613	1.0000

Reliability coefficient:

Six items: Alpha = .0151

Table II: Total statistics of reliability analysis of six Hispanic features

	Scale mean if item deleted	Scale variance if item deleted	Corrected item-total corr.	Squared mult. Correlation	Alpha if item deleted
Familismo	7.0112	3.1476	.1775	.0449	.4135
Simpatia	7.3483	3.1387	.1431	.0276	.4533
Respeto	7.2921	2.5955	.3663	.1528	.2085
Personalismo	8.3820	3.0342	.2730	.1119	.3210

Reliability Coefficient:

Four items: Alpha = .4241

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Table III: First draft of the Hispanic Features Measure: Comparison of Hispanic and non-Hispanic groups: T-Tests results

Variable	Mean	Std. Dev.	t-value	df	one-tailed p
Familismo					
Non-Hisp	2.43	.867	-5.88	59.98	.000
Hispanic	3.40	.603			
Simpatia1					
Non-Hisp	2.24	.925	-3.83	69.86	.000
Hispanic	2.96	.791			
Respeto					
Non-Hsp	2.24	.955	-4.47	60.35	.000
Hispanic	3.06	.669			
Personalis					
Non-Hisp	1.41	.551	-2.46	84.96	.008
Hispanic	1.79	.915			

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Second draft of the Hispanic Features Measure

Table IV: Reliability analysis of patient scores on the twelve Hispanic Feature items

	Scale mean if item deleted	Scale variance if item deleted	Corrected item-total corr.	Alpha if item deleted
Familismo	30.0413	20.9066	.2827	.5225
Simpatia	30.5289	19.7512	.3593	.5013
Respeto	29.6612	21.5759	.3136	.5225
Personalismo	31.2479	20.7380	.2390	.5318
Simpatia	29.9669	23.9489	-.0732	.5986
Familismo	30.8017	19.1789	.3338	.5049
Marianismo	29.6942	21.0807	.3088	.5191
Simpatia	30.8017	23.7770	-.0708	.6053
Marianismo	30.9917	20.8083	.2584	.5272
Personalismo	30.6777	19.6036	.3451	.5035
Familismo	29.6860	24.3672	-.0974	.5877
Marianismo	30.0413	17.9733	.5227	.4518

Reliability Coefficient:

Four items: Alpha = .5567

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Table V: Reliability analysis of clinician scores on the twelve Hispanic Feature items

	Scale mean if item deleted	Scale variance if item deleted	Corrected item-total corr.	Alpha if item deleted
Familismo	21.2609	3.5652	.1985	-.4671
Simpatia	22.5217	5.1700	-.1713	-.0992
Respeto	21.9565	4.4980	.0293	-.2272
Personalismo	22.7826	4.9051	.0310	-.1985
Simpatia	20.6087	3.6126	.2033	-.4609
Familismo	21.5217	4.7154	-.1666	-.0240
Marianismo	22.2174	5.6324	-.3284	.0880
Simpatia	20.8696	5.3004	-.2692	.0697
Marianismo	22.8261	5.0593	-.0801	-.1676
Personalismo	22.6087	4.7036	.0629	-.2265
Familismo	20.6957	4.0395	.1646	-.3595
Marianismo	22.6957	4.9486	-.0413	-.1722

Reliability Coefficient:

Four items: Alpha = -.1835

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TABLE VI: CHI SQUARE MODEL OF DROPOUT PREDICTORS

Predicted

Observed		**Did not drop out**	**Dropped out**	
		0	**1**	**% correct**
Dropped out	**1**	**9**	**29**	**76.32%**
Did not dropout	**0**	**67**	**7**	**90.54%**
			Overall	**85.71%**

$X^2 = 54.637$ $df = 6, p = .0000$

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TABLE VII: PEARSON CORRELATION MATRIX OF MISSED SESSIONS

N = 112

	Missed ses	Disc-accul	Disc-val	Dominan	Nurturan	Empathy
Missed ses		.039 .341	.131 .085	.398 .000	.022 .409	-.460 .000
Disc-accul	.039 .341		.100 .148	.256 .003	-.178 .031	-.302 .001
Disc-val	.131 .085	.100 .148		.209 .014	.069 .235	-.193 .021
Dominan	.398 .000	.256 .003	.209 .014		.154 .053	-.666 .000
Nurturan	.022 .409	-.178 .031	.069 .235	.154 .053		-.088 .181
Empathy	-.460 .000	-.302 .001	-.193 .021	-.666 .000	-.088 .181	

Missed ses = missed sessions Disc-accul = discrepancy on acculturation

Disc-val = discrepancy on Hispanic values/features

Dominan = intake workers' dominance

Nurturan = intake workers' nurturance

Empathy = perceived intake worker's empathy by patient

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Appendix A: Consent forms

Appendix A1: Patient version (in Spanish)

NEW YORK UNIVERSITY MEDICAL CENTER
AND
BELLEVUE HOSPITAL CENTER
CONSENTIMIENTO INFORMADO PARA PARTICIPAR DE INVESTIGACION

Se le esta pidiendo que sea sujeto voluntario en una investigacion (disertacion). Este formulario esta disenado para proveerle la informacion que usted deberia saber y entender, asi como tambien para contestarle cualquier pregunta que usted tenga sobre esta investigacion.

Directora de proyecto: Carmen Vazquez, Ph.D., ABPP Dept: Psiquiatria Tel: 212-562-3933

EL PROPOSITO DE ESTA INVESTIGACION ES:

Lograr una mejor comprension de ciertas caracterisiticas de nuestros pacientes Hispanos, asi como tambien su evaluacion del servicio que recibio. Estas caracteristicas incluyen datos demograficos y cualidades personales, sociales y culturales.

LOS PROCEDIMIENTOS SERAN:

Si usted acepta participar se le pedira que conteste un cuestionario demografico y otros cuestionarios acerca de varias areas de funcionamiento personal, social y cultural. No deberia tomar mas de 35 a 45 minutos el completarlos.

Toda la informacion que usted provea sera confidencial. Esto quiere decir que su nombre sera reemplazado por un numero y nadie salvo la investigadora sabra quien contesto cada cuestionario.

Si usted decide participar en esta investigacion puede cambiar de opinion en cualquier momento. El rehusar participar no afectaria su tratamiento en la clinica u hospital.

Si usted desea discutir sus derechos como sujeto de investigacion y/o su participacion en este estudio con un representante institucional que no forme parte de este estudio, por favor llame al Administrador, Institutional Board of Research Associates, telefono: 212-263-6705.

________________________ ______________________
Firma del paciente Fecha

________________________ ______________________
Firma del que obtiene el consentimiento Fecha

________________________ ______________________
Firma de investigadora principal Fecha

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Appendix A: Consent forms

Appendix A2: Patient version (English translation)

NEW YORK UNIVERSITY MEDICAL CENTER
AND
BELLEVUE HOSPITAL CENTER
INFORMED CONSENT TO PARTICIPATE IN RESEARCH

You are being asked to volunteer to be a subject in a research (dissertation) study. This form is designed to provide you with information about this study, which you should know and understand, as well as to answer any questions.

Project Director: Carmen Vazquez, Ph.D., ABPPDept: Psychiatry Tel: 562-3933

THE PURPOSE OF THIS RESEARCH IS:

To increase our understanding of certain characteristics of our Hispanic patients, and to obtain your assessment of the services you received. These characteristics include demographic information, and personal, social, and cultural qualities.

THE FOLLOWING PROCEDURES WILL BE USED:

If you agree to participate you will be asked to complete a demographic questionnaire and other questionnaires on various areas of personal, social, and cultural functioning. The time needed to fill out these questionnaires should be no longer than 35-45 minutes.

All the information you provide will be confidential. This means that a number will replace your name and no one, except for the investigator will know who answered each questionnaire.

If you decide to participate in this research, you may change your decision at any time. Your treatment in the clinic or hospital will not be affected by your refusing to participate.

If you would like to discuss your rights as a research subject and/or your participation in this study with an institutional representative who is not part of this study, please call the Administrator, Institutional Board of Research Associates, telephone number: 212-263-6705.

If you wish to know the results of the study, please contact Lorna Myers-Pizarro at 212-562-7309.

__________________________ __________________
Signature of patient Date

__________________________ __________________
Signature of person obtaining consent Date

__________________________ __________________
Signature of principal investigator Date

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Appendix A3: Interviewer version

NEW YORK UNIVERSITY MEDICAL CENTER
AND
BELLEVUE HOSPITAL CENTER
INFORMED CONSENT TO PARTICIPATE IN RESEARCH

You are being asked to volunteer to be a subject in a research (dissertation) study. This form is designed to provide you with information about this study, which you should know and understand as well as to answer any questions.

Project Director: Carmen Vazquez, Ph.D., ABPPDept: Psychiatry Tel: 562-3933

THE PURPOSE OF THIS RESEARCH IS:

To better understand certain characteristics of therapists who work with Latino populations. These characteristics include demographic data, as well as personal, social, and cultural qualities. These will then be compared with your intake patients' characteristics.

THE FOLLOWING PROCEDURES WILL BE USED:

If you agree to participate you will be asked to complete a demographic questionnaire and other questionnaires on various areas of personal, social, and cultural functioning. The time needed to fill out these questionnaires should be no longer than 35-40 minutes.

All the information you provide will be confidential. The results obtained will be reported as group results; no individual results will be reported.

Should you agree to participate in this research, you may change your mind at any time. Refusal to participate will not in any way affect your position in the clinic or hospital.

If you would like to discuss your rights as a research subject and/or your participation in this study with an institutional representative who is not part of this study, please call the Administrator, Institutional Board of Research Associates, telephone number: 212-263-6705.

If you wish to know the results of the study, please contact Lorna Myers-Pizarro at 212-562-7309.

____________________________ ____________________
Signature of therapist Date

____________________________ ____________________
Signature of person obtaining consent Date

____________________________ ____________________
Signature of principal investigator Date

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Appendix B: Demographic Questionnaire

Appendix B1: Patient version (in Spanish)

Cuestionario Demográfico

Número de identificación:____________ Fecha: ____________

1) Edad: ________________
Fecha de nacimiento: ___/_____/____
Mes Día Año

2) Estado civil:
- ( ) soltera/nunca casada
- ( ) casada/con pareja
- ( ) separada
- ( ) divorciada
- ( ) viuda
- ( ) otra ____________________

3) Información académica y laboral:
a) Hasta el presente, en total, cuántos años de educación han sido completados (incluyendo la primaria, secundaria, y estudios terciarios)

Usted:
- Número de años:
- Título:
- Ocupación laboral:

Pareja/marido (si vive actualmente con usted):
- Número de años:
- Título:
- Ocupación laboral:

Su padre:
- Número de años:
- Título:
- Ocupación laboral:

Su madre:
- Número de años:
- Título:
- Ocupación laboral:

4) Antecedentes étnicos:
a)Elija el antecedente que mejor se aplique a su familia y amigos:

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	Madre	Padre	Abuelos maternos	Abuelos paternos	Amigos	Pareja
Anglo-Americano						
Centro-Americano						
Cubano						
Dominicano						
Mejicano						
Puerto Riqueño						
Sud Americano						
Africano-Americano						
Otro						

b) En términos de grupo étnico, me considero: ___________________________
(Use las categorias mencionadas arriba)

c) En términos de raza, me considero:
( ) Blanca
( ) Negra
( ) Oriental
( ) Nativa/indigena

Nací en (pais)_________________________________
Edad de llegada a los EEUU:_____________________
Cuântos años ha vivido usted en los EEUU? ______________________________

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Appendix B2: Patient version (English translation)

Demographic Questionnaire

ID Number: ________________ Date: ____________

1) Age: ___________
   Date of birth: _____/_____/_____
   Mo. Day Yr.
2) Marital status:
   ( ) single/never married
   ( ) married/living with partner
   ( ) separated
   ( ) divorced
   ( ) widowed
   ( ) other ____________________

3) Educational and occupational information:
a) In total, so far, how many years of education have you completed (including elementary, high school, college, and graduate studies)

You:
   Number of years:
   Diploma:
   Occupation:

Significant other (if he/she is currently living with you):
   Number of years:
   Diploma:
   Occupation:

Your father:
   Number of years:
   Diploma:
   Occupation:

Your mother:
   Number of years:
   Diploma:
   Occupation:

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	mother	father	Mat-grand-parents	Pat-grand-parents	Friends	Partner
American (Anglo)						
Central American						
Cuban						
Dominican						
Mexican						
Puerto Rican						
South American						
African-American						
Other						

b) In terms of ethnic group, I consider myself to be ______________________________

(Use the above categories)

c) In terms of race I consider myself to be:

( ) White

( ) Black

( ) Asian

( ) Native/indigenous

I was born in ______________________________

Age of arrival to the USA (if applicable)______________________

How many years have you lived in the USA? ____________________

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Appendix B3: Therapist version

Demographic Questionnaire

ID Number: ________________ Date: ____________

4) Age: ___________
   Date of birth: _____/_____/_____
   Mo. Day Yr.
5) Marital status:
   ( ) single/never married
   ( ) married/living with partner
   ( ) separated
   ( ) divorced
   ( ) widowed
   ( ) other ____________________

6) Educational and occupational information:
b) In total, so far, how many years of education have you completed (including elementary, high school, college, and graduate studies)

You:
   Number of years:
   Diploma:
   Occupation:

Significant other (if he/she is currently living with you):
   Number of years:
   Diploma:
   Occupation:

Your father:
   Number of years:
   Diploma:
   Occupation:

Your mother:
   Number of years:
   Diploma:
   Occupation:

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	mother	father	Mat-grand-parents	Pat-grand-parents	Friends	Partner
American (Anglo)						
Central American						
Cuban						
Dominican						
Mexican						
Puerto Rican						
South American						
African-American						
Other						

b) In terms of ethnic group, I consider myself to be ______________________________
(Use the above categories)

c) In terms of race I consider myself to be:

( ) White
( ) Black
( ) Asian
( ) Native/indigenous

I was born in ______________________________
Age of arrival to the USA (if applicable)_________________________
How many years have you lived in the USA? ____________________

5) Exposure to Hispanic issues.

a) Have you participated in educational activities, which specifically related to Hispanic topics?
Conferences/courses: _____________ How many: ____________________
b) Approximately how many of your Psychology and general readings have involved Hispanic issues in the last year? ____________________
c) Approximately how many Hispanic patients have you ever treated? _____________
d) Approximately how many Hispanic supervisors have you had during your training?
____

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Appendix C: Bidimensional Acculturation Scale

Appendix C1: Spanish version

1) Con qué frecuencia habla usted inglés?
   (4) Casi siempre (3) Frecuentemente (2) Algunas veces (1) Casi nunca
2) Con qué frecuencia ve usted programas de televisión en inglés?
   (4) Casi siempre (3) Frecuentemente (2) Algunas veces (1) Casi nunca
3) Con qué frecuencia habla usted español?
   (4) Casi siempre (3) Frecuentemente (2) Algunas veces (1) Casi nunca
4) Con qué frecuencia escucha usted programas de radio en inglés?
   (4) Casi siempre (3) Frecuentemente (2) Algunas veces (1) Casi nunca
5) Con qué frecuencia habla usted en español con sus amigos?
   (4) Casi siempre (3) Frecuentemente (2) Algunas veces (1) Casi nunca
6) Con qué frecuencia escucha usted programas de radio en español?
   (4) Casi siempre (3) Frecuentemente (2) Algunas veces (1) Casi nunca
7) Qué tan bien habla usted inglés?
   (4) Muy bien (3) Bien (2) No muy bien (1) Muy mal
8) Qué tan bien habla usted español?
   (4) Muy bien (3) Bien (2) No muy bien (1) Muy mal
9) Qué tan bien entiende usted los programas de televisión en inglés?
   (4) Muy bien (3) Bien (2) No muy bien (1) Muy mal
10) Qué tan bien entiende usted los programas de radio en español?
   (4) Muy bien (3) Bien (2) No muy bien (1) Muy mal
11) Qué tan bien escribe usted en inglés?
   (4) Muy bien (3) Bien (2) No muy bien (1) Muy mal
12) Qué tan bien entiende usted los programas de televisión en español?
   (4) Muy bien (3) Bien (2) No muy bien (1) Muy mal
13) Qué tan bien lee usted en inglés?
   (4) Muy bien (3) Bien (2) No muy bien (1) Muy mal
14) Qué tan bien lee usted en español?
   (4) Muy bien (3) Bien (2) No muy bien (1) Muy mal
15) Qué tan bien entiende usted música en inglés?
   (4) Muy bien (3) Bien (2) No muy bien (1) Muy mal
16) Qué tan bien entiende usted los programas de radio en inglés?
   (4) Muy bien (3) Bien (2) No muy bien (1) Muy mal
17) Qué tan bien escribe usted en español?
   (4) Muy bien (3) Bien (2) No muy bien (1) Muy mal
18) Qué tan bien entiende usted música en español?
   (4) Muy bien (3) Bien (2) No muy bien (1) Muy mal
19) Con qué frecuencia habla usted en inglés con sus amigos?
   (4) Casi siempre (3) Frecuentemente (2) Algunas veces (1) Casi nunca
20) Con qué frecuencia piensa usted en inglés?
   (4) Casi siempre (3) Frecuentemente (2) Algunas veces (1) Casi nunca
21) Con qué frecuencia escucha usted música en inglés?
   (4) Casi siempre (3) Frecuentemente (2) Algunas veces (1) Casi nunca
22) Con qué frecuencia ve usted programas de televisión en español?
   (4) Casi siempre (3) Frecuentemente (2) Algunas veces (1) Casi nunca
23) Con qué frecuencia piensa usted en español?
   (4) Casi siempre (3) Frecuentemente (2) Algunas veces (1) Casi nunca

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24) Con qué frecuencia escucha usted musica en español?
(4) Casi siempre (3) Frecuentemente (2) Algunas veces (1) Casi nunca

Scoring for the BAS

Out of the total 24 items, 12 refer to the English domain and 12 refer to the Spanish domain. The final results provide one score for the English domain and one score for the Spanish domain.

English domain: The total score is obtained by summing across all items and obtaining the mean (1, 2, 4, 7, 9, 11, 13, 15, 16, 19, 20, and 21).

Spanish domain: The total score is derived by summing across items and obtaining the mean (items 3, 5, 6, 8, 10, 12, 14, 17, 18, 22, 23, 24).

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Appendix C2: English version

1) How often do you speak English?
(4) almost always (3) often (2) sometimes (1) almost never
2) How often do you watch television programs in English?
(4) almost always (3) often (2) sometimes (1) almost never
3) How often do you speak Spanish?
(4) almost always (3) often (2) sometimes (1) almost never
4) How often do you listen to radio programs in English?
(4) almost always (3) often (2) sometimes (1) almost never
5) How often do you speak Spanish with your friends?
(4) almost always (3) often (2) sometimes (1) almost never
6) How often do you listen to radio programs in Spanish?
(4) almost always (3) often (2) sometimes (1) almost never
7) How well do you speak English?
(4) very well (3)well (2) poorly (1) very poorly
8) How well do you speak Spanish?
(4) very well (3)well (2) poorly (1) very poorly
9) How well do you understand television programs in English?
(4) very well (3)well (2) poorly (1) very poorly
10) How well do you understand radio programs in Spanish?
(4) very well (3)well (2) poorly (1) very poorly
11) How well do you write in English?
(4) very well (3)well (2) poorly (1) very poorly
12) How well do you understand television programs in Spanish?
(4) very well (3)well (2) poorly (1) very poorly
13) How well do you read in English?
(4) very well (3)well (2) poorly (1) very poorly
14) How well do you read in Spanish?
(4) very well (3)well (2) poorly (1) very poorly
15) How well do you understand music in English?
(4) very well (3)well (2) poorly (1) very poorly
16) How well do you understand radio programs in English?
(4) very well (3)well (2) poorly (1) very poorly
17) How well do you write in Spanish?
(4) very well (3)well (2) poorly (1) very poorly
18) How well do you understand music in Spanish?
(4) very well (3)well (2) poorly (1) very poorly
19) How often do you speak English with your friends?
(4) almost always (3) often (2) sometimes (1) almost never
20) How often do you think in English?
(4) almost always (3) often (2) sometimes (1) almost never
21) How often do you listen to music in English?
(4) almost always (3) often (2) sometimes (1) almost never
22) How often do you watch television programs in Spanish?
(4) almost always (3) often (2) sometimes (1) almost never
23) How often do you think in Spanish?
(4) almost always (3) often (2) sometimes (1) almost never
24) How often do you listen to music in Spanish?
(4) almost always (3) often (2) sometimes (1) almost never

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Appendix D: Barrett-Lennard Relationship Inventory

Appendix E1: Spanish version

*** = empathy items**
A continuacion escuchara diversas maneras en que una persona puede sentirse o comportarse en relacion a otra persona. Por favor considere cada frase con referencia a la relacion que usted tuvo con su entrevistadora.
Evalue cada frase y diga cuanto cree que es cierta , o no cierta, en esta relacion. Senale su respuesta con el dedo en la hoja que le voy a dar.
(You will now hear various ways that one person may feel or behave in relation to another person. Please consider each phrase with reference to the relationship that you had with your interviewer. Evaluate each phrase and say how much you feel it is true or not true in this relationship. Indicate your response with your finger on the answer sheet that I will give you).

Elija una de las siguientes respuestas para cada pregunta que se le haga.

+3 = Si, tengo la ***absoluta conviccion*** de que ***esto es verdad.***
+2 = Si, siento que ***esto es verdad.***
+1 = Si, siento que probablemente esto es verdad, o ***mas verdadero que falso.***
-1 = No, siento que esto es probablemente falso, o ***mas falso que verdadero.***
-2 = No, siento que esto **no es verdad**
-3 = No, tengo la **absoluta conviccion** de que esto **no es verdad.**

1. ________ me respeto como persona.
*2. ________quiso entender como yo veo las cosas.
3. El interes de ________ en mi dependio de lo que yo hiciera o dijera.
4. _____ se sintio comoda y a gusto en nuestra relacion.
5. A ______ realmente le cai bien.
*6. _____ pudo entender mis palabras, pero no se dio cuenta de lo que yo siento.
7. Que yo estuviera contenta o descontenta conmigo misma no influyo lo que _____ sintiera por mi.
8. Senti que _____ se puso una mascara o actua un rol cuando estuvo conmigo.
9. _____ se impaciento conmigo.
*10. ______ casi siempre supo con exactitud lo que queria decir.
11. Segun mi comportamiento, ______ algunas veces tuvo mejor opinion de mi que en otras.
12. Siento que _____ fue verdadera y autentica conmigo.
13. Creo que _____ me estimo.
*14. _____ miro lo que yo hago desde su propio punto de vista.
15. Lo que _____ sintio por mi no dependio de lo que yo estuviera sintiendo por ella.
16. _____ se sintio incomoda cuando yo pregunte o hable respecto de ciertos temas.
17. Para _____ le fui indiferente.
*18. Generalmente _____ intuyo o se dio cuenta de lo que estaba sintiendo.
19. _____ queria que yo fuera de una forma determinada.
20. Senti que lo que _____ dijo expresaba exactamente lo que ella estaba sintiendo o pensando.
21. _____ me encuentro mas bien aburrida y poco interesante.
*22. La actitud de _____ hacia ciertas cosas que yo dije o hice le impidieron entenderme.
23. Pude criticar o agradecerle a _____ abiertamente y sin que cambiara lo que ella sentia por mi.

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24. _____ quiso que yo creyera que me entendio o que le agrade mas de lo que en realidad me entendio o le agrade.
25. _____ se ocupo de mi.
*26. _____ creyo a veces que yo me sentia de cierta manera porque asi es como lo sentia ella.
27. A _____ hay cosas de mi que le agradaron y otras cosas que no le agradaron.
28. _____ no evito nada que fuera importante para nuestra relacion.
29. Senti que _____ no apruebo de mi manera de ser.
*30. _____ entendio lo que queria decir aun cuando tuve dificultades en decirlo.
31. La actitud de _____ hacia mi fue constante: no estaba satisfecha conmigo en algunas ocasiones y critica o desilusionada en otras.
32. A veces _____ se sintio realmente incomoda, sin embargo hicemos como que no nos dabamos cuenta y seguimos adelante.
33. _____ a penas si me tolero.
*34. Generalmente _____ capto la totalidad de lo que queria decir.
35. Si me enoje con _____, ella tambien se enojo o se sintio dolida.
36. _____ expreso sus verdaderas impresiones y sentimientos.
37. _____ fue simpatica y calida conmigo.
*38. _____ simplemente paso por alto algunas cosas que yo siento o pienso.
39. Cuanto yo le guste o disguste a _____ no cambio segun lo que yo le dijera sobre mi misma.
40. A veces percibi que _____ no se daba cuenta de lo que realmente estaba sintiendo por mi.
41. Siento que _____ realmente me valoro.
*42. _____ reconocio exactamente como siento las cosas que me pasan.
43. _____ apruebo algunas veces de mi y desapruebo abiertamente de mi otras veces.
44. _____ estaba dispuesta a decirme lo que realmente estaba pensando, incluyendo sentimientos personales que tiene hacia si misma o mi.
45. A _____ no le guste por ser quien soy.
*46. A veces _____ creyo que mis sentimientos por algo en particular eran mucho mas fuertes de lo que yo los siento en realidad.
47. Si yo me sentia de buen humor o descontenta, no cambio el aprecio que sintio _____ por mi.
48. En nuestra relacion ______ se mostro tal como es ella.
49. Parece que a _____ la moleste e irrite.
*50. _____ no se dio cuenta de lo sensible que soy respecto de algunas de las cosas de las que hablamos.
51. El que yo expresara ideas o sentimientos "buenos" o "malos" no parecio influir los sentimientos de _____ hacia mi.
52. Los verdaderos sentimientos de _____ hacia mi son bastante diferentes de lo que ella expreso abiertamente.
53. ____ me desprecio.
*54. _____ me entendio.
55. Hubo ocasiones en que _____ me valoro mas que en otras.
56. _____ no escapo de los sentimientos que yo le genere.
57. _____ se intereso realmente en ***mi***.
*58. Las respuestas de _____ por lo general eran tan fijas y automaticas que no pude realmente llegar a ella.
59. Nada de lo que yo hiciera o dijea podria cambiar lo que _____ sintio por mi.
60. Con frecuencia lo que _____ me dijo me genero una impresion equivocada de todo lo que ella estaba pensando o sintiendo en ese momento.
61. _____ sintio un afecto profundo por mi.
*62. Cuando yo me senti dolida o alterada, _____ pudo reconocer claramente mis sentimientos sin alterarse ella tambien.

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63. Lo que otros piensen de mi afecto (o afectaria, si lo supiera) lo que sintio _____ por mi.
64. _____ sintio cosas de las que no me hablo que produjeron dificultades en nuestra entrevista.

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Appendix D2: English version

* = empathy items
Below are listed various ways that one person might feel or behave in relation to another person. Please consider each numbered statement with reference to your present relationship with (intake person).
Mark each statement in the answer column on the right, according to how strongly you feel that it is true or not true, in this relationship. Please be sure to mark every one. Write in a plus number (+3, +2, +1) for each 'yes' answer, and minus numbers (-3, -2, -1) to stand for 'no' answers. Here is the exact meaning of each answer number:

+3 = Yes (!), I strongly feel that it is true.	-1 = (No) I feel that it is probably untrue, or more untrue than true
+2 = Yes, I feel that it is true.	-2 = No, I feel that it is untrue.
+1 = (Yes) I feel that it is probably true, or more true than untrue.	-3 = No (!), I strongly feel that it is not true.

1. _____ respects me as a person.
2. _____ wants to understand how I see things.*
3. _____'s interest in me depends on the things I say or do.
4. _____ is comfortable and at ease in our relationship.
5. _____ feels a true liking for me.
6. _____ may understand my words but he/she does not see the way I feel.*
7. Whether I am feeling happy or unhappy with myself makes no real difference in the way _____ feels about me.
8. I feel that _____ puts on a role or front with me.
9. _____ is impatient with me.
10. _____ nearly always knows exactly what I mean.*
11. Depending on my behaviour, ______ has a better opinion of me sometimes that he/she has at other times.
12. I feel that _____ is real and genuine with me.
13. I feel appreciated by _____.
14. _____ looks at what I do from his/her own perspective.*
15. _____'s feeling toward me doesn't depend on how I am feeling toward him/her.
16. It makes _____ uneasy when I ask or talk about certain things.
17. _____ is indifferent to me.
18. _____ usually senses or realizes what I am feeling.*
19. _____ wants me to be a particular kind of person.
20. I feel that what _____ says expresses exactly what he/she is feeling and thinking at that moment.
21. _____ finds me rather dull and uninteresting.
22. _____'s own attitudes toward things I do or say prevent him/her from understanding me.*
23. I can be (could be) openly critical or appreciative of _____ without making him/her feel differently about me.

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24. _____ wants me to think that he/she likes or understands me more than he/she really does.
25. _____ cares for me.
26. Sometimes _____ thinks that I feel a certain way, because that's the way he/she feels.*
27. _____ likes certain things about me, and there are other things that he/she does not like in me.
28. _____ does not avoid anything that's important for our relationship.
29. I feel that _____ disapproves of me.
30. _____ realizes what I mean even when I have difficulty saying it.*
31. _____'s attitude toward me stays the same: he/she is not pleased with me sometimes and critical or disappointed at other times.
32. Sometimes _____ is not at all comfortable but we go on, outwardly ignoring it.
33. _____ just tolerates me.
34. _____ usually understands the whole of what I mean.*
35. If I show that I am angry with _____ he/she becomes hurt or angry at me too.
36. _____ expresses his/her true impressions and feelings with me.
37. _____ is friendly and warm with me.
38. _____ just takes no notice of things I think or feel.*
39. How much _____ likes or dislikes me is not altered by anything that I tell him/her about myself.
40. At times I sense that _____ is not aware of what he/she is really feeling with me.
41. I feel that _____ really values me.
42. _____ appreciates exactly how the things I experience feel to me.*
43. _____ approves of me sometimes, or in some ways, and plainly disapproves of me at other times/in other ways.
44. _____ is willing to express whatever is actually in his/her mind with me, including personal feelings about him/herself or me.
45. _____ doesn't like me for myself.
46. At times _____ thinks that I feel a lot more strongly about a particular thing than I really do.*
47. Whether I happen to be in good spirits or feeling upset, does not make _____ feel any more or less appreciative of me.
48. _____ is openly himself/ herself in our relationship.
49. I seem to irritate and bother _____.
50. _____ does not realize how sensitive I am about some things we discuss.*
51. Whether the ideas and feelings I express are "good" or "bad" seems to make no difference to _____'s feeling toward me.
52. There are times when I feel that _____'s outward response to me is quite different from the way he/she feels underneath.
53. ______ feels contempt for me.
54. _____ understands me.*
55. Sometimes I am more worthwhile in _____'s eyes than I am at other times.
56. _____ doesn't hide from him/herself anything that he/she feels with me.
57. _____ is truly interested in me.

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58. _____'s response to me is usually so fixed and automatic that I don't really get through to him/her.*
59. I don't think that anything I say or do really changes the way ____ feels toward me.
60. What _____ says to me often gives a wrong impression of his/her total thought or feeling at the time.
61. _____ feels deep affection for me.
62. When I am hurt or upset _____ can recognize me feelings exactly, without becoming upset too.*
63. What other people think of me (or would, if he/she knew) affect the way _____ feels toward me.
64. I believe that _____ has feelings he/she does not tell me about that are causing difficulty in our relationship.

Scoring for the RI

The empathy score is obtained by adding the eight positive empathy items (#s 2, 10, 18, 30, 34, 42, 54, and 62). The eight negative items (#s 6,14, 22, 26, 38, 46, 50, and 58) are also added up and then multiplied by a constant (-1) to change the negative sign (if it was in fact negative) into a positive sign. This subtotal is then added to the above subtotal and gives the total empathy score.

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Appendix E: Interpersonal Adjectives Scale

This booklet contains 64 words. Please rate how accurately each of the words *describes you as a person.* If you feel that a word is an "extremely accurate" description of you, circle the number "8" from the choices directly below that word. If you feel that a word is an "extremely inaccurate" description of you, circle the number "1" from the choices below that word. If you feel that neither of those extremes describes you, please use the choices "2" through "7" to indicate other degrees of accuracy. Please refer to the key provided below.

1 = Extremely Inaccurate
2 = Very Inaccurate
3 = Quite Inaccurate
4 = Slightly Inaccurate
5 = Slightly Accurate
6 = Quite Accurate
7 = Very Accurate
8 = Extremely Accurate

1. Self-assured
1 2 3 4 5 6 7 8
2. Wily
1 2 3 4 5 6 7 8
3. Uncharitable
1 2 3 4 5 6 7 8
4. Uncheery
1 2 3 4 5 6 7 8
5. Timid
1 2 3 4 5 6 7 8
6. Unargumentative
1 2 3 4 5 6 7 8
7. Softhearted
1 2 3 4 5 6 7 8
8. Cheerful
1 2 3 4 5 6 7 8

9. Self-confident
1 2 3 4 5 6 7 8
10. Crafty
1 2 3 4 5 6 7 8
11. Ironhearted
1 2 3 4 5 6 7 8
12. Unneighborly
1 2 3 4 5 6 7 8
13. Bashful
1 2 3 4 5 6 7 8
14. Undemanding
1 2 3 4 5 6 7 8
15. Accommodating
1 2 3 4 5 6 7 8
16. Friendly
1 2 3 4 5 6 7 8

17. Assertive
1 2 3 4 5 6 7 8
18. Boastful
1 2 3 4 5 6 7 8
19. Unsympathetic
1 2 3 4 5 6 7 8
20. Distant
1 2 3 4 5 6 7 8
21. Shy
1 2 3 4 5 6 7 8
22. Uncalculating
1 2 3 4 5 6 7 8
23. Gentlehearted
1 2 3 4 5 6 7 8
24. Neighborly
1 2 3 4 5 6 7 8

25. Persistent
1 2 3 4 5 6 7 8
26. Cunning
1 2 3 4 5 6 7 8
27. Ruthless
1 2 3 4 5 6 7 8
28. Dissocial
1 2 3 4 5 6 7 8
29. Meek
1 2 3 4 5 6 7 8
30. Uncrafty
1 2 3 4 5 6 7 8
31. Tenderhearted
1 2 3 4 5 6 7 8
32. Extraverted
1 2 3 4 5 6 7 8

(next page)

33. Firm
1 2 3 4 5 6 7 8
34. Cocky
1 2 3 4 5 6 7 8
35. Coldhearted
1 2 3 4 5 6 7 8
36. Unsociable
1 2 3 4 5 6 7 8
37. Unbold
1 2 3 4 5 6 7 8

41. Dominant
1 2 3 4 5 6 7 8
42. Sly
1 2 3 4 5 6 7 8
43. Cruel
1 2 3 4 5 6 7 8
44. Antisocial
1 2 3 4 5 6 7 8
45. Unauthoritative
1 2 3 4 5 6 7 8

49. Forceful
1 2 3 4 5 6 7 8
50. Tricky
1 2 3 4 5 6 7 8
51. Hardhearted
1 2 3 4 5 6 7 8
52. Unsparkling
1 2 3 4 5 6 7 8
53. Forceless
1 2 3 4 5 6 7 8

57. Domineering
1 2 3 4 5 6 7 8
58. Calculating
1 2 3 4 5 6 7 8
59. Warmthless
1 2 3 4 5 6 7 8
60. Introverted
1 2 3 4 5 6 7 8
61. Unaggressive
1 2 3 4 5 6 7 8

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38. Boastless 1 2 3 4 5 6 7 8	46. Unwily 1 2 3 4 5 6 7 8	54. Uncunning 1 2 3 4 5 6 7 8	62. Unsly 1 2 3 4 5 6 7 8
39. Charitable 1 2 3 4 5 6 7 8	47. Tender 1 2 3 4 5 6 7 8	55. Sympathetic 1 2 3 4 5 6 7 8	63. Kind 1 2 3 4 5 6 7 8
40. Enthusiastic 1 2 3 4 5 6 7 8	48. Outgoing 1 2 3 4 5 6 7 8	56. Perky 1 2 3 4 5 6 7 8	64. Jovial 1 2 3 4 5 6 7 8

Scoring for the IAS

Begin scoring by summing across each row (e.g. row one includes 1,9,17,25,33,41,49, and 57). This will produce eight raw octant scores. To obtain average raw octant scores, divide each raw octant score by 8 (if there is an answer for each item in the octant), round to the first decimal place and write the scores in the Average raw octant score column. In the appropriate appendix of the IAS Professional Manual, locate the T scores that correspond to the respondent's group, gender, and average raw octant scores, and write the T scores in the T score column. To calculate the Dominance (DOM) and Nurturance (LOV) scores, write the T scores obtained in the previous step and perform the following equations:

Calculating the DOM score:
Step 1: _____ NO + ______ BC - ______ FG - _______ JK ______ (a)
Step 2: .707 (_____a) ______ (b)
Step 3: ______ PA - _______ HI + ______ b ______ (c)
Step 4: .03 (_____c) ______ DOM

Calculating the LOV score:
Step 1: _____ NO - ______BC - ______FG + ______ JK ______ d
Step 2: .707 (_____d) ______ e
Step 3: _____ LM-_____DE + ________ e ______ f
Step 4: .03 (_____f) ______ LOV

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Appendix F: Hispanic Features Measure

Appendix F1: First draft (six items)

Thank you very much for agreeing to answer the following phrases. Your answers will be utilized for validation, so that they may be later incorporated into a doctoral dissertation.
Please read each phrase and answer if you think it seems: 1) not at all true, 2) somewhat true, 3) true, 4) very true.

1) One has the obligation of offering economical aid to one's family, if one's family needs it, **even if** this implies making sacrifices. **(familism)**
1) not at all true 2) somewhat true 3) true 4) very true

2) One should change one's opinion in favor of the other person's opinion to avoid causing problems in the relationship. **(simpatia1)**
1) not at all true 2) somewhat true 3) true 4) very true

3) I feel more trusting of therapist who is **professional** than of one who is **warm**. **(simpatia2)**
1) not at all true 2) somewhat true 3) true 4) very true

4) One must be respectful and obedient to those persons who occupy positions of authority. **(respeto)**
1) not at all true 2) somewhat true 3) true 4) very true

5) It is good to compete with others. **(simpatia3)**
1) not at all true 2) somewhat true 3) true 4) very true

6) When I go to an institution, if I don't find someone who can help me, (for example, by accompanying me to the different parts of the institution), there are things I leave undone. **(personalismo)**
1) not at all true 2) somewhat true 3) true 4) very true

Scoring for the Hispanic Features Scale (6 items)

The total score is derived by reversing the negative items (indicated by "R"), summing across items, and obtaining the mean (Items 1, 2, 3R, 4, 5R, 6).

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Appendix F2: Second extended Spanish version:

Despues de escuchar cada frase responda si le parece: (4) muy cierta, (3) cierta, (2) algo cierta, (1) para nada cierta.

1) Una tiene la obligación de ofrecer ayuda económica a su familia (hermanos, tíos, tías, primos), aunque eso sea un sacrificio para uno. **(familism1)**
1) para nada cierto 2) algo cierto 3) cierto 4) muy cierto

2) Para no causar una discusión, una debería callar su opinión y estar de acuerdo con lo que piensa la otra persona. **(simpatia1)**
1) para nada cierto 2) algo cierto 3) cierto 4) muy cierto

3) Una siempre debe ser respetuosa y obediente con aquellas personas que ocupan puestos de autoridad, tales como doctores o directores de escuela. **(respeto)**
1) para nada cierto 2) algo cierto 3) cierto 4) muy cierto

4) Si tengo que ir a muchas partes de una institución grande y no encuentro a alguien que me ayude a transitar por las diferentes oficinas, me voy sin hacer todas mis diligencias. **(personalismo1)**
1) para nada cierto 2) algo cierto 3) cierto 4) muy cierto

5) En la escuela o el trabajo, es bueno tratar de ser la mejor y dejar a otros por debajo. **(simpatia2-inverted)**
1) para nada cierto 2) algo cierto 3) cierto 4) muy cierto

6) Yo viajaría a la boda de un pariente aunque eso significara dejar mi trabajo por varios dias y no ganar mi sueldo durante ese tiempo. **(familism2)**
1) para nada cierto 2) algo cierto 3) cierto 4) muy cierto

7) Una madre ideal es aquella que se dedica completamente al cuidado de sus hijos. **(marianismo1)**
1) para nada cierto 2) algo cierto 3) cierto 4) muy cierto

8) Si mi doctor es competente, yo continuaría con él aunque sea frío y distante. **(simpatia3-inverted)**
1) para nada cierto 2) algo cierto 3) cierto 4) muy cierto

9) Si un hombre es infiel, la culpa no es del hombre sino de la mujer que lo atrajo.**(marianismo2)**
1) para nada cierto 2) algo cierto 3) cierto 4) muy cierto

10) Si falto a una cita del hospital y mi doctor no me llama, siento que no se preocupa por mi. **(personalismo2)**
1) para nada cierto 2) algo cierto 3) cierto 4) muy cierto

11) En las amigas se puede confiar mas que en la familia. **(familism3-inverted)**
1) para nada cierto 2) algo cierto 3) cierto 4) muy cierto

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12) Aunque trabaje fuera de la casa, el cuidado del hogar es la responsabilidad total de la mujer. **(marianismo3)**

1) para nada cierto 2) algo cierto 3) cierto 4) muy cierto

Scoring for the Hispanic Features Scale (12 items)

The total score is derived by reversing the negative items (indicated by "R"), summing across items, and obtaining the mean (items 1, 2, 3, 4, 5R, 6, 7, 8R, 9, 10, 11R, 12).

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Appendix F3: Second extended English version

1) One has the obligation of helping one's family (siblings, uncles, aunts, cousins) out financially even if this implies making a sacrifice. **(familism1)**

1) not at all true 2) somewhat true 3) true 4) very true

2) So as to not cause an argument, one should silence one's opinion and coincide with what the other person thinks.**(simaptia1)**

1) not at all true 2) somewhat true 3) true 4) very true

3) One should always be respectful and obedient to those persons who occupy positions of authority, such as doctors or school principals. **(respeto)**

1) not at all true 2) somewhat true 3) true 4) very true

4) If I have to go to many different parts of a big institution, and there is no one who can help me navigate through them, I leave without having done everything. **(personalism1)**

1) not at all true 2) somewhat true 3) true 4) very true

5) In school or at work, it is good to try to be the best and to leave others beneath you. **(simaptia2- inverted)**

1) not at all true 2) somewhat true 3) true 4) very true

6) I would travel to a relative's wedding even if this meant leaving my work for several days and losing my salary for that time period. **(familism2)**

1) not at all true 2) somewhat true 3) true 4) very true

7) An ideal mother is one who dedicates herself completely to caring for her children.**(marianismo1)**

1) not at all true 2) somewhat true 3) true 4) very true

8) If my doctor is competent, I would continue to see him/her even if he/she is cold.**(simpatia3-inverted)**

1) not at all true 2) somewhat true 3) true 4) very true

9) If a man is unfaithful, it is not the man's fault, it is the woman who attracted him who is at fault. **(marianismo2)**

1) not at all true 2) somewhat true 3) true 4) very true

10) If I miss an appointment at the hospital and my doctor does not call me, I feel he/she is not concerned about me. **(personalism2)**

1) not at all true 2) somewhat true 3) true 4) very true

11) You can trust your girlfriends more than your family. **(familism 3-inverted)**

1) not at all true 2) somewhat true 3) true 4) very true

12) Even if a woman has an outside job, taking care of the home is her responsibility. **(marianismo3)**

1) not at all true 2) somewhat true 3) true 4) very true I feel

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APPENDIX H: Hollingshead's Four Factor Index of Social Position

The Four Factor Index of Social Position (1975) was created based on the premise that social status is a multidimensional concept. This premise covers three points: that an unequal status structure exists in our society, that the primary factors indicative of status are occupation and education, sex and marital status, and that these factors may be combined so that the status positions that individuals occupy in our society could be estimated.

Scales are provided for education and occupation. In the Educational Scale the scores are assigned s follows: 1 to less than seventh grade, 2 to junior high school, 3 to partial high school, 4 to high school graduate, 5 to partial college, 6 to standard college or university graduate, 7 to graduate professional training. In the Occupational Scale, a score of 1 is assigned to farm laborers and menial service workers, 2 to unskilled workers, 3 to machine operators and to semiskilled workers, 4 to skilled manual workers, crafts persons, and tenant farmers, 5 to clerical and sales workers, small farm and business owners, 6 to technicians, semiprofessionals, and small business owners, 7 to small business owners, managers and minor professionals, 8 to administrators, lesser professionals, proprietors of medium sized businesses, 9 to higher executives, proprietors of larger businesses, and major professionals.

The two scores are multiplied by a fixed factor weight (5 for occupation and 3 for education) derived from multiple correlation techniques. The weighed occupation and education scores are added together to provide a combined score for a single head of household individual who does not have a partner. For individuals who have a partner, the weighed occupation and education scores are added and divided by two. The range of the combined scores varies from 8 to 66. The Index of Social Position or Social Class is obtained by matching the combined score to the social class categories listed below.

Social Class	Range of Combined Scores
I	8-19
II	20-29
III	30-39
IV	40-54
V	55-66

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