This is to certify that the

dissertation entitled

MEXICAN AMERICANS' EXPECTATIONS
AND UTILIZATION PATTERNS OF
MARRIAGE AND FAMILY
THERAPY SERVICES

presented by

GLORIA ELENA GONZALEZ-KRUGER

has been accepted towards fulfillment
of the requirements for

Ph.D. degree in Family & Child Ecology

Dolores Borland-Hunt, Ph.D.
Major professor

Date 12/18/98

MEXICAN AMERICAN'S EXPECTATIONS AND UTILIZATION PATTERNS OF MARRIAGE AND FAMILY THERAPY SERVICES

By

Gloria Elena Gonzalez-Kruger

A DISSERTATION

Submitted to
Michigan State University
in partial fulfillment of the requirements
for the degree of

DOCTOR OF PHILOSOPHY

Department of Family and Child Ecology

1998

ABSTRACT

MEXICAN AMERICAN'S EXPECTATIONS AND UTILIZATION PATTERNS OF MARRIAGE AND FAMILY THERAPY SERVICES

By

Gloria Elena Gonzalez-Kruger

Several studies have found that people of Mexican origin have the highest drop-out rates and underutilization of mental health services. This study considers the relationship between acculturation (behavioral and cognitive), expectations for marriage and family therapy (MFT) services, level of knowledge of various mental health services, openness to learning about mental health services, and utilization of counseling, therapy, and marriage and family therapy by people of Mexican-origin. The Mexican-origin population, like the Latino, is growing at a faster rate than any other ethnic group in the United States and is facing serious concerns in their communities, including high rates of poverty, school dropouts, unemployment, and substance abuse. This growing group will require accessible and effective mental health services consistent with the expectations and needs of people in this diverse community. The factors that influence the utilization of resources, specifically mental health services, is a critical area of inquiry in need of extensive study. The majority of studies in this area were conducted with student and clinical populations and samples from the southwest that are not generalizable to the

Mexican-origin population in the Midwest.

This research was designed to be culturally sensitive and ecological in nature. It utilized a cross sectional, inferential, explanatory, two-stage design. Data was collected from a sample of Mexican-origin individuals over age 24 who resided in either one rural or one urban county. Data collection was completed in bilingual, face-to-face interviews conducted in non-controlled settings. The 230-item questionnaire consisted of: (a) demographic questions, (b) two standardized instruments measuring level of behavioral and cognitive acculturation, (c) a revised standardized instrument examining expectations about MFT, and (d) questions related to their level of knowledge of, openness to learning about, and utilization of mental health services, including coun-seling, therapy, and MFT. A second audiotaped interview was conducted with a subsample of 15 individuals, using open-ended questions to encourage them to share their ideas and feelings about help-seeking and mental health issues as people of Mexican-origin.

The results of this study indicate that a very low percentage of people of Mexican-origin in this population utilized MFT and that subjects' responses to the types of services they utilized were suspect due to lack of under-standing of the differences between counseling, therapy, and MFT.

DEDICATION

This dissertation is dedicated to loving and supportive family and friends that have endured with me this long and arduous process. They have experienced the joys and excitement that have been part of my journey, but, even more appreciated, are the times that they have sustained me in times of great stress and pain. Without their support, I have no doubt that I would not be writing this dedication. Each of them have taught me more about children, family, and systems than I could ever learn from my academic endeavors. They sustained me and helped me to stay connected to friends, family, community, and my Mexican roots during this process of completing the dissertation and my doctoral program. When they would see me being consumed by academia, they gave me the love, nurturance, and/or guidance to return to what I value most in my life, the relationships with them and the larger community. Each of these unique and special relationships provide richness to my life and serve to motivate me in my work to enhance the lives of children, families, and communities. The life they represent and live keeps me grounded and enhances my personal life as well as my professional life as an educator, therapist, and researcher.

An incredible thank you to my husband, David, and my son, Christopher, who endured this journey alongside me. Thank you to my parents, Jaime y Elena, who have taught me

to cherish family and our rich Mexican culture. I treasure you as my parents and the support you gave me, especially during those times when you did not agree or understand my choices in life. This dissertation and Ph.D. belongs to us; with you, my journey has been rewarding.

The decision to attend graduate school and obtain my doctorate has been a gratifying and painful experience. I have discovered many worlds that were unknown to me, which has helped me grow and flourish in many respects. As a Mexicana, I have been challenged as I have attempted to learn to live within two cultures that are often in conflict with each other. Blending the beliefs and values of each culture has been a challenging but rewarding experience. It has enhanced my life by allowing me to experience and integrate the richness of my Mexican and Anglo American cultures. Now, I understand more about the process of "becoming and being bicultural."

ACKNOWLEDGEMENTS

There are so many people to acknowledge that have contributed to the development and writing of this dissertation. Gracias (Thank you) to mi familia for the love, support, and tolerance that you gave to me over the last eight years as I have encountered the challenges of juggling family, friends, work, and graduate school. To my husband, Dave, who has given me unconditional love and has taken more than his share of household chores and stress as we each battled through the stressors of graduate school and life. To my son, Christopher, who has challenged me as a parent, taught me the importance of listening to children, and kept me rooted in reality. To my parents, who worked many hours helping me prepare for and conduct this research study. To my brothers and sisters-David, Rene, Laura, Ruben, Raul, Irene, and Jaime-who challenged me to find ways to stay connected to family when I would drift away. I know we will always find our way back to each other. To all of my professors, who have supported me and taught me the importance of looking at life through another lens and experiencing multiple realities. To my committee members, who have been patient and understanding while I tried to find my way through the dissertation. To Dr. Borland-Hunt and Dr. Villarruel, who invested and trusted in me and my goals, even when I was unable to invest and trust in myself.

To Ruth and Mary, who have provided many years of friendship and encouragement. To my supportive and tolerant friends, Kathy, Julie, and Lynn, who rode the waves of connectedness and separateness. To my new friend, Rosemary, who provided wonderful editorial and typing support in finalizing the dissertation and who went beyond the call of duty by providing encouragement and friendship. Finally, but most importantly, I thank and appreciate my dear friend, Dorothy, who has given me a unique and treasured relationship. She has provided me the affective and instrumental support that most contributed to me completing this dissertation. Thank you for the home away from home, the encouragement, the input and feedback, the laughter, your willingness to learn and experience my Mexican culture, and your willingness to teach me and let me experience your German culture.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER 1

INTRODUCTION

Scope of the Problem

There is an increasing need to study the factors that influence effectiveness and utilization of therapy services in ethnic and racial groups to enhance the understanding and treatment of diverse populations (Aronson Fontes & Thomas, 1996; Goldner, 1985; Leslie, 1995; Saba, Karrer, & Hardy, 1989). Leslie identified three characteristics of marriage and family therapy (MFT) that are consistently found in critiques of how this field has been oppressive or insensitive to ethnicity, gender, and sexual orientation. First, MFT has not applied a contextual approach in the study of family dynamics; second, it ignores power differences within the family and in the larger society; and, third, it assumes a monolithic family form. The oppression results from therapy being based on predominantly Euro-Anglo, paternalistic therapy models conducted by primarily Euro-Anglo therapists. Criticisms of the MFT field's insensitivity to and oppression of diverse groups have motivated the increased attention to research and changes in clinical treatment in these areas (Doherty & Baptiste, 1993; Goldner, 1985; Hardy, 1989; Saba, Karrer, & Hardy, 1989).

spec

com

stre

ther

Virg

Unde

one

read

equa

Ther

Stud

Neur

de a

Anxi

Subs

Foun

Anxi

Syst

The issue of whether counseling needs to be culture specific (emic) or universalistic (etic) has generated controversy (Pike, 1954). Culture specific counseling stresses the need to use culturally sensitive and relevant therapy models (Sue & Morishima, 1982; Kagawa-Singer & Chi-Ying Chung, 1994), while universalistic counseling underscores the common elements of mental health needs. If one is approaching this issue from a systems perspective, it readily becomes apparent that both types of counseling are equally relevant. The system's concepts of wholeness and hierarchy (Whitchurch & Constantine, 1993) supports the study of therapy using both the emic and etic approaches. Neither approach should be used in isolation if there is to be a holistic understanding of how each impacts therapy with ethnic and racial groups. The hierarchy is composed of subsystems, systems, and suprasystems. The latter sets the foundation for the study of families in relation to their ethnic and racial subcultures and in relation to larger systems.

Piercy and Sprenkle (1990) summarized trends in theory and research on MFT over the 1980s. They offered suggestions for research in the 1990s which included increasing specificity, describing and defining client and therapist variables, and distinguishing among clinical populations. Specifically, they suggested (a) documentation of therapists' adherence in the use of treatment protocols,

(b) descriptions of the uniqueness of client populations, (c) consistency in therapist equivalency in treatment studies, (d) valid and reliable measurement of family therapy constructs, (e) qualitative research, and (f) consistency and longevity in conducting research.

The present investigation was undertaken in response to the call to study the uniqueness of potential client populations and to develop multiculturally appropriate research. It was based on the tenet that culture strongly influences the beliefs, expectations, behaviors, and choices that people make in their lives. The focus of the investigation was to take an emic perspective in examining the relationship between the cognitive and behavioral constructs of acculturation that influence expectations and utilization of marriage and family therapy services. People of Mexican origin live within two cultures, the Anglo and the Mexican, in varying degrees. The level of acculturation is impacted by a plethora of factors, including place of birth, generation, beliefs, cognitions, place of residence, and family. The interaction of these dynamic factors leads to an ever changing environment that is continuously being influenced by outside forces. This investigation was designed to examine how culture is related to the help-seeking behaviors, expectations, and utilization of therapy services by people in this ethnic group with a focus on the in-group variation.

The mental health system purports to serve diverse populations to access and acquire effective resources and services and, thereby, to achieve an improved quality of life. The majority of studies conclude that there is an underutilization of mental health services by people in the Hispanic or Latino community (Acosta & Sheehan, 1976; Keefe, 1979; Marin, Marin, Padilla, & de la Rocha, 1983; Sue, 1977; Sue & Zane, 1987) and a high drop-out rate by those who use the services (Sue). However, there is a lack of prevalence data available in the literature and from mental health organizations on the Mexican origin community specifically (Torres, 1991).[1]

There is a continuing debate about the explanation for this underuse of mental health services by the Latino community. Some researchers claim that counseling or therapy is not perceived as a viable option by people in the Latino community who are seeking help. Others contend such services are not culturally sensitive to the needs of ethnic groups, and there is a deficiency in research and therapeutic models that are culturally sensitive and respectful (Martinez,

---

[1]The term "Hispanic" is generic and refers to all Spanish-speaking or Spanish-surnamed people who reside in the United States or Puerto Rico. The term "Latino" signifies a person of Latin American origin. This paper will use terms as they are used by original authors when citing their work. The terms "people of Mexican origin" and Mexican- origin prople or community are used to specify the group of people who reside in the United States and whose ancestors or who themselves came from Mexico.

1994; Soto-Fulp & DelCampo, 1994; Sue, 1977). Many researchers believe that an increased understanding of acculturation patterns, cultural beliefs, and expectations of counseling/therapy will serve to enhance the appropriateness of mental health services. The results will also add useful data to the growing debate related to utilization of mental health services by this group.

The number of Mexican-origin people has been increasing at a faster rate than any other ethnic or racial group. The Latino population was the fastest growing ethnic group (7.7 million people) between 1980 and 1990, with a rate of growth that more than doubled that of the African American population. The Latino population constitutes nine percent of the population in the United States, with the Mexican origin group representing 60.4% of the Latino population (U.S. Bureau of the Census, 1990). This national pattern is evident in the Midwest, with Mexican-origin people representing approximately three quarters of the growth and almost two thirds (65%) of the Hispanic population. The growth of the Latino population highlights the cultural variation within and between ethnic groups. Moreover, it will have a considerable impact on the larger society through reciprocating interactions between people in the dominant culture and people who have varying degrees of culturally bound beliefs, values, expectations, and behaviors which differ from those of the dominant culture.

The growing Mexican-origin community is faced with a multitude of issues that are stressing the relationships and resources of families. Families are facing powerful obstacles, such as poverty, unemployment, underemployment, discrimination, and substance abuse. It must be recognized also that this community has strengths that are inherent within individuals, family systems, and the community as a whole. Mental health providers must understand and appreciate these issues within the context of three discrete, but interrelated, environments-- the Natural Physical-Biological, the Social-Cultural, and the Human Built--if they are to become an increasingly viable option for people of Mexican origin.

People select support systems and resources that are congruous with their beliefs and expectations to assist them with mental, emotional, and relational problems. Systems exist within the Mexican-origin community, such as extended family, compadres,[2] and the church, that are accepted as appropriate sources of support to individuals and families in times of need. The mental health system has not been a primary resource utilized by the Mexican-origin community. Mental health providers must be aware and accepting of common beliefs and practices of this community as they

[2]Compadre refers to a religious kinship between adults, in which one person may serve as a support system or a second parent to a child of the other.

attempt to become a more recognized and sanctioned option for people to utilize.

The mental health system must make adaptations in its delivery of services and assessment and treatment of clients. Attention to providing culturally competent mental health services will increase its effectiveness and insure an increase in the level of utilization by people of Mexican origin. It will also be necessary to build trust between the Mexican-origin community and the mental health system. Trust can be developed among people involved in the mental health system if providers listen to the voices of people of Mexican origin and dialogue with them. In this way professionals can become educated about the types of changes that would be necessary to create culturally relevant services. Studies must take into account the larger outside environment and its impact on the Mexican-origin community; research must assist in clarifying the necessary modifications which the mental health system needs to make to adequately and effectively respond to the needs of the Mexican-origin population. This process can also serve as an opportunity to develop a relationship with this community in which trust can be cultivated.

Individuals and families in the Mexican-origin community, and ultimately the community as a whole, will fail to make use of a potential resource if culturally competent mental health services that respect the special

needs

peopl

help

incre

safet

close

in al

stres

popul

deter

polic

State

categ

selec

consi

and i

peopl

Strug

discr

Obtai

In the

To a g

Studi

needs of this ethnic population are not made available. People may suffer in isolation rather than seek professional help because of the stigma that is associated with choices inconsistent with their culture. The professionals can be a safety net to the community in circumstances where systems closer to the individual or family have not been successful in alleviating or minimizing the negative impact of the stressor.

Statement of the Problem

Definition and identification of the Mexican-origin population is a major issue for researchers due to the heterogeneity of this people and the historical and political climate in which they have existed in the United States. The dominant population group has sought to categorize people who belong to the Mexican-origin group by selecting a stratifying variable, such as nativity, that was consistent with their perception of how to define, identify, and label persons of Mexican origin. Simultaneously, the people within this ethnic group have engaged in internal struggles over the identity issue that has compounded the difficulty of finding resolutions, which become more critical as this population grows.

Traditional and accepted modes of the research process in the academic and professional community have disregarded, to a great degree, the need to develop methodologies for studies respectful of the community being studied. Research

para

stud

the

stre

Rest

info

coll

popu

oper

deve

proc

Rech

Anal

cont

grow

Rend

comp

it i

Data

Deco

An i

Logg

Mark

Rend

Logg

paradigms that are Anglo-oriented and inappropriate to the study of diverse groups have produced areas of weakness in the study of cultural groups. This has also decreased the strength and validity of the studies and their conclusions. Historically, there has been disagreement or a lack of information in the study of ethnic or cultural groups in the following areas: (a) defining and identifying the Latino population and its cultural subgroups; (b) defining and operationalizing culturally appropriate constructs; (c) developing culturally sensitive and valid instruments and procedures; (d) engaging culturally appropriate methodologies in recruiting, interacting, and gathering information; and (e) interpreting data within a cultural context.

The importance of culture and its influence on human growth and development has been increasingly acknowledged by members of the academic, research, and professional communities. This has prompted an expansion in the funneling of time and energy to efforts aimed at building a robust data base related to cultural issues. Researchers have also become more cognizant of including people of ethnic groups in their studies of mental health (Aronson Fontes & Thomas, 1996; Comas-Diáz & Greene, 1994; Gregory & Leslie, 1996; Marin & VanOss Marin, 1991; Odell, Shelling, Scott Young, Hewitt, & L'Abate, 1994; Sue, Fujino, Hu, Takeuchi, & Zane, 1991). However, the majority of these and other studies

have been conducted "comparing" Hispanic samples with "normative" Anglo groups, who are primarily white middle-class populations or student samples.

Therefore, this study was designed to identify: (a) the characteristics of people of Mexican origin who seek out help when they need it; (b) their level of knowledge about various mental health services, specifically MFT; (c) what the Mexican-origin community expects from helpers; (d) their openness to learning about MFT; and (e) their utilization of counseling, therapy, and MFT. This information about Mexican-origin populations will increase the breadth and depth of mental health practitioners' effectiveness.9 The mental health system can utilize this information to generate the changes that must be made to increase utilization and efficacy rates of services within the Mexican-origin community.

In summary, assuming that expectancies are related to the utilization of services, this research highlights areas that mental health providers must address to develop culturally competent services.

Significance of this Study

The mental health system must respond to the changing populations it will be serving as the demographics and characteristics of this country are transformed by the increasing numbers of people from diverse ethnic and racial backgrounds. Mental health services and service providers

must develop culturally competent support systems that correspond with expectations held by members in this community. Culture impacts each of the participants' perspectives of the objectives and process of therapy. In order to achieve a positive outcome, professionals in the field must acknowledge the influence of culture and acculturation on the expectations held by persons of Mexican origin since this influence has been shown to moderate the effectiveness of therapy (Tinsley, Bowman, & Westcot Barich, 1993). Providers must have an awareness of important cultural norms in order to demonstrate credibility and trustworthiness with Mexican-origin communities. This research study exemplifies culturally competent research that considers the ecology, the strengths, and the needs of the Mexican-origin population.

This investigation was unique in the following ways: (a) The researcher/interviewer and the participants of the study were of the same culture; (b) the researcher was bilingual; (c) the researcher was a marriage and family therapist; and (d) the researcher utilized a community sample of people with varying levels of acculturation and experience with therapy. Thus, the study provided data on the variations within this ethnic group. The study functioned as a channel for the people in a midwestern, mid-sized Mexican-origin community to be heard in a manner that was respectful, encouraged dialogue, and integrated

important variables into the study of cultural meaning. Finally, this research contributes information to the field of MFT, which is increasing the energy devoted to the study of ethnic and minority families.

The methodology and instruments were designed to be consistent with the cultural norms of the Mexican origin group. The subjects participated in bilingual face-to-face interviews conducted by a person of Mexican origin. Care was taken throughout the various stages of research, such as planning, development, collection, and analysis, to engage in culturally appropriate behaviors that were respectful and consistent with conducting research with Hispanic populations. These steps were taken to assure the completion of a culturally sensitive investigation that secured reliable and valid results and, simultaneously, fostered trust in mental health services among members of the Mexican-origin community.

The development of a positive relationship between the researcher and the Mexican-origin community increased the likelihood that members of this community engage in future studies that serve to enhance their quality of life. Participation in this study served to minimize the stigma or, at best, normalize the option of seeking mental health services in response to experiencing difficulties in their lives. Finally, this study increased the visibility of the MFT field, which this author believes is consistent with

many of the values and beliefs held by a majority of the Mexican-origin community.

Generalizability

Conclusions from this investigation are based on a purposive sample; therefore, they will not be generalizable to the larger Mexican-origin population. However, the use of a community sample improves upon studies that have been conducted primarily with student samples. It will also provide a basis for future studies to be conducted with random samples from various geographical areas.

CHAPTER 2

REVIEW OF THE LITERATURE AND CONCEPTUAL FRAMEWORKS

Over the last ten years, professionals in the field of marriage and family therapy (MFT) have focused more time and energy on issues related to ethnicity (Berg & Jaya, 1993; Cohen, 1993; Goldberg, 1993a, 1993b; McAdoo, 1993; McGoldrick, Pearce, & Giordano, 1982; McGoldrick, Preto, Hines, & Lee, 1991; Odell, Shelling, Scott Young, Hewitt, & L'Abate, 1994; Saba, Karrer, & Hardy, 1989). In a recent review of family therapy literature, Leslie (1995) identified specific goals for this field, such as consideration of the broader social context, acknowledgement of power differences within and between systems, and more attentiveness and adeptness at working with diverse family systems. She provided multiple suggestions for research and clinical work. Parameters that have been exemplified in this study include examining racial and ethnic groups more extensively and looking to organizations as sources for creating change.

This chapter is organized into four sections: (a) theoretical frameworks, including human ecological theory, acculturation theory, and the multicultural perspective; (b) current status of research related to multicultural family therapy; (c) the ecology of the Mexican-origin population; and (d) mental health services with a focus on factors that

are related to help-seeking and utilization of services in this population.

Theoretical Frameworks

A brief summary of each of the theories that are integrated into this investigation is presented to provide a structure within which to understand the research being conducted.

Ecological Perspective

An ecological framework (Bubolz & Sontag, 1993) supports examination of the interrelationships between the human ecosystem and its three environments: the Natural Physical-Biological, the Social-Cultural, and the Human Built. This perspective is based on a hermeneutic philosophy that is grounded in values. The ecological perspective draws attention to groups that experience prejudice and discrimination and have problems in accessing resources. In addition, this perspective incorporates systems concepts and emphasizes the subjectivity of people's experiences. Finally, the ecological perspective requires that an effort be made to understand perceptions, interpretations, and meanings that are created as a result of their interdependence on and interaction with the three discrete, but interrelated, environments.

This study of expectations and utilization of MFT took into account the various climates that people in the Mexican-origin community are embedded within and how each

influences the other (Figure 1). In this study, the human environed unit was the individual of Mexican origin, and the Natural Physical-Biological environment was represented by an individual's ancestry, birthplace, generation, age, country of origin, and length of residence in the United States. The social-cultural environment included the person's gender, ethnic self-identification, type of citizenship, primary language, level of acculturation, education, religion, and level of expectations. Finally, type of employment, amount of income, socioeconomic status, and utilization rates of therapeutic services illustrated the human built environment.

Herrin and Wright (1988) assert that family therapy, which is based on systems theory, has shown a growing tendency to use the ecological approach in its studies since it requires consideration of the interdependence of humans and their environment in the therapeutic process. This is illustrated by the manner in which family therapy (a) addresses or examines issues in relation to age, ethnicity, race, gender, socioeconomic status, and family type; (b) recognizes the processes by which systems function and adapt, internally and as systems interdependent with their environment; (c) contributes to the betterment of individuals and families (human or family ecosystem) by providing a safe place to explore the changes necessary to achieve goals; (d) assists families in identifying what they

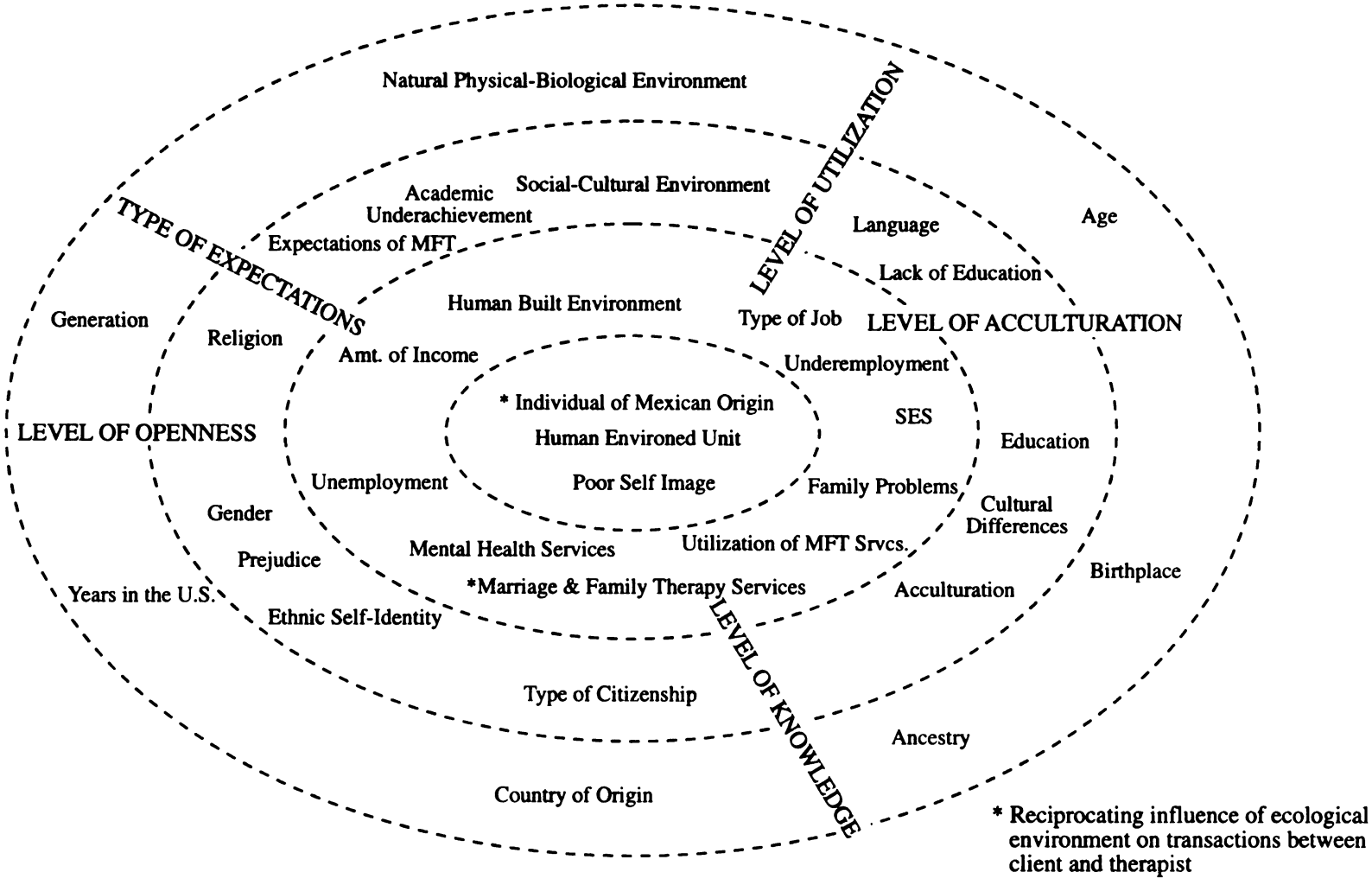

Figure 1. Ecological Model of Constructs: Mexican Americans Expectations and Utilization of Marriage and Family Therapy Services.

can do to create, manage, or enhance their environments to improve their quality of life or vice versa; (e) supports the examination of meaning which structures human behavior; (f) encourages adaptation within, among, and between systems; (g) recognizes the need to consider the individual or family in the context of society and the ecosystem; (h) establishes a caring relationship in which to conduct therapy; and (i) focuses on achievement of a "good fit" between human environed units and their environment.

In summary, family therapy works with the system, which is conceptualized as being comprised of multiple subsystems that are dynamic, interdependent, and have a reciprocal influence. Family therapy deals with across systems problems by considering the part each subsystem plays in establishing and maintaining overall patterns and then focusing on helping each one make change of their own rather than attempting to change others.

Multicultural Perspective

The multicultural perspective supports the movement toward cultural sensitivity by increasing awareness of culture and its role in people's lives. Within the mental health field, counseling and psychology have been the dominant contributors to the study of culture and counseling. As early as 1940, researchers were developing psychological and intelligence tests that were designed to be culture free (Catell, 1940). By the 1970s, the awareness

of the importance of culture increased dramatically, and a foundation was established for the growth of research, models, and treatment based on the culturally sensitive approach (Bloom, 1964; Kluckhohn & Strodteck, 1961; Padilla, 1971; Ruiz & Padilla, 1977). During this same period of time, the family therapists were focused on developing theories and techniques and affirming their standing in the academic and professional domains (see Doherty & Baptiste, 1993, for review of MFT history). The bulk of the work from this period was devoid of ethnicity and race (Aronson Fontes & Thomas, 1996; Doherty & Baptiste, 1993; Hardy, 1989; Leslie, 1995) leading to treatment and training based on the "theoretical myth of sameness" (Hardy).

By the 1980s, key figures in the field of psychology and family therapy began to take a more active role in studying the value and significance of ethnicity and developing multicultural counseling models that moved from pathologizing ethnic and racial groups (Boyd-Franklin, 1989; Falicov, 1983, 1988; Ho, 1987; Karrer, 1987; Levine & Padilla, 1980; McGoldrick et al., 1982; Pinderhughes, 1982; Sue and Zane, 1987). Although controversy continues about the role and importance of culture in the field of mental health, the 1990s has seen the emphasis change in the field of family therapy. The focus has moved from applying existing models to diverse groups to (a) considering biases of the models, (b) highlighting the culture of client and

therapist and their therapeutic relationship, (c) increasing culturally relevant research with diverse populations, (d) examining the biases in theory and practice and integrating contextual variables into the work (Aronson Fontes & Thomas, 1996; Breunlin, Schwartz & Mac Kune-Karrer, 1992; Comas-Díaz & Green, 1994; McGoldrick, Giordano, & Pearce, 1996; Roberts, 1993; Saba, Karrer, & Hardy, 1989).

The multicultural perspective has stressed the need to develop culturally appropriate theory, research, and models. Although family therapists have traditionally conducted research on White, middle-class populations (Gurman & Kniskern, 1991; Pinsof, 1991), there has been a call for "family therapy research into cultural issues" (Aronson Fontes & Thomas, 1996, p. 273). Aronson Fontes & Thomas recommend acknowledging the importance of cultural issues in family therapy and research. They believe this can be accomplished by (a) conducting research with various groups, especially non-white convenience samples; (b) including and controlling for cultural variables; and (c) conducting research that highlights positive aspects of ethnic/racial groups. Two of the questions that Aronson Fontes & Thomas pose are: (a) "How can the cultural awareness and sensitivity of the therapist be raised, and how can the increase be evaluated?" and (b) "How can cultural fit between therapist and client be evaluated, and how does the fit influence therapy outcome?"

For research with ethnic groups to be culturally sensitive necessitates that researchers employ methodology, procedures, instruments, and variables that are identified as important to the study of ethnic groups (cf. Fisher, Jackson, & Villarruel, 1997; Herrera, DelCampo, & Ames, 1993; Marin & Marin, 1991). In response to this need, an increasing number of family researchers and clinicians have focused their work on matters associated with diverse populations (Berg & Jaya, 1993; Boyd-Franklin, 1989; Braverman, 1990; Comas-Diaz, 1994; Dillworth-Anderson, Burton, & Turner, 1993; Flores-Ortiz & Bernal, 1989; Gregory & Leslie, 1996; Herrera et al., 1993; Martinez, 1977, 1994; McAdoo, 1993; Padilla, 1995; Porter, 1994). Included in this approach (Marin & Marin; Rogler, 1989) is: (a) being cognizant of similarities and differences within cultural groups; (b) using theories that encourage a focus on the interaction between systems and their larger environment; (c) developing methodologies consistent with the group's culture; (d) adding sociocultural variables (Martinez, 1994); (e) involving researchers who are from the subject's culture; (f) conducting research in the language of participants; (g) developing bilingual instruments for use in studies; (h) providing opportunities for people to self-identify their ethnicity; (i) using acculturation measures as a proxy for ethnic identity; (j) including open-ended, qualitative questions to allow for participants to talk

about what is important to them; and, finally, (k) measuring societal factors and cultural characteristics that impact access and delivery of services to ethnic-racial groups (Martinez, 1994).

People of Mexican origin must contend with pressures that result from living in a society that is frequently in conflict with the needs of their families and communities (Kaplan & Marks, 1990; Markides & Coreil, 1986; Saenz, 1984). The social, economic, and political ecosystems often create environments that are inconsistent with or invalidate the cultural values and beliefs of the Mexican-origin population. The low percentage of experienced Latino mental health professionals (.7% to .9% of marriage and family therapists and 3.3% to 9.9% from other therapeutic fields; see AAMFT Family Therapy News, April 1997, for details), the lack of affordable and bilingual services, and the lack of marketing directed at this community bespeak a disregard for serving this ethnic group and illustrate that the application of a culturally sensitive approach is still deficient in the delivery of services to the Mexican-origin community. Development of a "good fit" between this community and larger systems necessitate that culture become a consistent part of making decisions regarding the access and delivery of services. Although this deficiency continues in many areas of the mental health field, this paper will focus on the MFT profession.

Cross cultural research provides a framework for studying therapy through an emic (culture specific) and etic (universalistic) lens (see Ekstrand & Ekstrand, 1986, for a review of these concepts). An understanding and utilization of each perspective by therapists would maximize their ability to conceptualize and respond to the therapeutic needs of Mexican-origin clients. One manner in which this can be accomplished is by listening to their expectations, which may correlate with their level of acculturation. Professionals must understand that acculturation can also be a proxy indicator for negative processes and outcomes. For example, the variations in the environment surrounding the context of immigration have been changing for people of Mexican origin, and this has necessitated a reexamination of the acculturation process and its impact on individual, family, and community development.

Acculturation Theory

Acculturation theory assumes that there is an intergenerational transfer of culture and that people change as a result of interactions with people from diverse cultures (Berry, 1994; Padilla, 1980; Redfield, Linton, & Herkovitz, 1936). Acculturation theory and models have developed as definitions and perspectives of the acculturation process continued to change over time (for details, see Berry, 1980; Berry & Kim, 1988; Newcomb & Myers, 1995; Orzoco, Thompson, Kapes, & Montgomery, 1993;

Ponce &

Sabogal

There h

the ter

among t

.Burnam

1993; M

Stable,

ethnic

in the

defined

.Negy &

Europea

transfe

the min

the for

& Lindh

and mul

Marin,

deen ac

of subj

Th

Specif

The mar

Marin &

acculta

Ponce & Atkinson, 1989; Rogler, Cortes, & Malgady, 1991; Sabogal, Pérez-Stable, Otero-Sabogal, and Hiatt, 1995). There has been an inconsistent but generally common use of the term "acculturation." There has been more variability among researchers regarding how to measure this concept (Burnam, Telles, Karno, Hough, & Escobar, 1987; Franco, 1983; Marin, Sabogal, VanOss Marin, Otero-Sabogal, & Perez-Stable, 1987; Montgomery, 1992). This has made the study of ethnic groups challenging and has contributed to weaknesses in the research. Historically, acculturation has been defined and perceived from an assimilationist perspective (Negy & Woods, 1992a, 1992b; Sena-Rivera, 1976) based on the European immigrants' experience. In this perspective, the transfer of culture was always from the dominant group to the minority group until the latter conformed completely to the former's culture. Only recently has the dynamic (Padilla & Lindholm, 1984), systemic (Rueschenberg & Buriel, 1989), and multidimensional nature (Cuéllar, Harris, & Jasso, 1980; Marin, 1992, Szapocznik & Kurtines, 1980) of acculturation been acknowledged and incorporated more fully into the study of cultural groups.

There is a continuing controversy regarding the specific characteristics that represent acculturation and the manner in which it should be measured (Marín, 1993; Marín & Marin, 1991; Neff & Keir Hoppe, 1993). Measures of acculturation have been utilized as a proxy for ethnic

identity, although some scholars argue that they are related but unique concepts (Phinney, 1991; Ruiz, 1977). Berry considers acculturation as the process of change that an individual encounters when they are in contact and interaction with a new culture. Berry (1980) proposed a model that identified six aspects of psychological functioning that are impacted by acculturation: language use, attitudes, personality, identity, cognitive style, and stress. The acculturation process has been described as a staged process of adaptation by which individuals tend to assimilate, integrate, or reject the new culture (Marin, 1993; Rogler et al., 1991). Studies have indicated that people experience higher levels of acculturation as their interactions with the new culture increase (Padilla, 1980; Szapocznik & Kurtines, 1980). However, it is increasingly accepted that people are bicultural and can be competent in more than one culture (Cuéllar, Arnold, & Gonzàlez, 1995; Cuéllar, Arnold, & Maldonado, 1995; LaFramboise, Hardin, Coleman, & Gerton, 1993; Tropp, Erkut, Alarcon, Garcia Coll & Vazquez, 1994).

Cuéllar, Arnold, and Maldonado (1995) utilized a definition of acculturation advanced by Redfield et al. (1936) in the development of the ARSMA-II. Acculturation is defined as changes in the original cultural patterns of either or both groups (i.e., client and therapist) which results from individuals from the different cultures having

continuous first-hand contact with each other. The process of acculturation entails change which occurs at the micro (individual) and macro (social/group) levels. The former is referred to as psychological acculturation (Graves, 1967), which comprises changes in attitudes, beliefs, behaviors, and values in the individual. Contextual factors include aspects of the social, political, cultural, and economic climates, such as education level, employment, underemployment, and prejudice, to name a few. This model illustrates the interactive, developmental, multifactorial, multidirectional, and multidimensional process of acculturation; and it is consistent with ecological theory (see Cuéllar, Arnold, & Maldonado, 1995).

In spite of the controversies surrounding the study of acculturation, researchers tend to agree that acculturation is the process of cultural learning and change that occurs when individuals come into close proximity to a different culture. In addition, they agree that acculturation is a significant moderating variable in studies for understanding intracultural differences (Cuéllar, Arnold, & Maldonado, 1995; Padilla, 1995). Acculturation was found to be a significant moderating variable in studies on Hispanics' mental health status (Szapocznik & Kurtines, 1980) and levels of social support (Griffith & Villavicencio, 1985). This finding is leading to greater interest and consensus among researchers studying ethnic and minority groups.

The debate on acculturation has resulted in the development of numerous instruments with primarily Mexican-origin samples (see Cuéllar, Arnold, & González, 1995; Cuéllar, Arnold, & Maldonado, 1995; Cuéllar et al., 1980; Marín & Marín, 1991; Marín et al., 1987; Olmedo, Martinez, & Martinez, 1978; Padilla, 1980). Until recently, many of the instruments focused on behavioral constructs of acculturation (e.g., language utilization, food preferences).

Recent research has underscored the importance of examining psychological and cognitive referents of acculturation, such as beliefs, values, and attitudes (Cuéllar, Arnold, & Gonzalez, 1995; Domino & Acosta, 1987; Marin, 1993; Tropp et al., 1994). The instruments used vary in the strength of their psychometric properties, and additional research is necessary to further validate their use in the field. Consensus does not exist in the field on what instruments should be used primarily in this area of study. Until more studies are conducted that add support to the use of a specific instrument or set of instruments, it is essential that researchers select the strongest instruments that measure behavioral and cognitive components.

In summary, human ecological theory, cross-cultural theory, and acculturation theory have provided a framework for this study that facilitated examination of the factors

that influenced utilization rates of MFT among people of Mexican origin. Acculturation comprises of behavioral and cognitive or psychological constructs that are continuously in the process of influencing or being influenced. Many, if not all, of the components of these constructs can impact mental health status, access to services, and service delivery to varying degrees. For example, individuals of Mexican origin who hold supernatural beliefs about a traumatic incident (i.e., *malo ojo, susto*) might increase their level of openness to therapy if the therapist was able to be knowledgeable and respectful of their culture and beliefs. This encourages dialogue and development of trust between the therapist and client. Regardless of their level of acculturation, people of Mexican-origin have strengths and resources within their culture. A greater understanding of these systems by the MFT field will provide a broader and deeper understanding of people of Mexican origin. It will also serve to provide more effective services and increase the likelihood that people in the Mexican-origin community would utilize these services.

Multicultural Family Therapy

Fine (1993, pp. 235-237) summarized 12 issues related to family diversity and their implications for multicultural family therapy (MCFT). These issues included:

> (1) "demographic changes increase the extent of family diversity; (2) definitions of family have important implications and are inextricably intertwined with

> values; (3) different types of families are themselves heterogeneous; (4) understanding family diversity requires attention to similarities as well as differences among families; (5) social institutions experience difficulties in being sensitive to different type of families; (6) appreciation of diverse types of families illuminates how families can adapt to adversity; (7) empirical findings are needed to test professionals' theories and popular speculation; (8) understanding of family diversity is enhanced by attending to multiple generations within families; (9) teaching individuals to appreciate family diversity is a challenging endeavor; (10) understanding family diversity requires attention to processes that occur within families; (11) concepts and techniques used with white, English-speaking American families may not be applicable to other types of families; and (12) knowledge of diverse families is facilitated by understanding family members' perceptions of their experiences" (Odell et al., 1994, p. 146).

There are multiple indicators of a field's commitment to the study of and service to ethnic communities. Indicators include amount of time and energy in the area of research, the quality of the research, the number of publications on related topics in the field's primary journals, the number of minority/ethnic people in the field, the recruitment efforts made to increase the numbers of minority staff and professionals, the existence of advertisements in multiple languages, advertising in modes typically seen or heard by the specific population, and the number of ethnic/minority people that are served by professionals in the field. The success of the MFT field varies depending on the indicator and tends to be a first order change. Although there has been either an acknowledgement or an improvement in each of the indicators,

more changes in thinking and action are necessary for second order change to occur.

The field of mental health has spent the last decade trying to become culturally responsive to increase mental health access and resources for minority populations by following Sue's (1977) recommendations to provide culturally sensitive training of providers, to increase the percentage of bilingual and bicultural providers, and to develop services for ethnic populations. According to some researchers, implementation of these suggestions have increased utilization and reduced dropout rates (Flaskerud & Liu, 1991; O'Sullivan, Peterson, Cox, & Kirkeby, 1989; Sue et al., 1991;). Nonetheless, aA search of the MFT literature reveals a scarcity of strong empirical research conducted in the Latino community by clinicians and researchers in this field. A 10-year review by Bean and Crane (1996) of the major MFT-related journals revealed that fewer than 5% of published articles focused on racial and ethnic minority populations and issues. The existing studies are conducted primarily by Anglo Europeans on primarily white populations. Another investigation conducted by Naden, Rasmussen, Morrissette, and Johns (1997) reviewed articles from 1980 through 1995 in three major journals in the MFT field: *Journal of Marriage and Family Therapy, Family Process, and American Journal of Family Therapy*. The goals of this study included extending Gurman's work (1981) and generating a

list of topics that have provoked interest in the field since the early 1980s, as exemplified by the number of publications in each area. This information clarifies and increases understanding of the history, current state, and future needs of the field of MFT. Based on previous research, these three journals have been identified as most representative of the field of MFT (Snyder & Rice, 1994). The journals rank as first, second, and fifth, respectively, in terms of prominence (Shortz et al., 1994). Eighteen percent of the articles examined were related to clinical issues regarding specific populations. From this group, almost 10% of the articles and 2% of the research articles focused on ethnic/minority/cross-cultural populations. However, the percentage of ethnic/minority/ cross-cultural articles (2%) and research reports (.2%) were extremely low when the 15 years of publications were examined.

Other studies indicate increasing efforts at studying clinical approaches that are sensitive to various populations, including men (Dienhart & Myers Avis, 1994; Pittman, 1991), people with AIDS (Bograd, 1990; Green & Bobele, 1994), women (e.g., Bograd, 1984, 1992; Kaufman, 1992), and people of color (Boyd-Franklin, 1989; Flores-Oritz & Bernal, 1989; Gregory & Leslie, 1996). Much of the research on ethnic/racial/minority groups examines multiple racial or ethnic groups, discusses characteristics of various groups, and examines concepts related to culture and

therapy (Leslie, 1995; Odell et al., 1994). There is also wide use of panethnic labels or inconsistent use of ethnic labels. These approaches result in confusion and a minimization of the heterogeneity among and between ethnic populations and make generalization between studies challenging (Gimenéz, 1989; Marin & VanOss Marin, 1991; Trevino, 1987). Although the existing work still provides important information, it is imperative that professionals negotiate a common and consistent form of identifying ethnic groups. Researchers must also engage in culturally appropriate research designed to produce in depth studies of issues relevant to serving the Latino population. For example, in-group and among-group similarities and differences within the Latino population would help to clarify the needs of the various ethnic groups and would increase therapists' understanding of factors that influence help-seeking and clinical work with various cultural/ethnic groups.

A study by Killian and Hardy (1998) examined other indicators of minority representation in the field of MFT. They assessed how the American Association for Marriage and Family Therapy (AAMFT), the national organization for MFT, had progressed in the inclusion of minority people and issues among its concerns from 1980 to 1996. Results indicate positive changes and also a need for continued growth and change in this area. There was an increase in

programs related to minority issues; but there was low representation of ethnic minority members (about 3%), when compared to the national population, and a lack of minority members as keynote speakers and in the executive level of the organization.

A comparison of minority professionals in other mental health fields was reported by AAMFT with data collected by the Center for Mental Health Services (Manderscheid & Sonnenschein, 1996). A summary of data on eight disciplines in the mental health field-- MFT, psychology, school psychology, psychiatry, psychiatric nursing, counseling, social work, and psychosocial rehabilitation--reveals the status of each discipline in terms of its effectiveness in increasing minority membership (AAMFT, 1997). According to the data collected, none of the disciplines in the field of mental health have a number of minority members comparable to their ratio in the total U.S. population. The percentages of minority members reported for social work, psychiatry, psychosocial rehabilitation, psychology, and school psychology ranged from .5% to 21%. The percentage of minority marriage and family therapists is lower than that in other mental health disciplines, with Hispanic therapists having an extremely low presence in the MFT discipline (.7 to .9). Females who identified as Asian/Pacific Islander (Mental Health United States, 1996, cited in AAMFT, 1997) were the only group that had lower rates (.4) of MFTs.

Finally, the first national survey of the clinical practice patterns of MFTs (Doherty & Simmons, 1996) provided a profile of the clients served by marriage and family therapists. It provided critical data, which has contributed a baseline of information regarding who is accessing MFT services. Clients were primarily female (58%), the median age was 38 years, and the majority held at least a high school diploma (83%). Specifically, 40% had graduated from high school or had completed some college work, and 43% had a college degree. A shortcoming of this study was the omission of ethnic, racial, and/or cultural data for therapists and clients. This information is critical to evaluating the progress made over time in increasing minority recruitment to the professional field and increasing access and delivery of services to diverse populations. Sixty-three percent of MFTs reported feeling competent treating racial and ethnic minorities.

Ecology of the Mexican Origin Population

Changing Demographics

The importance and relevance of conducting research with the Hispanic population is supported by changing demographics. The Census Bureau estimates that between 1995 and 2050, the Hispanic-origin population will add the largest number of people to the population and that by 2010, the Hispanic-origin population may become the first or second-largest racial/ethnic group in the United States

(U.S. Bureau of the Census, 1996). Sixty percent of the 22 million Hispanics in the United States are of Mexican origin, making them the largest of the Latino/Hispanic nationality groups. The state of Michigan ranked twelfth in the nation in 1990, with over 200,000 Hispanics in the state (U.S. Bureau of Census, 1990), 69% of whom are of Mexican origin (Aponte & Siles, 1996). Consequently, there is a need for research to be conducted in Mexican communities located in Michigan so that practitioners can increase their understanding of the significance of ethnicity, culture, and environment to the lives of people in this ethnic group and to the delivery of mental health services.

Environmental Influences in Latino Communities

Understanding of mental health in the Latino community cannot occur without contemplating the social, cultural, and economic factors that have been found to be related to the mental health problems experienced in Latino communities (Neff & Keir Hoppe, 1993; Ponterotto, 1987; Rogler et al., 1991; Sue, 1992; Torres, 1991). These factors are illustrated by the ecological model (see Figure 1, p. 17) and consist of alienation resulting from prejudice, cultural differences, family problems, language barriers, poor-self image, lack of education, academic underachievement, and

unemployment and underemployment. An examination of the demographic data on the Hispanic origin population reveals a variability in their educational, economic, and employment status, with a significant percentage struggling to access suitable resources. There is a slightly higher rate of males (51%) to females (49%) in the Hispanic population, with the median age being 26 years. Fifty-three percent were high school graduates or had some college, and the majority of people over 18 years of age were married (51%). Data on Mexicans indicate that their educational attainment is lower (47%) than Hispanics, and more than three quarters did not have any college (77%) (U.S. Bureau of the Census, 1994). Risk factors for Hispanic people include the highest rate of dropouts (35%), higher rates of unemployment over the last ten years (11%) when compared to non-Hispanics, and a high rate of poverty (28%) (U.S. Bureau of the Census, 1993). Although there is wide variability in the incomes within the Hispanic population, 26% of families were identified as being below poverty level compared to 10% of non-Hispanic families (Bureau of the Census, 1993).

Mental Health Services in the Mexican-Origin Population

Mental Health Status of Latinos

Some studies indicate that people of Mexican origin may be more susceptible to mental health problems or symptoms because of environmental factors, such as discrimination, poverty, language barriers, low academic achievement,

unemployment and underemployment (Keefe & Casas, 1980; Saenz, 1984; Vega, Warheit, & Palacio, 1985; Vega, Warheit, Auth, & Meinhardt, 1984). The conclusions of these and other studies must be considered with caution, however, due to weaknesses in methodology, instruments, and sampling design. Variation in the definitions of variables, lack of bilingual instruments, data collected without differentiating among ethnic groups in the Hispanic or Latino population, and a lack of sensitivity to contextual and cultural variables contribute to the weaknesses of the studies (Price-Williams, 1987; Rogler, Malgady, Constantino, & Blumenthal, 1987; Rogler, Malgady, & Rodriguez, 1989). In addition, the conclusions of studies related to mental health in the Latino communities cannot be generalized since the majority have been conducted with students, clinical populations, and community participants from the southwest or the east or west coasts (Wells, Hough, Golding, Burnam, & Karno, 1987).

Increased utilization of mental health services will require more than the provision of services to this community (Santiago, Villarruel, & Leahy, 1996). Although there is a lack of research that specifically addresses reasons for the underutilization of MFT by Mexican-origin people, there are related studies that provide insight into the issue of service utilization. Training multicultural therapists, developing more bilingual providers, establishing services designed for specific populations

(O'Sullivan et al., 1989; Sue et al., 1991), creating linkages with respected community organizations (Fischman, Fraticelli, Newman, & Sampson, 1983; Guiterrez, Ortega, & Suarez, 1990), and improving location and hours of services (Sue & Morishima, 1982) have been found to be effective in improving utilization of mental health services in minority populations (Santiago et al., 1996). Providers of services will need to recognize the values and norms of the particular community that is being served in order to decide which of the factors are of importance to a potential client population.

Torres (1991) examined the data on the mental health status of Latinos in the Midwest and discovered a grave need for further research on health-related issues. The data indicated serious risk factors within the Latino community, including mental illnesses, substance abuse, and AIDS. Torres called for the development of health programs tailored to the needs of Latinos in the Midwest. However, without research that focuses on studying ethnic groups in depth, it is unlikely that information will be collected that provides a strong basis on which to develop and deliver culturally appropriate services. Since the data were collected from a mixed group of people of Mexican, Puerto Rican, Cuban, Central American, and South America origin who resided in the Midwest, it is often difficult to differentiate between the needs of the various groups. For

examp

examin

depres

and ac

health

within

profes

the ne

to con

Mexica

Hale-S

H

factor

Knowle

of bil

Todd,

that H

Rogler

Indige

Baezoo

Medve

have s

Baezoo

in mor

Origin

Comput

example, a study in Michigan conducted by Saenz (1984) to examine the mental health needs of Latinos revealed depression, alcoholism, anxiety, lack of identity, drug use, and adjustment reactions to be the most frequent mental health problems; but it is impossible to know the rates within each subgroup. This information is critical to professionals as they develop services that correspond to the needs of diverse populations. Studies must be designed to consider the heterogeneity within each subgroup (e.g., Mexicans, Puerto Ricans, Cubans)(Torres).

Help-Seeking: Sources, Access, and Utilization

Help-seeking behavior is determined by pre-disposing factors (i.e., age, sex, education), enabling factors (i.e., knowledge of services, availability of services, existence of bilingual services), and need for assistance (Starret, Todd, Decker, & Walters, 1989). Numerous studies have shown that Hispanics prefer alternative sources of help (see Rogler et al., 1989; Santiago et al., 1996) that are indigenous to their culture, such as family (Golding & Baezconde-Barbanati, 1990), extended family, and church (Medvene, Mendoza, Lin, Harris, & Miller, 1995). Studies have shown that families tend to be larger (Golding & Baezconde-Barbanati), to live in closer proximity, and to be in more frequent contact with each other in the Mexican-origin community (Antonucci, 1985) than in Anglo communities. Family is a primary source of identity, self-

worth, and social support (Keefe, Padilla, & Carlos, 1979; Salgado de Snyder, 1986). The literature reveals that people of Mexican origin place greater importance on (Raymond, Rhoads, & Raymond, 1980; Sabogal, Marin, Otero-Sabogal, Marin, & Perez-Stable, 1987) and have greater satisfaction with (Sabogal et al.; Schumm et al., 1988) family support than do non-Hispanic whites. Golding and Burnam (1990) analyzed data from the largest epidemiologic study of social support among people of Mexican origin (see Eaton & Kessler, 1985; Regier et al., 1984, for details on Los Angeles Epidemiologic Catchment Area [LA-ECA] project). Despite differences in culture, Golding and Burnam found many similarities among non-Hispanic whites, U.S.-born Mexicans, and Mexican-born Mexicans in their level of social support.

Medvene et al. (1995) found that parents of children who were diagnosed with schizophrenia reported family members as their most frequent source of support. Sixty-nine percent of the parents received help from their other children. Non-family support was most frequently accessed through neighbors (41%), people associated with their religion, or the parish priest (34%). The results of the study were limited because the sample was small (N=32) and the study targeted a group that was coping with a family member with a severe mental illness, compounded by the effects of acculturation and SES.

A study conducted by Santiago et al. (1996) provided

insight into perceptual barriers to accessing services. Qualitative responses regarding participants' decision to not seek formal rehabilitation services for their disability were reported. The three primary reasons given for not accessing services were (a) does not want or feel need for service (26%), (b) family disapproval (22%), and (c) relative/friends' disapproval (18%). Other reasons cited were cost of services (9%), limited English proficiency (5.5%), lack of transportation (5.5%), and lack of knowledge of services (3%).

Utilization of Mental Health Services and Marriage and Family Therapy

Contradictory conclusions may be drawn regarding the utilization of mental health services by the Mexican-origin community (see Ponterotto, 1987; Rogler et al., 1989). Criticisms of Hispanic utilization studies include a lack of consistency in how utilization is defined, a focus on descriptive studies, and a lack of differentiation between and among ethnic groups. Despite the criticisms, it is important to note that the majority of studies indicate a higher dropout rate and underutilization of mental health services by diverse populations (Acosta & Sheehan, 1976; Keefe, 1979; Keefe & Casas, 1980; Sue, 1977, 1992; Sue et al., 1991; Sue & Zane, 1987; Torres, 1991). Wells et al. (1987) documented an underutilization of outpatient mental health services by people of Mexican origin in the Los

Angeles ECA study, which had an extremely large sample of over 1,200 Mexican-origin subjects. Much of the disagreement in the literature regards the degree of underutilization and the reasons for this underutilization (i.e., alternative theory or barrier theory) (Lin, 1982 Snowden & Lieberman, 1994). Starrett et al. (1989) called for studies that employ "a sophisticated conceptual framework or multiple analysis to clarify the process by which Hispanics utilize formal helping networks when in need of emotional support" (p. 260).

One reason for the underutilization of mental health services by the Hispanic community has been suggested and is identified as a form of a barrier. Although there are limited studies to confirm or negate these ideas, there is an increasing body of literature examining barriers and enablers to service. Organizational barriers can be language that is incompatible with the clientele (Guiterrez et al., 1990; Rogler et al., 1989), lack of linkage with respected community institutions (Guiterrez et al.), financial barriers, and transportation difficulties. Starrett et al. (1989) identified three additional variables that affected the utilization of formal support systems by Hispanic elderly. The Hispanic elderly, who had a higher number of health problems, greater illness severity (need factors), and higher church attendance (enabling factor), had higher utilization rates of formal services. Elderly people of

Mexican origin, primarily the females, who attended church more frequently utilized mental health services more often. The study found that this population evidenced a need for mental health services; however, the utilization rates were still low (13%). The people in this sample chose to seek the church or a doctor (13%) more frequently than a professional (4%) to access help.

Some studies indicate that Mexican-origin people are utilizing mental health services. Hispanics (9%) were found to utilize self-help groups (peer led) slightly more than Caucasians (8%) and more than African Americans (2%) (Snowden & Lieberman, 1994). A mental health center in Northern California experienced success in increasing the Spanish-surname patient population by 40.5% over a four-year period by instituting enablers. This included adding bilingual staff and linking to community agencies accessed by the Mexican-origin population (Fischman et al., 1983). O'Sullivan et al. (1989) repeated Sue's study (1977) in the Seattle area to investigate the level of utilization of mental health services by ethnic groups there. The study concluded that dropout rates had decreased for ethnic groups and there had been changes that created a more culturally responsive system. Acculturation level has been shown to impact utilization rates (Wells et al., 1987). People of Mexican origin who had low acculturation levels had a very low (3.1%) utilization rate of services. Those with high

acculturation levels had a moderate (11.3%) utilization rate compared to non-Hispanic whites (16%). Although the studies cited are not from the field of MFT, most studies have been conducted with restricted (limited) populations; and the inference can be drawn that these services, like MFT, are highly specialized and, therefore, may be indicative of patterns of service utilization.

Knowledge of Mental Health Services

There is a scarcity of literature related to this variable. More recent studies conclude that knowledge of, and need for, services are predictive of utilization of social services (Mindel & Wright, 1982; Starrett et al., 1989). Knowledge of services increases the awareness about available resources and services to potential clients who are experiencing individual, couple, or family problems. No studies were found in the counseling or therapy literature that discussed the best method of dispersing service related knowledge.

Openness to Learning about Mental Health Services

Leaf, Livingston, Bruce, Tischler, and Holzer (1987) examined attitudes and beliefs about mental health which are closely related to openness to learning about mental health services. The results indicated that 81% of the sample had a high receptivity to mental health services. However, 83% perceived at least one barrier to accessing services. The results of this study must be considered cautiously in

relation to ethnic minority populations. The sample of non-White participants was small (13%) and did not specify the ethnic identity of this group.

Expectations About Counseling (MFT)

Scholars and psychologists in the field of counseling, counseling psychology, and psychology have been studying client expectations about counseling for over 30 years (Apfelbaum, 1958; Robinson, 1950; Tinsley, 1982; Tinsley, Bowman, & Westcot Barich, 1993). A major drawback in the existing studies is that the majority of information on expectations has been collected from samples that are predominantly Anglo-European, students, clinical populations, or comparison samples that dilute the information on ethnic groups due to smaller sample size. Other literature concludes that minority groups often receive ineffective mental health treatment (Acosta, Yamamoto, & Evans, 1982) and that therapists may fail to acknowledge the larger context of clients' goals and expectations of therapy (Acosta et al.).

There is agreement in the mental health field that client expectations influence the therapeutic process and outcome of therapy (Tinsley, Bowman, & Ray, 1988; Tinsley, Holt, Hinson, & Tinsley, 1991; Varvil-Weld & Fretz, 1983; Yanico & Hardin, 1985). The counseling literature indicates that ethnicity is related to counseling expectations (Cherbosque, 1987; Kunkel, 1990), and expectations are

believed to impact the counseling process, outcome, and termination (Pope, Seigman, Blass, & Cheek, 1972; Tinsley, Bowman, & Ray, 1988; Tinsley, Bowman, & Westcot Barich, 1993; Tinsley & Harris, 1976). Expectations have also been found to influence perceptions (Postman, 1951), judgements (Festinger, 1957), learning (Overmeier, 1988), and behaviors (Bandura, 1986). More specifically, expectations are believed to impact people's decisions regarding whether to enter or terminate therapy, and they have been shown to have a moderating effect on the therapy itself. Expectations that are not met in a therapeutic relationship may lead to negative outcomes in therapy and may be related to the underutilization of MFT services. Research has also indicated that expectations are influenced by ethnicity (Cherbosque; Kunkel; Kunkel, Hector, Gongora Coronado, & Castillo Vales, 1989), as well as societal, cultural (Yuen & Tinsley, 1981), and economic (Subich & Hardin, 1985) factors. The influence of acculturation must be an integral part of any study that is examining the lives of individuals who have beliefs, values, and attitudes that vary to some degree from those of the dominant culture. A study of client expectations in the Mexican-origin community may serve to help in understanding the changes the MFT field can make that will decrease the dropout rates and increase the effectiveness and utilization rates of therapy.

Professionals in the MFT field must become involved in

this area of study in order to serve the needs of groups that are not now being served by this discipline. Identifying the understanding and expectations of Mexican-origin people regarding MFT will benefit the field. This ethnic group was selected for study due to the complexity of studying the Hispanic or Latino population and the need to increase the amount of information on each cultural subgroup. This study also allowed for an in-depth examination of the intracultural similarities and differences within this group, which are related to the variables under study. In order for the field of MFT to serve this population more effectively, it is necessary to examine the knowledge, expectations, and utilization rates within this community. This information will provide indicators to the MFT profession that will assist in developing objectives and goals that will allow for a stronger relationship to be built between these two systems.

Marriage & Family Therapy: An Alternative Resource

The federal government recognizes the MFT discipline as one of the five mental health professions. MFT is a specialized discipline in the field of mental health whose goal is to provide treatment to individuals, couples, and families who are experiencing problems in their lives. The goals are to consider the system the client lives in, to examine how the system contributes to the maintenance of the problem, and to consider alternatives to the system that

would alleviate or eliminate the problem. In order to successfully examine the system the client lives in, the MFT profession must also be willing to examine themselves.

A recent study indicates that MFT services were rated as good or excellent by 98.1% of all clients surveyed (Doherty & Simmons, 1996). The clients surveyed included females (58%) and males (42%), and the majority (82.5%) reported having a high school degree or higher. A high percentage (42.5%) had a college degree or higher. Racial and ethnic data was not reported. The cost of a therapy session ranged from $0 to $170 per hour, with an average of $63 and a median of $65. Sessions were conducted primarily in private practice settings (65%). The results of this study are consistent with research that concluded that MFT is not serving populations that tend to have lower levels of education and income, which are overrepresented among people of color, based on census data (Green & Bobele, 1994). Yet, 63% of the marriage and family therapists who participated in the study reported feeling competent in treating racial and ethnic minorities. Given that the study did not report the racial or ethnic composition of their participants, it is unknown what percentage of their clients were from ethnic or racial groups.

The MFT field can facilitate increased access and utilization for special populations by developing marketing strategies, taking actions to create services that are a

"good fit" with ethnic communities, and designing educational goals and curriculum in professional programs that will prepare multiculturally sensitive therapists. At this time, insufficient services are available to the Mexican-origin community, and therapists fail to acknowledge problems people of Mexican origin experience as members of a minority group. For example, acculturation stress or cultural stress is not identified as a sign of distress in the American Association for Marriage and Family Therapy's (AAMFT, 1998) pamphlet, "A Consumer's Guide to Marriage and Family Therapy." This marketing tool is not available in Spanish, which makes the information ineffective to those who are primarily Spanish-speaking or cannot read English. The reading level also appears to be directed at individuals with at least a high school education. An increasing amount of attention is being given to evaluating and changing MFT curriculum and educating AAMFT members to become more culturally sensitive. Although their efforts have had varying degrees of success, their goal is to integrate the teaching and study of diversity into MFT programs across the nation. The national organization, AAMFT, has made great efforts to increase the number of workshops and audiotapes that focus on topics and issues related to racial and ethnic minority groups. This may be the reason why 63% of marriage and family therapists reported feeling competent in treating racial and ethnic

minorities (Doherty & Simmons, 1996). Nonetheless, feeling competent and being competent are not the same, and the actual level of competence will only be tested if marriage and family therapists are treating racial and ethnic minorities.

Review of the Literature: Summary

In summary, individual, relational, and societal factors influence the level of acculturation of people of Mexican origin, which, in turn, influences their knowledge and expectations of and openness to MFT services. It has been hypothesized that a combination of some or all of these variables influence the decision to access or not access MFT services. It was the purpose of this study to examine the similarities and differences among the various groups on each of the designated variables in this study.

This study examined client variables in a Mexican-origin community to increase MFT's cognizance of and sensitivity to the following: (a) level of acculturation, (b) level of knowledge of MFT, (c) expectations about MFT, (d) level of openness to learning about MFT, and (e) manner in which these three factors influenced the level of utilization of MFT for people of Mexican origin. Specifically, this study considered sociocultural variables such as income, education, employment, and acculturation. It acknowledged that MFT needs to consider expectations of Mexican-origin people to address power differences and to

become more cognizant of how to more effectively work with individuals and families from diverse groups. The review of the literature supported this investigation of the relationship among and between the variables identified in this study.

Operational Definitions

Ethnicity: refers to a "shared culture and lifestyles" (Wilkinson, 1993, p. 19) that can include culture, values, beliefs, language, religion, color, ancestry, and norms, to name a few. Ethnicity can be the result of self-identification (determined by individual) or ascription (ascribed by larger society) and influences individual and group identify formation. Ethnicity was measured by asking people what word they used to describe their ethnicity. Seven common responses in the Latino community were provided along with an "other" category.

Culture: refers to the shared history, common language, common religion, and shared memories of the past as they have unfolded themselves in the arts and literature and in commonality of customs and traditions.

Hispanic: This is a generic term that refers to all Spanish-speaking or Spanish-surnamed people who reside in the United States or Puerto Rico. The major groups among Hispanics are people of Mexican origin, Chicanos, Cuban Americans, and Puerto Ricans. The term "Hispanic" is generally more accepted on the East Coast.

Latino: This term signifies that a person is of Latin American origin. It is the preferred term on the West Coast. It includes the same ethnic origin terms used to define Hispanic above.

Mexican: Residents of the United States who self-identify as Mexican. This term is often used by people who were born in Mexico.

Mexican-origin person: Residents of the U.S. who self-identify as being of Mexican origin. Frequently used by those who were born in the United States but have parents or grandparents who were born in Mexico.

Chicano: This term refers to persons of Mexican origin or heritage who were born in the United States. It was initiated in 1960 by blue-collar people of Mexican origin and college student activists (Melville, 1988). This term is traditionally preferred on the West Coast.

Mental Health: Loosely defined to include issues of assessment and treatment of mental disorders, individual, marital, or family problems as well as social, economic, and cultural factors that can be directly linked to the etiology of mental health problems.

Marriage and Family Therapy: This is one of multiple disciplines in the field of mental health. It is based on models of therapy and scientific findings that assume that "individuals and their problems are best seen in context, and the most important context is the family" (AAMFT

pamphlet, 1997, p. 1). The goal of MFT is to resolve problems by creating opportunities for change for the individual and/or family.

Delimitations

There were several delimitations in this study.

1. A snowball sample was used to increase the researcher's contact with the Mexican-origin community.
2. A self-selected sample was accepted since this was an exploratory study and the first study of expectations and utilization of MFT in the Mexican- origin community.
3. The principal investigator, a Mexican female trained in MFT, conducted all the interviews due to the unavailability of a male of Mexican origin who was trained in the field of MFT.

Assumptions

1. Studying one ethnic group would provide more culturally sensitive research data.
2. Marriage and family therapy must take an emic (culture-specific) and etic (universal) perspective when conducting therapy with persons of Mexican origin.
3. Marriage and family therapy can be an effective means of support to Mexican-origin families.

CHAPTER 3

METHODOLOGY

Introduction

This investigation was designed to be ecological in nature and emphasized a multicultural perspective. The study considered acculturation (natural-physical-biological and social-cultural environment) and its dynamic relationship to individuals of Mexican origin (human environed unit) and mental health services (human-built environment) using an ecological framework (see Figure 1). The multicultural framework provided a foundation that recognized and respected the strengths and diversity of the Mexican culture.

The study identified (a) the characteristics of people of Mexican origin who seek out help when they need it, (b) what the Mexican origin community expects from helpers, (c) their level of knowledge about various mental health services, (d) their level of openness to learning about marriage and family therapy (MFT), and (e) their level of utilization of counseling, therapy, and MFT.

Research Design

This investigation utilized a cross sectional, exploratory, inferential, two-stage study using an interview survey design in non-controlled settings with individuals of Mexican origin as the unit of analysis.

This chapter will give an overview of the following: (a) research questions, (b) variable definitions, (c) hypotheses, (d) sample design, (e) data collection, (f) proposed data analysis, and (g) limitations.

Research Questions

Several research questions guided the development of this study.

1. Whom do people of Mexican origin seek out when they need help?
2. What factors impact the level of utilization of marriage and family therapy services by people of Mexican origin?
3. What do people of Mexican origin expect from "helpers"?
4. How does the openness to learning about MFT in people of Mexican origin impact their expectations?

Variables

The dependent variables in this study were level of utilization of counseling services, level of utilization of MFT services, and the type of expectations of MFT services.

The independent variables were level of behavioral acculturation, level of cognitive acculturation, level of integrated acculturation, type of expectations of MFT services, level of knowledge of MFT services, level of knowledge of mental health services, and level of openness to learning about MFT services (see Table 1 for variable list).

Table 1

Variable List and Measures

Variable Classes	Measures
Independent Variables	
Level of Behavioral Acculturation	Acculturation Rating Scale for Mexican Americans (ARSMA-II) (Bilingual)
Level of Cognitive Acculturation	Multiphasic Assessment of Cultural Constructs (MACC-SF) (Bilingual)
Level of Integrated Acculturation	Integrated Score from ARSMA-II and MACC-SF
Type of Expectations About MFT Services	Expectations About Counseling-Brief Form (adapted to Expectations about Marriage and Family Therapy-BF), English Version and Spanish Version
Level of Knowledge of Mental Health Services	How much do you know about the services provided by (a)counselors, (b)therapists, (c)marriage and family therapists?
Level of Openness to Learning about MFT Services	I have some written information about MFT. Would you like me to leave you a copy?
	Interviewer's observation of participant's verbal and non-verbal response

(table continues)

Table 1 continued

Variable Classes	Measures
Dependent Variables	
Level of Utilization of Counseling Services	Have you ever received services from a counselor? Have you ever received services from a therapist? Have you ever received services from a marriage and family therapist?
Level of Utilization of MFT Services	Have you ever heard the term "marriage and family therapy Or therapist?" How much do you know about MFT? Have you ever been to see a professional MFT?
Type of Expectations of MFT Services	See above
Control Variables:	
Respondent's	
Age	Self-Report of Age in Years
Gender	Interviewer Observation
Birthplace	Self-Report of Country of Birth
Marital Status	Self-Report (Single, Living with Partner, Married, separated, widowed, divorced, or remarried)
Religious Preference	Self-Report
Level of Education	Self-Report
Ethnicity	Self-Report of Ethnic Label
Immigration Status	Self-Report of Citizenship Status
Occupation	Self-Report
Income	Self-Report (Individual and Household)
Generational Status	Self-Report

The control variables were age, gender, birthplace, marital status, religious preference, level of education, ethnicity, immigration status, occupation, income, and generational status. Data are based on self-reports collected in the demographic section of the instrument (see Appendix A, Research Instrument, questions 3-27). The hypotheses are written in the null form if there is a lack of information in the literature that would support the alternate hypotheses.

Level of Utilization of Counseling Services was defined as the level of services received from counselors. The dependent variable was measured by one item that asked the respondent if they have been to see a professional counselor (see question 216, Appendix A). A five-point scale was developed to determine the individual's level of contact with the counselor. The scores of one to four were collapsed into "don't use services" (0) and a score of five was identified as "used services" (1).

Level of Utilization of MFT Services was defined as the level of services received from marriage and family therapists. The dependent variable was measured by one item that asked the respondent if they have been to see a professional marriage and family therapist (see Appendix A, question 224). A five-point scale was developed to determine the individual's level of contact with the therapist.

Scores of one to four were collapsed into "don't use" (0) and a score of five was categorized as "used" (1).

Level of Acculturation was defined by Herskovits (1936) as "those phenomena which result when groups of individuals having different cultures come into continuous first-hand contact, with subsequent changes in the original cultural patterns of either or both groups" (cited in Cuéllar, Arnold, & Maldonado, 1995, p. 278). Acculturation was measured by two standardized acculturation instruments. The two measures of acculturation were utilized to create a measure of integrated acculturation for use in this study.

The Level of Behavioral Acculturation (ARSMA-II) construct refers to behavioral aspects of acculturation, including "(a) language use and preference, (b) ethnic identity and classification, (c) cultural heritage and ethnic behaviors, and (d) ethnic interaction" (Cuellar et al., 1995, p. 282). This variable was measured by the bilingual Acculturation Rating Scale for Mexican Americans-II (ARSMA-II; see Appendix A, questions 29-76; Cuéllar, Arnold, & Maldonado, 1995). The ARSMA II categorized people by measuring behavioral constructs of acculturation.

The ARSMA-II, comprised of two scales, measures a linear acculturation level, a multidimensional acculturation category, and a level of marginality. The linear acculturation level is based on Scale 1 which is comprised of two scales, the Mexican Orientation Scale (MOS) and the

Anglo Orientation Scale (AOS). There were 17 items (29, 31, 33, 34, 36, 39, 40, 42, 45, 46, 48, 49, 50, 52, 54, 56, 57) that comprised the MOS and 13 items (30, 32, 35, 37, 38, 41, 43, 44, 47, 51, 53, 55, 58) in the AOS. The choice of responses ranged from *"not at all (1)"* to *"extremely often or almost always (5)"*.[3] Mean scores were calculated for each scale by summing the responses and dividing by the number of items in each scale. The behavioral acculturation level (CATACC), a linear acculturation score, was computed by subtracting the Mexican Orientation Scale (MOS) mean ($\underline{M}$ = 3.49, $\underline{SD}$ = .61) from the mean on the Anglo Orientation Scale (AOS) ($\underline{M}$ = 3.71, $\underline{SD}$ = .63). Cutting scores (see Appendix B) determined the five ordinal levels of acculturation, *"Very Mexican oriented (1),"* *"Mexican oriented to approximately balanced bicultural (2),"* *"Slightly Anglo oriented bicultural (3),"* *"Strongly Anglo oriented (4),"* and *"Very Assimilated--Anglicized (5)."*

The acculturation category was based on a multidimensional, orthogonal, bicultural classification frame. The frame had two axes (AOS and MOS) and four quadrants (*1=high integrated bicultural, 2=Mexican oriented bicultural, 3=low integrated bicultural, and 4=assimilated bicultural;* see Appendix B for definitions). Classification

---

[3]Words in italics in this and following sections are from the instrument used in this study.

of biculturalism used the mean scores on the AOS and MOS. Scores greater than -1/2 standard deviation were considered to be *high* and scores ranging from -1.5 standard deviations below the mean to -.5 standard deviations below the mean were identified as *low*. Individuals with high scores on the AOS and the MOS were classified as *high integrated biculturals (1)*, those with high scores on the MOS and low scores on the AOS were identified as *Mexican oriented biculturals* (2), respondents with low scores on the AOS and MOS were *low integrated biculturals* (3), and finally, people with high scores on the AOS and low scores on the MOS were identified as *assimilated biculturals* (4).

The marginality scores, derived from Scale 2, (Marginality scale) is an experimental scale with 18 items. The responses were based on the same 5-point Likert scale as the AOS and MOS. This was used to measure separation and marginality from three cultural groups. Specifically, it measured the level of difficulty accepting Anglo ($\underline{M}$ = 16.98, $\underline{SD}$ = 4.95), Mexican ($\underline{M}$ = 14.95, $\underline{SD}$ = 5.14), or Mexican American ($\underline{M}$ = 13.58, $\underline{SD}$ = 4.21) culture (i.e., customs, values, beliefs, and ideas). Types or cutting scores "were based on standard deviations or fractions thereof, which made intuitive sense based on the likelihood of individuals falling within a given portion of the normal distribution

curve" (p. 287) (see Appendix B for cut off scores). Individuals fell into more than one typology or subtypology since the scores were based on multiple criteria.

The Level of Cognitive Acculturation (LEVEL) refers to cognitive cultural constructs, such as beliefs, ideas, and attitudes. This variable was measured by the Multiphasic Assessment of Cultural Constructs-Short Form (MACC-SF; see Appendix A, questions 77-136; Cuéllar, Arnold, & Gonzalez, 1995. See Appendix C for detailed review of instrument).

The MACC-SF included five scales that were comprised of 60 true-false items. It measured five constructs, using an interval level of measurement, which were identified as cognitive referents of acculturation. The scales were: (a) Familism (12 items: 77, 80, 93, 97, 107, 110, 111, 112, 117, 120, 135, and 136); (b) Fatalism (8 items: 82, 86, 90, 96, 99, 118, 124, 128); (c) Machismo (17 items: 78, 83, 84, 85, 91, 93, 100, 102, 105, 107, 109, 115, 116, 125, 127, 129, 130), (d) Folk Illness Beliefs (14 items: 87, 92, 94, 101, 103, 106, 108, 119, 122, 126, 131, 132, 133, 134), and (e) Personalismo (11 items: 79, 81, 88, 89, 95, 98, 104, 113, 114, 121, 123). A three step process was used to calculate the level of cognitive acculturation (LEVEL). First, the *true* items were summed (note: item 94 was reverse scored) and divided by the number of items in each scale to calculate the mean for each of the cognitive constructs. Next, scores above the mean were identified as having *high*

(1) levels of the construct and scores below the mean signified *low (0)* levels of the cognitive construct. Finally, the high scores were summed to create a level of cognitive acculturation score. The scores ranged from zero (no high scores on any cognitive construct) to five (high scores on all five constructs).

The Level of Integrated Acculturation (INTEGRAT) refers to the behavioral and cognitive cultural constructs identified above. It was derived by creating a profile type that combined the scores of the behavioral acculturation measure (ARSMA-II) with the five cultural constructs of the cognitive acculturation measure (MACC-SF) (see Table 2).

The Level of Behavioral Acculturation from the ARSMA-II and the Level of Cognitive Acculturation from the MACC-SF were employed to create an integrated acculturation score. A five-step process was employed to create four ordinal levels of integrated acculturation. First, the exact scores from the level of behavioral acculturation were computed. Secondly, the scores on level of cognitive acculturation were recoded to identify the number of constructs respondents scored below the mean. This number indicated they were more Anglo oriented in their cognitions and provided a scale consistent with the one used for the level of behavioral acculturation. This scale measured increasing levels of acculturation from 1 to 5 with higher numbers indicating higher levels of acculturation to the Anglo

Table 2

Crosstab in Development of Level of Integrated Acculturation

Cognitive Acculturation Level		Behavioral Acculturation Level (CATACC)						
		Low Anglo Orientation		High Anglo Orientation				
		1	2	3	4	5	Row	Row*
		Number of Respondents					Total	%
Low Anglo orientation	0	2	2	1	0	0	5	8
		I (n=15, 25%)		II (n=16,27%)				
	1	3	2	6	0	0	11	18
	2	0	6	7	2	0	15	25
	3	2	1	6	5	0	14	23
		III(n=6,10%)		IV (n=23,38%)				
	4	0	2	4	3	0	9	15
High Anglo orientation	5	0	1	5	0	0	6	10
Column Totals		7	14	29	10	0	60	99*
Column %		12	23	48	17	0	100	

culture. Third, a crosstab of the Level of Cognitive Acculturation (0-5) (MACC-SF) by Level of Behavioral Acculturation (1-4) (ARSMA-II) was constructed in order to create an acculturation profile (see Table 2). Fourth, the cognitive and behavioral levels were categorized into *low* and *high* levels of acculturation to the Anglo orientation. Scores on the vertical axis of zero to two were classified as *low* Levels of Cognitive Acculturation and a score of three to five was considered a *high* Level of Cognitive Acculturation (MACC-SF). Next, the Level of Behavioral Acculturation scores of one and two were classified as a *low* Level of Acculturation and scores of three and four were identified as *high* Levels of Behavioral Acculturation. Finally, a four-level classification system was devised based on the clusters created by the crosstab of Level of Cognitive Acculturation by Level of Behavioral Acculturation. The four integrated acculturation categories were labeled (I) Low Integrated Acculturation, (II) Mixed Integrated Acculturation: Acculturated Behavior, (III) Mixed Integrated Acculturation: Acculturated Cognitions, and (IV) High Integrated Acculturation. Groups I and IV indicated congruency in behaviors and cognitions. Groups II and III were incongruent in measurements of their levels of behavioral and cognitive acculturation.

Level of Expectations of MFT Services was defined as "probability statements regarding the likelihood that an

event will occur" (e.g., I expect the therapist will understand my problem)(Tinsley, Bowman, & Ray, 1988, p. 100). This variable was measured by the Expectations about Counseling-Brief Form (Tinsley, 1982; adapted to Expectations about Marriage and Family Therapy-Brief Form; see Appendix A, questions 137-202; see Appendix D for a detailed review of instrument) and the translated Spanish version by Buhrke & Jorge (1992; see Appendix A, questions 137-202; see Appendix D for review of instrument).

The 53-item instrument was comprised of 18 scales although only 17 scales were used in this study (see Appendix D for listing and definitions of subscales). The 7-point Likert scale for this ordinal measure ranged from *not true (1) to definitely true (7)* with higher numbers indicating a higher level of expectation for an event to occur. The scale scores for type of expectations of MFT were derived by summing the responses and dividing by number of items in the Subscales. The 17 expectation variables are level of: responsibility, openness, motivation, attractiveness, immediacy, concreteness, outcome, acceptance, confrontation, genuineness, trustworthiness, tolerance, directiveness, empathy, expertise, self-disclosure, and nurturance. All were identified in this study so comparisons could be made between expectations. Individuals with scores above four indicated higher levels of expectation on the scales while scores below four were

designated as having low expectations for the construct.

A factor analysis of the data found three factors: Expectation of Personal Commitment, Expectation of Counselor Expertise, and Expectation of Facilitative Conditions. Factor scores were obtained by summing the scale scores that comprised each factor and dividing by the number of scales in each factor. The higher the mean, the more the individuals expected to (a) take on the responsibility for making progress in therapy (Personal Commitment), (b) have therapists that were directive, empathetic, and expert (Counselor Expertise), and (c) find the necessary conditions in therapy that would allow progress to occur (Facilitative Conditions).

Level of Knowledge of MFT Services was defined as having information or knowledge about the profession of MFT.

The Level of Knowledge of MFT was originally quantified using a series of three items, a recognition question (*have you ever heard the term marriage and family therapy or therapist, 0=no, 1=yes);* a knowledge question (*how much do you know about marriage and family therapy, 1=not at all to 5=a lot*); *and* a use question (*have you ever been to see a professional marriage and family therapist, 1=no, 2=no, but tried to get information, 3=no, but made a telephone call, 4=yes, went for initial intake session, and 5=yes, attended more than 2 sessions*).

The latter two questions were recoded. The responses for the amount of knowledge was collapsed into an interval 3-point scale *(0=no knowledge [1, 2], 1=a little knowledge [3], and 2=a lot of knowledge [4,5])*. The use of MFT responses were recoded into a 2-point scale *(0=no use [1] to [4], 1=used services [5])*. The three items were summed (0-4) and categorized into a 3-point interval scale (KNOWMFT) of *0=No Knowledge (0,1), 1=Low to Moderate Level of Knowledge (2), 3=High Level of Knowledge (3,4)* (see Appendix A, questions 218, 222, and 224 in research instrument).

Level of Knowledge of Mental Health Services was defined as reported knowledge or information about the profession of counseling, therapy, and/or MFT.

The Level of Knowledge of mental health services was measured by three items, 220, 221, and 222 *(how much do you know about counseling, how much do you know about therapy, and how much do you know about marriage and family therapy, respectively)*. Responses to the items ranged from 1 (not at all) to 5 (a lot). The scores were recoded into a 3-point interval scale *(0=no knowledge, 1=a little knowledge, and 2=a lot of knowledge)*. These scores were used to create a 3 digit number that would measure full knowledge of mental health services. The digit in the one's place was knowledge of counseling, the digit in the ten's place was knowledge of therapy, and the digit in the hundred's place was knowledge

of marriage and family therapy (i.e, 000=no knowledge of any service; 012=a lot of knowledge of counseling, a little knowledge of therapy, and no knowledge of marriage and family therapy).

Level of Openness to Learning about MFT Services was a descriptive variable in this study defined as whether a person appears to be open to learning about the profession of MFT.

Participants in the study were given a score for two items: (a) acceptance or refusal of a consumer's pamphlet on MFT and (b) the interviewer's observation of their attitude and response to offer of a pamphlet designed for potential consumers of MFT. The former was a dichotomous scale (no and yes), and the latter was a 3-point scale (negative, neutral, and positive, respectively). The respondent's comments, questions, demeanor, and body language were assessed as part of the researcher's evaluation of openness.

Specifically, this variable was quantified using two items: (a) one question asked the respondent if they wanted the interviewer to leave written information on MFT, providing a nominal level of measurement (0=no, 1=yes) (see Appendix A, question 225 of research instrument), and (b) a score ranging from zero to two, based on interviewer's observation of the participant's negative (0), neutral (1), or positive (2) responses or reactions (see question 226 of Research Instrument) to the offer of the pamphlet and the

opportunity to initiate a discussion about MFT services. The summed scores provided an ordinal scale of zero (no openness to learning about MFT), one (low openness), two (neutral or moderate openness) and three (high openness) with higher numbers evidencing a higher level of openness to learning about MFT services.

Hypotheses

Six hypotheses were central to this study:

H_{11} Among people of Mexican origin, there will be a significant difference between level of acculturation and level of utilization of counseling services.

H_{12} Among people of Mexican origin, there will be a significant difference between level of acculturation and level of utilization of MFT services.

H_{03} Among people of Mexican origin, there will be no significant differences between type of expectations about MFT and level of utilization of MFT services.

H_{14} Among people of Mexican origin, there will be a significant difference between level of acculturation and type of expectations about MFT services.

H_{15} Among people of Mexican origin, those who have a presence of knowledge of counselors, therapists, or marriage and family therapists will have significantly different types of expectations of MFT than those who do not have a presence of knowledge of counselors, therapists, or marriage and family therapists.

H_{06} Among people of Mexican origin, there will be no significant differences between level of openness to learning about MFT and type of expectations of MFT.

A two-tailed test ($p \leq .05$) was required to reject the null hypotheses and accept the working hypotheses that were developed for this study.

Criteria for Sample

A purposive sample was obtained using a snowball sampling technique in two counties in central mid-Michigan; one county was primarily urban and the other primarily rural. Hispanics (13,575) constituted 3.7% of the total population (281,912) for the urban county, with Mexicans comprising 77.1% of this group (Census of Population and Housing, Ingham County, 1990). The rural county had a Hispanic population base of approximately 1.6% of the total population (92,879) with Mexicans (1,479) being the largest group (76.9 %) of the Hispanic rural population (Census of Population and Housing, Eaton County, 1990).

The sample for this study included 60 individuals who met the following criteria: (a) self-identified as being of Mexican origin or had parents or grandparents who self-identified as being of Mexican origin, (b) was a resident of Eaton or Ingham county, and (c) who was 25 years or older. Selection of respondents from households with multiple members was based on the individual who had the next birthday. This increased the likelihood of accessing males,

although the final sample, as in most studies, was primarily female. The purpose of selecting an urban and a rural county was to increase the likelihood of a more diverse community sample. The age requirement was developed to access a sample who had moved into young adulthood so they were more likely to be independent and self-sufficient. They had more opportunity to have experienced challenges in their lives that could necessitate seeking support from familial and non-familial sources. The unit of analysis, individuals, was selected for the sample due to: the lack of data on individual perspectives; the low response rate of males, which can negatively affect family participation; and, most importantly, the response bias that could result due to a partner's influence. The latter was more likely to occur due to the cultural values and beliefs that give the husband more power in the relationship (e.g., machismo, marianisma).

A subset of 15 individuals was selected from the sample of 60. Qualitative interviews were conducted in order to provide respondents an opportunity to share their knowledge, beliefs, and experiences regarding the Mexican origin community, help seeking, and therapeutic services. At the end of each completed interview, every respondent with an even-numbered identification number was asked to participate in an audiotaped interview until there were 15 completed interviews. People were assigned the identification numbers at the initiation of each interview. This gave everyone the

opportunity to be assigned an even number, depending on when they chose to schedule the quantitative interview.

Recruiting of Sample

Potential respondents were contacted through referral sources that conveyed verbal and written information about the research study, the use of advertisements to inform the Mexican-origin community of the research study, and by asking potential respondents and participants to inform and provide contact information to people of Mexican origin in their familial, social, and occupational systems. Specifically, the principal investigator provided informational papers and business cards to key contacts in the Mexican-origin community. Contact was made with key people from informal and formal groups, churches, agencies, and organizations that tend to be connected to or frequented by people of Mexican origin. The principal investigator followed up with referral sources on a regular basis. Information regarding the study was also disseminated through use of English and Spanish informational advertisements (Appendix E) placed in newspapers, newsletters, and flyers that were likely to be seen and read by people of Mexican origin. The flyers were disbursed by referral sources and by the principal investigator at key locations frequented by people of Mexican origin. This informed people of the existence of the study so they felt

more comfortable when approached to participate in the study.

People were able to refer potential respondents of Mexican origin directly to the researcher, or they facilitated contact by providing the researcher's contact numbers to potential respondents. Potential respondents called the researcher directly or gave their name and number to the referral source. Potential participants were given the opportunity to ask questions during the initial contact and were asked if they wanted to meet the researcher and talk before they made a decision. Participants who indicated an interest in participating in the study were informed of the eligibility criteria, the level of commitment necessary to participate in the study, and of the $5.00 appreciation gift they would receive at the completion of the interview. Members from households with multiple members were selected based on who had the next birthday.

Data Collection

A multifacted, three-stage approach was designed to respond to the needs of the Mexican origin population. Upon being notified of a potential respondent, the principal investigator initiated the first stage of data collection by contacting the respondent by telephone or in person. The initial communication was dedicated to engaging in a social stage with the potential participant. This allowed the investigator to develop a rapport with the respondent, to

address individual questions or concerns regarding the study, and to verify the respondent's eligibility criteria. During the initial contact by telephone or in person, the researcher assessed the respondent's comfort with participating in the study. Based on their level of comfort, the researcher engaged in various degrees of "platica" (talk) until the individual indicated at least a moderate level of comfort with the researcher. The second stage of the data collection process was devised for individuals who sounded guarded. They were invited to meet with the researcher at a self-selected time and location to enable them to make a decision regarding their willingness to participate in the research. Upon meeting the people who were undecided, some made a decision to participate in the interview after a 10- to 30-minute social session. The remainder visited with the researcher for 30 to 60 minutes before making a decision to participate. The third stage was to schedule another appointment for people in the latter group to complete the interview.

Potential respondents who reported that they were (a) of Mexican origin,(b) a minimum of 25 years of age, and (c) residents of Eaton or Ingham County were scheduled for a semi-structured, face-to-face interview conducted by the principal investigator. Individuals selected the location for the interview to be conducted from the following choices: (a) home, (b) school, (c) a local college or

university, (d) a community center, (e) church, (f) a community business, or (g) respondent's place of employment. The data were collected during face to face interviews that were predominantly held in the participant's home (48%) or place of business (25%). Respondents also selected the language in which the interview was conducted, English or Spanish. The amount of time needed to complete the interview ranged from one hour to four hours, with an average of two hours.

The interview commenced with an informal social stage that was designed to increase the respondent's *confianza* (confidence or trust) with the interviewer. When the respondent appeared comfortable, an informational sheet (see Appendix F) and consent form (see Appendix G for IRB Approval Letter from UCRIHS) were read to participants. Respondents were reassured about the confidentiality of the interview, informed about their right to refuse any question, and provided an opportunity to asks questions. Upon securing the respondent's signature, a 45-90 minute interview was conducted. Respondents were provided response cards (see Appendix H), in the language of their choice, for reference. The interviewer read the questionnaire and recorded the participant's responses. The interview started with a section of demographic questions (see Appendix A, questions 3-27 of research instrument), followed by three standardized Likert-scale instruments (see Appendix B-D for

overview of instruments), and concluded with a brief section of closed-ended questions (see Appendix A, questions 203-225 of research instrument). Responses were hand-recorded on the 227-item questionnaire by the researcher (see Appendix A). Probes were utilized when respondents indicated a need for clarity of a question. At the completion of the interview, participants were presented with a monetary appreciation gift of $5.00 and the telephone number of the principal investigator. In addition, information on potential support systems and referral sources was also provided at the participant's request or when it was deemed appropriate by the principal investigator, based on the information provided in the interview.

At the end of the interview, respondents who had an even identification number on their questionnaire were asked to listen to the interviewer read an informational sheet regarding a second interview (see Appendix I). The information sheet indicated the purpose of the second interview, the level of commitment necessary for participation, and that no monetary gift would be provided for participating in the second interview that would be audio-taped. This process was conducted until a subset of at least 15 subjects completed the second interview. Most of the respondents made the choice to complete the second interview at that time although some scheduled the interview for a separate time. Before the open-ended interview was

started, a second consent form (see Appendix J) was secured from the respondent. The interview was conducted in the language preferred by the respondent. Seventy-seven percent of the interviews were completed in English, and 23% were conducted in Spanish. The 15-45 minute interview comprised 16 open-ended questions (see Appendix K). Responses were audiotaped in order to increase the reliability of data collection. Notes were taken by the interviewer on non-verbal data that was not able to be documented by the tape recorder. The use of the audiotapes maintained the completeness and the reliability of the data, which offset the risk of getting responses that were not as truthful. In addition, the established relationship and the nature of the questions increased the likelihood that honest and truthful responses were provided. Many of the questions were written in the third person, and participants chose the depth of disclosure that was comfortable to them.

The second session utilized a questionnaire that consisted of 16 open-ended questions (see Appendix K) that encouraged the respondent to share their cognitions and emotions about their experiences as a person of Mexican origin in relation to help seeking and mental health issues.

The standardized instruments were bilingual (English and Spanish) and have been used with bilingual populations. (a) The Expectations about Counseling-Spanish Version has been validated and was developed using the four techniques

commonly used in the translation process; back-translation, bilingual technique, committee approach, and pretest procedures (see Buhrke & Jorge, 1992, for details; see Campbell, Brislin, Stewart, and Werner, as cited in Brislin, 1970, for description of four techniques). (b) The original Acculturation Rating Scale for Mexican Americans (ARSMA) has been in use since 1980, is considered one of the most consistently used measures of acculturation, and has been used with English- and Spanish-speaking Mexican-origin populations. (c) The Multiphasic Assessment of Cultural Constructs-Short Form (MACC-SF) was also developed to be a bilingual instrument when it was developed for use with the Mexican origin community. (d) The informational sheets, consent forms, demographic section, and questions related to openness to and utilization of mental health services were available in bilingual forms. The back translation or double translation technique was utilized to make the forms and instruments culturally equivalent to each other. The instruments were translated from English to Spanish by two translators who were Mexican and highly educated in the English and Spanish language. A computer translation program (Globalink's Power Translator, 1996) was used as another method to translate the versions from English to Spanish and then from Spanish to English. A third translator, who was from Puerto Rico, conducted a back-translation on one of the three instruments. The other two instruments were back

translated by a Mexican member of the community who had a high school education and had worked within the Mexican community with people from the lower and middle SES groups for 18 years. The various Spanish versions were compared, and then the original two translators reviewed each instrument and came to an agreement on the translated versions. This version was compared to the original English version and the computer translated English version. The final version of the instrument was piloted with six people with varying degrees of bilingualism to eliminate inconsistencies or misunderstandings in the instrument.

Respondent Characteristics/Demographic Section

This section was adapted from the demographic section of the Acculturation Rating Scale for Mexican Americans-II (ARSMA-II; Cuéllar, Arnold, & Maldanado, 1995) and the Multiphasic Assessment of Cultural Constructs-Short Form (MACC-SF; see Appendix A, research questions 2-28). Questions designed to elicit background information on the participant and their family members were added in order to examine the influence of contextual factors on the variables being studied in this research. This information included gender, age, birth place, self-identification of ethnicity, perception of skin color, immigration status, residency, religious preference, level of education, marital status, occupation, and income. Respondents were asked to provide the label they used to self-identify their ethnicity and

their race. This was conducted to clarify with what groups people of Mexican origin identify. There were seven possible responses and an "other" category for the former and an open-ended question for the latter. Occupation was categorized using the Michigan Occupational Information System Index (Michigan Jobs Commission, 1988), and respondents gave their individual gross income and the family's total gross income.

Interview Number 2

The instrument for interview number two consisted of 16 open-ended questions (see Appendix K) designed to gather in-depth data on what people of Mexican origin thought or felt about the following issues: (a) the role of familial, social, and professional support systems; (b) their knowledge base of professional sources of support; (c) their belief systems and needs related to help-seeking; (d) utilization of familial, social, and professional support systems by people of Mexican origin; and (e) their suggestions to professionals regarding provision of services to the Mexican-origin community.

CHAPTER 4

RESULTS AND DISCUSSION

This investigation examined the expectations and utilization of marriage and family therapy (MFT) services using quantitative and qualitative methods. This provided the researcher a richer and more in-depth understanding of this area of study. This chapter will focus on the analyses of the quantitative data. The qualitative data will be analyzed in the future. However, conclusions from the results of the empirical data analyses have been influenced by the material that was collected in the qualitative interviews.

The results in this chapter will be divided into four sections: (a) sample description, (b) reliability of standardized measures, (c) development and comparison of integrated acculturation with standardized acculturation instruments, and (4) hypothesis testing.

Introduction: Instrument and Sample

Instrument

The quantitative portion of the study consisted of a 226-item questionnaire (see Appendix L for copyright permission for use of standardized instruments) that contained (a) sociodemographic items, (b) three standardized instruments, and (c) a section related to help-seeking behavior and openness to and utilization of mental health

services. A breakdown of the instruments and the number of items in each measure appear in Table 3.

Sample Description

Less than half of the participants reported speaking Spanish very or extremely often (42%). Almost 90% spoke English as their primary language, and 7% cited speaking English very little or with minimal frequency. Seventy-seven percent of the sample chose to have the interview conducted in English, and 23% selected Spanish.

There were 60 participants in this study who identified themselves as being of Mexican origin. However, there was a wide range of ethnic and racial identity categories provided by the participants. Thirty-seven percent of the

Table 3

Contents of Research Instrument

Instrument	Number of Items
Sociodemographic	27
Acculturation Rating Scale-II	48
Multiphasic Assessment of Cultural Constructs	60
Expectation about Counseling	66
Openness and Utilization of Marriage and Family Therapy	25
Total	226

participants self-identified themselves as "Mexican, Mexicano, or Mejicano." (See Table 4 for a breakdown of self-defined ethnic identity and racial identity labels for participants and their partners.) Ninety percent of the participants were United States citizens through birth or naturalization. Twenty percent of the total sample was born in Mexico. Forty-two percent of the sample identified themselves as being second generation Mexicans with Michigan (40%) and Texas (37%) being the primary birthplaces of the participants.(See Table 5 for a breakdown of demographic characteristics of sample.)

The majority of the sample was female (60%). The ages of the participants ranged from 24 to 75 with a mean age of 41.9 (*SD* = 11.4). Over half of the sample was composed of college-educated individuals (37%) and college graduates (15%). Twelve percent were educated in Mexico, and another five percent had one to six years of education in Mexico. Over half of the sample was married. A little over one third of the participants (37%) reported having three to five children (*M* = 2.58, *SD* = 2.19), and 20% had no children.

Catholicism was the primary religious affiliation (63%), with the next largest group identifying themselves as Christians (17%). Seven percent identified themselves as having no religion, and one individual self-identified as agnostic. Thirty nine percent reported being very or extremely religious or spiritual.

Table 4

Racial and Ethnic Characteristics for Respondents and Their Partners (N = 60)

Category	%	Category	%
Participants: Ethnic Identity		**Time in U.S. (M=38, SD=13)**	
Mexican, Mexicano, Mejicano	37%	Less than 5 years	3%
Mexican American	27%	6-10 years	3%
Hispanic	25%	24-30 years	15%
Latino	3%	31-40 years	37%
Chicano	3%	42-50 years	27%
Other[a]	6%	52-58 years	14%
Total	101%	Over 60 years	2%
		Total	101%
Participants: Racial Identity		**Partner: Ethnic Identity**	
Mexican	30%	No Partner	20%
Mexicano	17%	Mexican Origin	27%
Mexican American	13%	Anglo Origin	20%
Hispanic	10%	Hispanic or Latino	10%
Caucasian	8%	American	10%
White	5%	African Amer./Black	3%
Latino	5%	Mexican/Anglo Mixed	3%
American	3%	Mexican/Black Mixed	2%
Male	3%	Black/White Mixed	2%
Meztizo/Mesclada	2%	Mixed: Other	2%
Don't consider race	2%	Meztiza/Español	2%
Human	2%	Total	100%
Total	100%		
		Partner: Racial Identity	
Time in Michigan (M=30.5, SD=13.8)		Mexican	7%
Less than 5 years	8%	Mexicano	10%
7-10 years	7%	Mexican American	7%
19-29 years	27%	Hispanic	3%
30-39 years	32%	Caucasian	10%
40-52 years	27%	White	13%
Total	101%*	American	3%
		Meztizo/Mesclada	2%
		Don't consider race	2%
		Human	2%
		African Amer/Black	7%
		No Partner	20%
		European	5%
		Mixed: Mex & Anglo/Wht	3%
		Mixed: Wht/Native Amer	2%
		Other[b]	5%
		Total	101%

Note. Percentages over 100 are due to rounding up numbers.

[A]American, Hispanic American, Hispanic, and Mixed

[b]Chicano, Latino Europea, Español

Table 5
Demographic Characteristics for Respondents: Means and Percentages (N=60)

Category	%	Category	%
Age (M=41.9, SD=11.4)		Marital Status	
24-29	15%	Never Married	22%
30-39	28%	Married	52%
40-49	35%	Separated	2%
50-58	15%	Divorced	17%
Over 60	7%	Cohabiting	5%
Total	100%	Widowed	3%
		Total	101%
Gender			
Female	60%	Religion	
Male	40%	Catholic	63%
Total	100%	Christian	17%
		No Religion/Agnostic	8%
Birthplace		Non-Denominational	3%
Michigan	40%	Protestant, Baptist, or Born Again	5%
Texas	37%	Mixed or Believer with No Affiliation	3%
Mexico	20%	Total	99%
New Mexico	2%		
Mississippi	2%		
Total	101%		
		Religiosity or Spirituality	
Citizenship Status		Not religious/spiritual	2%
U.S. Citizen	90%	A little	15%
Mexican citizen	10%	Somewhat	45%
Total	100%	Very	32%
		Extremely	7%
Gen. Status (M=2.6, SD=1.5)		Total	101%
1st generation	20%		
2nd generation	42%	# of Children (M=2.6,SD=2.2)	
3rd generation	12%	None	20%
4th generation	15%	1-2 Children	33%
5th generation	10%	3-5 Children	37%
Total	100%	6-8 Children	10%
		Total	100%
Language			
Primary: English	90%	% Participants with Children in Age Groups(multiple resp)	
Primary: Spanish	7%	0-4	12%
Both	3%	5-10	33%
Total	100%	11-14	27%
		15-19	23%
Interview: English	77%	20 or over	32%
Interview: Spanish	23%	Total	100%
Total	100%		

Note. Percentages below or above 100 are due to rounding up numbers.

A broad range of occupations was represented in the sample. The most prevalent jobs were related to business and education (33%). Health and social services positions (17%) ranked as the second most represented type of employment. Over one quarter (27%) of the sample was not working outside the home. There was a major difference in annual income depending on whether individual or household income was being cited. Forty-five percent of the sample reported an annual earned income of less than $20,000 (individual income). In comparison, only 17% of the sample had annual earned household incomes of less than $20,000. A small percentage of participants had individual annual incomes over $50,000 (10%), but there was a large increase in the percentage of households with annual incomes over $50,000 (42%). Less than one third (27%) of the respondents reported being in unpaid positions, such as being unemployed, disabled, students, housewives, or in low-paying services jobs (5%) (See Table 6 for specific information on occupation and annual income.)

Reliability of Measures

Each standardized instrument was analyzed using statistical tools (SPSS/PC+). The Cronbach's alpha test was used on each scale to measure internal consistency. The results are reported below for each instrument.

Table 6

Mean and Percentages: Education and Income of Respondents
(N=60

Category	%	Category	%
Education		Individual Income	
Less than 12th grade	22%	Less than 12,000	32%
High School Grad/GED	27%	12,000-19,999	13%
1-4 years college	37%	20,000-29,999	23%
College grad/higher	15%	30,000-49,999	20%
Total	101%	Over 50,000	10%
		Don't know	2%
Country of Education		Total	100%
United States	83%		
Mexico	12%	Household Income	
Most US, 1-3 yrs Mex.	3%	Less than 12,000	10%
Most US, 4-6 yrs Mex.	2%	12,000-19,999	7%
Total	100%	20,000-29,999	12%
		30,000-49,999	23%
Occupation or SES		Over 50,000	42%
Category 1[a]	27%	Don't know	7%
Business & Education	33%	Total	101%
Health & Social Svcs	16%		
Category 4[b]	8%		
Art, Design, Comm.	7%		
Service Occupations	3%		
Total	99%		

Note. Percentages below or above 100 are due to rounding up numbers.
[a]Category 1 includes Homemakers, Students, Retired, Disabled, and Unemployed.
[B]Category 4 includes Industrial, Construction, Mechanics, and Repair.

Acculturation Rating Scale for Mexican Americans (ARSMA-II)

Internal Consistency: ARSMA-II. The reliability or internal consistency of the ARSMA-II (see Appendix B for overview and psychometric properties of instrument) was evaluated using Cronbach's Alpha (SPSS 6.1.3). Alpha coefficients were calculated for the five subscales (AOS, MOS, ANGMAR, MEXMAR, and MAMARG) that comprise the two scales (Acculturation and Marginality; see Table 7). The results indicated good internal consistency for all of the scales and subscales (K = .80 to .87).

Factor Analysis: ARSMA-II. The varimax rotation method was used in a factor analysis on the AOS and MOS subscales to test validity over the group of subjects. In Table 8, the

Table 7

Comparing Means and Correlations for ARSMA-II to Cuéllar's Study

Instrument	Cuéllar			Study		
	M	SD	K	M	SD	K
Scale 1: Acculturation						
AOS	3.82	.57	.83	3.71	.63	.82
MOS	3.28	.84	.88	3.49	.61	.80
Scale 2: Marginality						
ANGMAR	14.70	5.28	.90	16.98	4.95	.81
MEXMAR	13.98	5.68	.68	14.95	5.14	.86
MAMARG	12.61	4.73	.91	13.58	4.21	.87

Table 8

Rotated Factor Matrix for Anglo Orientation Scale of ARSMA-II

Factor	Commun-ality	Eigen-value	% of Variance Explained	Correla-tion
1) Ethnic Interaction	.74475	4.463	34.3	
Associate w/ Anglos				.81
Anglo friends as child				.79
Speak English				.71
2) Language: media	.6769	1.612	12.4	
Enjoy English movies				.86
Enjoy English TV				.81
3) Language: hearing	.6189	1.393	10.7	
Think in English				.78
Enjoy English music				.61
4) Language: written	.7668	1.081	8.3	
Write letters in English				.77
Enjoy English books				.60
Cuéllar's Factors (AOS)				
Language		4.23	32.54	
Ethnic Interaction/ Distance		1.47	11.35	

13-item Anglo Orientation Scale (AOS) generated four factors with an eigenvalue of 1.08 or higher. These four factors accounted for 65.7% of the total variance explained by the factors. The first factor, ethnic interaction, accounted for 34.3% of the total variance explained. Based on their item composition, the factors for the AOS have been identified as (1) ethnic interaction, (2) language/media, (3) auditory language, and (4) written language. The three language factors combined explained 31.4% of the variance. In Table 9, the 17-item Mexican Orientation Scale (MOS) generated five factors with an eigenvalue of 1.3 or higher and accounted for 68.9% of the variance explained by the factors. The first factor is hard to interpret, but it has been identified here as "Involvement with Cultural Heritage" and accounts for 36.1% of the variance. Factor 1 reveals low to high correlations between items. The correlations of the items within the factor illustrated that the items are measuring a common construct or factor.

Multiphasic Assessment of Cultural Constructs-Short Form: (MACC-SF)

Internal Consistency: MACC-SF. This instrument consists of five subscales (see Appendix C for definitions) that embody characteristics of the Mexican-origin culture. The subscales and psychometric properties of each construct appear in Table 10. Internal consistency for the machismo (Macho; K = .78) and folk illness beliefs (FOLK; K = .75)

Table 9

Rotated Factor Matrix for Mexican Orientation Scale of ARSMA-II

Factor ↓	Commun-ality ↓	Eigen-value ↓	% of Variance Explained ↓	Correla-tion ↓
1) Involvement with Cultural Heritage	.7619	6.492	36.1	
Mexican friends as child				.8105
Enjoy Spanish books				.7438
Cook Mexican foods				.6807
Contact with Mexico				.6176
2) Contact with Cultural Language	.7079	1.627	9.0	
Enjoy Spanish movies				.7889
Enjoy Spanish TV				.7174
Enjoy Spanish music				.6899
Speak Spanish				.6173
3) Current Ethnic Interaction	.7560	1.558	8.7	
Associate w/ Mex/M. Amer.				.7823
Mexican friends				.6377
4) Ethnic ID-Father	.5318	1.438	8.0	
Father identifies Mexican				.8709
5) Ethnic ID-Self	.7439	1.277	7.1	
Self Identify as Mexican				.5620
Cuéllar's Factors (MOS)				
Language		6.52	38.36	
Ethnic Identity		1.81	10.70	
Ethnic Interaction/ Distance		.94	5.54	
		4.23		
		1.47		

Table 10

Means and Internal Consistency: MACC-SF Subscales

Instrument	Cuéllar (N=379)			Study (N=60)		
	M	SD	K	M	SD	K
Subscales						
Machismo	4.66	3.33	.73	5.65	2.98	.78
Folk Beliefs	4.60	3.15	.71	6.15	2.86	.75
Familism	5.71	2.48	.50	6.83	2.02	.65
Fatalism	2.89	1.92	.42	3.80	1.54	.63
Personalismo	5.96	1.94	.42	6.50	1.85	.47

subscales were fair. The remaining three scales--Familism (FAM; K = .65), Fatalism (FATAL; K = .63), and Personalismo (PERSON; K = .47) were not acceptable. Cuéllar's results on internal consistency of these three subscales were low as well (K = .42 to .50). Overall, the five factors were more consistent in the current study. The internal consistency was close to meeting the .80 standard, and the alphas were higher than the acceptable .60 standard for exploratory studies.

Factor Analysis: MACC-SF. A confirmatory factor analysis was conducted using the varimax rotation method on each of the five constructs. Selection of the factor solutions for each of the five subscales were determined by their eigenvalues being above 1.0 and each factor making up at least 10% of the explained variance.

Machismo: A three-factor solution was selected for the Machismo Subscales: Traditional Gender Values (21.1), Male

Gender Role (12.6), and Male Superiority (9.4). These factors explained 43% of the variance (See Table 11).

Folk Illness Beliefs: The Folk Illness Beliefs Subscales yielded a three-factor solution which accounted for 47% of the variance: Experience (24.1), Folk Practice Ideologies (12.5), and Belief in Supernatural (10.6)(See Table 12).

Familism: The 12-item Familism Subscales yielded 5 factors with an eigenvalue above 1.0. The five factors together explained approximately 55% of the variance: Parental Roles (19.8), Family Priority (12.7), Dependency on Relatives (12.3), Parental Authority (9.9), and Value of People (9.9) (see Table 13).

Fatalism: A three-factor solution was selected for the Fatalism Subscales which accounted for 61% of the variance: Inevitability (27.9), Present Orientation (19.5), and Mastery (13.6) (See Table 14).

Personalismo: A four-factor solution that accounted for 55% of the variance was selected for the Personalismo Subscales; Social Influence (17.8), Supportiveness (14.7), Friendliness (12.5), and Sociability (10.1) (See Table 15).

Reliability of Spanish Version: MACC-SF. The bilingual Multiphasic Assessment of Cultural Constructs-Short Form (MACC-SF) has also been found to be reliable and valid (Cuéllar, Arnold, and González, 1995). The Spanish version of the Expectations about Counseling was developed and

Table 11

Rotated Factor Matrix for Machismo Scale of MACC-SF

Factor ↓	Communality ↓	Eigenvalue ↓	% of Variance Explained ↓	Correlation ↓
1) Traditional Gender Role	.79507	3.585	21.1	
*Better to be man than woman				.75
*Parents stricter control over daughters				.73
*Boys not play with girls' toys				.64
*Some jobs, women should not have				.61
2) Male Gender Role	.67174	2.138	12.6	
*Women like dominant men				.75
*Man not marry taller woman				.69
*Men more intelligent than women				.62
3) Male Superiority	.70204	1.593	9.4	
*Father, main say, family matters				.84
*Wife respects man, head of home				.71
*Women learn housework, not college				.57
Total Factor Explained			43.1	

Note. In Tables 11-15, statements have been shortened, but they retain the meaning of the original. See MACC-SF for exact statements.

Table 12

Rotated Factor Matrix for Folk Illness Beliefs Scale of MACC-SF

Factor	Commun-ality	Eigen-value	% of Variance Explained	Correla-tion
1) Experience	.73161	3.370	24.1	
*Treated for empacho				.76
*Used curanderos in past				.55
*Used curandero more than once				.73
*Treated for "Susto" when young				.79
*Treated for "Mal de Ojo"				.72
2) Folk Practice Ideologies	.74273	1.747	12.5	
*Take child to curandero				.77
*Curandero better, some illnesses				.85
3) Belief-Supernatural	.78384	1.488	10.6	
*Possible to place hex				.75
*Hexed in past				.81
Total Factor Explained			47.2	

Table 13

Rotated Factor Matrix for Familism Scale of MACC-SF

Factor ↓	Commun-ality ↓	Eigen-value ↓	% of Variance Explained ↓	Correla-tion ↓
1) Parental Roles	.609842	2.376	19.8	
*Stricter parents, better child				.76
*Father, main say, family matters				.76
*Woman care for house/family				.75
2) Family Priority	.50955	1.518	12.7	
*Mother, dearest person for child				.84
*Parents approve girl's date				.60
*Parents teach children loyalty to family				.55
3) Dependency on Relatives	.63901	1.475	12.3	
*Expect relatives' help				.81
*Relatives' problems come first				.81
4) Parent Authority	.62234	1.193	9.9	
*Children obey, no question				.66
*Family participate, school activities				-.77
5) Value of People	.71986	1.098	9.2	
*Relatives more important than friends				.66
*Respect all adults				-.75
Total Factor Explained			63.9	

Table 14

Rotated Factor Matrix for Fatalism Scale of MACC-SF

Factor ↓	Commun-ality ↓	Eigen-value ↓	% of Variance Explained ↓	Correla-tion ↓
1) Inevitability	.74976	2.231	27.9	
*People die when it is their time				.84
*Future in the hands of God				.82
*Don't plan ahead, just good/bad fortune				.52
2) Present Orientation	.74311	1.556	19.5	
*Enjoy life now				.85
*Live for present, future unknown				.80
3) Mastery	.65270	1.086	13.6	
*Someone controls me				-.67
*Make plans, they work				.66
*Believe doctor more than self				.63
Total Factor Explained			61.0	

Table 15

Rotated Factor Matrix for Personalismo Scale of MACC-SF

Factor ↓	Commun-ality ↓	Eigen-value ↓	% of Variance Explained ↓	Correla-tion ↓
1) Social Influence	.49365	1.960	17.8	
*Know people of power				.65
*Start talk: weather				.69
2) Supportiveness	.47885	1.619	14.7	
*Trust people to do me favors				.65
*Don't mind asking for favors				.64
*Often ask people to do me favors				.59
3) Friendliness	.61778	1.374	12.5	
*Try to get to know everyone I meet				.66
*Better to meet someone if know their family				.69
*Friendly people get further than cold people				.67
4) Sociability	.44295	1.116	10.1	
*Enjoy being with people				.60
*Greet people in friendly manner				-.64
Total Factor Explained			55.1	

validated by two studies (Buhrke & Jorge, 1992) that found it to correspond significantly to the English version for student and non-student samples. Buhrke and Jorge did find some items and scales to have lower than desirable correlations. They explained that concepts do not translate directly, that there was the potential for different dialects, and that there were differences in the subjects' language proficiency (see Buhrke & Jorge for details).

Expectations about Counseling-Brief Form (EAC-BF; adapted to Expectations about Marriage and Family Therapy-Brief Form, EAMFT-BF

Internal Consistency: EAC-BF (EAMFT-BF). The internal consistency for each of the 17 scales was calculated using Cronbach's alpha (see Table 16). The alphas for the subscales ranged from .64 to .90 for this study. Almost half of the correlations in this study (46%) were within .05 of Tinsley's results, and another 36 percent were within .15. More specifically, the Immediacy, Motivation, Directiveness, and Empathy scales were found to be much more reliable, and Concreteness was slightly more reliable. Unlike Tinsley, lower reliability was found for the Attractiveness, Tolerance and Realism subscales. A decision was made not to use the Realism scale in this study. It is an experimental scale that lacked meaningfulness in this study due to the diversity in the sample, and there was no intention to

Table 16

Means and Internal Consistency Scores for Scales of Expectations about Counseling-Brief Form (adapted to Expectations about Marriage and Family Therapy-Brief Form)

Scales	Study (N=60)			Tinsley(N=446)
	M	SD	K	K
Motivation	5.12	1.64	.90	.77
Concreteness	5.02	1.49	.85	.79
Confrontation	4.93	1.62	.85	.82
Openness	5.19	1.64	.83	.81
Outcome	5.67	1.25	.82	.81
Directiveness	3.78	1.77	.82	.69
Empathy	3.56	1.61	.82	.71
Trustworthiness	5.88	1.26	.82	.78
Immediacy	5.43	1.34	.81	.69
Nurturance	5.05	1.47	.76	.75
Expertise	4.70	1.61	.75	.75
Genuineness	6.39	0.91	.75	.76
Acceptance	4.46	1.55	.74	.81
Self-disclosure	2.73	1.60	.74	.80
Responsibility	6.00	0.96	.72	.70
Tolerance	4.71	1.52	.68	.71
Attractiveness	4.04	1.46	.64	.76

assess how realistic the individual's expectations were within this study.

Tinsley's study (Tinsley, Workman, & Kass, 1980), based on the responses of 446 undergraduate students, had internal consistency reliabilities that ranged between .69 and .82. In a secondary analyses of data from six studies (Biscardi & Helms, 1980, as cited in Tinsley, 1982; Rode, 1979; Tinsley, Brown, De St. Aubin, & Lucek, 1984; Tinsley et al., 1980; Workman, 1978; Yuen & Tinsley, 1981), Tinsley (1982)

correlated the full and brief scale and factor scores and achieved a correlation less than or equal to .83.

Factor Analysis: EAC-BF (EAMFT-BF). A factor analysis supported a three-factor solution that was similar to other studies (see Hayes & Tinsley, 1989; Kunkel et al., 1989; Tinsley, Holt, Hinson, & Tinsley, 1991). Three components satisfied the eigenvalue criterion of being greater than one (Kaiser criterion). They accounted for 73% of the total variance explained. When Cattell's Scree test (1940) and the percentage of total variance explained was examined, the first two factors accounted for the majority (66%) of the common variance in scores on the EAC-B. A varimax rotation indicated that Openness, Immediacy, Responsibility, Outcome, Motivation, Trustworthiness, and Attractiveness loaded highest on the first factor, which was identified as the Expectation of Personal Commitment factor. It is similar to the Expectation of Personal Commitment factor identified in the earlier studies, with the exception of trustworthiness that replaced concreteness in this study. This factor primarily measured clients' expectations to take on responsibility for achieving progress in therapy. A varimax rotation indicated that Empathy, Expertise, Self-Disclosure, Directiveness, Confrontation, Nurturance, and Concreteness had the highest loadings on the second factor, Expectation of Counselor Expertise. Prior research has not included the latter three in this factor. In past studies, Confrontation,

Nurturance, and Concreteness loaded high on the third factor in this study, Expectation of Facilitative Conditions. The highest loadings on this Expectation of Facilitative Conditions factor were Tolerance, Genuineness, and Acceptance. These have comprised part of the Expectation of Facilitative Conditions factor identified in other studies. A decision was made to include the Expectation of Facilitative Conditions factor in the factor solution in this study even though the percent of total variance explained was low (6.6%). In addition, Genuineness and Tolerance have been identified as being "necessary and sufficient" (Rogers, Gendlin, Kiesler, & Truax, 1967, in Tinsley, Workman, & Kass, 1980, p. 565) to facilitate change, and other studies have indicated that Acceptance is also a facilitative condition.

Internal consistency coefficient alphas for the three expectancy factors ranged from .74 to .93 (see Table 17). The means of the factors ranged from 4.25 to 5.33 (SD, 1.10 to 1.31).

Spanish Version: EAC-BF (EAMFT-BF). Reliability and factor analyses were not conducted on the Spanish versions of the instrument due to the results of an investigation conducted by Buhrke and Jorge (1992) and the small sample (n=14) that completed the interview in Spanish in this study. Buhrke and Jorge found the Spanish version to be a

Table 17

Mean, Standard Deviation, and Internal Consistency for Factors of the Expectations about Counseling-Brief Form (adapted to Marriage and Family Therapy-Brief Form)

Factors and Scales	M	SD	K
I Counselor Expertise	4.25	1.31	.92
Confrontation			
Concreteness			
Directiveness			
Empathy			
Expertise			
Nurturance			
Self-Disclosure			
II Personal Commitment	5.33	1.15	.93
Attractiveness			
Immediacy			
Motivation			
Openness			
Outcome			
Responsibility			
Trustworthiness			
III Facilitative Conditions	5.19	1.10	.74
Acceptance			
Genuineness			
Tolerance			

"viable and potentially useful tool" (p. 369) for various Hispanic populations.

Measure of Level of Integrated Acculturation

Introduction

A goal of this study was to calculate a Level of Integrated Acculturation score that represented a combined measurement of the behavioral acculturation constructs from the ARS of MA-II and the cognitive acculturation constructs from the MACC-SF. This section focuses on providing a description of how the level of integrated acculturation measure was created by this author. The Level of Integrated Acculturation score will be used in analyses conducted for the hypotheses related to acculturation

Development of Measure

A review of the Level of Behavioral Acculturation scores and the Level of Cognitive Acculturation scores is provided to clarify how they were used in the development of the Level of Integrated Acculturation score.

Level of Behavioral Acculturation (ARSMA-II). The scores from Scale 1 (Anglo Orientation Scale and Mexican Orientation scale) were utilized for the "X" axis of the crosstab used to develop the Level of Integrated Acculturation score. These included Very Mexican oriented (1), Mexican oriented to approximately balanced bicultural (2), Slightly Anglo oriented bicultural (3), Strongly Anglo oriented (4), and Assimilated/Anglicized (5).

Level of Cognitive Acculturation (MACC-SF). The number of scales below the mean (0-5) were counted to create a Level of Acculturation score. A decision was made to use the same labels from the ARSMA-II. Since there were only five levels in the Level of Behavioral Acculturation, it was necessary to add a sixth label since the range of scores for this variable was 0 to 6. The final scale was Very Mexican oriented (0), Mexican orientation (1), Mexican oriented to approximately balanced bicultural (2), Slightly Anglo oriented bicultural (3), Strongly Anglo oriented (4), and Assimilated/Anglicized (5). For example, respondents with low scores (below the mean) on all of the five constructs had a "5" for their cognitive acculturation score.

Level of Integrated Acculturation

The level of behavioral acculturation score (CATACC) (level 1-5) from the ARSMA-II and the level of cognitive acculturation (LEVEL) (level 0-5) from the MACC-SF were utilized in creating the level of integrated acculturation.

A crosstab of the Cognitive Acculturation Level (0-5) (MACC-SF) by Level of Behavioral Acculturation (1-5)(ARSMA-II) was constructed in order to create a Level of Integrated Acculturation profile. Scores of zero to two on the Level of Cognitive Acculturation axis and scores of 1-2 on the Level of Behavioral Acculturation axis measured low levels of Integrated Acculturation to the Anglo culture. Scores ranging from three to five on either scale symbolized an

increasingly higher level of acculturation to the Anglo culture. In this study, there were no respondents with scores that identified them as Assimilated/Anglicized (level 5) on the behavioral acculturation measure, but this level was included in the crosstab. A four-level classification system was devised for this study (see Table 2, p. 64) based on the clusters created by the crosstab of the behavioral and cognitive acculturation levels developed by Cuéllar, Arnold, and Maldonado (1995) and Cuéllar, Arnold, and Gonzalez (1995). The four levels of integrated acculturation were labeled: (I) Low Integrated Acculturation (low levels of acculturation on beliefs and behaviors); (II) Mixed Integrated Acculturation: Acculturated Behaviors (high level of acculturation on behaviors and low level of acculturated cognitions); (III) Mixed Integrated Acculturation: Acculturated Cognitions (high level of acculturation on cognitions and low level of acculturation in behaviors); and (IV) High Integrated Acculturation (high levels of acculturation in cognitions and behaviors). Levels I and IV identified the Very Mexican and Strongly Anglo or Assimilated/Anglicized groups, respectively. Levels II and III identified the bicultural groups.

Results of Level of Integrated Acculturation

The majority of the respondents (63%; groups I and IV) evidenced congruency in their level of acculturation on

beliefs and behaviors (high-high or low-low). Over one third (37%) of the respondents had incongruent levels of behavioral and cognitive acculturation (groups II and III). Group II had the larger percentage of respondents (27%) with an incongruent level of integrated acculturation. These respondents were more acculturated in Anglo behaviors and held Mexican beliefs. A small percentage of respondents (10%) were highly acculturated in cognitions but maintained a Mexican orientation in their behaviors (group III). This supports the literature which asserts that the rate of behavioral and cognitive acculturation is varied (Cuéllar, Arnold, & Gonzalez, 1995; Cuellar, Arnold, & Maldonado, 1995).

Results of Study by Research Questions and Hypotheses

The results of the study indicated that there were more similarities than differences between the Anglo-oriented and Mexican-oriented group (see Figure 2). This figure shows the behavioral and cognitive variables that were considered in developing the integrated acculturation categories. It also demonstrates that the demographic variables, such as age, gender, marital status, and generational status impact the level of integrated acculturation. Only a few of the differences between groups were statistically significant (see 1, 2, and 7 in Figure 2). The majority of differences were identified as patterns that existed between groups (3, 4, 5, and 6 in Figure 2). These results are discussed below.

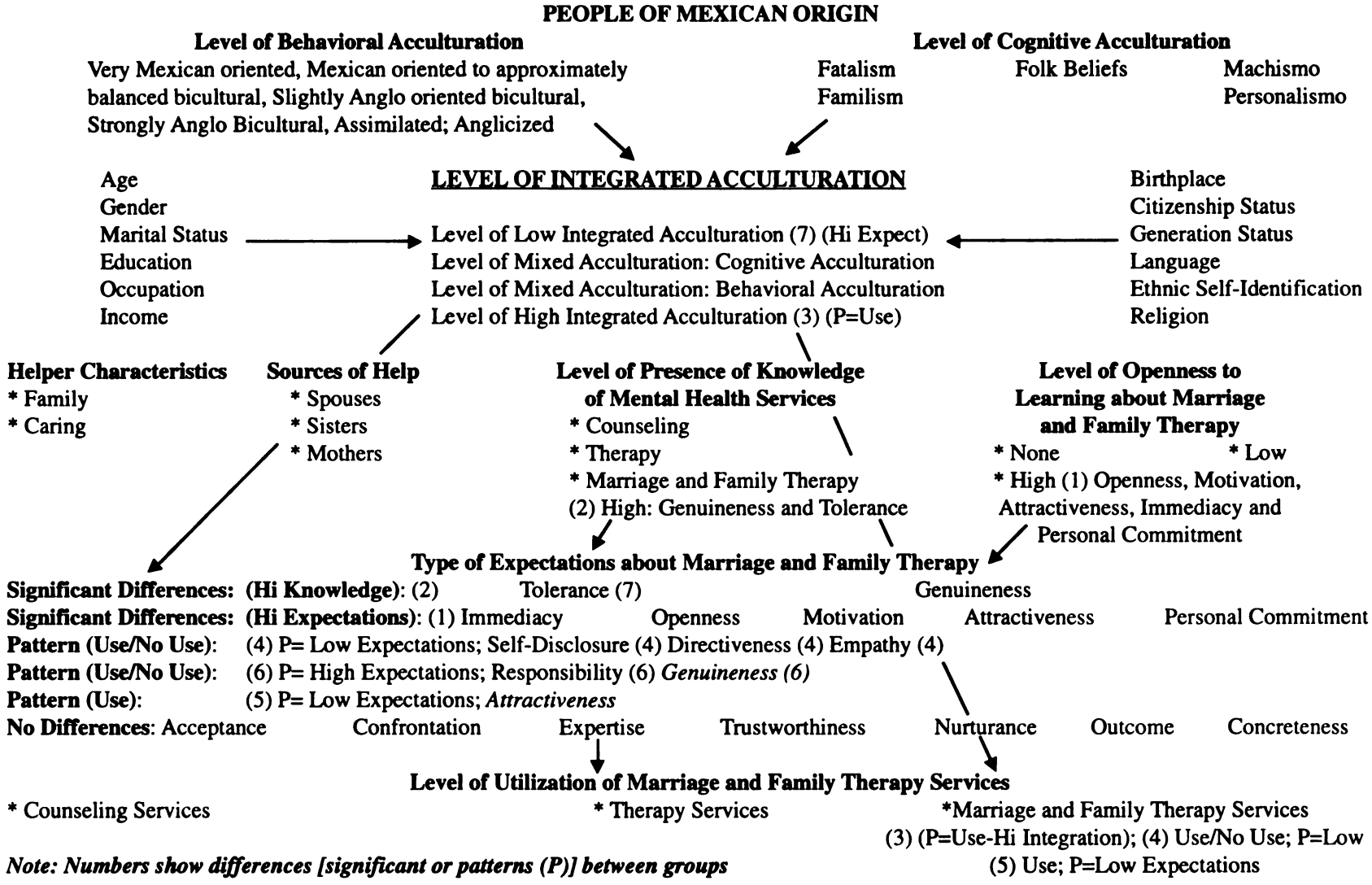

Figure 2. Theoretical Model of Constructs Related to Mexican Americans' Expectations and Utilization Patterns of Marriage and Family Therapy Services

Help-Seeking

Research Question # 1: Whom Do People of Mexican Origin Seek Out When They Need Help? An examination of the help-seeking data indicate that the majority of people had three to eight sources of help (70%). Spouses were the most prevalent initial source of help (40%) for respondents, followed by sisters (18%) and mothers (13%). Family members would be the first source of support for 80% of the respondents. A very small minority (4%) stated they turned to "God" first. Seeking help from a counselor or therapist was also an option for another 4% of the respondents. This sample did not have a mutual agreement on what primary characteristics were important in their helpers. The two most common responses were that they were "family" (28%) and they were "caring" (23%). The majority of the sample found seeking help from family and friends to be very easy (28% and 18%) or somewhat easy (28% and 28%). Surprisingly, social/community services and professional sources were very easy (18% and 32%) or somewhat easy (12% and 25%) to access as well. The rate dropped to 17% when subjects were asked about seeking help from neighbors.

Utilization of Mental Health Services

Research Question # 2: What factors impact the level of utilization of marriage and family therapy services by people of Mexican origin?

Hypothesis H_{11}. The first hypothesis predicted that

there would be a significant difference between level of integrated acculturation and level of utilization of counseling services in the Mexican origin community. The hypothesis was not confirmed, even though acculturation was measured in three modes, behavioral, cognitive, and integrated. (Detailed results for behavioral and cognitive acculturation measures can be found in Appendix M.)

Due to the confusion of many participants in differentiating between MFT and counseling during the study, it was decided to begin the analyses by examining counseling use. The use of counseling services was a dichotomous variable; respondents who did not use services were given a zero, and users of counseling were given a score of one. Counseling use was found to be independent of any of the acculturation measures: (a) behavioral ($df = 3$, $A^2 = 6.77$, $r = .338$, $p<.05$), (b) cognitive ($df = 5$, $A^2 = 10.80$, $r = .056$, $p<.05$), or (c) integrated ($A^2 = .33801$, $df = 3$, $r = .338$, $p<.05$). Crosstabs and the chi square (A^2) were used to examine the discrepancy of counseling use among the Level of Integrated Acculturation groups (see Table 18). Although there was an increased use of counseling services in the groups that were Anglo-oriented (51%), when compared to the Mexican-oriented group (29%), the differences were not significant at the .05 level. For example, almost twice as many people who were Anglo-oriented reported that they had utilized counseling services at least two times when

Table 18

Use of Counseling Services by Level of Integrated Acculturation (N=60)

Type of Acculturation	Counseling (%)				
	Used	No Use	A^2	DF	p
III) Mixed Integrated Acculturation: Acculturated Cognitions (Mexbeh/Anglobel)	1.7	8.3	3.37	3	.338
I) Low Integrated Acculturation (Mex Congruency)	8.3	16.7			
IV) High Integrated Acculturation (Anglo Congruency)	20.0	18.3			
II) Mixed Integrated Acculturation: Acculturated Behaviors (Anglobeh/Mexbel)	13.3	13.3			
Total	43.3	56.7			

compared to the Mexican-oriented group. The lack of significance for the hypotheses may be due to the small sample size in this study, as well as to the even smaller sample numbers when the group of 60 respondents was classified into the four acculturation groups. It may also demonstrate that there were more similarities than differences among this community, regardless of level of acculturation.

Hypothesis H_{12}. This hypothesis predicted that there would be a significant difference between Level of

Acculturation and Level of Utilization rates of Marriage and Family Therapy services. A crosstab and chi square analysis was used for examining the differences in the level of use of MFT among the three measurements of acculturation (see Table 19 for results of Integrated Acculturation and Use of MFT Services and Appendix M for behavioral and cognitive acculturation and use of MFT services). Consistent with hypothesis 11, no significant differences were found among Levels of Integrated Acculturation for Use of MFT services. However, a pattern was evident of increased usage by

Table 19

Use of Marriage and Family Therapy (MFT) Services by Level of Integrated Acculturation (N=60)

Type of Acculturation	MFT (%)				
	Use	No Use	A^2	DF	p
I) Low Integrated Acculturation (Mex Congruency)	5.0	20.0	1.55	3	.670
II) Mixed Integrated Acculturation: Acculturated Behaviors (Anglobeh/Mexbel)	5.0	21.7			
III) Mixed Integrated Acculturation: Acculturated Cognitions (Mexbeh/Anglobel)	0.0	10.0			
IV) High Integrated Acculturation (Anglo Congruency)	8.3	30.0			
Total	18.3	81.7			

participants who were classified as being more Anglo-oriented, regardless of the acculturation measure that was used. Based on people's comments during the quantitative and qualitative interviews, it appeared that people of Mexican origin did not perceive MFT as an option or necessity. ("We would never think about telling some stranger about our problems." "I turn to God, people don't have answers for me.")

Hypothesis H_{03} examined whether there were significant differences among the types of expectations about MFT in the level of utilization of MFT services. None of the two sample independent t-tests on the 17 scales were significantly different when compared across Use of MFT services (see Table 20). While subjects in the Use MFT group had slightly higher levels of expectations in 11 of the 17 subscales, the differentiation was insignificant. However, a review of the data indicates that a pattern of low expectations ($M \leq 4.0$) was evident with the Used and No Use groups in self-disclosure, empathy, and directiveness. The Use MFT group also was low ($M = 3.88$, $SD = .96$) in attractiveness. The highest expectations ($M \geq 6.00$) were related to responsibility and genuineness, regardless of the utilization group. Trustworthiness and attractiveness was slightly higher for the Used MFT group ($M = 6.30$, $SD = .97$) than the No Use group ($M = 5.79$, $SD = 1.31$).

Table 20

Relationship Between Type of Expectations and Level of Utilization of MFT Services (N=60)

Type of Expectation (df=58)	Level of Utilization of MFT Services: Don't Use MFT M	Don't Use MFT SD	Use MFT M	Use MFT SD	t ratio ↓	p ↓
Responsibility	6.00	.92	6.05	1.18	- .16	.88
Openness	5.07	1.68	5.73	1.35	-1.20	.23
Motivation	5.10	1.65	5.21	1.68	- .21	.83
Attractiveness	4.08	1.55	3.88	.96	.41	.68
Immediacy	5.34	1.38	5.82	1.11	-1.08	.29
Concreteness	5.01	1.58	5.09	1.08	- .17	.87
Acceptance	4.51	1.61	4.18	1.31	.64	.52
Confrontation	4.81	1.68	5.48	1.25	-1.26	.21
Genuineness	6.36	.92	6.55	.90	- .61	.55
Tolerance	4.72	1.57	4.64	1.35	.17	.87
Trustworthiness	5.79	1.31	6.30	.97	-1.23	.23
Directiveness	3.82	1.85	3.61	1.42	.35	.73
Empathy	3.57	1.66	3.52	1.47	.10	.82
Expertise	4.65	1.72	4.94	1.01	- .54	.59
Self-Disclosure	2.80	1.66	2.42	1.33	.69	.49
Nurture	4.99	1.51	5.30	1.35	- .63	.53
Outcome	5.61	1.28	5.97	1.09	- .87	.39
Factors***						
Personal Commitment	5.17	1.23	5.39	.96	- .56	.58
Facilitative Conditions	5.20	1.12	5.37	.75	- .49	.63
Counselor Expertise	4.01	1.55	4.02	1.11	- .02	.99

These results must be interpreted with caution due to the confusion that was apparent in respondents' difficulty in differentiating between counseling, therapy, and MFT. Comments heard frequently in the interviews illustrated that respondents were unclear about what type of professional background their "helper" had. ("I'm not sure, they just helped me with my problems. I think it was a marriage therapist, and I never asked them what kind of counseling they did.") This pattern of response impacted the utilization percentages of services. Almost half (45%) of respondents reported that they had used therapy services. A slightly lower percentage (43%) reported using counseling services. A dramatic decrease (18%) was evident in the reported use of MFT services.

Type of Expectations of Marriage and Family Therapy Services

Research Question # 3: What do people of Mexican origin expect from helpers?

Hypothesis H_{14} examined the relationship between the level of each of the acculturation variables and the 17 scales on type of expectations about MFT services (see results of Level of Behavioral and Cognitive Acculturation Variables in Appendix M). Scale scores were calculated for each respondent by summing the responses to the items assigned to each scale and dividing by the number of items. A one-way analysis of variance (ANOVA) was calculated for each of the 17 expectancy scales by each type of

acculturation-behavioral, cognitive, and integrated (see Appendix M for results related to the first two variables).

Expectations of MFT Services by Level of Integrated Acculturation. Expectancy by integrated acculturation ANOVAs indicate a significant difference in one scale, tolerance ($F = 5.56$, $p = .002$; see Table 21). The respondents who scored low on both acculturation measures scored in the low integrated acculturation group (Group I). They have a Mexican orientation in cognitions and behaviors. This Mexican-oriented group had significantly higher expectations for the therapist to be tolerant ($M = 5.69$, $SD = 1.42$) than the respondents who scored in the Mixed Integrated Acculturation: Cognitive Acculturation ($M = 3.56$, $SD = 1.24$) group, who were Anglo-oriented in their cognitions but Mexican-oriented in their behaviors. The Low Integrated Acculturation group was also significantly different from the High Integrated Acculturation group, who were high in Anglo behaviors and beliefs ($M = 4.15$, $SD = 1.42$).

Hypothesis H_{15} examined the relationship between the level of knowledge of counselors, therapists, or marriage and family therapists and expectations of counselors, therapists, and MFT services. Knowledge of counseling, therapy, and MFT were scored initially on a 5-point Likert scale. First, the responses were grouped into three categories: None to Very Little (0), Some (1), and Quite a Bit or A lot (2). The majority of the sample had Some to

Table 21

Comparison of Expectations about MFT by Level of Integrated Acculturation

Type of Expectation	Group 1 M/(SD)	Group 2 M/(SD)	Group 3 M/(SD)	Group 4 M/(SD)	F	p
Responsibility						NS
Openness						NS
Motivation						NS
Attractiveness						NS
Immediacy						NS
Concreteness						NS
Acceptance						NS
Confrontation						NS
Genuineness						NS
Tolerance	*5.69 (1.42)	5.02 (1.27)	*3.56 (1.24)	*4.15 (1.42)	5.56	.002**
Trustworthiness						NS
Directiveness						NS
Empathy						NS
Expertise						NS
Self-Disclosure						NS
Nurture						NS
Outcome						NS

Note. Groups: 1=Low Integrated Acculturation; 2=Mixed Integrated Acculturation (Acculturated Behavior); 3=Mixed Integrated Acculturation (Acculturated Cognitions); 4=High Integrated Acculturation. No significance found with three factors: Expectation of Personal Commitment, Expectation of Facilitative Conditions, or Expectation of Counselor Expertise.

A Lot of knowledge of counseling (61%), but the percentages dropped when the respondents were asked about their knowledge of therapy (45%) and MFT (38%)(see Table 22). The next step was to create a Respondent's Sum of Knowledge by creating and then summing a 3-digit number based on their level of knowledge (0, 1, 2). The one's place provided level of knowledge of counseling, the ten's place provided level of knowledge of therapy, and the hundred's place provided level of knowledge of MFT. For example, the number 012 indicated a lot of knowledge of counseling (2), some knowledge of therapy (1), and none to very little knowledge of MFT (range = 0-6). Results indicate that over one third of the sample (37%) did not have any knowledge of any of the three types of mental health services, and only 15% believed they had a high level of knowledge in all three areas. The remaining 48% had a little to a lot of knowledge of at least one type of mental health services.

T-tests were calculated with level of knowledge of mental health services as the independent variable and the 17 expectancy scales as the dependent variable. Data confirmed that there were significant differences between the two knowledge groups in two of the seventeen scales. The respondents with no knowledge of mental health services had stronger expectations that therapists would be tolerant (M = 5.46, SD = 1.11; F = 5.228, p = .026) when compared to the group with knowledge of services (M = 6.25, SD = 1.06

Table 22

Frequencies for Knowledge of Mental Health Services

Level of Use of Svc*	Knowledge of Counseling		Knowledge of Therapy		Knowledge of MFT	
	n	%	n	%	n	%
None	23	38	33	55→	←37	62→
Some	14	23	12	20→	←12	20→
A Lot	23	38	15→	25→	←11	18→
Total	60	99	60	100	60	100

Note. Use of services = attending a minimum of two sessions (unduplicated count of services).

and M = 4.27, SD = 1.57, respectively). The genuineness expectancy must be highlighted and questioned due to the extremely close means and the large difference in standard deviations.

Impact of Openness to Learning about MFT on Expectations

Research Question #4: How does the openness to learning about marriage and family therapy in people of Mexican origin impact their expectations?

Hypothesis H_{06} examined the relationship between expectations about MFT services and openness to learning about marriage and family therapy services. First, the majority of participants were assessed by the researcher to have a high level of openness to learning. This was demonstrated by their willingness to take a consumer's

pamphlet about MFT and their initiative to continue a discussion regarding this topic. Respondents were given a score ranging from zero (no openness to learning) to three (high openness to learning). The "openness to learning" score was based on the researcher's evaluation of the participant's comments, questions, demeanor, and body language to the offer of the pamphlet. The higher scores (2) indicated positive and accepting responses, questions, and comments regarding the offer; lower scores (0) indicated a negative response and/or an unwillingness to accept the pamphlet; a neutral response (0) indicated a willingness to accept the pamphlet, but the observer indicated through their response and non-verbal behavior that they were uninterested and accepting the pamphlet to be polite.

The majority of respondents (62%) demonstrated a high level of openness to learning while slightly less than one third (27%) were not open to learning about MFT. The majority of the latter group made it clear in their responses that they were unwilling to consider MFT and, in most cases, any type of counseling or therapy as an option. Most of these participants stated that they would go to their family, the priest, or a friend if they needed help. The balance (11%) of the participants who were neutral in their level of openness to learning did accept the pamphlet, but their comments and/or behavior indicated to the researcher that they were accepting the pamphlet out of

politeness and did not intend to ask or read about MFT. Given that the respondents were self-selected to participate in this study about therapy, it was surprising to find that 38% of the sample was either not open or neutral in their willingness to learn about MFT. Their openness and willingness to participate in a one- to two-hour interview that they knew was about mental health and therapy had suggested to the researcher that the majority of subjects would be open to accepting and learning about MFT.

Secondly, one-way expectancies by openness to learning ANOVAs were computed to determine if there were significant differences between the groups who were open to learning about MFT and those who were not receptive to accepting information about MFT. The null was accepted for the majority of the expectancy scales due to the lack of significant differences (see Table 23). The null was rejected for four expectancy scales and one expectancy factor due to significant differences found when ANOVAs and Tukey HSDs were calculated. Respondents with high levels of openness to learning about MFT had stronger expectations for immediacy (expectation to talk about the relationship between client and therapist)($\underline{M}$ = 5.62, $\underline{SD}$ = 1.26; F = 4.66, p = .013) and for therapists to be open ($\underline{M}$ = 5.80, $\underline{SD}$ = 1.05; F = 4.67, p = .013) than the group who was slightly less open to learning ($\underline{M}$ = 3.86, $\underline{SD}$ = 1.91 and $\underline{M}$ = 4.50, $\underline{SD}$ = 1.23, respectively). The group with a high

Table 23

Openness to Learning About Marriage and Family Therapy (MFT) and Expectations of MFT

Scale	Group 0 M/(SD)	Group 2 M/(SD)	Group 3 M/(SD)	F	p
Responsibility					NS
Openness	4.77 (1.94)	3.86 (1.91)	5.62 (1.26)	4.66	.013
Motivation	4.23 (1.78)	4.86 (1.40)	5.55 (1.49)	4.09	.022
Attractiveness	3.25 (1.40)	3.62 (1.30)	4.47 (1.37)	4.79	.012
Immediacy	4.95 (1.67)	4.50 (1.23)	5.80 (1.05)	4.67	.013
Concreteness					NS
Acceptance					NS
Confrontation					NS
Genuineness					NS
Tolerance					NS
Trustworthiness					NS
Directiveness					NS
Empathy					NS
Expertise					NS
Self-Disclosure					NS
Nurture					NS
Outcome					NS
Factors***					
Personal Commitment	4.72 (1.38)	4.48 (1.17)	5.56 (0.96)	4.95	.010
Facilitative Conditions					NS
Counselor Expertise					NS

Note. 0 = None to low level of openness to learning about MFT; 1 = Neutral in openness to learning about MFT; 2 = High level of openness to learning about MFT.

level of openness to learning also scored significantly higher than the group that was not open to learning on the following scales: motivation (M = 5.55, SD = 1.49 and M = 4.23, SD = 1.78, respectively; F = 4.09, p = .022); attractiveness (M = 4.47, SD = 1.37 and M = 3.25, SD = 1.40, respectively; F = 4.79, p = .012); and the Personal Commitment factor (M = 5.56, SD = .96 and M = 4.72, SD = 1.38, respectively; F = 4.95, p = .010).

CHAPTER 5

SUMMARY, CONCLUSIONS, LIMITATIONS, DIRECTIONS FOR FUTURE RESEARCH, AND IMPLICATIONS FOR CLINICAL PRACTICE

Summary

The purpose of this study was to investigate how groups within the Mexican-origin community compared to each other on the following issues: (a) utilization rates of mental health services/marriage and family therapy (MFT) services when the group's level of acculturation and type of expectations of MFT were examined; and (b) type of expectations of MFT when level of acculturation, level of knowledge of MFT, and degree of openness to MFT were considered.

The results of the study supported the finding that people of Mexican origin were more similar than different regardless of their level of acculturation (see Figure 2). No significant differences between the groups were found on the following variables: (a) Level of Integrated Acculturation and Level of Utilization of Counseling Services, (b) Level of Integrated Acculturation and Level of Utilization of MFT Services, and (c) Type of Expectations about MFT and Level of Utilization of MFT.

Significant differences were found between the following groups:

1. People with low levels of Integrated Acculturation (Mexican orientation) had an expectation for their therapist

to be patient or tolerant. This was inconsistent with people who were identified as having a bicultural orientation with a high Cognitive Acculturation. The former group was also significantly different from people from the highly Integrated groups on tolerance.

2. The group with a high level of knowledge of mental health services had a significantly higher expectation for tolerance and genuineness.

3. People who were highly open to learning about MFT had significant expectations for openness, motivation, attractiveness, and personal commitment on the part of the therapist.

Help-seeking behaviors and utilization of mental health services were examined with a focus on the in-group variation. Support was found for literature that shows family as the chosen support system. Minimal variation was found in the characteristics and sources of help people of Mexican origin sought (caring and family). The majority of people in this sample (62%) did not have any knowledge of MFT services which influences the low utilization rates of MFT (18%). Most people's expectations of marriage and family therapists or therapy were not based on knowledge or experience. The utilization rates across mental health services indicated that less than half of the people of Mexican origin perceived and utilized counseling and therapy as sources of help, 43% and 45%, respectively. Acculturation

was not found to be significant to the utilization rates of counseling or MFT within the Mexican origin community. However, patterns were evident that people with high levels of Integrated Acculturation had a higher use of MFT services.

Participants were asked what they believed were the challenges facing the Mexican origin community. They were not limited in the number of responses they provided. Although no one issue was consistent among the participants, the ones most frequently identified by respondents as problems within the Mexican origin community were related to (a) forms of abuse (27%) (i.e., alcohol/drugs [20%], physical [5%], and emotional [2%]), (b) issues related to teens (10%), (c) marriage/divorce problems (9%), and (d) family (8%). Although this was not an identified hypothesis in this study, these contextual issues are relevant in understanding the mental health needs of this community. Each has the potential to strongly impact the functioning of families and communities and is a factor in identifying appropriate services. For the MFT profession, it is critical that these issues be understood within the context in which the Mexican origin population resides. As the Mexican-origin population continues to grow at a rapid rate, the importance of knowing, understanding, and addressing the needs of this community becomes more relevant to increasing access to and providing culturally relevant

services by this helping profession.

The findings also supported the assertion made by Cuéllar, Arnold, Maldonado (1995) that behavioral acculturation and cognitive acculturation occur at divergent rates. The Anglo-oriented group, which included the slightly Anglo to bicultural and the strongly Anglo subgroups (65%), was largest when it was based on behavioral acculturation. Only 48% of the study population were Anglo-oriented (0-2 high scores on cultural constructs) when cognitive acculturation was measured. This appears to indicate that behavioral acculturation occurs at a faster rate than cognitive acculturation. When data was classified into profile types which were created from behavioral and cognitive acculturation scores, the total Anglo oriented group remained the same. However, an examination of the subgroups demonstrate that the profile type, Anglo Congruent, which corresponds to the strongly Anglo group, increased from 17% (behavioral acculturation) and 10% (cognitive acculturation) to 38% of the respondents, illustrating that there is an impact on acculturation level of participants when profile types are used.

Even when the analyses did not indicate statistically significant differences between the groups, the type of expectations that were important to this sample was highlighted. There appeared to be a pattern of low levels of expectations for the therapist to self-disclose, be

directive, or empathetic for Used and No Use groups (see Figure 2). This can be beneficial in understanding the types of interactions and conditions that would facilitate the group's participation in therapy. Persons with low levels of Integrated Acculturation (Mexican orientation) had an expectancy for their therapist to be patient or tolerant. This was inconsistent with people who were identified as having a bi-cultural orientation with a high Anglo orientation in their cognition. The former group was also significantly different from people identified as having a highly Anglo orientation in behavior and cognition on their expectation that the therapist be tolerant. A high expectation for tolerance and cognition was also relevant for the group with a high level of knowledge of mental health services. In addition, these respondents wanted their therapist to be genuine. Openness, motivation, attractiveness, and personal commitment were important to those who were highly open to learning about MFT. An area of interest that was intriguing was the lack of consistent expectations across variables.

A review of the data on utilization of services indicate that a small percentage of respondents have used MFT services (18%). This is consistent with the percentage (18%) that reported having "a lot" of knowledge of MFT. There was a higher use of counseling (37%) and therapy (42%) services. The low percentage of people (18%) who indicated

knowledge and use of MFT services illustrates the need to educate and/or market this component of the mental health field to the Mexican-origin people. These percentages may be misleading because some respondents were unclear about the type of therapist or therapy services they had received, leading to inflated or deflated numbers, with a higher likelihood of the former. Level of acculturation was not found to have statistical significance when related to utilization rates of counseling or MFT. This finding was consistent with the literature, despite analyses being conducted using behavioral, cognitive, and integrated measurements of acculturation.

Unlike with other studies, no support was found for the notion that acculturation level differentiated people with respect to expectations. The group with a Mexican orientation did indicate a significantly higher level of expectation for tolerance than the strongly Anglo or cognitively acculturated group. Support was suggested for the differential rate of behavioral and cognitive growth that have been suggested by other studies (Cuéllar, Arnold, and González, 1995). The development and use of the Level of Integrated Acculturation, which combined behavioral and cognitive acculturation measures, highlight the orthogonal and multidimensional aspects of the process of acculturation. The study also suggests that this group of people of Mexican origin were more similar than different,

regardless of their level of acculturation: "Mexican people are no different than white people in my mind or black people for that matter or Asian people - we all want for the most part, I believe, we all want to be the best we can and we want to feel proud that our life has meant something and more importantly, those of us with children, want to see the best for them" (42 year old female).

Although there was a lack of significant differences between most variables, the patterns of responses did provide practical information. The study found people of Mexican origin to have a low level of knowledge of MFT, a high openness to learning about MFT, and expectations for the therapist to be tolerant, genuine, and open. They also expected to talk to the counselor about their problems, to be motivated to participate in therapy, and to enjoy being with the therapist. This group also had a low utilization rate of MFT services and a moderate utilization rate of counseling and therapy. This information is important in the process of clarifying the areas that need to be addressed to increase their level of access and use of MFT services. Knowledge of their expectations must be understood within the context of their lives so assessment and treatment can be consistent with their background, thereby increasing the prospect of delivering effective, culturally sensitive, and culturally competent services.

People who had a high level of knowledge of mental

health services (counseling, therapy, and MFT) had high expectations for the therapist to be genuine and tolerant. The group with a high level of openness to learning about MFT indicated high expectations for openness, motivation, attractiveness, immediacy, and personal commitment (see Figure 2). No pattern was evident when the relationship between Integrated Acculturation and MFT Use was examined. At any rate, there was a higher rate of use of mental health services than expected.

In summary, there were more similarities than differences among and between the acculturation, knowledge, and utilization groups. This study did provide guidance on expectations held for therapy and the therapist. This information can be added to the base of knowledge that is being collected from this ethnic community.

Conclusions

Overall, this study illustrated the importance of examining within-group variables; it highlighted a few differences and revealed that there are more commonalities within the Mexican-origin community. There were two significant components of this study that were unrelated to the data that was collected. They were the opportunity the study provided to develop and implement a culturally sensitive research design and methodology and the opportunity for interaction to occur between a representative of the MFT profession and individuals in the

Mexican-origin community. The face-to-face interviews and the instruments (quantitative and qualitative) provided a context in which the respondents and researcher could engage in data collection and dialogue that was conducive to making a connection, mutual education of researcher and participants, and identification of needs and goals of each communicant.

These were small steps to building a relationship and improving communication between the two groups, and they illustrated the need for discourse on the transactive nature of the therapist-client relationship when examining access and utilization of MFT services. A greater awareness and depth of understanding occurred throughout the process of this study for many of the respondents and for the researcher. Participant's reported their appreciation of having an opportunity for their voice to be heard as they had the experience of being valued: "It is so good to be able to talk about these things - they're important - our culture and the problems we have and what can help us all be better in our families - I think about these things - being Mexicana - and I'm so glad I didn't cancel with you - I almost did because it wasn't a good day today and I just didn't want to think about talking to someone - thank you for coming and letting me talk - this was fun and it was special to my heart." This respondent also asked for a referral to a marriage and family therapist to "finally deal

with" parent-child conflicts. This is an example of how dialogue can serve to give people choices so they can access services that have the potential to enhance or at least stabilize their lives.

Finally, the letterhead of the national organization, American Association for Marriage and Family Therapy, states "AAMFT seeks wisdom and strength of diversity" (Killian & Hardy, 1998, p. 207). This research is another component in demonstrating and promoting this position.

The findings of this study suggest a critical need for marriage and family therapists to: (a) find a way to more clearly differentiate themselves from other mental health professions, (b) promote a change in licensing laws that support the clear identification of marriage and family therapists, (c) increase understanding of the meaning that this community places on the expectations that were defined as significant, and (d) find ways to educate the people of Mexican origin about the services provided by MFT.

In order to collect accurate data on the utilization rates and effectiveness of MFT, it is crucial to clarify the definition of a marriage and family therapy/therapist and find a reliable and consistent manner with which to identify MFT. Given that many of the respondents appeared unclear about the type of therapist they had received services from, it is unlikely that the data reported in this study on utilization is accurate. Most of the individuals who

reported utilization indicated that they were unclear about whether their therapist or counselor was or had been a marriage and family therapist. There was a tendency for respondents to use the vernacular (i.e., therapist, counselor) in their responses and in discussion with the interviewer.

The use of different terms within the same conversation was another indicator of the confusion. Identification of the marriage and family therapist was sometimes based on the type of issues that were discussed in the session rather than on the education, experience, or licensing of the therapist. For example, a 48 year old female respondent reported, "we went to the therapy because my son was having trouble at school - the therapist talked to both of us - me and my husband - so yeah, I think she was a marriage and family therapist." A 43 year old man reported, "it was one of those family therapists - yeah, a marriage and family therapist - we were having family troubles - we talked a lot about our marriage and family." These comments reflect the remarks of many of the respondents who reported that they had seen a marriage and family therapist. None of the people had information about the therapist's education or credentials. This illustrates the ambiguity in the participants' understanding regarding the similarities and differences between the various mental health providers. Another issue related to the confusion of

professional identity was the belief that counselor, therapist, and marriage and family therapist were synonymous. The question was asked, "what do the words 'counselor,' 'therapist,' and 'marriage and family therapist' each mean to you?" The response of a 31-year old male was "I believe they're mostly the same thing. I see it more as a professional who can work either way - counselor, counselor is a more positive word than therapist." This study did not have any way to identify or verify the counselor/therapist's educational background, type of profession, or type of license, which are each relevant to the goal of obtaining precise utilization rates among the Mexican-origin community.

A related issue is the multiple licenses or professional identities held by professionals in the mental health field. There can be incongruence between the education, training, licensing, and practice of a mental health practitioner. The laws and regulations are stated in a manner that allow for therapists to identify themselves as "doing" MFT although they do not have the education and training required of a licensed marriage and family therapist. Even some therapists who are licensed as MFTs are not educated or trained in a systemic approach to therapy, due to being "grandfathered" in when new laws were passed that provided licensing to and required licensing of MFTs. The professional identity of a therapist is likely to

strongly influence the practice of therapy. The laws and licensing process make it challenging to identify MFTs that practice using a systemic approach, which is assumed in this study to be consistent with the values and beliefs of the people in this community. These issues are bound to contribute to the ambiguity and confusion surrounding this community's ability to know the type of services they have received. The impact on this study was that some to most of the respondents replied to questions regarding therapeutic services based on their perception rather than on actual data or knowledge of the therapist's education, training, or licensing.

No pattern was evident when the relationship between Integrated Acculturation and MFT Use was examined, except that it does indicate that people of Mexican origin are utilizing mental health services. However, 10% of the sample that was classified as having Mexican behaviors and Anglo beliefs did not report any use of MFT services, which was inconsistent with findings for the other three acculturation groups.

Overall, there were more similarities than differences among and between the acculturation, knowledge, and utilization groups. This study did provide guidance on expectations held for therapy and the therapist and can alert the field to increase their efforts to engage and interact with this group. This information can be added to

the base of knowledge that is being collected on this ethnic community. It can increase the awareness of clinicians and therapists so that they can continue building their skills as culturally sensitive therapists.

This study partially responds to the controversy regarding emic or etic therapy models. The heterogeneity in this group illustrates the importance of using both approaches, even when working with people of the same culture. The study incorporated both approaches to meet the needs of respondents. Providing the interview and the instrument in their preferred language illustrated the use of an emic approach. The etic approach was exemplified by using variables that tend to be common across groups in therapy (i.e., tolerance, trustworthiness). This work described and defined a potential client population, which is consistent with suggestions offered within the profession (Piercy & Sprenkle, 1990).

This investigation has also taken a step in developing a relationship with the people of Mexican origin. It has served to inform the community of another resource that they may find consistent with their values and beliefs about the family. This information is important as the Mexican-origin group struggles with the challenges that are universal as well as unique to our culture. Discourse must continue if there is to be progress in exploring whether there is a "good fit" between the needs of this community and the

services and skills of professionals in the field of MFT.

An important conclusion of this study comes from the feedback from respondents that reported a desire and/or need for their culture or ethnicity to be recognized and supported (Social Cultural Environment). They reported that consideration of the cultural aspects of their lives (i.e., country of origin, language, prejudice) and their individual development (ethnic self-identity) (see Figure 1) conveyed to them an understanding and a sense of respect, as illustrated by two of many comments related to this topic: "I don't really get to talk about how being Mexican affects me-and even how I make decisions. This is good - I mean for me to be talking about this." "Even my kids don't understand about being Mexican anymore - it's like we don't like to make a big deal of it, we want to fit in - but I know it is, it is a big deal - it's great that someone like you - in your work - understands this." It was evident that some of the people experienced a cut-off from a part of themselves (cultural self) that was nurtured by the opportunity to talk about their cultural history, beliefs, and cognition. These exemplify the importance of the ecological model of constructs (see Figure 1) that were utilized in this study. The MFT field's response to this need in a culturally sensitive and competent manner will serve many people in the Mexican-origin community, as well as the profession.

Limitations

Limitations exist in all studies due to the humanness of the researcher, subjects, context, and the complexity of conducting a research study that addresses multiple issues. Utilization of non-probability sampling limits the generalizability of the results. Due to the self-selection of respondents, some groups were over-represented in the sample, i.e., females, individuals who had moderate to high levels of acculturation, and people who were young to middle-aged (Franco, Malloy, & Gonzalez, 1984; LeVine & Franco, 1981). Individuals who were less acculturated and those who were older were less willing to participate in an interview and disclose information regarding services that they may not see as viable alternatives. Other limitations included the reliability of the data due to weaknesses in self-reports, such as inaccurate reporting, various levels of self-disclosure, and extreme acquiescence, or socially desirable response sets.

Another limitation found during the study was the lack of clarity and discreteness in the terms "counseling," "therapy," and "marriage and family therapy." This resulted in collecting data on perceptions of utilization of MFT services rather than on the actual utilization of MFT services.

Finally, the small sample size decreased the power and confidence of the statistical analyses. This may be related

to the inflated numbers of the utilization rate of MFT services due to the confusion surrounding participants identifying the type of mental health services they received. It was expected that the utilization rate would be below 5%, which would have increased the power of the statistics. Walonick (1988), creator/author of the Stat Pac Gold (Version 3.0,) and manual, states, "...[I]f too small a sample is chosen, you will not have sufficient confidence that the sample represents that population and if too large of sample is chosen, you will have wasted a considerable amount of effort and money surveying an excessive number of people. Obviously, the ideal solution is to choose the smallest sample possible that still gives confidence that the sample represents the population" (p. 488). The Stat Pac Gold was used to assess the adequacy of the sample size (N=60). This was determined by entering four numbers: (a) the best estimate of the population size (N=10,500), (b) the best estimate of the population rate or percentage of survey characteristics being measured (4%, 5%, 10%, and 15%), (c) the maximum difference between the true population rate and the rate that could be accepted or tolerated (5%), and (d) the level of certainty that the difference between the population rate and the study's sample rate was less than the difference in number three (95% or alpha = .05). The size of the sample necessary for the study decreased as the best estimate of the population rate and percentage of

survey characteristics being measured decreased. If 15% of the sample was expected to utilize MFT services, the sample would need to be 192 participants. An expectation of 10% of the sample the sample size decreased to 136 people. A 5% expectation would necessitate a sample size of 72, and an expectation that 4% of the sample would utilize MFT indicated a need for the sample size to be 58 participants. Given that this was an exploratory study and that it was expected that a small percentage of the participants (less than 5%) would have knowledge of or utilize MFT services, the decision was made to use a sample of 60 respondents. Since the utilization rate was 18%, the power of the statistics were decreased.

Directions for Future Research and Clinical Practice

While this study created acculturation profile types from combining the AOS and MOS of the ARSMA-II with the cultural constructs of the MACC-SF (Cuéllar, Arnold, & Golzalez, 1995; Cuéllar, Arnold, & Maldonado, 1995), additional research needs to be conducted that will validate the use of the integrated acculturation profile types. The crosstab that was used to created the Integrated Acculturation variable had small sample sizes in each of the four cells (range = 6 to 23). Future studies with larger samples are needed to replicate the process of creating the Integrated Acculturation measure.

The need for research designs and studies which take

into account multiple variables become more apparent as there is an increased understanding of the contextual influence and the complexity of factors that influence people's decisions to seek therapeutic services. Some respondents indicated that they were "told" who to go to by the school, the court, or the church. Some were receiving services due to a court-mandated order. It is possible that the referrals from courts, schools, and other community agencies are to non-MFT providers, which would influence the use rates in non-MFT therapeutic services. It is critical that MFTs position and/or align themselves with organizations that work with the Mexican-origin community. Educating the social and legal arena about MFT and conveying the appropriateness of the services to the Mexican-origin community will be an important step in making a connection to this community.

One potential goal would be to increase the utilization of MFT services by the Mexican-origin community and to increase utilization of the Mexican-origin community by the MFTs. MFT will need to become more proactive in engaging and interacting with this community by becoming more sensitive and competent ("I think they (MFT) need to be more aware of the culture, the traditions, why religion would be so important, and those things that are related to religion. I know that some women are still practicing Novenarios," i.e., a ritual in which people participate in saying the rosary

for nine days, often after a funeral or before a religious day). Knowledge and experience of the processes of "being" of Mexican origin can be instrumental in the development of a culturally competent therapist and therapeutic process. In addition, the therapists' level of acculturation and expectancies of their racially/ethnically diverse clients can also be an avenue to enhance cultural sensitivity and competence. A systemic approach that considers the transaction between these subsystems (therapist/client) allows for the study of the dynamic and complex influence of co-acculturation and co-adaptation that occurs when two cultures are working together.

Of particular importance is the study of how to inform and educate diverse populations of the practice of MFT, especially if there appears to be a good fit between the values of MFT and the targeted group. Focusing on the knowledge base and openness of diverse populations to learning about MFT will provide critical information about how to effectively educate and market the services to various groups. In the area of marketing, it is critical that literature be developed that will be written in the language of the group and in a manner that is consistent with the needs of their culture (e.g., ethnic- or culture-related development issues, parent-child conflict related to differences in acculturation level and language ability). Focus groups that review informational and marketing

pamphlets is an obvious focus of future research.

Practice and research need to be developed so that MFTs and people in the Mexican-origin community are mutually involved in developing relationships and goals. A mutual devotion of time and energy to creating a context that allows for learning and positive adaptation to occur between the groups would serve to increase their access to one other. MFT's goal of serving diverse populations and increased access to support systems for the Mexican-origin community could result from this work.

Research and practice strategies that find ways for the people and the MFT professionals to become involved with each other would encourage the profession-community and/or therapist/client system to educate one other in methods that are consistent with the needs and beliefs of the community. It would also provide opportunities for trust to be developed and maintained. For example, training key community people who are of Mexican origin in the philosophy, theoretical tenets, and skills of MFT would allow them to serve as links to the people in the community. The mutual learning, teaching, and experiencing that could occur in this context would facilitate the process of building trust and relationships, increasing knowledge, and enhancing cultural competency for all involved. Trust is an important component of any therapeutic process. A lack of trust for therapists was indicated by multiple comments made

by this group of respondents:

> "I only went because my compadre recommended it to me" and "they need to drop the paternalistic attitude" (24 year old female).
>
> "This is a total stranger (therapist) - I, myself, personally, wouldn't feel comfortable saying certain things to just anybody;" "oh, it makes me feel like it's just a money issue for them (therapist) - a fast way to make a buck. It's not they're so much concerned about your well being at times" (29 year old female).
>
> "You're just going to be cheated (in therapy)" and "...especially those that are a little older, I don't think they're very trusting of agencies" (75 year old female);
>
> "Mexicans are very stubborn, especially if the therapist is Anglo-'cause usually for some reason, I don't know, they just feel-because it's always been the white culture being more superior and they feel degraded-Mexicans. It's like, you can't tell me what to do" (29 year old female).

There are two primary clinical implications from the present study. First, cultural beliefs, values, experiences, and behaviors impact the construction of the meaning related to the expectations of tolerance, genuineness, openness, personal commitment, immediacy, motivation, and attraction that were found to be significant in subgroups of the sample. Therapists who are knowledgeable and attend to the meaning of the expectations will increase their ability to join, build trust, and work with the clients. A 48 year old female made two comments that may suggest her need for tolerance from a therapist. "I think that having had to live and survive as a minority you gain strengths, you can get beat up and still function" and "there's some reason we don't melt (melting pot), we're not melting in - we're not doing a very good job of mixing in." The respondent went on

to talk about her experiences of isolation and intolerance due to her being "Mexican" and not being able to melt in.

Cultural sensitivity and effectiveness may be enhanced by being able to understand and analyze the cultural contexts of each member of the therapeutic system (Breunlin, Schwartz, & Mac Kune-Karrer, 1992). The respondent's definition of and need for tolerance must be examined within the cultural map. The experience of minority people has been one of oppression by people who were not tolerant of the differences. The high expectation for tolerance may be related to this history of oppression and feeling as if they do not fit in. A member of a minority group may attach a meaning to tolerance or genuineness that is related to their need to be accepted as a person of Mexican origin or to have their Mexican culture acknowledged and accepted. However, it is not enough to stop with awareness and sensitivity. This must be followed with cultural competency, which is indicated by the ability to build or act on the differences created by being from a diverse culture. This approach to working with diverse populations may decrease the drop-out rates that tend to occur after one or two sessions.

Second, the importance of "family" and the need for helpers to be "caring" was conveyed by the majority of respondents ("any time I have a problem, my mother is the first one that is there by my side every time," 30 year old female). There is a need for therapists to be sensitive and

competent in conveying this sensitivity and knowledge or curiosity to their clients. A 43-year old male made a statement that was indicative of comments made by multiple participants in the sample. He expressed that therapists

> "need to learn more about Mexican culture and the people and their beliefs and their superstitions, their history and their culture, because it's different. The community is not about to just give all of that up, just to become Americans. They wanna hold on to their culture, their language, and if you don't respect all of that, you're not gonna be able to understand and succeed with whatever services you wanna provide until you understand where we're coming from and what makes us Mexican. Mexicans are good Americans, you know, the ones that are here. And they're - we're here to stay. They're (Mexicans) proud to be Americans and they'll fight and die for this country 'cause it's a great country, but our history is too long and it's too good- our culture is, it's a really good culture. There's a lot of good things about it for us."

The recruitment phase, the quantitative and qualitative data collected during the interview, and the feedback about the study and the interview were consistent in conveying the importance of "family," "caring," and story-telling to the respondents. The following comments illustrate the comments made by the majority of people in the study: "I think they need to know basically that the family is, that family unity is a very important factor....if a son or daughter is - has a problem, everyone is feeling that setback, and has a responsibility for that person" (42 year old female). "I guess there's a lot of family oriented things, I mean Mexican people to me, all the ones I have come in contact with, me too, family is everything" (30 year old female).

The participants suggested that they would be more likely to seek out services that communicate that they are cared about. ("I don't think they (therapists) really care about me or my family - they just are doing their job - I don't need that," 34 year old female.) Therefore, there must be a continued effort to design outreach efforts and therapy models that are inclusive of the people's desire to have family involved and for caring to be a necessary element in the therapeutic process in order to provide the opportunity for people of Mexican origin to take part in the MFT process. Throughout the qualitative and quantitative interviews, the consistent ingredient was the story-telling. Regardless of the structure that had been set up for the interview, respondents evidenced a desire and need to share the information through story-telling. It was challenging for the respondents to respond to closed-ended, true-false, and Likert scale questions during the quantitative interviews. Frequently, a respondent would answer the question with a story; and when the question was repeated again after the story had been told, they would make comments such as "you decide where it fits best-I told you my answer" (67 year old female) or "my answer doesn't fit in a box - everything I told you is important" (27 year old male). Involving people of Mexican origin in the development of a methodology that would quantify the story-telling that is consistent with their beliefs would be a direction for

future research.

The interviews indicated that there are people of Mexican origin who believe that there have been changes in the Mexican-origin community and that the people are changing their perceptions of professional help ("I think now though, that things might be a little different in that people are realizing that sometimes their family doesn't always have the answers and that it's not wrong to go outside of your little circle asking for help," 42 year old female; "there would be some that would say 'well, I'm glad, I'm glad they're getting help because they need it,'" (25 year old female; "I think the problems that would probably be easiest, would be like with the children - it would probably be easier for parents to take their children to go to counseling, you know, because that's on the outside [of the parental relationship]," 31 year old male).

Finally, future research must confront the issue of differentiating between professions so that the data that is collected is indicative of what is occurring in the MFT field. This will require that laws and policies be changed so that professionals from the various mental fields (i.e., MFT, clinical social work, psychology, and psychiatry) can be differentiated clearly. Changes need to occur so that professionals from the various mental health disciplines can not assert that they "do" MFT when they do not have the education or the credentials that are consisent with that of

an AAMFT-licensed marriage and family therapist. This will contribute to the abatement of the confusion that tends to occur for clients and potential clients. Simultaneously, the MFT profession must take more action in finding effective ways to educate and market to the Mexican-origin community. This will give the people an opportunity to understand how the profession can assist in creating the desired changes in their lives.

The importance of context is exemplified by the qualitative data that provides insight into why the respondents were utilizing the various mental health disciplines. Some of the clients revealed that they went to therapy because they were "made to go to the counselor" (27 year old male). This information tended to come out in the quantitative interviews after the respondent indicated that they had seen a counselor, therapist, and/or marriage and family therapist. The clients were mandated or referred by courts, schools, churches, and community agencies. Historically, these systems have referred to non-MFT providers. In order for MFTs to get referrals, they will need to engage and educate these systems that come into contact and/or work directly with people in the Mexican-origin community. This will be more successful if MFTs educate the referral sources of the type of services that would be consistent with the needs of the Mexican-origin people as well as the systems.

Personal Reflection

This experience has been completely gratifying and has challenged me to grow as a professional who strives to work with populations at risk to develop strategies that they believe would improve their quality of life. The process of developing and completing this study accentuated the separation I had made in my cultural self. As a professional, my Anglo orientation was the major aspect in my interactions. In my personal or family role, my Mexican orientation was dominant. In my interactions with people of Mexican origin, I was challenged to find a way to integrate the cognitive and behavioral aspects of myself to allow my bicultural self to interact with the people in the study.

APPENDICES

Appendix A

Complete Instrument for Research Study

1 ID #/I.D. Number: _____ **Demographic Information** 1 ID #/I.D. Numero: _____

Date: _____ Fecha: _____

2 _____ In what language would you like to do the interview?1. English 2.Spanish

2 _____ ¿En cuál lenguaje (lengua) quiere usted hacer la entrevista?
1. Ingles 2. Español

English Version

Versión en Español

3. _____ What term do you use to describe your ethnicity?
1. Latino
2. Hispanic
3. Mexicano
4. Mexican
5. Chicano
6. Mexican American
7. American
8. Other

3. _____ Cuál término usa para describir su etnicidad?
1. Latino(a)
2. Hispanico/Espanol
3. Mexicano(a)
4. Mexican
5. Chicano(a)
6. Mexicano Americano(a)
7. Americano(a)
8. Other

4. _____ What is your race? _____

4. _____ ¿Quál es su raza? _____

5. _____ Where were you born? _____

5. _____ ¿Dónde naciste? _____

6. _____ How much time have you lived in the United States? _____

6. _____ ¿Cuánto tiempo ha vivido usted en los Estados Unidos?_____

7. _____ How much time have you lived in Michigan? _____

7. _____ ¿Cuánto tiempo ha vivido usted en Michigan?_____

8. _____ How much time have you lived in Eaton/Ingham County? _____

8. _____ ¿Cuánto tiempo ha vivido usted en el condado de Eaton/Ingham? _____

9. _____ What is your immigration status? (If 1, go to 13)
1. U.S. Citizen 2. Mexican Citizen

9. _____ ¿Cuál es su condición de emigrante? o cuidadanía? Ciudadano de
1 = los Estados Unidos 2 = Mexico

10. _____ *(If 2)*, Are you a permanent resident? *(If 1, to 13)*
1. Yes 2. No

10. _____ *(Si es 2)*, ¿Eres residente permanente? *(Es 1, a #13*
1. Si 2. No

11. _____ *If 2*, Do you have a work visa?
1. Yes 2. No

11. _____ *(Si es 2)*, ¿Tienes una visa para trabajar? 1. Si 2. No

12. _____ *If 2*, Do you have a student visa?
1. Yes 2. No

12. _____ *(Si es 2)*, ¿Tienes una visa para estudiante? 1. Si 2. No

13. _____ Gender: 1= Male 2 = Female

13. _____ Género: 1 = Masculino 2= Femenino

14. _____ Age

14. _____ Edad

15. _____ Marital Status

1 = Never Married 2 = Married
3 = Separated 4 = Divorced
5 = Cohabitating 6 = Remarried
7 = Widowed

16. _____ *(If there is a partner)* What is your spouse's/partner's ethnicity?

_____

17. _____ *(If there is a partner)* What is your spouse's/partner's race?

_____

18. _____ What is your religious preference?

1 = Catholic 2 = Christian
3 = Protestant 4 = Baptist
5 = Methodist 6 = Lutheran
7 = Jewish 8= Eastern Religion
9= Curandismo 10=Mixed
11=No religion 12= Other_____

19. _____ How many children do you have?_____
0 = None

20. _____ What are their ages? (List all that apply)

1. 0 - 4 4. 15 - 19
2. 5 - 10 5. 20 or over
3. 11 - 14 6. Does not apply

21. _____ How religious/spiritual are you?

1 = Not Religious or Spiritual at all
2 = A Little Religious or Spiritual
3 = Somewhat Religious or Spiritual
4 = Very Religious or Spirtual
5 = Extremely Religious or Spiritual

15. _____ Estado Civil

1 = Nunca Casado(a) 2 = Casado(a)
3 =Separado(a) 4=Divorciado(a)
5=Cohabitar 6=Vuelto A Casar
7=Viudo(a)

16. _____ *(Si hay un compañero)* ¿Qué es el/la etnicidad de su cónyuge/compañero?

_____

17. _____ *(Si hay un compañero)* ¿Qué es el/la raza del su cónyuge/compañero?

_____

18. _____ Cuál es su religión predilecta?

1 = Catolica 2 = Cristiana
3 = Protestante 4 = Baptista
5 = Metodista 6 = Luterana
7 = Judío 8 = Religiones Orientales
9 = Curandismo 10=Revuelta
11= No religión 12 = Otro _____

19. _____ ¿Cuántos niños tienes?_____
0 = Ninguno

20. _____ ¿Cuáles son las edades? (Escoga todos los que aplican)

1. 0 - 4 4. 15 - 19
2. 5 - 10 5. 20 o mas
3. 11 - 14 6. No applica

21. _____¿Qué tan religioso(a) o espiritual eres?

1 = No religioso(a) o espiritual
2 = Un poco religioso(a) o espiritual
3 = Algo religioso(a) o espiritual
4 = Muy religioso(a) o espiritual
5 = Extremadamente religioso(a) o espiritual

22. _____ Last grade you completed in school
1 = Elementary - 6
2 = 7 - 8
3 = 9 - 12
4 = 1 - 2 years of college
5 = 3 - 4 years of college
6 = College graduate and higher

23. _____ In what country?
1 = United States 2 = Mexico
3 = Other _____

24. _____ What type of work do you do?
(Occupation) _____

25. _____ From your work, please give me the number on this card that corresponds with your annual income before taxes.

1.	Less than $6,000	7.	25,000 - 29,999
2.	6,000 - 8,999	8.	30,000 - 49,999
3.	9,000 - 11,999	9.	50,000 - 69,999
4.	12,000 - 15,999	10.	70,000 - 89,999
5.	16,000 - 19,999	11.	Over $90,000
6.	20,000 - 24,999	12.	Don't Know

26. _____ Using the same card, what is the total annual income of your family? (includes all sources of money)

22. _____ ¿Ultimo grado que fué a la escuela?
1 = Primaria - 6
2 = Secundaria 7 - 8
3 = Preparatoria 9 - 12
4 = Universidad o Colegio 1 - 2 años
5 = Universidad o Colegio 3 - 4 años
6 = Graduado, o grado más alto de Colegio o Universidad

23. _____ ¿En que país?
1 = Estados Unidos 2 = México
3 = Otro _____

24. _____ Cuál es su trabajo? (Ocupación)
_____

25. _____ De su trabajo, déme por favor, el numero en esta carta que corresponda al ingreso aproximadamente antes de que se lo descuenten los impuestos.

1.	Menos de $6,000	7.	25,000 - 24,999
2.	6,000 - 8,999	8.	30,000 - 49,999
3.	9,000 - 11,999	9.	50,000 - 69,999
4.	12,000 - 15,999	10.	70,000- 89,999
5.	16,000 - 19,999	11.	Sobre $90,000
6.	20,000 - 24,999	12.	No se

26. _____ Usando la misma escale, ¿cuál es su ingreso neto total familiar (incluyendo todas las fuentes de ingreso)?

27. _____ Which generation best applies to you?

1. 1st generation = You were born in Mexico or other country. [Not in the United States (USA)]

2. 2nd generation = You were born in USA; either parent born in Mexico or other country.

3. 3rd generation = You were born in USA, both parents born in USA and all grandparents born in Mexico or other country.

4. 4th generation = You and your parents born in USA and at least one grandparent born in Mexico or other country with remainder born in the USA.

5. 5th generation = You and your parents born in the USA and all grandparents born in the USA.

28. _____ Regarding skin color, I have a scale that goes from very light to very dark. Please place an "x" on the line where you see yourself.

Very Light ——————————————— Very Dark

27. _____ Indique la generación que considere adecuada para usted. Dé solamente una repuesta.

1. 1a. generación = Usted nació en Mexico o otro país [no en los Estados Unidos (USA)].

2. 2a. generación = Usted nació en los Estados Unidos Americanos (USA), sus padres nacieron en México o en otro país.

3. 3a. generación = Usted nació en los Estados Unidos Americanos (USA), sus padres tambien nacieron en los Estados Unidos (USA) y sus abuelos nacieron en México o en otro país.

4. 4a. generación = Usted nació en los en los Estados Unidos Americanos (USA), sus padres nacieron en los Estados Unidos Americanos (USA) y por lo menos uno de sus abuelos nació en México o algun otro país.

5. 5a. generación = Usted y sus padres y todos sus abuelos nacieron en los Estados Unidos (USA).

28. _____ Con respecto a color de la piel, yo tengo una balanza de la que va muy la luz a muy oscuro. Por favor ponga un "x" en la línea donde usted se ve.

Muy Luz (Guero) ——————————————— Muy Oscuro/Moreno

ID #:_____ Acculturation Rating Scale (ARSMA-II) ID Numero: _____

SCALE 1

Give me the number between 1-5 next that best applies to each item.	Deme el número entre 1 y 5 a la respuesta que sea más adecuada para usted.
1=Not At All 2=Very Little or Not Very Often	1 = Nada 2 = Un Poquito o A Veces
3=Moderately 4=Much or Very Often	3 = Moderado 4 = Mucho o Muy Frecuente
5 = Extremely Often or Almost Always	5 = Muchísmo o Casi todo el tiempo
29. _____ I speak Spanish	29. _____ Yo hablo Español
30. _____ I speak English	30. _____ Yo hablo Inglés
31. _____ I enjoy speaking Spanish	31. _____ Me gusta hablar en Español
32. _____ I associate with Anglos	32. _____ Me asocio con Anglos
33. _____ I associate with Mexicans and/or Mexican Americans	33. _____ Yo me asocio con Mexicanos o con Norte Americanos de origen Mexicano
34. _____ I enjoy listening to Spanish language music	34. _____ Me gusta la musica Mexicana(musica en idioma Español)
35. _____ I enjoy listening to English language music	35. _____ Me gusta la musica de idioma Ingles
36. _____ I enjoy Spanish language TV	36. _____ Me gusta ver programas en la televisión que sean en Español
37. _____ I enjoy English language TV	37. _____ Me gusta ver programas en la televisión que sean en Inglés
38. _____ I enjoy English language movies	38. _____ Me gusta ver películas en Inglés
39. _____ I enjoy Spanish language movies	39. _____ Me gusta ver películas en Español
40. _____ I enjoy reading (e.g., books) in Spanish	40. _____ Me gusta leer (e.g., por ejemplo, libros) en Español
41. _____ I enjoy reading (e.g., books) in English	41. _____ Me gusta leer (e.g., por ejemplo, libros) en Inglés
42. _____ I write e.g., letters in Spanish	42. _____ Escribo e.g., (por ejemplo) cartas en Español
43. _____ I write e.g., letters in English	43. _____ Escribo e.g., (por ejemplo) cartas en Inglés

44.	_____	My thinking is done in the English language
45.	_____	My thinking is done in the Spanish language.
46.	_____	My contact with Mexico has been
47.	_____	My contact with the USA has been
48.	_____	My father identifies or identified himself as 'Mexicano'
49.	_____	My mother identifies or identified herself as 'Mexicana'
50.	_____	My friends, while I was growing up, were of Mexican origin
51.	_____	My friends, while I was growing up, were of Anglo origin.
52.	_____	My family cooks Mexican foods.
53.	_____	My friends now are of Anglo origin.
54.	_____	My friends now are of Mexican origin
55.	_____	I like to identify myself as an Anglo American.
56.	_____	I like to identify myself as a Mexican American.
57.	_____	I like to identify myself as a Mexican
58.	_____	I like to identify myself as an American

END OF SCALE 1

44.	_____	Mis piensamientos ocurren en el idioma Inglés
45.	_____	Mis piensamientos ocurren en el idioma Español
46.	_____	Mi contacto con Mexico ha sido
47.	_____	Mi contacto con los Estados Unidos Americanos ha sido
48.	_____	Mi padre se identifica (o se identificaba) como Mexicano
49.	_____	Mi madre se identifica (o se identificaba) como Mexicana
50.	_____	Mis amigos(as) de mi niñez eran de origen Mexicano
51.	_____	Mis amigos(as) de mi niñez eran de origen Anglo Americano
52.	_____	Mi familia cocina comidas Mexicanas
53.	_____	Mi familia cocina comidas Norte Americanas (Anglo Americanas)
54.	_____	Mis amigos recientes son Mexicano
55.	_____	Me gusta identificarme como Anglo Americano
56.	_____	Me gusta identificarme como Norte Americano* (México-Americano)
57.	_____	Me gusta identificarme como Mexicano
58.	_____	Me gusta identificarme como un(a) Americano(a)

*Norte Americanos de origen Mexicano

FIN DE ESCALA 1

SCALE 2

English Version

ESCALA 2

Version en Español

SCALE 2

English Version

Use this scale to answer questions 59-76.

1	2	3	4	5
Not at all	Very Little or Not Very Often	Moderately	Much or Very Often	Extremely Often or Almost Always

59. _____ I have difficulty accepting ideas held by some Anglos.

60. _____ I have difficulty accepting certain attitudes held by Anglos.

61. _____ I have difficulty accepting some behaviors exhibited by Anglos.

62. _____ I have difficulty accepting some values held by some Anglos.

63. _____ I have difficulty accepting certain practices and customs commonly found in some Anglos.

64. _____ I have, or think I would have, difficulty accepting Anglos as close personal friends.

65. _____ I have difficulty accepting ideas held by some Mexicans

66. _____ I have difficulty accepting certain attitudes held by Mexicans.

ESCALA 2

Versíon en Español

Utilice esta escala para contester preguntas 61-78.

1	2	3	4	5
Nada	Un poquito o	Moderado A Veces	Mucho o Muy Frecuente	Muchisimo o Casi Todo El Tiempo

59. _____ Tengo dificultad aceptando ideas de algunos Anglo Americanos.

60. _____ Tengo dificultad aceptando ciertas actitudes de los Anglo Americanos.

61. _____ Tengo dificultad aceptando algunos comportamientos de los Anglo Americanos.

62. _____ Tengo dificultad aceptando algunos valores que tienen los Anglo Americanos.

63. _____ Tengo dificultad aceptando ciertas costumbres entre algunos Anglo Americanos.

64. _____ Tengo, o creo que sí tuviera, dificultad aceptando Anglo Americanos como buenos amigos.

65. _____ Tengo dificultad aceptando ideas de algunos Mexicanos

66. _____ Tengo dificultad aceptando ciertas actitudes de algunos Mexicanos.

1=Not at all 2=Very Little or Not Very Often
3=Moderately 4=Much or Very Often
5=Extremely Often or Almost Always

67. _____ I have difficulty accepting some behavior exhibited by Mexicans.
68. _____ I have difficulty accepting some values held by some Mexicans.
69. _____ I have difficulty accepting certain practices and customs commonly found in some Mexicans.
70. _____ I have, or think I would have, difficulty accepting Mexicans as close personal friends.
71. _____ I have difficulty accepting ideas held by some Mexican Americans.
72. _____ I have difficulty accepting certain attitudes held by Mexican Americans.
73. _____ I have difficulty accepting some behaviors exhibited by Mexican Americans.
74. _____ I have difficulty accepting some values held by Mexican Americans.
75. _____ I have difficulty accepting certain practices and customs commonly found in some Mexican Americans.
76. _____ I have, or think I would have, difficulty accepting Mexican Americans as close personal friends.

1=Nada 2=Un poquito o A Veces
3=Moderado 4=Mucho o Muy Frecuente
5=Muchisimo o Casi Todo El Tiempo

67. _____ Tengo dificultad aceptando algunos comportamientos de los Mexicanos.
68. _____ Tengo dificultad aceptando algunos valores que tienen los Mexicanos.
69. _____ Tengo dificultad aceptando ciertas costumbres entre algunos Mexicanos.
70. _____ Tengo, o creo que si tuviera, dificultad aceptando a Mexicanos como buenos amigos.
71. _____ Tengo dificultad aceptando ideas de algunos Mexico-Americanos*
72. _____ Tengo dificultad aceptando ciertas actitudes de algunos Mexico-Americanos.*
73. _____ Tengo dificultad aceptando algunos comportamientos de los Mexico-Americanos.*
74. _____ Tengo dificultad aceptando algunos valores que tienen Mexico-Americanos.*
75. _____ Tengo dificultad aceptando ciertas costumbres entre algunos Mexico-Americanos.*
76. _____ Tengo, o creo que si tuviera, dificultad aceptando Mexico-Americanos* como buenos amigos.

END OF SCALE 2
*Norte Americanos de origen Mexicano

ID #: _____ MULTIPHASIC ASSESSMENT OF CULTURAL CONSTRUCTS (MACC-SF) (Short Form) ID Numero: _____

ID #: _____ MULTIPHASIC ASSESSMENT OF CULTURAL CONSTRUCTS (MACC-SF) (Short Form) ID Numero:_____

English Version	Versión en Español
In this section, I will read each statement and you decide whether it is true as applied to you or false as applied to you. If the statement is TRUE or mostly TRUE, say the number "1" and if the statement is FALSE or mostly FALSE, say the number "5". Remember to give YOUR OWN opinion and try to answer every statement.	En esta sección, yo leeré cada declaración y usted decide si es verdad como aplicó a usted o falso como aplicó a usted. Si la declaración es VERDAD o principalmente VERDAD, diga "1" y si la declaración es FALSA o principalmente FALSA, diga "5." Recuerde dar SU PROPIA opinión y intentar contestar cada declaración.
1 = True (Cierto) 5 = False (Falso)	1 = Cierto (True) 5 = Falso (False)

77.	_____	All adults should be respected.	77.	_____	Todos los adultos deben ser respectados.
78.	_____	A man should not marry a woman who is taller than him.	78.	_____	Los hombres no deben casarse con mujeres que sean más altas que ellos
79.	_____	Good manners are more important than a formal education.	79.	_____	Los buenos modales son más importantes que una educación formal.
80.	_____	More parents should teach their children to be loyal to the family	80.	_____	Los padres de familia deben de enseñarles a sus hijos que la familia es primero.
81.	_____	I often ask people to do favors for me	81.	_____	Frequentemente pido favores a la gente
82.	_____	It is more important to enjoy life now than to plan for the future.	82.	_____	Es más importante disfrutar la vida hoy que hacer planes para el futuro
83.	_____	It is the mother's special responsibility to provide her children with proper religious training.	83.	_____	La educación religiosa de los niños es la responsabilidad especial de la madre.
84.	_____	Boys should not be allowed to play with dolls, and other girls' toys	84.	_____	A los niños no se les debe dejar que jueguen con muñecas u otros juguetes de niñas.

85. _____ Parents should maintain stricter control over their daughters than their sons.

86. _____ People die when it is their time and there is not much that can be done about it

87. _____ I believe it is possible to place a hex on someone (embrujar a alguien)

88. _____ I like to greet people in a friendly manner when I see them.

89. _____ I make it a point to know people that hold important jobs (positions of power)

90. _____ We must live for the present, who knows what the future may bring

91. _____ There are some jobs that women simply should not have

92. _____ I have been hexed (embrujado) in the past

93. _____ It is more important for a woman to learn how to take care of the house and the family than it is for her to get a college education

94. _____ Mental illness cannot be caused by witchcraft and evil spirits

95. _____ I don't mind calling on people that I know to do favors for me

85. _____ Los padres de familia deben de ser más estrictos con sus hijas que con sus hijos

86. _____ La gente se muere cuando le toca y no hay nada que lo pueda remediar

87. _____ Yo creo que si es posible embrujar a alguien

88. _____ Me gusta saludar amistosamente a las personas cuando las veo.

89. _____ Es importante para mi conocer personas que tengan puestos importantes

90. _____ Debemos vivir en el presente, uno nunca sabe lo que el futuro traerá.

91. _____ Hay algunos trabajos en los que las mujeres no deben meterse

92. _____ Me han embrujado en el pasado

93. _____ Es más importante para la mujer aprender a cuidar de casa y de su familia, que tener una educacion de colegio o de la universidad

94. _____ Las enfermedades mentales no pueden ser causadas por brujerías, o por mal espiritus

95. _____ No me molesta pedir favores a las personas que conozco

96. _____ If my doctor said I was disabled, I would believe it even if I disagreed.

97. _____ The stricter the parents the better the child

98. _____ I try to get to know everyone I meet

99. _____ It is not always wise to plan too far ahead because many things turn out to be a matter of good and bad fortune anyway

100. _____ A wife should never contradict her husband in public

101. _____ I have been treated for "empacho" *(indigestion)*

102. _____ Men are more intelligent than women

103. _____ My family and I have used the services of curanderos, curanderas *(healers)* in the past

104. _____ I always feel better about meeting someone if I know their family

105. _____ No matter what people say, women really like dominant men.

106. _____ I have been treated by a curandero(a) more than once

107. _____ Some equality in marriage is a good thing, but for the most part the father ought to have the main say so in family matters.

96. _____ Si mi doctor me dice que estoy desabilitado le creo aunque no este de acuerdo

97. _____ Entre más estrictos sean los padres más bueno será el hijo

98. _____ Trato de conocer bien a las personas que me presentan

99. _____ No siempre es bueno hacer muchos planes para el futuro, porque muchas cosas dependen de la buena o la mala suerte

100. _____ Una mujer nunca debe contradecir a su esposo en publico

101. _____ Me han curado de empacho

102. _____ Los hombres son más inteligentes que las mujeres

103. _____ Nosotros en mi familia, hemos ido a consultar con un curandero(a)

104. _____ Cuando me presentan a una persona, me siento más agusto si sé quien es su familia

105. _____ No importa lo que la gente diga, las mujeres prefieren a hombres que las dominan

106. _____ He sido curado por un curandero más de una vez

107. _____ Cierta igualdad dentro del matrimonio es buena, pero por lo general el padre es el que debe tener la ultima palabra en las cosas de la familia

108.	_____	I would take my child to a curandero(a) if needed	108. _____	Si tuviera necisidad de llevar a mi hijo(a) con un curandero(a) lo haría
109.	_____	For the most part, it is better to be a man than a woman	109. _____	Por lo general, es mejor ser hombe que mujer
110.	_____	My family frequently participates in school sponsored activities for our children	110. _____	Mi familia participa con frecuencia en las actividades planeadas por la escuela de nuestros hijos
111.	_____	Even if a child believes that his parents are wrong, he should obey without question	111. _____	Aún cuando un niño cree que sus padres están equivocados deben obedecerlos sin pregunta
112.	_____	Relatives are more important than friends	112. _____	Los parientes son más importantes que los amigos
113.	_____	Friendly people get much further in life than cold people	113. _____	Las personas que son amistosas le sacan más a la vida que las que no lo son
114.	_____	I like to talk about the weather with people to help start up a conversation	114. _____	Me gusta hablar del tiempo con la gente cuando quiero empezar una conversación
115.	_____	Most women have little respect for weak men	115. _____	La mayoría de las mujeres no respetan a los hombes débiles
116.	_____	I would be more comfortable with a male boss than a female boss	116. _____	Yo me sentiría mas a gusto si, en el trabajo, mi jefe fuera un hombre y no una mujer
117.	_____	For a child a mother should be the dearest person in the world.	117. _____	Para un niño la madre debe ser la persona más preciada del mundo
118.	_____	It doesn't do any good to try to change the future because the future is in the hand of God	118. _____	De nada sirve tratar de cambiar el futuro porque el futuro está en manos de Dios
119.	_____	When I was young, I was treated for "Susto"	119. _____	De más joven fui curado de "susto"

120. _____	A girl should not date a boy unless her parents approve	120. _____ Una muchacha no debe salir con un muchacho al los menos que sus padres esten de acurerdo
121. _____	I enjoy being with people	121. _____ Me gusta estar en compañia de otras personas
122. _____	When I was young I was treated for "Mal de Ojo"	122. _____ De mas joven fui curado del "Mal de Ojo"
123. _____	I can trust many people to do me favors	123. _____ Hay mucha gente en la que puedo confiar para que me hagan favores
124. _____	When I make plans, I am almost certain I can make them work	124. _____ Cada vez que hago planes, casi estoy suguro de que me saldran bien
125. _____	It is important for a man to be strong	125. _____ Es importante para un hombre ser fuerte
126. _____	For some illnesses a curandero is better than a doctor	126. _____ Para algunas enfermedades es mejor ir a ver un curandero que a un doctor
127. _____	Girls should not be be allowed to play with boy's toys such as soldiers and footballs	127. _____ A las niñas no se les debe permitir jugar con juguetes de niños tales como soldaditos o pelotas de futbol
128. _____	I sometimes feel that someone controls me	128. _____ A veces siento que alguien me controla
129. _____	Wives should respect the man's position as head of the household	129. _____ Las mujeres deben respetar la posición de sus maridos como jefes del hogar
130. _____	The father always knows what is best for the family	130. ____ El padre siempre sabe qué es los mejor para la familia
131. _____	Caida de Mollera (fallen fontenelle) happens mostly to a very young infant	131. _____ La caida de la mollera le sucede por general a bebitos pequeños

ID #: _____

Expectations About Marriage and Family Therapy

NOW WE ARE GOING TO CHANGE TO ANOTHER SECTION

DIRECTIONS

Pretend that you are about to see a marriage and family therapist for your first interview. I would like to know just what you think marriage and family therapy will be like. On the following pages are statements about marriage and family therapy. In each instance you are to indicate what you expect marriage and family therapy to be like. This is the rating scale you will use. For each statement, I will record your responses on this instrument.

Again, your responses will be kept in strictest confidence and your answers will be combined with the answers of others like yourself and reported only in the form of group averages.

Expectations about Marriage and Family Therapy (1996). Adapted from: Expectation about Counseling-Brief Form, Copyright 1982, Howard E. A. Tinsley, and Spanish Version of the EAC-B, 1992, Robin A. Buhrke and Michael Jorge

ID Numero: _____

Expectativas de Terapia de Matrimonio y Familia

AHORA VAMOS A CAMBIAR A OTRO SECCIÓN

INSTRUCCIONES

Imaginese que usted esta a punto de ver a un(a) terapeuta para su primera entrevista. Me gustaria saber lo que usted espera del proceso terapeutico. A continuación encontrara declaraciones acerca del proceso de terapia.

En cada caso usted indicara cuales son sus expectativas en relación a la Terapia de Matrimonio y Familia. La escala presentada a continuación es la que usted utilizara. Para cada declaración, yo anotare su respuesta en el cuestionario.

Recuerde, su respuesta se mantendra estrictamente confidencial y sus resultádos se combinaran con las de otros participantes y se reportaran en un solo grupo de promedio.

Expectativas de Terapia de Matrimonio y Familia (1996). Adaptado de: Expectación de Consejero-Forma Breve, Derecho de Propriedad Literaria, 1982, Howard E. A. Tinsley, y El Versión en Español del EAC-B, 1992, Robin A. Buhrke y Michael Jorge

Expectations of Marriage and Family Therapy

I EXPECT TO.....

146. _____ Get practice in relating openly and honestly to another person within the therapy relationship.

147. _____ Enjoy my interviews with the therapist.

148. _____ Practice some of the things I need to learn in the therapy relationship.

149. _____ Get a better understanding of myself and others.

150. _____ Stay in therapy for at least a few weeks, even if at first I am not sure it will help.

151. _____ See the therapist for more than three interviews.

152. _____ Never need therapy again.

153. _____ Enjoy being with the therapist.

154. _____ Stay in therapy even though it may be painful or unpleasant at times.

155. _____ Contribute as much as I can in terms of expressing my feelings and discussing them.

156. _____ See the therapist for only one interview.

157. _____ Go to therapy only if I have a very serious problem.

Expectativas de Terapia de Matrimonio y Familia

YO ESPERO...

146. _____ Aprender como relacionarme abierta y honestamente con otra persona dentro de la relación terapéutica.

147. _____ Disfrutar mis sesiones con el terapéuta.

148. _____ Practicar, dentro de la relación terapéutica, alguna de las cosas que necesito aprender.

149. _____ Obtener un mejor entendimiento de mí mismo(a) y de otros.

150. _____ Permanecer en terapia por lo menos algunas semanas, aunque al principio no esté seguro(a) de que me vaya a ayudar.

151. _____ Ver al terapéuta por más de tres sesiones.

152. _____ Nunca volver a necesitar terapia.

153. _____ Disfrutar estar con el terapéuta.

154. _____ Permanecer en terapia aunque a veces pueda ser doloroso o desagradable.

155. _____ Contribuir en lo que pueda a expresar mis sentimientos y discutirlos.

156. _____ Tener solamente una entrevista con el terapéuta.

157. _____ Ir a terapia sólo si tengo un problema muy serio.

Expectations of Marriage and Family Therapy

THE FOLLOWING QUESTIONS CONCERN YOUR EXPECTATIONS ABOUT THE MARRIAGE AND FAMILY THERAPIST

I EXPECT THE MARRIAGE AND FAMILY THERAPIST TO...

158. _____ Find that the therapy relationship will help the therapist and me identify problems on which I need to work.

159. _____ Become better able to help myself in the future.

160. _____ Find that my problem will be solved once and for all in therapy.

161. _____ Feel safe enough with the therapist to really say how I feel.

162. _____ See an experienced therapist.

163. _____ Find that all I need to do is to answer the therapist's questions.

164. _____ Improve my relationships with others.

165. _____ Ask the therapist to explain what he or she means whenever I do not understand something that is said.

166. _____ Work on my concerns outside the therapy interviews.

Expectación de Terapia de Matrimonio y Familia

LAS SIGUIENTES PREGUNTAS SE REFIEREN A LO QUE USTED ESPERA DEL TERAPÉUTA DE MATRIMONIO Y FAMILIA.

YO ESPERO QUE el TERAPÉUTA de MATRIMONIO y FAMILIA

158. _____ Que la relación terapéutica nos ayude al terapeuta y a mi a identificar los problemas en los cuales tengo que trabajar.

159. _____ Capacitarme para ayudarme a mí mismo(a) para el futuro.

160. _____ Encontrar que, por medio de la terapia, mi problema se va a resolver de una vez por todas.

161. _____ Sentirme lo suficientemente seguro(a) con el terapéuta para expresar lo que realmente siento.

162. _____ Ver a un terapéuta con experiencia.

163. _____ Encontrar que todo lo que tengo que hacer es contestar las preguntas del terapéuta.

164. _____ Mejorar mis relaciones con otra gente.

165. _____ Pedirle al terapéuta que me explique lo que el/ella quiere decir cuando yo no entienda algo que se haya dicho.

166. _____ Lidiar con mis inquietudes y preocupaciones fuera de las sesiones terapéuticas.

Expectations of Marriage and Family Therapy

I EXPECT THE MARRIAGE AND FAMILY THERAPIST TO...

167. _____ Find that the interview is not the place to bring up personal problems.

168. _____ Explain what's wrong.

169. _____ Help me identify and label my feelings so I can better understand them.

170. _____ Tell me what to do.

171. _____ Know how I feel even when I cannot say quite what I mean.

172. _____ Know how to help me.

173. _____ Help me identify particular situations where I have problems.

174. _____ Give encouragement and reassurance.

175. _____ Help me to know how I am feeling by putting my feelings into words for me.

176. _____ Be a "real' person not just a person doing a job.

177. _____ Help me discover what particular aspects of my behavior are relevant to my problems.

178. _____ Inspire confidence and trust.

179. _____ Frequently offer me advice.

Expectación de Terapia de Matrimonio y Familia

YO ESPERO QUE el TERAPEUTA de MATRIMONIO y FAMILIA

167. _____ Encontrar que la entrevista no es el sitio apropriado para discutir problemas personales

168. _____ Me explique lo que está mal.

169. _____ Me ayude a identificar y a catalogar mis sentimientos de manera que yo los pueda entender mejor.

170. _____ Me diga qué hacer.

171. _____ Sepa cómo me siento aún cuando yo no pueda expresarlo exactamente.

172. _____ Sepa cómo ayudarme.

173. _____ Me ayude a identificar situaciones específicas en las que tengo problemas.

174. _____ Me dé ánimo y seguridad.

175. _____ Me ayude a entender cómo me siento cuando el/ella exprese mis sentimientos verbalmente.

176. _____ Sea una persona genuina y no sólo alguien que esté desenpeñando un trabajo.

177. _____ Me ayude a descubrir qué aspectos de mi comportamiento, en particular, están relacionados a mis problemas.

178. _____ Inspire confianza y confidencia.

179. _____ Me ofrezca consejos a menudo.

Expectations of Marriage and Family Therapy

180. _____ Be honest with me.

181. _____ Be someone who can be counted on.

182. _____ Be friendly and warm towards me.

183. _____ Help me solve my problems.

184. _____ Discuss his or her own attitudes and relate them to my problem.

185. _____ Give me support.

186. _____ Decide what treatment plan is best.

187. _____ Know **how** I feel, at times, without my having to speak.

188. _____ Do most of the talking.

189. _____ Respect me as a person.

190. _____ Discuss his or her experiences and relate them to my problems.

191. _____ Praise me when I show improvement.

192. _____ Make me face up to the differences between what I say and how I behave.

Expectación de Terapia de Matrimonio y Familia

180. _____ Sea honesto(a) conmigo.

181. _____ Sea alguien con quien yo pueda contar.

182. _____ Sea amistoso(a) y acogedor(a) conmigo.

183. _____ Me ayude a resolver mis problemas.

184. _____ Discuta sus actitudes y las relacione a mis problemas.

185. _____ Me dé apoyo.

186. _____ Decida qué plan de tratamiento es mejor para mi.

187. _____ Sepa **cómo** me siento a veces sin tener necesidad de decírselo.

188. _____ Sea quien más hable.

189. _____ Me respete como persona.

190. _____ Discuta sus experiencias y las relacione a mis problemas.

191. _____ Me elogie cuando yo demuestre mejoría.

192. _____ Me haga ver la diferencia entre lo que digo y la manera en que me comporto.

Expectations of Marriage and Family Therapy

193. _____ Talk freely about himself or herself.

194. _____ Have no trouble getting along with people.

195. _____ Like me.

196. _____ Be someone I can really trust.

197. _____ Like me in spite of the bad things that he or she knows about me.

198. _____ Make me face up to the differences between how I see myself and how I am seen by others.

199. _____ Be someone who is calm and easygoing.

200. _____ Point out to me the differences between what I am and what I want to be.

201. _____ Just give me information.

202. _____ Get along well in the world.

Expectación de Terapia de Matrimonio y Familia

193. _____ Hable libremente acerca de sí mismo(a).

194. _____ No tenga problemas relacionándose con las personas.

195. _____ Yo le agrade.

196. _____ Sea alguien en quien yo pueda realmente confiar.

197. _____ Me aprecie a pesar de las cosas malas que sepa de mí.

198. _____ Me haga ver la diferencia entre cómo yo me veo a mí mismo(a) y cómo otros me ven.

199. _____ Sea alguien tranquilo(a).

200. _____ Me señale la diferencia entre lo que soy y lo que quiero ser.

201. _____ Sólo me dé información.

202. _____ Se desenvuelva bien en el mundo.

ID #: _____ Openness and Utilization of Marriage & Family Therapy

Now we are going to change to another section. Please respond to the following questions. This information will be used in combination with your other responses and other participants like yourself.

203. _____ Who would you turn to for "help" if you needed it? Select all that apply.

1. Mother Figure(s)
2. Father Figure
3. Sister(s)
4. Brother(s)
5. Grandmother(s)
6. Grandfather(s)
7. Aunts(s)
8. Uncle(s)
9. Cousin(s)
10. Godparent
11. Spouse/Partner
12. Son(s)
13. Daughter(s)
14. Friend(s)
15. Neighbor(s)
16. Clergy
17. Counselor
18. Therapist
19. Healer
20. Social Org.
21. Other

21 = _____

Of those people you selected, who would you turn to first? second? third? fourth? and fifth?

204. _____ (Use # from responses to # 204)

205. _____ (Use # from responses to # 204)

206. _____ (Use # from responses to # 204)

207. _____ (Use # from responses to # 204)

208. _____ (Use # from responses to # 204)

ID Numero: _____ Aprendizaje (Espaciosidad) y Uso de Terapia de Matrimonio y Familia ----------

Ahora vamos a cambiar a otra sección. Por favor, responda a las siguientes preguntas acerca de usted. Esta información será utilizada en combinación con sus respuestas y la de otros/otras participantes como usted.

203. _____ ¿A quien vas por "ayuda" si la nececitas? Puedes escojer cuantos quieras.

1. Madre
2. Padre
3. Hermana(s)
4. Hermano(s)
5. Abuelita(s)
6. Abuelito(s)
7. Tia(s)
8. Tio(s)
9. Primo/a(s)
10 Padrino/Madrina(s)
11. Esposo(a)/Compañero
12. Hijo(s)
13. Hija(s)
14 Amigo/a(s)/Compadre(s)
15. Vecino(s)
16. Clero
17. Consejero
18. Terapéutica
19. Curandero
20. Organ. Social
21. Otro

21 = _____

De la gente que usted selecciono, con quién vas primero? segundo? tercero? cuarto? y quinto?

204. _____ (Usa numero del repuesta a # 204)

205. _____ (Usa numero del repuesta a # 204)

206. _____ (Usa numero del repuesta a # 204)

207. _____ (Usa numero del repuesta a # 204)

208. _____ (Usa numero del repuesta a # 204)

Openness and Utilization of Marriage and Family Therapy

209. What characteristics do these people have that lead you to seek them out?

1 = Friendly
2 = Caring
3 = Strong
4 = Accepting
5 = Family
6 = Knowledgeable
7 = Wise
8 = Elder (Age)
9 = Good Listener
10 = Good Advice
11 = Trustworthy
12 = Other_____
12 = _____

210. _____ How easy is it for you to seek or ask for help from family members?

1 = Very Easy
2 = Somewhat Easy
3 = A Little Hard
4 = Hard
5 = Very Hard
6 = I don't seek or ask for help

211. _____ from friends?

212. _____ from neighbors?

213. _____ from social and community services, programs, etc.?

214. _____ from professionals?

Aprendizaje y Uso de Terapia de Matrimonio y Familia

209. ¿Cuales características tienen las personas que te hace ir a ellos para ayuda?

1 = Amable
2 = Dedicado(da)
3 = Fuerte
4 = Aceptación
5 = Familia
6 = Entendido(da)
7 = Sabio(bia)
8 = Mayor
9 = Bueno Oyente
10 = Bueno consejos
11 = Digno(na) de confianza
12 = Otro_____
12 = _____

210. _____ ¿Que fácil es para usted buscar, solicitar, o pedirle ayuda a su familia?

1 = Muy Fácil
2 = Algo Fácil
3 = Un Poquito Difícil
4 = Difícil
5 = Muy Difícil
6 = Yo no busco, solicito, o pido ayuda

211. _____ de amigo(a)s

212. _____ de vecinos

213. _____ de programas sociales y servicios de la comunidad, etc.

214. _____ de profesionales

Now I have some questions about mental health services.

215. _____ Have you ever received mental health services?

1 = Yes 2 = No

216. _____ Have you ever been to see a professional counselor?

1 = No
2 = No, but tried to get information
3 = No, but made a telephone call to get information
4 = Yes, went for an initial intake/1st session
5 = Yes (attended more than 2 sessions)

217. _____ Have you ever been to see a professional therapist?

1 = No
2 = No, but tried to get information
3 = No, but made a telephone call
4 = Yes, went for an initial intake/1st session
5 = Yes (attended more than 2 sessions)

218. _____ Have you ever heard the term "marriage and family therapy or therapist"?

1 = Yes 2 = No *(If no, go to 223)*

219. _____ How have you heard about marriage and family therapy (therapists)? (Choose all that apply *(circle)* (What is the primary source of your information?) *(write the number)*

1 = Word of Mouth (ie., family, friends, co-workers)
2 = Advertisement(s)
3 = Yellow Pages
4 = School(s)
5 = Professional(s)
6 = Other _____

Ahora tengo unas preguntas sobre los servicios de salud mental.

215. _____ ¿Ha recibido servicios de salud mental anteriormente?

1 = Si 2 = No

216. _____ ¿Ha visto usted a un(a) consejero(a) profesional anteriormente?

1 = No
2 = No, pero trate de encontrar información
3 = No, pero llame para obtener información
4 = Si, fui a mi admisión/la primero sesión
5 = Si (atendi mas de dos sesiónes)

217. _____ ¿Ha visto usted a un terapéuta profesional anteriormente?

1 = No
2 = No, pero trate de encontrar información
3 = No, pero llame para obtener información
4 = Si, fui a mi admisión/la primero sesión
5 = Si (atendi mas de dos sesiónes)

218. _____ ¿Has oído de el término "Terapia (Terapeuta) de Matrimonio y Familia" anteriormente?

1 = Si 2 = No *(Si es no, vas a 223)*

219. _____ ¿Como has oído de "Terapia (Terapeuta) de Matrimonio y Familia? (Escoge todos que aplican) *(círculo)* (¿Cúal es la fuente primaria de su información?) *(escribe el numero)*

1 = la palabra de Boca (ie., familia, amigos, co-trabajadores)
2 = Anuncio(s)
3 = Las Páginas Amarilla
4 = Escuela(s)
5 = Profesional(es)
6 = Otro _____

Openness and Utilization of Marriage and Family Therapy

Use the following responses for # 220 - 222:

1 = Not at all 3 = Some 5 = Alot
2 = Very Little 4 = Quite a bit

220. _____ How much do you know about counseling (for example, family counseling, for mental health, for personal problems)?

221. _____ How much do you know about therapy?

222. _____ How much do you know about marriage and family therapy?

223. _____ What type or kind of problems encourage people of Mexican origin to seek therapy or mental health services?

1 = Personal 6 = Physical Abuse
2 = Marital 7 = Sexual Abuse
3 = Family 8 = Emotional
4 = Children's 9 = Mental Illness
5 =Teenager 10 = Other _____

224. _____ Have you ever been to see a professional marriage and family therapist?

1 = No
2 = No, but tried to get information
3 = No, but made a telephone call
4 = Yes, went for an initial intake/1st session
5 = Yes (attended more than 2 sessions)

Aprendizaje y Uso de Terapia de Matrimonio y Familia

Usa las sigientes repuestas por # 220 - 222:

1 = Nada 3 = Algo 5 = Mucho
2 = Un Poquito 4 = Bastante

220. _____ ¿Cuánto sabe acerca de consejar (por ejemplo consejar de familia, de salud mental, de asuntos personales)?

221. _____ ¿Cuánto sabe de terapia?

222. _____ ¿Cuánto sabe de terapia de matrimonio y familia?

223. _____ ¿Qué tipo de problemas animan que las personas de origen mexicano busquen terapia o los servicios de salud mentales?

1 = Personal 6 = el Abuso Físico
2 = Matrimonial 7 = el Abuso Sexual
3 = La familia 8 = Emocional
4 = Niños 9 = la Enfermedad Mental
5 = Joven 10= Otro _____

224. _____ ¿Ha visto usted a un terapéuta profesional de Matrimonio y Familia anteriormente?

1 = No
2 = No, pero trate de encontrar información
3 = No, pero llame para obtener información
4 = Si, fui a mi admisión/la primero sesión
5 = Si (atendi mas de dos sesiónes)

Openness and Utilization of Marriage and Family Therapy

225. _____ **I have some written information about marriage and family therapy. Would you like me to leave you a copy?**

1 = No 2 = Yes

226. _____ **Interviewer's Observation of Participant's Response (Verbal and Non-Verbal)**
0 = Negative Response
1 = Neutral Response
2 = Positive Response

227. _____ **Interviewer Comments:** _____

Aprendizaje y Uso de Terapia de Matrimonio y Familia

225. _____ Tengo información escrita sobre la terapia del matrimonio y la familia. ¿Quiere usted que le deja una copia?

1 = No 2 = Si

226. _____ Observación del Entrevisador de la Repuesta de el Participante (Verbal y No Verbal)
0 = Repuesta Negativo
1 = Repuesta Neutral
2 = Repuesta Positivo

227. _____ Comentario de el Entrevisador: _____

SESSION 2 INSTRUMENT

ID Number: _____ Date: _____

Openness and Utilization of Marriage and Family Therapy

Qualitative Questions

1. How does your family help or support you when you are having problems in your life?

2. What do you want from your family when you go to them for help?

3. Who do people in the Mexican community go to when they need help or support and their family is not able to help?

4. What are the similarities and differences between counselors and therapists giving support?

5. What are the similarities and differences between professional therapists and non-professionals (e.g., family members, friends) giving support?

6. Do you believe that people of Mexican origin go to therapy to get help or support when they have problems?

7. What makes you believe this?

SESIÓN NUM. 2 INSTRUMENTO

ID Numero: _____ Fecha: _____

Aprendizaje y Uso de Terapia de Matrimonio y Familia

Preguntas Cuantitativo

1. ¿Cómo le ayuda su familia a resolver problemas en su vida cuando vas con ellos?

2. ¿Qué quiere de su familia cuándo vas a ellos por ayuda?

3. ¿Con quién van la gente en la comunidad Mexicana cuando necesitan ayuda y la familia no puede ayudarlos?

4. ¿Cuáles son las similaridades y diferencias entre consejeros y terapéutas dando soporte/apoyo?

5. ¿Cuáles son las similaridades y diferencias entre terapeutas profesionales y no-profesionales (por ejemplo, familia y amigos) dando soporte o apoyo?

6. ¿Usted cree que las personas de origen Mexicano van a terapia a obtener ayuda cuando tienen problemas?

7. ¿Porqué cree usted esc?

SESSION 2 INSTRUMENT

8. Do you believe it would help people and families in the Mexican community to get therapy?

9. Can you tell me why you believe this?

10. What would other members of your community, who are of Mexican origin, think or feel if they knew a family member or friend was recieving services from a counselor (i.e., for personal problems, for mental health issues, for family problems)?

11. What would other members of your community, who are of Mexican origin, think or feel if they knew a family member or friend was receiving services from a marrriage and family therapist?

12. What kind of problems cannot be handled inside the family or with friends?

13. Give me a few examples of when a person or family of Mexican origin would consider going to a counselor or therapist.

14. What do professional therapists need to know about families of Mexican origin and the type of problem(s) they experience?

SESIÓN NUM. 2 INSTRUMENTO

8. ¿Cree usted que ayuda a la gente y familias en la comunidad Mexicana ir a terapia?

9. ¿Me puede decir usted porqué cree esto?

10. ¿Cómo piensa o se siente la gente que son de origen Mexicano si saben que algien en la familia o un amigo estan recibiendo servicios de un consejero (por ejemplo, de asuntos personales, de salud mental, por problemas de la familia)?

11. ¿Cómo piensa or siente la gente que son de origen Mexicano si saben que algien en la familia o un amigo estan recibiendo servicios de un terapeuta de Matrimonio y Familia?

12. ¿Qué tipo de problemas no pueden manejarse entre la familia o con amigo(a)s?

13. Déme unos ejemplos de cuando una persona o familia de origen mexicano considerarían yendo a consejero o terapeuta.

14. ¿Qué necesitan saber los terapeutas profesionales de las familias de origen Mexicano y las problemas que experiencian?

SESSION 2 INSTRUMENT

15. What do professional therapists need to know about families of Mexican origin and the way they handle the difficulties in life?

16. What type of changes need to be made by "professional therapists and organizations" to improve services to people of Mexican origin?

Miscellaneous Notes: _____

SESIÓN NUM. 2 INSTRUMENTO

15. ¿Qué necesitan saber los terapeutas profesionales de familias de origen Mexicano y los modos en que ellos arreglán las dificultades en la vida?

16. ¿Cuáles tipo de cambios necesitan hacer los "terapeutas profesionales y organizaciónes" para mejorar servicios para la gente de origen Mexicano?

Apuntes Diverso: _____

Appendix B

Acculturation Rating Scale for Mexican Americans-II (ARSMA-II): Original Instrument and Descriptive Information

Questions 29 - 76 on Research Instrument, Appendix A

Overview

The Acculturation Rating Scale for Mexican Americans-II (ARSMA-II) (Cuéllar, Arnold, & Maldonado, 1995) focuses on categorizing people by generation and measuring behavioral constructs of acculturation, although it has incorporated a few affective measures as well. It has been found to have good internal consistency, strong construct validity, and strong concurrent validity (Cuéllar, Arnold, & Maldonado). Generational Status is defined as the number of generations that someone has lived in the United States, and it is operationalized by asking the respondent to provide the place of birth of themselves, their parents, and their grandparents. It delineates five generational levels, which are on the demographic section of the instrument. Although the ARSMA-II is fairly new, it is based on the ARSMA (Cuéllar et al., 1980), which was shown to be the most common acculturation measure when thirty publications on acculturation and mental health were reviewed (Rogler, Cortes, & Malgady, 1991).

The ARSMA-II comprises two independent scales. The first scale, Acculturation Levels, is composed of the Anglo Orientation Subscale and the Mexican Orientation Subscale, which identify five acculturation levels: Very Mexican (1), Mexican oriented to approximately balanced bicultural (2), Slightly Anglo oriented bicultural (3), Strongly Anglo oriented (4), and Assimilated/Anglicized (5). ARSMA-II

scores highly correlate (Pearson's product-moment correlation coefficient) with the original ARSMA scale (r = .89, n = 171). The scales measure three of the four original factors for the Mexican and Anglo culture: (a) language factor (i.e., "I enjoy speaking Spanish."); (b) ethnic identity factor (i.e., "My father identifies [or identified] himself as 'Mexicano.'"); and (c) ethnic interaction or ethnic distance (i.e., "I enjoy reading books in English.") (Cuéllar, Arnold, & Maldonado, 1995). Scale 1 is a 30-item self-report instrument that uses a 5-point Likert scale to measure Anglo orientation (AOS, 13 items) and Mexican Orientation (MOS, 17 items). The internal consistency scores (coefficient alpha) are .83 and .88, respectively. Scale 2 (Marginality Scale) is an 18-item scale that is experimental and needs to be validated. Scale 2 attempts to measure the difficulty experienced in accepting Anglo, Mexican, and Mexican-American culture. Scores are obtained by summing the items for each scale and dividing the sums by total number of items to figure the mean score for each subscale. Scale 1 measures integration and assimilation, and Scale 2 measures separation and marginalization. In order to figure a linear acculturation score of "1" to "5," from Very Mexican Oriented to Very Anglo Oriented, the MOS mean must be subtracted from the AOS mean. Acculturation level can be obtained by using the cutoff scores and the multidimensional, orthogonal,

bicultural classification frame to categorize acculturation level. Scores greater than -.05 standard deviations (SD) below the mean on both the AOS and the MOS scales are categorized as high integrated biculturals, and those scores between -1.5 standard deviation below the mean and -.5 standard deviation below the mean on either scale are defined as low integrated biculturals. These quadrants are consistent with four of Berry's (1980) modes of acculturation, which include assimilation, integration, separation, and marginalization. Finally, Scale 2 measures the marginality among cultures. Although Scale 2 is currently defined as being experimental, researchers report that it is appropriate to use it in conjunction with Scale 1. The authors of the instrument call for more studies that can serve to validate it for further use.

Cut Off Scores

The acculturation levels and cutoff scores for determining Acculturation Level are as follows:

Level I	Very Mexican Orientation	< 1.33
Level II	Mexican Orientation to Approximately Balanced Bicultural	≥ -1.33 and ≤ -.07
Level III	Slightly Anglo Oriented Bicultural	> -.07 and < 1.19
Level IV	Strongly Anglo Oriented	≥ 1.19 and < 2.45
Level V	Very Assimilated or Anglicized individuals	> 2.45

The raw score means were used to calculate the Acculturation

Score. The choices selected for each item were added, and the sum was divided by the number of items on the MOS and AOS scales separately to obtain the raw score mean for each scale. The formula used to calculate the Acculturation Score is AS = AOS (Mean) - MOS (Mean). (Cuéllar, Arnold, & Maldanado, 1995).

Table B1

Raw and Mean Scores for ARSMA-II Subscales

Scale	Raw Scores	MEAN Scores	NORM MEANS
Mexican Oriented Scale (MOS)	71	4.18	3.28
Anglo Oriented Scale (AOS)	54	4.15	3.82
Marginality Score (MARG)	44	2.44	41.30
Difficulty Anglo Culture (ANGMAR)	6	1.00	14.70
Difficulty Mexican Culture (MEXMAR)	23	3.83	13.98
Difficulty M-A Culture (MAMAR)	15	2.50	12.61

Note. Acculturation Score = -0.023; Acculturation Level = 3. From "Acculturation Rating Scale for Mexican Americans-II: A Revision of the Original ARSMA Scale," by I. Cuéllar, B. Arnold, and R. Maldonado, 1995, Hispanic Journal of Behavioral Sciences, 17(3), pp. 275-304. Copyright 1995 by Cuéllar, Arnold, and Maldonado. Reprinted with permission of the authors.

Table B2

Reliability Data for ARSMA-II Scales and Subscales

	AOS N=364	MOS N=362	MARG N=367	ANGMAR N=374	MEXMAR N=374	MAMAR N=375
Split-half	.77	.84	.82	.87	.60	.90
Spearman-Brown	.87	.91	.90	.93	.75	.94
Guttman (Rulon)	.87	.91	.90	.92	.73	.94
Coefficient alpha (all items)	.83	.88	.87	.90	.68	.91
Test-retest (1 week interval, n=31)	.94	.96	.78	.72	.80	.81

Note. AOS = Anglo Orientation Scale; MOS = Mexican Orientation Scale; MARG = Marginality Scale; ANGMAR = Anglo Marginality Subscale; MEXMAR = Mexican Marginality Subscale; MAMAR = Mexican American Marginality Subscale. From "Acculturation Rating Scale for Mexican Americans-II: A Revision of the Original ARSMA Scale," by I. Cuéllar, B. Arnold, and R. Maldonado, 1995, Hispanic Journal of Behavioral Sciences, 17(3), pp. 275-304. Copyright 1995 by Cuéllar, Arnold, and Maldonado. Reprinted with permission of the authors.

Table B3

Acculturative Types Generated by ARSMA-II

Typology	Number in Norm Sample (N=379)	Criteria
Traditional Mexican	40 (10.5%)	MOS≥3.7 and AOS≤3.24
Integrated	165 (43.5%)	Meets criteria for Type 2a or Type 2b
Integrated (low) bicultural	7 (.02%)	AOS > 2.95 and MOS > 3.53 and <2.86
Integrated (high) bicultural	158 (42.0%)	AOS ≥ 3.53 and MOS ≥ 2.86
Marginal	39 (10.3%)	ANGMAR ≥ 17.34 and MEXMAR ≥ 16.82 and MAMAR ≥ 14.98
Integrated (low) marginal bicult.	1 (.004%)	Meets criteria for Type 2a and Type 3
Integrated (high)* marginal bicult.	18 (.05%)	Meets criteria for Type 2b and Type 3
Assimilated marginal*	5 (.01%)	Meets criteria for Type 3a or 3b and Type 5
Separation	61 (16.1%)	Meets criteria for Type 4a
Mexican separation	7 (.02%)	MEXMAR ≤ 11.14 and ANGMAR ≥ 14.70 and MAMAR ≥ 14.98
Mex-American separation	34 (.09%)	MAMAR ≤ 12.61 and ANGMAR ≥ 14.70 and MEXMAR ≥ 13.98
Anglo separation	20 (.05%)	ANGMAR ≤ 12.06 and MEXMAR ≥ 13.98 and MAMAR ≤ 14.98
Integrated (low) bicult. sep.*	0	Meets criteria for Type 2a and Type 4a
Integrated (high) bicult. sep.*	27 (.07%)	Meets criteria for Type 2b and Type 4a
Assimilation separation*	0	Meets criteria for Type 5 and/or Type 4a
Assimilated (all types)	49 (.13%)	MOS ≤ 2.44 and AOS ≥ 4.11
Unable to classify	67 (18.0%)	

Note. MOS = Mexican Orientation Scale; AOS = Anglo

Orientation Scale; ANGMAR = Anglo Marginality Subscale; MEXMAR = Mexican Marginality Subscale; MAMAR = Mexican American Marginality Subscale. From "Acculturation Rating Scale for Mexican Americans-II: A Revision of the Original ARSMA Scale," by I. Cuéllar, B. Arnold, and R. Maldonado, 1995, Hispanic Journal of Behavioral Sciences, 17(3), pp. 275-304. Copyright 1995 by Cuéllar, Arnold, and Maldonado. Reprinted with permission of the authors.
*These subtypes must meet multiple typology and subtypology criteria; therefore, frequencies and percentages do not add to totals, since not everyone who meets criteria for a major typology also meets criteria for a subtypology.

Appendix C

Multiphasic Assessment of Cultural Constructs-Short Form (MACC-SF): Original Instrument and Descriptive Information

Questions 77-136 of Research Instrument, Appendix A

Overview

The Multiphasic Assessment of Cultural Constructs-Short Form (MACC-SF; Cuéllar, Arnold, & Gonzalez, 1995) is a 60-item instrument with a true/false scale that was selected from a larger scale, Multiphasic Assessment of Cultural Constructs (MACC), developed by Arnold & Cuéllar (1985). It is designed to measure five constructs that are hypothesized to have the potential to influence the experience of illness and/or help-seeking behaviors. The cognitive referents of acculturation are: (a) Familism (12 items), (b) Fatalism (8 items), (c) Machismo (17 items), (d) Folk Illness Beliefs (14 items), and (e) Personalismo (11 items)(see list below). All of the scales, with the exception of personalismo, were shown to be significantly related to generational status and acculturation (Cuéllar, Arnold, & Gonzalez, 1995). Personalismo was found to be negatively correlated with the four scales, adding support to the literature that has indicated that cultural attitudes, ideas, beliefs, and values are associated with the acculturation process (Domino & Acosta, 1987; Marin, 1993), that they can be reliably measured, and that the processes have empirical construct validity.

Data analysis on the internal consistency of the subscales reveals that coefficient alphas are fair to good for folk beliefs and machismo (alpha = .74 to .82), poor for familism and fatalism (alpha = .59 to .67), and below the

accepted levels for Personalismo (alpha = .47 to .53). A factor analysis using the varimax rotation method was conducted on each of the five subscales. An ANOVA was conducted on each of the five acculturation groups for each of the five constructs. With the exception of personalismo, each was found to have significant differences between acculturation and the following: familism, $F(4,350) = 6.336$, $p < .001$; fatalism, $F(4, 350) = 4.868$, $p < .001$; folk beliefs, $F(4, 350) = 9.057$, $p < .001$); and machismo $F(4, 350) - 4.806$, $p < .01$. Correlations between acculturation and familism, machismo, folk beliefs, and fatalism were relatively low (-.19 to -.32) but statistically significant. Finally, multiple regressions were conducted for each of the five constructs using acculturation, SES, grade, age, and generation. All but the personalismo scale were found to have substantial construct validity. Acculturation, the strongest of the predictors, was shown to be correlated in the negative direction, which supports acculturation theory (i.e., the lower the level of acculturation, the higher the score on the construct measured). The amount of variance ranged from 4.5% to 8.8%.

This instrument has been shown to have psychometric properties that support its use in studying acculturation. Research has indicated clearly that there is a relationship between cognitive changes and generational status and behavioral acculturation (Cuéllar, Arnold, & González,1995).

Survey Instrument Items Representing Five Scales: Familism, Fatalism, Machismo, Folk Beliefs, and Personalism

Familism (12 items)

1. All adults should be respected.
2. More parents should teach their children to be loyal to the family.
3. It is more important for a woman to learn how to take care of the house and the family than it is for her to get a college education.
4. The stricter the parents the better the child.
5. Some equality in marriage is a good thing, but by and large, the father ought to have the main say so in family matters.
6. Even if a child believes that his parents are wrong, he should obey without question.
7. Relatives are more important than friends.
8. For a child the mother should be the dearest person in the world.
9. A girl should not date a boy unless her parents approve.
10. No matter what the cost, dealing with my relatives' problems comes first.
11. I expect my relatives to help me when I need them.
12. My family frequently participates in school-sponsored activities for our children.

Fatalism (8 items)

1. It is more important to enjoy life now than to plan for the future.
2. People die when it is their time and there is not much that can be done about it.
3. We must live for the present, who knows what the future may bring.
4. If my doctor said I was disabled, I would believe it even if I disagreed.
5. It is not always wise to plan too far ahead because many things turn out to be a matter of good and bad fortune anyway.
6. It doesn't do any good to try to change the future because the future is in the hands of God.
7. When I make plans, I am almost certain I can make them work.
8. I sometimes feel that someone controls me.

Personalismo (11 items)

1. Good manners are more important than a formal education.
2. I often ask people to do favors for me.
3. I like to greet people in a friendly manner when I see them.
4. I make it a point to know people that hold important jobs (positions of power).
5. I don't mind calling on people that I know to do favors for me.
6. I try to get to know everyone I meet.
7. I always feel better about meeting someone if I know their family.
8. Friendly people get much further in life than cold people.
9. I like to talk about the weather with people to help start up a conversation.
10. I enjoy being with people.
11. I can trust many people to do me favors.

Folk Illness Beliefs (14 items)

1. I believe it is possible to place a hex on someone (*embrujar a alguien*).
2. I have been hexed (*embrujado*) in the past. Mental illness cannot be caused by witchcraft and evil spirits. *I have been treated for "*empacho.*" My family and I have used the services of *curanderos, curanderas* in the past. I have been treated by a *curandero(a)* more than once.
3. I would take my child to a *curandero* if needed.
4. When I was young, I was treated for *"Susto."*
5. When I was young, I was treated for *"Mal de Ojo."*
6. For some illnesses a *curandero* is better than a doctor.
7. *Caida de Mollera* (fallen fontenelle) happens mostly to a very young infant.
8. If a person has special powers to do good or evil they should not be used too much.
9. Physicians should accept gratuities rather than charge a fee for their services.
10. It is essential to involve the family in healing a sick relative.

Machismo (17 items)

1. A man should not marry a woman who is taller than him.
2. It is the mother's special responsibility to provide her children with proper religious training.
3. Boys should not be allowed to play with dolls, and other girls' toys.
4. Parents should maintain stricter control over their daughters than their sons.
5. There are some jobs that women simply should not have.
6. It is more important for a woman to learn how to take care of the house and the family than it is for her to get a college education.
7. A wife should never contradict her husband in public.
8. Men are more intelligent than women.
9. No matter what people say, women really like dominant men.
10. Some equality in marriage is a good thing, but by and large, the father ought to have the main say so in family matters.
11. For the most part, it is better to be a man than a woman.
12. Most women have little respect for weak men.
13. I would be more comfortable with a male boss than with a female boss.
14. It is important for a man to be strong.
15. Girls should not be allowed to play with boys' toys such as soldiers and footballs.
16. Wives should respect the man's position as head of the household.
17. The father always knows what is best for the family.

(Cuéllar, Arnold, & Gonzalez, 1995).

Table C1

Internal Consistency Data for Five Cultural Constructs (MACC-SF)

Scale Score Statistic	Cultural Construct				
	1	2	3	4	5
Spearman-Brown	.67	.59	.77	.82	.53
Guttman (Rulon)	.66	.59	.74	.82	.53
Coefficient Alpha-- All Items	.65	.63	.78	.75	.47

Note. 1 = Familism; 2 = Fatalism; 3 = Machismo; 4 = Folk Beliefs; 5 = Personalismo

Table C2

Factor Analysis (MACC-SF)

Subscale	Eigenvalue	Variance
Familism		
Dependence on Relatives	1.0 or higher	16%
Family Priority	1.0 or higher	16%
Respect for Parental Authority	1.0 or higher	9%
Fatalism		
Inevitability		26%
Mastery		17%
Machismo		
Male Superiority		15%
Male Gender Role		9%
Female Gender Role		14%
Male Strength		9%
Folk Belief		
Experience		23%
Belief in Supernatural		15%
Folk Practice Ideologies		10%
Personalismo		
Friendliness		15%
Sociability		14%
Social Influence		12%

From "Cognitive Referents of Acculturation: Assessment of cultural constructs in Mexican Americans," by I. Cuéllar, B. Arnold, and G. Gonzalez, October 1995, Journal of Community Psychology, 23, pp. 339-356.

Appendix D

Expectations about Counseling-Brief Form (EAC-BF): Original Instrument and Descriptive Information

Questions 137-202 of Research Instrument, Appendix A

Overview

The Expectations about Marriage and Family Therapy-Brief Form (EAMFT-BF) is an adaptation of Tinsley's (1982) Expectations about Counseling-Brief Form. The terms "counseling" and "counselor" were replaced with "marriage and family therapy" and "marriage and family therapist" to provide some consistency with the terminology utilized in this study. The EAMFT-BF is a 53-item instrument that consist of 17 scales (see below) that measure four factors: (a) Client Attitudes and Behaviors, (b) Counselor Attitudes and Behaviors, (c) Counselor Characteristics, and (d) Counseling Process and Outcome. Each sentence starts with "I expect to..." or "I expect the therapist to...." The respondents use a 7-point Likert scale with choices ranging from (1) not true to (7) definitely true. Scale scores are calculated by summing responses and dividing by number of items. Factor scores can be obtained by summing the scale scores that comprise each factor and dividing by the number of scales in each factor. Six investigations have indicated that the scales have strong psychometric properties (Biscardi & Helms, 1980, as cited in Tinsley, 1982; Rode, 1979; Tinsley et al., 1984; Tinsley et al., 1980; Workman, 1978; Yuen, & Tinsley, 1981). The brief form of the Expectations about Counseling Form has a high internal consistency (.71 to .89), sufficiently high test-retest reliabilities (Median = .71), and a high correlation (.85)

with the full form of the Expectation for Counseling (Tinsley, 1982) which make it a good choice to use in research. Psychometric properties provide inconclusive information on the Realism scale which is still experimental.

Four general areas of expectations are measured by 17 subscales: 1) Client Attitudes and Behaviors (Motivation, Openness, and Responsibility); 2) Counselor Attitudes and Behaviors (Acceptance, Confrontation, Directiveness, Empathy, Genuineness, Nurturance, and Self-Disclosure); 3) Counselor Characteristics (Attractiveness, Expertise, Tolerance, and Trustworthiness); and 4) Counseling Process and Outcome (Concreteness, Immediacy, and Outcome).

Correlation of the full scale and brief scale and factor scores on the Expectations About Counseling instrument was undertaken in six investigations; these investigations were reported on in a metastudy by Tinsley (1982). The six studies include: Biscardi & Helms, 1980 (as cited in Tinsley, 1982); Rode, 1979; Tinsley et al., 1984; Tinsley et al., 1980; Workman, 1978; Yuen & Tinsley, 1981.

Definitions of expectancy scales for expectations about counseling (adapted to MFT)

1. Responsibility: Expect to take responsibility for making my own decisions.
2. Openness: Expect to speak frankly about my problems.
3. Motivation: Expect to be motivated to work with the counselor (MFT).

4. Acceptance: Expect the counselor (MFT) to think that I am worthwhile.

5. Confrontation: Expect the counselor (MFT) to point out contradictions in things I say, feel, or do.

6. Genuineness: Expect the counselor (MFT) to be a sincere person.

7. Directiveness: Expect the counselor (MFT) to take the initiative in bringing up things to talk about.

8. Empathy: Expect the counselor (MFT) to know how I feel even when I cannot say quite what I mean.

9. Self-Disclosure: Expect the counselor (MFT) to discuss his or her own experiences and to relate them to my problem.

10. Nurturance: Expect the counselor (MFT) to give me support.

11. Attractiveness: Expect to enjoy being with the counselor (MFT).

12. Expertise: Expect the counselor (MFT) to know how to help me.

13. Trustworthiness: Expect the counselor (MFT) to be someone who can be counted on.

14. Tolerance: Expect the counselor (MFT) to be patient.

15. Immediacy: Expect to talk about the relationship between myself and the counselor (MFT).

16. Concreteness: Expect the counselor (MFT) to talk very specifically about problems I am having now.

17. Outcome: Expect to experience a significant change in my life.

Spanish Version of Expectations about Counseling-Brief Form: Descriptive Information (Questions 137-202 of Research Instrument, Appendix A)

Recently, Buhrke & Jorge (1992) translated the EAC-BF into Spanish, using all four translation techniques that are suggested by Campbell, Brislin, Stewart, & Werner (as cited in Brislin, 1970) to increase the strength of their instrument, the Spanish Version of the EAC-BF (Buhrke & Jorge). This included a combination of back translation techniques and committee procedures. The authors added demographic variables to access information on multicultural experiences, such as length of time in the United States and place of birth.

Two studies were conducted to develop and test the Spanish version of the EAC-BF. The study conducted with students supported the use of this instrument with various Hispanic populations as it met the criterion (above .60) for translated instruments (Butcher, 1982). However, the nonstudent population did not have correlations for items and scales that were as high as the first group. A brief discussion included potential reasons for the differences, i.e., difficulty of making a direct translation for some words, variations in dialects of Spanish, and varying degrees of proficiency with the Spanish language. Each of these factors would impact the correlations between English and Spanish versions of the instrument. However, even with

these problems, overall, the Spanish version of this instrument fared very well; and it was concluded that it is a reliable and valid translation for students and nonstudents.

Appendix E

Informational Advertisements: English and Spanish

WHAT DO YOU THINK THE MEXICAN (AMERICAN) COMMUNITY EXPECTS FROM MENTAL HEALTH SERVICES?

- Study conducted by Gloria Gonzalez-Kruger, Doctoral Student, Family Studies, Michigan State University
- N E E D E D: People over 24 years of age who are of Mexican Origin who would be willing to talk to me about 45 minutes
- For More Information: Call Gloria at 694-2937 and leave a message
- This is a Confidential Interview
- Recieve an Appreciation Gift of $5.00

¿Qué Piensa Usted Que La Comunidad Mexicana (Americana) Espera De Los Servicios de Salud Mental?

- El estudio es conducido por Gloria Gonzaléz-Kruger, Estudiante de Doctorado, Estudios de Familias, Michigan State University
- SE NECESITA: Gente de más de 24 años que sean de origen Mexicano que puedan hablar conmigo sobre servicios de salud mental por 45 minutos
- Para Mas Información: Hablele a Gloria al teléfono 694-2937
- La entrevista es Confidencial
- Se les dará un regalo de aprecio de $5.00

Appendix F

Informational Sheet for Subjects, Session 1, English and Spanish Versions

Introduction To Potential Participants: Interview No. 1

Hello, my name is Gloria Gonzalez-Kruger and I am a student at Michigan State University and I am working on my doctoral degree in Family Studies and specializing in Marriage and Family Therapy.

I am doing this study to learn what people, who are of Mexican origin, would expect of marriage and family therapists. This will help marriage and family therapists understand what they need to change so that you are more confident about our services.

Your responses in this interview will be kept in the strictest confidence. Your name will not appear on any of the questionnaires or in any of my reports. I will be talking with other individuals of Mexican origin and when the interviews are completed, I will be combining the answers of everyone who has participated and reporting the results of the group, not of any individual.

The report will be available to you when this study is completed. Your participation is completely voluntary. If you choose to do the interview and then change your mind, you are welcome to stop at any time during the interview. The interview will take about 45-50 minutes. When you complete the interview, I would like you to accept a monetary gift of $5.00 as a way of saying thank you for your willingness to participate and for giving me the time to conduct this interview.

- DO YOU HAVE ANY QUESTIONS AT THIS TIME?
  - *IF YES: Respond to questions and then ask*: Would you like to participate in this interview?
  - *IF NO:* Would you like to participate in this interview?
    - *IF YES:* In order to conduct the interview, you must sign this consent form that gives me permission to do the interview and use the information to complete my report.
    - *IF NO:* Thank you for your time and if you know anyone who might be interested in talking with me, please give them my name and number.

Again, thank you very much.

Introducción Para Participantes Potencial: Entrevista Num. 1

Hola, mi nombre es Gloria Gonzalez-Kruger y estudio en Michigan State University. Estoy trabajando en mi doctorado en Estudios de Familias y con especialización en Terapia de matrimonio y familia.

Realizo este estudio para aprender lo que la gente de origen Mexicano esperan de los terapeutas en matrimonio y familia. Tambien ayudara a entender que los terapeutas necesitan cambiar para que ustedes se sientan mas confiados de nuestro servicios.

Sus repuestas **en la entrevista es estrictamente confidencial**. El nombre de usted no va a parecer en el cuestionario, ni en mi investigacion. Yo voy a hablar con otros que son tambien de origen Mexicano, y cuando las entrevistas estan completas, yo voy a combinar las repuestas de todos los que han participado. La investigación va ser por grupo, no individual. La investigación va estar disponible para usted cuando este estudio este terminado.

Su participación es enteramente voluntaria y puedes dejar de contestar cualquier pregunta y puede terminar esta entrevista en cualquier momento. La entrevista toma entrè 45-50 minutos. Cuando acabemos la entrevista, me gustaria que aceptas un regalo de $5.00 como modo de decirte gracias por su participación y su tiempo para hacer la entrevista.

- ¿TIENES ALGUNA PREGUNTA EN ESTE MOMENTO?
  - *SI ES SI: Responder a las preguntas y luego preguntas*: Quieres participar en la entrevista?
  - *SI ES NO:* Quieres participar en la entrevista?
    - *SI ES SI:* Para poder hacer la entrevista, tienes que firmar esta forma de consentir que me da permiso hacer la entrevista y usar la informacion para completar mi reportaje.
    - *SI ES NO:* Gracias por su tiempo y si conoces a algien que podria tener interes en hablar con migo, por favor dales mi nombre y mi numero de telefono.

Nuevamente muchas gracias.

Appendix G

Approval Letter: University Committee on Research Involving Human Subjects

Consent Form: Session 1, English and Spanish Version

MICHIGAN STATE
UNIVERSITY

April 3, 1997

TO: Delores Borland-Hunt
102 Paolucci Building

RE: IRB#: 97-172
TITLE: MEXICAN AMERICANS' EXPECTATIONS AND UTILZATIONS PATTERNS OF MARRIAGE AND FAMILY THERAPY SESSIONS
REVISION REQUESTED: N/A
CATEGORY: 1-C
APPROVAL DATE: 04/02/97

The University Committee on Research Involving Human Subjects (UCRIHS) review of this project is complete. I am pleased to advise that the rights and welfare of the human subjects appear to be adequately protected and methods to obtain informed consent are appropriate. Therefore, the UCRIHS approved this project and any revisions listed above.

RENEWAL: UCRIHS approval is valid for one calendar year, beginning with the approval date shown above. Investigators planning to continue a project beyond one year must use the green renewal form (enclosed with the original approval letter or when a project is renewed) to seek updated certification. There is a maximum of four such expedited renewals possible. Investigators wishing to continue a project beyond that time need to submit it again for complete review.

REVISIONS: UCRIHS must review any changes in procedures involving human subjects, prior to initiation of the change. If this is done at the time of renewal, please use the green renewal form. To revise an approved protocol at any other time during the year, send your written request to the UCRIHS Chair, requesting revise approval and referencing the project's IRB # and title. Include in your request a description of the change and any revised instruments, consent forms or advertisements that are applicable

PROBLEMS/ CHANGES: Should either of the following arise during the course of the work, investigators must notify UCRIHS promptly: (1) problems (unexpected side effects, complaints, etc.) involving human subjects or (2) changes in the research environment or new information indicating greater risk to the human subjects than existed when the protocol was previously reviewed and approved.

If we can be of any future help, please do not hesitate to contact us at (517)355-2180 or FAX (517)432-1171.

Sincerely,

David E. Wright, Ph.D.
UCRIHS Chair

DEW:bed

cc: Francisco A. Villarruel
Gloria E. Gonzalez-Krueger

OFFICE OF
RESEARCH
AND
GRADUATE
STUDIES

University Committee on
Research Involving
Human Subjects
(UCRIHS)

Michigan State University
246 Administration Building
East Lansing, Michigan
48824-1046

517/355-2180
FAX: 517/432-1171

Consent Form to Participate in Interview No. 1

1 This study is being conducted by Gloria Gonzalez-Kruger, a doctoral student at Michigan State University. The name of this study is Mexican American's Expectations and Utilization of Marriage and Family Therapy Services.

2 This study is being done to learn what people, who are of Mexican origin, would expect of marriage and family therapists. This will help marriage and family therapists understand what they need to change so that you are more confident about the services.

3 The study will be supervised by the following professors:

- Dr. Dolores Borland-Hunt, Professor, Michigan State University, Department of Family & Child Ecology, Approved Marriage & Family Therapy Supervisor, and Director, MSU Family & Child Clinic
- Dr. Francisco Villarruel, Assistant Professor, Michigan State University, Department of Family & Child Ecology

4 As part of this study, you will take part in a 45-50 minute interview that will be held at a location acceptable to the interviewer and yourself.

5 Your participation in this study is entirely voluntary. If you agree to participate, you may refuse to answer any question and you can stop the interview at any time and choose to end your participation.

6 The information you give during the interview is completely confidential and your name will not appear on the questionnaires at any time.

7 The consent forms and questionnaires will be stored in a locked file cabinet that is available only to the researcher (Gloria Gonzalez-Kruger). The papers will be stored in a locked brief case inside a locked car trunk while traveling to and from the interview.

8 All of the reports will be based on group information and your name will not appear on any report. The report will be available to you when this study is completed.

9 For additional information, you can contact me, Gloria Gonzalez-Kruger, at 694-2937.

Signed: _____

Date: _____

Forma de Consentimiento Para Participar en la Entrevista: Num. 1

1 Este estudio que conduce Gloria Gonzalez-Kruger, estudiante de doctorado en Michigan State University. Yo estoy de acuerdo a participar en

2 El estudio esta intitulado "Mexico-Americano's Expectaciones, y Utilizaciones de Terapia en el Matrimonio y la Familia. Realizo este estudio para aprender lo que la gente de origen Mexicano esperan de los terapeutas en matrimonio y familia. Tambien ayudara a entender que los terapeutas necesitan cambiar para que ustedes se sientan mas confiados de nuestro servicios.

3 El estudio va estar supervisado por estos profesores:

- Doctora Dolores Borland-Hunt, Profesora, Michigan State University, Departamento de Ecología de Familia y Niños, Supervisora de Terapia del matrimonio y la familia, y directora de la Clinica de Familia y Niños en Michigan State University.
- Doctor Francisco Villarruel, MSU, Asistente de Profesor, Michigan State University, Departamento de Ecología de Familia y Niños

4 Yo entiendo la intención de el estudio, porque es efectuada, y mi participación en esta entrevista. La entrevista toma entrè 45-50 minutos.

5 Yo entiendo que mi participación es enteramente voluntaria y puedo dejar de contestar cualquier pregunta y puedo terminar esta entrevista en cualquier momento.

6 Yo entiendo que la información que doy en la entrevista es estrictamente confidencial y que mi nombre no va a paecer en el cuestionario.

7 Yo entiendo que la forma de consentimiento y los cuestionarios van a ser depositados en un archivo segura y que la investigadora nomas va tener accesibilidad. Los papeles van a estar adrentro de un maletín segura dentro de la cajuela cerrada con llave de un carro que maneja a la entrevista.

8 Yo entiendo que la investigación va a ser de información del grupo y que mi nombre no va parecer en la investigación.

9 Tengo el nombre y el numero de teléfono de la investigadora (Gloria Gonzalez-Kruger) en caso que tenga preguntas o preocupaciónes despues de participar en el estudio.

Firma: _____

Fecha: _____

Appendix H

Bilingual Response Cards

Card No. 1

Question 3

1 = Latino(a)
2 = Hispanic
3 = Mexicano(a)
4 = Mexican
5 = Chicano(a)
6 = Mexican American
7 = American
8 = Other _____

Pregunta 3

1 = Latino(a)
2 = Hispanico/Español
3 = Mexicano(a)
4 = Mexican
5 = Chicano(a)
6 = Mexicano(a) Americano(a)
7 = Americano(a)
8 = Otro _____

Card No. 2

Question 21

1 = Not Religious or Spiritual at all
2 = A Little Religious or Spiritual
3 = Somewhat Religious or Spiritual
4 = Very Religious or Spiritual
5 = Extremely Religious or Spiritual

Pregunta 21

1 =No Religioso(a) o Espiritual
2 = Un Poco Religioso(a) o Espiritual
3 = Algo Religioso(a) o Espiritual
4 = Muy Religioso(a) o Espiritual
5 = Extremadamente Religioso(a) o Espiritual

Card No. 3

Question 25

1 = Less than $ 6,000
2 = 6,000 - 8,999
3 = 9,000 - 11,999
4 = 12,000 - 15,999
5 = 16,000 - 19,999
6 = 20,000 - 24,999
7 = 25,000 - 29,999
8 = 30,000 - 49,999
9 = 50,000 - 69,999
10 = 70,000 - 89,999
11 = Over $ 90,000
12 = Don't Know

Pregunta 26:

1 = Menos de $ 6,000
2 = 6,000 - 8,999
3 = 9,000 - 11,999
4 = 12,000 - 15,999
5 = 16,000 - 19,999
6 = 20,000 - 24,999
7 = 25,000 - 29,999
8 = 30,000 - 49,999
9 = 50,000 - 69,999
10 = 70,000 - 89,999
11 = Más de $ 90,000
12 = No se

Card No. 4

Question 27: (English/Inglés)

1. 1st generation = You were born in Mexico or other country [not in the United States (USA)].
2. 2nd generation = You were born in USA; either parent born in Mexico or other country.
3. 3rd generation = You were born in USA, both parents born in USA and all grandparents born in Mexico or other country.
4. 4th generation = You and your parents born in USA and at least one grandparent born in Mexico or other country with remainder born in the USA.
5. 5th generation = You and your parents born in the USA and all grandparents born in the USA.

Pregunta 27: (Spanish/Español)

1. 1a. generación = Usted nació en Mexico o otro país [no en los Estados Unidos (USA)].
2. 2a. generación = Usted nació en los Estados Unidos Americanos (USA), sus padres nacieron en México o en otro país.
3. 3a. generación = Usted nació en los Estados Unidos Americanos (USA), sus padres tambien nacieron en los Estados Unidos (USA) y sus abuelos nacieron en México o en otro país.
4. 4a. generación = Usted nació en los en los Estados Unidos Americanos (USA), sus padres nacieron en los Estados Unidos Americanos (USA) y por lo menos uno de sus abuelos nació en México o algun otro país.
5. 5a. generación = Usted y sus padres y todos sus abuelos nacieron en los Estados Unidos (USA).

Card No. 5

Scale for Questions 29-76	Escala para Preguntas 29-76
1 = Not At All	1 = Nada
2 = Very Little/Not Very Often	2 = Un Poquito o A Veces
3 = Moderately	3 = Moderado
4 = Much or Very Often	4 = Mucho o Muy Frecuente
5 = Extremely Often or Almost Always	5 = Muchísmo o Casi todo el tiempo

Card No. 6

Scale for Questions 77-136	Escala para Preguntas 77-136
1 = True	1 = Verdad
2 = False	2 = Falso

Card No. 7

Scale for Questions 137-202	Escala para Preguntas 137-202
1 = Not True	1 = Falso
2 = Slightly True	2 = Ligeramente Cierto
3 = Somewhat True	3 = Algo Cierto
4 = Fairly True	4 = Moderadamente Cierto
5 = Quite True	5 = Bastante Cierto
6 = Very True	6 = Muy Cierto
7 = Definitely True	7 = Definitivamente Cierto

Card 8

Question 203-208: Who would you turn to for "help" if you needed it?

1. Mother Figure
2. Father Figure
3. Sister(s)
4. Brother(s)
5. Grandmother(s)
6. Grandfather(s)
7. Aunt(s)
8. Uncle(s)
9. Cousin(s)
10. Godparent(s)
11. Spouse/Partner
12. Son(s)
13. Daughter(s)
14. Friend(s)
15. Neighbor(s)
16. Clergy
17. Counselor
18. Therapist
19. Healer
20. Social Organizations
21. Other:_____

Pregunta 203-208: ¿A quien vas por "ayuda" si la necesitas?

1. Madre
2. Padre
3. Hermana(s)
4. Hermano(s)
5. Abuelita(s)
6. Abuelito(s)
7. Tia(s)
8. Tio(s)
9. Primo/a(s)
10. Padrino/Madrina(s)
11. Esposo(a)/ Compañero
12. Hijo(s)
13. Hija(s)
14. Amigo/a(s) Compadre(s)
15. Vecino(s)
16. Clero
17. Consejero
18. Terapéutica
19. Curandero
20. Organizaciónes Social
21. Otro:_____

Card No. 9

Question 210-214
How easy is it for you to look for, seek or ask for help from...

1. Very Easy
2. Somewhat Easy
3. A Little Hard
4. Hard
5. Very Hard
6. I don't seek or ask for help

Pregunta 210-214
¿Que facil es para usted a buscar, solicitar, o Perdirle ayuda a su...

1. Muy Facil
2. Algo Facil
3. Un Poquito Dificil
4. Dificil
5. Muy Dificil
6. Yo no busco, solicito, o pido ayuda

Card No. 10

Scale for Question 216, 217, and 224
1 = No
2 = No but tried to get information
3 = No but made telephone call to get information
4 = Yes went for an initial intake/1st session
5 = Yes (attended more than 1 session)

Escala para Preguntas 216, 217, and 224
1 = No
2 = No pero trate de encontrar información
3 = No pero llame para obtener información
4 = Fui a mi admisión/la Primero sesión
5 = Si (atendi mas de una Sesión)

Card No. 11

Scale for Question 220-222
1 = Not at all
2 = Very little
3 = Some
4 = Quite a bit
5 = A lot

Escala para Preguntas 220-222
1 = Nada
2 = Un Poquito
3 = Algo
4 = Bastante
5 = Mucho

Appendix I

Informational Sheet for Subjects, Session 2, English and Spanish Version

Introduction To Potential Participants for Interview No. 2

I know your time is valuable so I want to thank you again for taking part in the interview we just completed. Before I go, would you be willing to give me another 2 minutes to let me read the rest of this informational sheet that describes what I am doing as another part of my dissertation?

- *If Yes - Continue Reading*
- *If No* - Thank you and if you have any questions or need to talk about this study, please call me at this telephone number.

I have some questions that give people of Mexican origin the chance to talk about how they find help, who they go to when they need help, and what they think about counselors and therapists. People can talk about what they think the Mexican American community needs or wants from community mental health services, including marriage and family therapists. This additional information will help professionals understand how they can be sensitive to the needs of individuals and families of Mexican origin and whether their services are needed or wanted.

Again, your responses **in this interview will be kept in the strictest confidence**. I would like to tape record this part of the interview since it will help me make sure I do not miss anything you say. Your name will not appear on any questionnaire, audiotape, notes, or any reports and no one will listen to the tapes but this researcher. The audiotapes will be kept in a lock box that will be kept in a locked file cabinet and the tapes will be destroyed after 2 years. I will be talking with 15 individuals of Mexican origin and when the interviews are completed, I will be looking for and reporting common points. I will be using sentences in my report from the interview but it will only report, for example, a 39 year old female. A summary of the report will be available to you when this study is completed.

Your participation is completely voluntary and if you choose to do the interview and then change your mind, you can stop the interview at any time. If you do not want part of what you say to be recorded, I can turn off the recorder until you give me permission to turn it on again. The interview will take about 15-25 minutes, depending on how much you would like to share. We can do the interview now or we can schedule another day and time. It is not possible for me to offer you a monetary gift for this part of the interview. Again, thank you for letting me read you this informational sheet and you are welcome to accept or refuse this second interview. Either way, I have enjoyed having the chance to meet you and talk with you. Do you have any questions at this time?

- *IF YES: Respond to questions and then ask:* Would

you like to participate in this interview?

- *IF NO:* Would you like to participate in this interview?
  - *IF YES:* In order to conduct this interview, you must sign this consent form that gives me permission to do the audiotaped interview and use the information to complete my report. Again, thank you very much.
  - *IF NO:* Thank you for your time if you have any questions about the study, please call me at this telephone number.

Again, thank you very much.

Introducción Para Participantes Potencial Para Entrevista Num. 2

Hemos terminado. Yo se que su tiempo es valioso, asi que quiero darle las gracias otra vez por participar en la entrevista que terminamos. Antes de retirarme, consedame 2 minutos mas para leerle el resto de este hoja de información que describe lo que yo estoy haciendo para otra parte de mi disertación. ¿Me permite leerlo?

- *Si es Si - Continuare leiendo:*
- *Si es No* - Gracias y si usted tiene cualquier pregunta o necesitas hablar de el estudio, por favor me hablas en este numero de teléfono.

Yo tengo otras preguntas, que dan a la gente de origen Mexicano la oportunidad saber como pueden encontrar con quien ir cuando necesiten ayuda, y lo que ellos piensan de consejeros y terapeuticas. Usted puede hablar de lo que piensa de la comunidad de Mexico Americanos y lo que necesitan o quieren de los servicios en la comunidad para la salud mental, incluso las terapeuticas de marital y de familia. Esta información adicional va ayudar a los profesionales a comprender como ellos pueden estar mas sensitivos a las necesidades de individuos y familias de origen Mexicano y si necesitan or quieren los servicios.

Otra vez, sus repuestas **en esta entrevista son estrictamente confidencial**. Me gustaria hacer un grabación de esta entrevista para que me ayude y estoy segura que yo no pierdo algo que usted dices. El nombre de usted no va a parecer en el cuestionario, grabación, notas, or reportaje y nadie va escuchar las cintas, nomas yo. Las grabaciónes van a estar guardadas en un caja cerrada con llave que esta guardada en un gabinete (archivo) cerrado con llave y las cintas van a ser destruidas despues de 2 años. Yo voy a hablar con 15 individuos de origen Mexicano y cuando las entervistas esten completas, yo voy a estar buscando y reportando los puntos comúnes. Yo voy a usar sentencias en mi reportaje de las entrevistas pero nomas para reportaje, por ejemplo, un masculino o una femenina de 39 años. Un resumen del reportaje estará disponible a usted cuando este estudio se completa.

Su participación es enteramenta voluntaria y si usted escoje hacer la entrevista y luego cambia de opinion, usted puedes parar la entrevista en cualquier tiempo. Sí usted no quiere cualquier parte de lo que dices que esta en la grabación, yo puedo apagar la grabación hasta que me de su permiso de prenderlo otra vez. La entrevista agarra como 15-25 minutos, dependen en lo que usted tiene o quiere decir. Podemos hacer la entrevista ahora mismo o nosotros podemos hacer una cita para otro dia y tiempo. No es posible que yo pueda ofrecer otro regalo de dinero por esta parte de la entrevista. Gracias por dejar me leer la hoja de información y usted puede aceptar or rehusar la

entrevista. De cualquier modo, yo ha tenido mucho gusto de tener ocasión de conocerle/lo y hablar con usted. ¿Tienes alguna pregunta en este momento?

- *SI ES SI:* *Responder a las preguntas y luego preguntas:* ¿Quieres participar en la entrevista?
- *SI ES NO:* ¿Quieres participar en la entrevista?
  - *SI ES SI:* Para poder hacer la entrevista, tienes que firmar esta forma de consentimento que me da permiso de hacer la entrevista y usar la información para completar mi reporte. Otra vez, muchas gracias.
  - *SI ES NO:* Gracias por su tiempo y si tienes preguntas de el estudio, por favor hablame por telefono en este numero.

Nuevamente muchas gracias.

Appendix J

Consent Form: Session 2, English and Spanish Version

Consent Form to Participate in Interview No. 2

1 This study is being conducted by Gloria Gonzalez-Kruger, a doctoral student at Michigan State University. The name of this study is entitled Mexican Americans' Expectations and Utilization of Marriage and Family Therapy Services.

2 This part of the study will give you, as a person of Mexican origin, the chance to talk about how people of Mexican origin find help, who they go to when they need help, what they think about counselors and therapists, and what the Mexican American community needs or wants from mental health services.

3 The study will be supervised by the following professors:

- Dr. Dolores Borland-Hunt, Professor, Michigan State University, Department of Family & Child Ecology, Approved Marriage & Family Therapy Supervisor, and Director, MSU Family & Child Clinic
- Dr. Francisco Villarruel, Assistant Professor, Michigan State University, Department of Family & Child Ecology

4 As part of this study, you will take part in a 15-25 minute interview that will be tape recorded.

5 Your participation in this study is entirely voluntary. If you agree to participate, you may refuse to answer any question, you may ask that the tape recorder be turned off at any time, and you may stop the interview at any time and choose to end your participation.

6 The information you give during the interview is completely confidential and your name will not appear on the questionnaire, audiotape, notes, or reports at any time. The consent forms and questionnaires will be stored in a lock box that will be in a locked file cabinet that is available only to the researcher (Gloria Gonzalez-Kruger). The papers and audiotapes will be stored in a locked brief case inside a locked car trunk while traveling to and from the interview.

7 All of the reports will be based on group information and your name will not appear on any report. The report will be available to you when this study is completed.

8 For additional information, you may contact me, Gloria Gonzalez-Kruger, at 694-2937.

Signed:_____ Date:_____

Forma de Consentimiento Para Participar en Entrevista Num. 2

1 Yo estoy de acuerdo en participar en la segundo entrevista que va hacer usada en el estudio que conduce Gloria Gonzalez-Kruger, estudiante de doctorado en Michigan State University.

2 El estudio tiene intitular "Mexico-Americano's Expectaciónes, y Uso de Terapia de Matrimonio y Familia.

3 El estudio va estar supervisado por estos profesores:
- ♦ Doctora Dolores Borland-Hunt, Profesora, Michigan State University, Departamento de Ecología de Familia y Niños, Supervisora de Terapia de Matrimonio y Familia, y director de la Clinica de Familia y Niños en Michigan State University.
- ♦ Doctor Francisco Villarruel, Profesor Asistante, Michigan State University, Departamento de Ecología de Familia y Niños

4 Yo entiendo la intención de el estudio, porque es conducida, y que mi participación en la entrevista que va a ser grabada.

5 Yo entiendo que mi participación es enteramente voluntaria y puedo parar la grabación, dejar de contestar cualquier pregunta, o puedo terminar mi participación en esta entrevista en cualquier momento.

6 Yo entiendo que la información que doy en la entrevista es estrictamente confidencial y que mi nombre no va a paecer en el cuestionario, cinta de grabación, notas, or reportajes.

7 Yo entiendo que la forma de consentir y los cuestionarios van a estar depositados en una caja que va estar cerrada con llave que esta guardada en un gabinete (archivo) y que la investigadora (Gloria Gonzalez-Kruger) nomas va a tener accesibilidad. Los papeles y los cintas de grabación van a estar adrentro de un maletín segura que esta en la cajuela cerrada con llave de un carro que maneja a la entrevista.

8 Yo entiendo que el investigación (las reportajes) van a ser de información del grupo y que mi nombre no va a parecer en el investigación.

9 Tengo el nombre y el numero de teléfono de la investigadora (Gloria Gonzalez-Kruger) en caso que tenga preguntas or preocupaciónes despues de participar en el estudio.

Firma:_____ Fecha:_____

Appendix K

Research Instrument for Session 2, English and Spanish Versions

Openness and Utilization of Marriage and Family Therapy
Qualitative Questions

ID Number:_____ Date:_____

1. How does your family help or support you when you are having problems in your life?

2. What do you want from your family when you go to them for help?

3. Who do people in the Mexican community go to when they need help or support and their family is not able to help?

4. What are the similarities and differences between counselors and therapists giving support?

5. What are the similarities and differences between professional therapists and non-professionals (e.g., family members, friends) giving support?

6. Do you believe that people of Mexican origin go to therapy to get help or support when they have problems?

7. What makes you believe this?

8. Do you believe it would help people and families in the Mexican community to get therapy?

9. Can you tell me why you believe this?

10. What would other members of your community, who are of Mexican origin, think or feel if they knew a family member or friend was receiving services from a counselor (i.e., for personal problems, for mental health issues, for family problems)?

11. What would other members of your community, who are of Mexican origin, think or feel if they knew a family member or friend was receiving services from a marriage and family therapist?

12. What kind of problems cannot be handled inside the family or with friend?

13. Give me a few examples of when a person or family of Mexican origin would consider going to a counselor or therapist.

14. What do professional therapists need to know about families of Mexican origin and the type of problem(s) they experience?

15. What do professional therapists need to know about families of Mexican origin and the way they handle the difficulties in life?

16. What type of changes need to be made by "professional therapists and organizations" to improve services to people of Mexican origin?

Miscellaneous Notes:_____

Aprendizaje y Uso de Terapia de Matrimonio y Familia
Preguntas Cuantitativo

ID Numero:_____ Fecha:_____

1. ¿Cómo le ayuda su familia a resolver problemas en su vida cuando vas con ellos?

2. ¿Qué quiere de su familia cuándo vas a ellos por ayuda?

3. ¿Con quién van la gente en la comunidad Mexicana cuando necesitan ayuda y la familia no puede ayudarlos?

4. ¿Cuáles son las similaridades y diferencias entre consejeros y terapéutas dando soporte/apoyo?

5. ¿Cuáles son las similaridades y diferencias entre terapeutas profesionales y no-profesionales (por ejemplo, familia y amigos) dando soporte o apoyo?

6. ¿Usted cree que las personas de origen Mexicano van a terapia a obtener ayuda cuando tienen problemas?

7. ¿Porqué cree usted eso?

8. ¿Cree usted que ayuda a la gente y familias en la comunidad Mexicana ir a terapia?

9. ¿Me puede decir usted porqué cree esto?

10. ¿Cómo piensa o se siente la gente que son de origen Mexicano si saben que algien en la familia o un amigo estan recibiendo servicios de un consejero (por ejemplo, de asuntos personales, de salud mental, por problemas de la familia)?

11. ¿Cómo piensa o se siente la gente que son de origen Mexicano si saben que algien en la familia o un amigo estan recibiendo servicios de un terapeuta de Matrimonio y Familia?

12. ¿Qué tipo de problemas no pueden manejarse entre la familia o con amigo(a)s?

13. Déme unos ejemplos de cuando una persona o familia de origen Mexicano considerarían yendo a consejero o terapeuta.

14. ¿Qué necesitan saber los terapeutas profesionales de las familias de origen Mexicano y las problemas que experiencian?

15. ¿Qué necesitan saber los terapeutas profesionales de las familias de origen Mexicano y los modos en que ellos arreglán las dificultades en la vida?

16. ¿Cuáles tipo de cambios necesitan hacer los "terapeutas profesionales y organizaciónes" para mejorar servicios para la gente de origen Mexicano?

Apuntes Diverso:_____

Appendix L

Copyright Permission for Research Instruments

Acculturation Rating Scale for Mexican Americans (ARSMA II)

Multiphasic Assessment of Cultural Constructs-Short Form (MACC-SF)

Expectations about Counseling-Brief Form (EAC-BF)

Expectations about Counseling-Brief Form, Spanish Version (EAC-BF, SV)

SAGE PUBLICATIONS, INC.
COPYRIGHT PERMISSION AGREEMENT

Sage Publications, Inc
2455 Teller Rd.
Thousand Oaks, CA 91320
(805) 499 0721, x 7244
Fax 805 499 0871

email address: Jim_Henson@sagepub.com

Date : 7/15/96
Sage Reference No. : SRN 071596 0015B/HJBS

This number must accompany any correspondence and applicable fees.

Requestor Information

Ms. Gloria Gonzalez-Kruger

Fax Number : 517 432 1445

Requestor Title : Dissertation Use

1624 Jacqueline Dr.
Holt MI 48842

One time only, non-exclusive permission is granted to the above named requestor for the following selection:

Type of Excerpt : selection
Chapter/Article Title : ARSMA-II Scale
Sage Author : Cuellar
Sage Title : HISPANIC JOURNAL OF BEHAVIORAL SCIENCES **Vol./Issue# :** 17(3)
Pages : 275-305
Language : English
Flat Fee : $0.00 **Per Copy Fee :** $0.00 **Payment Upon Publication or End of School Term:** N

If Payment Upon Publication is marked "N, " payment must be received within sixty (60) days of this statement, otherwise this authorization is automatically rescinded without further notice.

Permission is granted under the following terms and conditions:

1. *The number of copies made must not exceed the number of copies as stated in the request.*
2. *Permission is for non-electronic print format only. Use of material in such forms as CD-ROM and on the Internet is strictly prohibited.*
3. *If the selection is intended for use in another publication, two copies must be submitted to Sage Publications, Inc. upon completion of the work. Subsequent editions of your work require additional permission.*
4. *It is understood that this permission does not apply to any interior material not controlled by Sage Publications, Inc.*
5. *Non-exclusive world rights are granted for the language listed above only.*
6. *The Flat Fee, unless otherwise noted in the request, represents a fee for a print run of a commercial publication of 3,500 copies or less. If the print run exceeds 3,500 copies, this agreement is automatically rendered null and void and the requestor must re-submit their request stating the correct print run.*
7. *Full acknowledgement your source must appear in every copy of your work as follows:*

Author(s) Book/Journal Title (Journal Volume Number and Issue number),
pp xx-xx, copyright (c) 19xx by (Copyright Holder)
Reprinted by permission of Sage Publications

PLEASE CHECK THE APPROPRIATE BOX:

☐ I agree to the terms and conditions as set forth in this copyright permission agreement.
☐ I have decided not to use the selection. Please cancel my request.

Gloria Gonzalez-Kruger
Signature of Requestor or Authorized Agent

12/7/98
Date

Please enclose a signed copy of this agreement and remittance of applicable fees (with accompanying Sage Reference Number) to:
Sage Publications, Inc. c/o Permissions, 2455 Teller Rd., Thousand Oaks, CA 91320
Sage Federal I.D.# 95-245902

SAGE PUBLICATIONS, INC.
CORWIN PRESS, INC.

REPRINT PERMISSION AGREEMENT

2455 TELLER RD., THOUSAND OAKS, CA 91320
OFFICE: (805) 499 0721 X 8565 FAX: (805) 375 1718
E-MAIL: VICTORIA_CHENG@SAGEPUB.COM
FEDERAL TAX ID#95-2454902

Effective Date: November 24, 1998

SAGE REFERENCE #: SRN 112398 0001/
(This number must appear on all correspondence and payment of fees.)
PHONE #: 402-472-5797 FAX #: 402-472-9170
RE :

Ms. Gloria Gonzalez-kruger, Assistant Professor
University of Nebraska @ Lincoln,
117 Home Economics
Lincoln, NE 68583-0801

One-time only, non-exclusive, world rights in the English language are hereby granted to Ms. Gloria Gonzalez-kruger (hereafter referred to as "The Requester") for the following selection:

BOOK/JOURNAL TITLE:	HISPANIC JOURNAL OF BEHAVIORAL SCIENCES
AUTHOR/EDITOR:	CUELLAR, ARNOLD, & MALDONADO
VOLUME/ISSUE #	17(3)
TITLE OF SELECTION:	ACCULTURATION RATING SCALE FOR MEXICAN AMERICANS-II
TYPE OF EXCERPT:	tables **PAGE(S):** 285, 288, 286
MAXIMUM PRINT RUN:	8(EACH TABLE)
AMOUNT DUE:	NO FEE(FOR DISSERTATION USE)

Permission is hereby granted under the following terms and conditions:

1. The number of copies must not exceed the copies as stated in the request, nor the Maximum Print Run stated on this agreement. If the Maximum Print Run is "unspecified," the number of copies hereby defaults to under 100 copies for institutional use, and 3,500 copies for commercial use. If requester requests 100 or more copies and the actual copies made drops below 100, the charge is $1 per copy
2. Permission is granted for non-electronic print format only. Use of selections in electronic media such as, but not limited to the Internet, Intranet, or CD-ROM is prohibited. However, permission is granted for transcription via non-standard size audio tape for use with the blind or visually impaired.
3. If the selection is to be reprinted for commercial use, two (2) copies must be submitted to Sage Publications, Inc., upon publication of the work. Use of selections in "course packs" for use in an educational setting are exempt from this clause.
4. The permission does not apply to any interior material not controlled by Sage Publications, Inc.
5. ***Unless otherwise noted in your request,*** the Flat Fee is based on a maximum print run of 3,500 copies. If the print run exceeds 3,500 copies, this agreement is automatically rescinded, and the request must be re-submitted, stating the correct print run.
6. If the selection is intended for use in a Master's Thesis and Doctoral Dissertation, additional permission is granted for the selection to be included in the printing of said scholarly work as part of UMI's "Books on Demand" program.
7. Full acknowledgment of your source must appear in every copy of your work as follows:
   Author(s), Book/Journal Title (Journal Volume Number and Issue Number)
   pp. xx-xx, copyright (c) 19xx by (Copyright Holder)
   Reprinted by Permission of (Publisher - either Sage Publications or Corwin Press), Inc.
8. Unless specified in the request or by prior arrangement with Sage Publications, Inc., payment is due from the Requester within sixty (60) days of the effective date of the agreement or upon publication of the book/journal, otherwise the agreement will be automatically be rescinded without further notice.
9. Payment is to be made by Check or Money Order only, with the complete Sage Reference Number listed on the check or check stub. **We do not accept Purchase Orders or Credit Cards, nor do we create separate invoices.**
10. It is assumed that the requester is using the selection in question, and is subject to billing and collections procedures, unless otherwise noted in the signature on the right hand side of this agreement, or the requester informs Sage Publications, Inc. in writing.

Your signature below constitutes full acceptance of the terms and conditions of the agreement herein.

Gloria E. Gonzalez-Kruger
Signature of Requester

12-7-98
Date

Your signature below constitutes your rejection of the terms and conditions of the agreement herein.

Signature of Requester

Date:

PLEASE REMIT ONE (1) SIGNED COPY OF THE AGREEMENT,
ALONG WITH ANY APPLICABLE PAYMENT TO THE ADDRESS LISTED ABOVE. THANK YOU.

DEPARTMENT OF PSYCHOLOGY AND ANTHROPOLOGY
THE UNIVERSITY OF TEXAS - PAN AMERICAN

1201 West University Drive • Edinburg, Texas 78539-2999 • (210) 381-3329 Office

March 31, 1997

Gloria Gonzalez-Kruger
1624 Jacqueline Drive
Holt, Michigan 48842

Dear Gloria:

Thank you for your interest in using the Multicultural Assessment of Cultural Constructs- Short Form (MACC-SF) and/or subscales from the MACC-SF in your research. As you know the psychometrics of the MACC-SF subscales are reported in the Journal of Community Psychology, Vol. 23, Oct. 1995, in the article entitled "Cognitive referents of acculturation: Assessment of cultural constructs in Mexican Americans." As copyright holder of the scale itself, you have my permission to make copies as needed for your research purposes. Best of luck in your research and if possible could you remember to send me an abstract of your findings?

Sincerely Yours,

Israel Cuellar, Ph.D.
Associate Professor
Department of Psychology & Anthropology

meaningful results. For example, clients routinely take psychological tests (item 1) and see practicum students and interns for counseling (item 6) in some counseling centers. The reverse is true in other counseling centers. Consequently, the "realism" of the client's expectancies must be juaged against local practices. Needless to say, the validity of this scale is uncertain. Only future research will reveal whether the realism scale provides information of scientific and/or practical value.

Calculating Scale Scores

Scale scores on the EAC are calculated by summing the responses to the items assigned to each scale (see pages 12-14) and dividing by the number of items. The scale score for motivation, for example, can be obtained by summing the responses to items 14, 15 and 18 and dividing by 3; the scale score for responsibility is the sum of the responses to items, 8, 9, 29 and 30, divide by 4.

Calculating Approximate Factor Scores

Once scale scores are calculated, scores on the factors reported by Tinsley, Workman and Kass (1980) can be obtained by adding the scale scores indicated below and dividing by the number of scale scores indicated.

Personal Commitment	Facilitative Conditions	Counselor Expertise	Nurturance
Responsibility	Acceptance	Directiveness	Acceptance
Openness	Confrontation	Empathy	Self-Disclosure
Motivation	Genuineness	Expertise	Nurturance
Attractiveness	Trustworthiness		Attractiveness
Immediacy	Tolerance		
Concreteness	Concreteness		
Outcome			
Divide by 7	Divide by 6	Divide by 3	Divide by 4

Permission to Use EAC

Permission to use the full or brief EAC in your research, or to use selected scales from the EAC is hereby granted. In return, I ask only that you give appropriate credit for the development of the instruments in reports of your research and that you provide me with a copy of your data or a summary of your results. I am currently evaluating the validity of the EAC and I plan to develop normative data in the future. Your help in providing me with this information will make it much easier for me to keep up-to-date on the research bearing on the EAC.

Duke University

DURHAM
NORTH CAROLINA
27708-0955

ROBIN A. BUHRKE, PH.D.
COUNSELING AND PSYCHOLOGICAL SERVICES
BOX 90955
SUITE 214 PAGE BUILDING

TELEPHONE (919) 660-1000
FACSIMILE: (919) 660-1024
EMAIL: rbuhrke@acpub.duke.edu

6.19.96

Gloria Gonzales Kruger
Michigan State University
101 Morrill Hall
East Lansing, MI 48823

Ms. Kruger:

Enclosed please find a copy of the Spanish version of the EAC-B. Feel free to use it as you wish, with, of course, appropriate citation. Good luck in your research.

Thank you for your interest.

Sincerely,

Robin A. Buhrke, Ph.D.

Appendix M

Results of Study based on Level of Behavioral and Cognitive Acculturation

Level of Acculturation of Sample

Level of Behavioral Acculturation

Level of Acculturation (Scale 1). Almost half (48%) of the sample was *Slightly Anglo oriented Bicultural* (M=2.7, SD=.89). When *Slightly Anglo to Bicultural* and *Strongly Anglo oriented* acculturation levels were combined, the rate increased to 65% of the sample. The remaining 35% had scores consistent with a Mexican orientation.

Marginality Scale (Scale 2). Approximately two thirds of the sample were typified as *Integrated Biculturals* (62%). The majority of respondents maintained themselves within the Mexican and Anglo cultures. Less than one quarter were *Marginal* (23%); they scored one half standard deviation above the mean on each of the marginality subscales. Fifteen percent scored as *Traditional Mexicans*, indicating strong involvement in the Mexican culture (≥3.7; M=3.28, SD=.84) and less than average involvement in the Anglo culture (≤3.24; M=3.82, SD=.57). With the *Separation* typology, the percentage of people found to be separated from the Mexican (3%), Mexican American (7%), and Anglo (2%) culture was small. The percentages for the subtypology did not add up to 100 percent, since they must meet multiple typology and subtypology criteria. As a result, only a small percentage of the sample meet criteria for a subtypology (see Appendix B).

Table M1

Acculturative Types Formulated by ARSMA-II

Type	Number in Study Sample (N=60)	% of Total Sample
Acculturation Level (Scale 1)		
1.Very Mexican Orientation	7	12
2.Mexican Oriented to approximately Balanced Bicultural	14	23
3.Slightly Anglo Oriented Bicultural	29	48
4.Strongly Anglo Oriented	10	17
5.Very Assimilated/Anglicized	0	0
	60	100
Acculturative Types (Scales 1,2)		
1.Traditional Mexican	9	15
2.Integrated	37	62
3.Marginal	14	23
4.Separation	7	12
a.Mexican	2	3
b.Mexican American	4	7
c.Anglo	1	2
5.Assimilated (all types)	1	2

Note. Frequency and percentage numbers in acculturative types do not add to 100%, because not everyone who meets criteria for a major typology also meets criteria for a subtypology.

In summary, behaviorally, this sample was primarily Anglo-oriented (65%) and was integrated (62%) into both cultures (see Table M1). However, over one third of the sample had a Mexican orientation (35%), with only 12% identified as being Very Mexican oriented. When the AOS and MOS scores were combined, 62% of the respondents were Integrated Biculturals and 15% identified as Traditional Mexican. Although the rate was low (7%), there was a greater separation from Mexican American culture when compared to Mexican (3%) and Anglo culture (2%).

Level of Cognitive Referents of Acculturation (MACC-SF)

Individuals with scores below the mean of a cultural construct (Familism, Fatalism, Folk Beliefs, Machismo, and Personalismo) were identified as having a high level of cognitive acculturation (Anglo oriented) on the subscales, and scores above the mean were rated as having a low level of acculturation on the construct (Mexican oriented).

An examination of the frequency distributions of the subscales indicated that over half of the participants had scores above the mean on the fatalism (62%) and familism (53%)(see Table M2), indicating a Mexican orientation in their beliefs or cognitions or a low level of acculturation on these constructs. Less than half of the sample scored high in Machismo (47%), Folk Beliefs (45%), and Personalismo (45%). Overall, the percentages indicate that a large group of participants still hold Mexican oriented beliefs.

Table M2

Cultural Constructs Generated by the MACC-SF

Cultural Construct (N=60)	M of raw score	SD	Range	n	% above mean
*Familism	6.83	2.02	0-12	32	53
*Personalismo	6.50	1.85	0-11	27	45
Folk Beliefs	6.15	2.86	0-14	27	45
Machismo	5.65	2.98	0-17	28	47
*Fatalism	3.80	1.54	0-8	37	62

Results: Level of Behavioral Acculturation by Level of Cognitive Acculturation

A one-way ANOVA was conducted using the four behavioral acculturation groups as the independent or group variable for each of the five cultural constructs on the MACC-SF, the dependent variable. Significant differences were found for familism (FAM; F=3.52, p=.02), Personalism (PERSON; F-3.34, p=.03), and Folk Beliefs (FOLK; F-3.06, p=.04)(see Table M3). A post hoc Tukey HSD test (p<.05) confirmed that the differences were significant. The *Very Mexican Oriented* group had significantlyt higher means than the *Strongly Anglo Bicultural* in the three cultural constructs (see Table M4). The former group also differed significantly from the *Slightly Anglo Bicultural* in Familism.

Table M3

ANOVAs for Cultural Constructs by Acculturation Levels

Construct	df	Mean Square	F
			Between groups
Familism	3	12.70	3.52*
Folk Beliefs	3	22.63	3.06*
Personalismo	3	10.26	3.34*
			Within groups
Familism	56		3.61
Folk Beliefs	56		7.39
Personalismo	56		3.08

*p<.05

Table M4

Means, Standard Deviations, and Significant Differences of Cultural Constructs by Acculturation Level

Cultural Construct		Acculturation Level			
		1	2	3	4
*Familism					
N	60	7	14	29	10
M	6.83	*8.71*	7.29	*6.41	6.10*
SD	2.01	1.60	2.55	1.59	1.85
Fatalism					
N	60	7	14	29	10
M	5.65	4.71	3.79	3.55	3.90
SD	1.54	1.60	1.48	1.50	1.66
Machismo					
N	60	7	14	29	10
M	5.65	6.29	6.21	5.48	4.90
SD	2.98	3.15	3.17	3.10	2.38
*Folk Beliefs					
N	60	7	14	29	10
M	6.15	7.86*	7.07	5.93	4.30*
SD	2.86	2.04	3.41	2.48	2.71
*Personalismo					
N	60	7	14	29	10
M	6.50	7.71*	6.71	6.59	5.10*
SD					

Note. 1=Very Mexican; 2=Mexican oriented to balanced bicultural; 3=Slightly Anglo to Balanced Bicultural; 4=Strongly Anglo; 5=Assimilated/Anglicized

Type of Expectations by Level of Acculturation

Level of Behavioral Acculturation. Examination of the behavioral acculturation by expectation ANOVAs reveals that the four behavioral acculturation groups had lowexpectations for the therapist to engage in self-disclosure (see Table M5). A post hoc analysis using Tukey's honestly significant difference (HSD) procedure was performed on the self-disclosure scale. Group 1, the very Mexican (M=3.91, SD=.85), and group 3, the slightly Anglo orientation to balanced bicultural (M=2.11, SD=1.28), were found to be significantly different in the self-disclosure scale. Although the results were not significant, the four acculturation groups scored high on genuineness ($M \geq 6.0$), indicating that they expected a therapist to be genuine and sincere. The means ranged from 6.33 to 6.62 with group 1, the very Mexican group (M=6.62, SD=.73), having the highest scores. Group 2, the Mexican oriented to approximately balanced bicultural (M=6.45, SD=1.15), had scores between the other three groups; and groups 3 and 4, slightly Anglo oriented bicultural and strongly Anglo oriented, respectively, shared the lowest mean (M=6.33, SD=1.17) for genuineness.

The very Mexican (M=6.04, SD=.60) and the slightly Anglo oriented bicultural (M=6.13, SD=.85) respondents had the highest expectancy scores in the responsibility scale (making their own decisions). The Mexican oriented to

Table M5

Comparison of Expectations about Marriage and Family Therapy by Level of Behavioral Acculturation

Type of Expectations	Group 1 M (SD)	Group 2 M (SD)	Group 3 M (SD)	Group 4 M (SD)	F	p p<.05
Responsibility	6.04(0.60)	5.89(1.20)	6.13(0.85)	5.78(1.18)		NS
Openness	4.81(1.79)	5.17(2.28)	5.22(1.36)	5.40(1.40)		NS
Motivation	4.38(2.01)	5.17(1.86)	5.20(1.47)	5.33(1.66)		NS
Attractiveness	4.29(1.57)	4.17(1.55)	4.07(1.52)	3.63(1.18)		NS
Immediacy	5.25(2.04)	5.23(1.54)	5.54(1.14)	5.48(1.19)		NS
Concreteness	5.33(2.00)	4.95(1.83)	4.99(1.20)	5.00(1.58)		NS
Acceptance	5.05(1.65)	4.55(1.84)	4.44(1.51)	3.97(1.20)		NS
Confrontation	5.43(1.17)	5.33(1.59)	4.66(1.74)	4.83(1.60)		NS
Genuineness	6.62(0.73)	6.45(1.15)	6.33(0.74)	6.33(1.17)		NS
Tolerance	5.62(1.27)	4.81(1.82)	4.69(1.47)	3.97(1.15)		NS
Trustworthiness	5.71(2.10)	6.05(1.35)	5.94(1.04)	5.60(1.15)		NS
Directiveness	5.00(2.06)	4.17(1.94)	3.21(1.44)	4.03(1.81)		NS
Empathy	4.48(1.91)	3.76(1.79)	3.15(1.32)	3.83(1.81)		NS
Expertise	5.05(2.03)	4.86(1.79)	4.66(1.52)	4.37(1.45)		NS
Self-Disclosure	3.91(0.85)*	3.21(1.95)	2.11(1.28)*	3.00(1.71)	3.65	.018*
Nurture	5.33(1.47)	5.31(1.50)	4.87(1.53)	5.00(1.42)		NS
Outcome	5.91(1.58)	5.60(1.50)	5.64(1.13)	5.70(1.12)		NS
Factors***						
Commitment	5.14(1.49)	5.17(1.55)	5.26(0.98)	5.19(1.09)		NS
Facilitative	5.63(1.07)	5.36(1.31)	5.17(0.99)	4.95(0.87)		NS
Counselor Expert.	4.84(1.94)	4.26(1.71)	3.67(1.12)	4.08(1.61)		NS

Note. Group 1=Very Mexican; Group 2=Mexican oriented to balanced bicultural; Group 3= Slightly Anglo oriented bicultural; Group 4=Strongly Anglo oriented; Group 5=Assimilated/ Anglicized

approximately balanced bicultural expected the therapist to be trustworthy (M=6.05, SD=1.35). The slightly Anglo oriented bicultural participants scored highest in responsibility (M=6.13, SD=.85), with the very Mexican group having scores that were slightly lower (M=6.04, SD=.60). Low expectancy scale scores (<4.0) indicated weak expectations for attractiveness (M=3.63, SD=1.18), acceptance (M=3.97, SD=1.20), and tolerance (M=3.97, SD=1.15) by the strongly Anglo oriented respondents. Respondents in the slightly Anglo oriented bicultural had a low expectation that the therapist would be directive (M=3.21, SD=1.44). With the exception of the very Mexican group, respondents had low expectations that the therapist would have empathy (M ranged from 3.15 to 3.83, SD ranged from 1.32 to 1.81).

Examination of the ANOVAs on the three factors (Expectations of Personal Commitment, Expectations of Facilitative Conditions, and Expectations of Counselor Expertise) revealed no significant differences among the behavioral acculturation groups. The slightly Anglo oriented bicultural group revealed a low mean (<4.0) for the Counselor Expertise (M=3.67, SD=1.12) factor. There were no high expectancy scores (≥6.0) for any of the expectancy factors.

Level of Cognitive Acculturation. A one way ANOVA was also calculated using the acculturation groups derived from the MACC-SF. A post hoc analysis using Tukey's honestly

significant difference procedure was performed whenever a statistically significant interaction was discovered. The groups were defined by the number of high scores (above the mean) respondents had in the five cultural constructs, ranging from no high scores on any scale (0) to high scores in all of the scales (5). Higher scores indicated a Mexican orientation in beliefs or cognitions. Significant differences were found for 3 of the 17 expectancy scales (see Table M6). Respondents with low scores on all of the five constructs (group 0, Assimilated/Anglicized; M=3.17, SD=1.56) were significantly different from individuals scoring low on none of the constructs (group 5, Very Mexican oriented; M=5.52, SD=1.06) in acceptance (F=2.40, df=5.59, p=.049). The Mexican oriented group had higher expectations for the therapist to think of them as worthwhile. The expectations for tolerance (F=3.67, p=.006) were found to be significantly different between group 0 (Assimilated/ Anglicized; M=3.50, SD=1.94) and group 5 (Mexican oriented; M=5.73, SD=1.12) and between group 3 (Slightly Anglo oriented bicultural; M=3.83, SD=1.11) and group 1. The scores reveal that expectancy for tolerance from the therapist was stronger for groups that held low scores in one or two of the cultural constructs, indicating a more Anglo oriented belief system. Although the empathy scores were low, Group 1, the Mexican oriented group (M=4.64, SD=1.59) had significantly higher scores in the empathy

Table M6

Comparison of Expectations about Marriage and Family Therapy by Level of Cognitive Acculturation

Type of Expectations (df=5,59)(.05)	*0 M (SD)	1 M (SD)	2 M (SD)	3 M (SD)	4 M (SD)	5 M (SD)	F	p p<.05
Responsibility								NS
Openness								NS
Motivation								NS
Attractiveness								NS
Immediacy								NS
Concreteness								NS
Acceptance		*4.93	*5.52	4.40	4.05	4.48	3.17	2.40
	(.55)	(1.06)	(1.61)	(1.64)	(1.59)	(1.56)	.049	
Confrontation								NS
Genuineness								NS
Tolerance	5.07	*5.73	5.16	*3.83	4.67	*3.50	3.67	.006
	(1.28)	(1.12)	(1.57)	(1.11)	(1.29)	(1.94)		
Trustworthiness								NS
Directiveness								NS
Empathy	3.27	*4.64	3.44	3.48	3.93	*1.78	3.04	.02
	(1.52)	(1.59)	(1.52)	(1.66)	(1.43)	(0.40)		
Expertise								NS
Self-Disclosure								NS
Nurture								NS
Outcome								NS
Factors***								NS

table continues

Table M6 continued

Note. Groups are: 0=Very Mexican oriented (low scores on none of the cultural constructs (Familism, Fatalism, Personalismo, Machismo, and Folk Illness/Beliefs; 1=Mexican oriented (low scores on 1:5 cultural constructs); 2=Mexican oriented to approximately balanced bicultural (low scores on 2:5 cultural constructs); 3=Slightly Anglo oriented bicultural (low scores on 3:5 cultural constructs); 4=Strongly Anglo (low scores on 4:5 cultural constructs); 5=Assimilated/Anglicized (low scores on all five cultural constructs). ***Factors: None were significant--Personal Commitment, Facilitative Conditions, and Counselor Expertise.

scale (F=3.04, p=.017) when compared to group 5, the Assimilated/Anglicized respondents (M=1.78, SD=.40).

Type of Expectations of MFT Services

Level of Behavioral Acculturation. The predicted positive relationship between acculturation level and expectations about MFT services was partially supported. The measure of acculturation (behavioral, cognitive, and integrated) did make a difference in the number and the type of expectations that were found to be significantly related. The respondents in the sample had low expectations for the therapist to engage in self-disclosure and high expectations for the therapist to be genuine when it was based on behavioral acculturation. When the cognitive acculturation measure was examined, the only consensus across acculturation groups was the low expectation for the therapist to be empathetic.

Behavioral Acculturation and Expectations. Although expectations for self-disclosure were low across grouops, a significant difference was found between the "very Mexican" group and the "slightly Anglo to balanced bicultural" group, with the former having higher expectations than the latter group. Significant differences were not found, but the expectancy mean for the therapist to be genuine increased as respondents became increasingly Mexican oriented. Two other expectations that had means over 6.0 but were not significantly different from other behavioral acculturation groups were (a) responsibility in the very Mexican and slightly Anglo to balanced bicultural groups and (b) trustworthiness in the Mexican oriented group. Another interesting finding that did not reveal any significant differences was the high number of low expectations in the Strongly Anglo group that included attractiveness, acceptance, tolerance, empathy, and the nurturance factor.

Table M7

Use of Counseling Services by Behavioral and Cognitive Acculturation (N=60)

Type of Acculturation	Counseling (%)		A^2	DF	P
	Used	NoUse			
Behavioral:ARSMA-II			6.77	3	.079
Very Mexican oriented	0	11.7			
Mexican oriented to approx. bal. bicult.	10.0	13.3			
Sl. Anglo to bicult.	23.3	25.0			
Strongly Anglo	10.0	6.7			
Assimilated/Anglicized	0	0			
Total	43.3	57.7			
Cognitive:MACC-SF			10.80	5	.056
Very Mexican oriented	0	10.0			
Mexican oriented	10.0	5.0			
Mexican oriented to approx. bal. bicult.	11.7	11.7			
Sl. Anglo oriented bicultural	15.0	10.0			
Strongly Anglo orient.	5.0	13.3			
Very Assim./Anglicized	1.7	6.7			
Total	43.3	56.7			

Note. Behavioral Acculturation scores from the ARSMA-II and Cognitive Acculturation scores from the MACC-SF.

Table M8

Use of Marriage and Family Therapy (MFT) Services by Behavioral and Cognitive Acculturation (N=60)

Type of Acculturation	Counseling (%)		A^2	DF	P
	Used	NoUse			
Behavioral:ARSMA-II			2.59	3	.459
Very Mexican oriented	0	11.7			
Mexican oriented to approx. bal. bicult.	5.0	18.3			
Sl. Anglo to bicult.	8.3	40.0			
Strongly Anglo	5.0	11.7			
Assimilated/Anglicized	0	0			
Total	18.3	81.7			
Cognitive:MACC-SF			0.293	5	.998
Very Mexican oriented	1.7	8.3			
Mexican oriented	3.3	11.7			
Mexican oriented to approx. bal. bicult.	3.3	20.0			
Sl. Anglo oriented bicultural	5.0	20.0			
Strongly Anglo orient.	3.3	15.0			
Very Assim./Anglicized	1.7	6.7			
Total	18.3	81.7			

Note. Behavioral Acculturation scores from the ARSMA-II and Cognitive Acculturation scores from the MACC-SF.

REFERENCES

References

Acosta, F. X., & Sheehan, J. G. (1976). Preferences toward Mexican-American and Anglo-American psychotherapists. *Journal of Consulting and Clinical Psychology, 44,* 272-279.

Acosta, F., Yamamoto, J., & Evans, L. (1982). *Effective psychotherapy for low-income and minority patients.* New York: Plenum.

American Association for Marriage and Family Therapy. (1997). *The consumer's guide to marriage and family therapy.* Washington, D.C.: Author.

American Association for Marriage and Family Therapy. (1997, April). How MFTs compare to other disciplines. *Family Therapy News,* pp. 16-17, 26.

Antonucci, T. C. (1985). Personal characteristics, social support, and social behavior. In R. H. Binstock & E. Shanas (Eds.), *Handbook of aging and the social sciences* (pp. 94-128). New York: Van Nostrand Reinhold.

Apfelbaum, D. (1958). *Dimensions of transference in psychotherapy.*. Berkeley: University of California Press.

Aponte, R., & Siles, M. E. (1996). *Latinos to emerge as largest U.S. minority in the coming decade* [NEXO, the Newsletter of Research Institute]. East Lansing: MI: Julian Samora Research Institute.

Arnold, B., & Cuéllar, I. (1985). Development of a bilingual multiphasic inventory for measurement of clinically relevant constructs in the Mexican American culture. Unpublished manuscript, University of Texas-Pan Am.

Aronson Fontes, L., & Thomas, V. (1996). Cultural issues in family therapy. In F.P Piercy, D.H. Sprenkle, & J.L. Wetchler (Eds.), *Family Therapy Sourcebook* (pp. 256-282). New York: Guilford Press.

Bandura, A. (1986). Fearful expectations and avoidant reactions as coeffects of perceived self-inefficiency. *American Psychologists, 41,* 1389-1391.

Bean, R., & Crane, D. R. (1996). Marriage and family therapy research with ethnic minorities: Current status. *American Journal of Family Therapy, 24,* 3-8.

Berg, I. K., & Jaya, A. (1993). Different and same: Family therapy with Asian-American families. *Journal of Marital and Family Therapy, 19,* 31-38.

Berry, J. W. (1980). Acculturation as varieties of adaptation. In A. M. Padilla (Ed.), *Acculturation: Theories, models, and some new findings* (pp. 9-25). Boulder, CO: Westview.

Berry, J. W. (1994). Acculturation stress. In J. W. Lonner & R. Malpass (Eds.), *Psychology and culture.* Boston: Allyn and Bacon.

Berry, J. W., & Kim, U. (1988). Acculturation and mental health. In P. R. Dasen, J. W. Berry & N. Sartorious (Eds.), *Health and Cross-Cultural Psychology* (pp. 207-236). London: Sage.

Bloom, B. (1964). *Stability and change in human characteristics.* New York: Wiley.

Bograd, M. (1984). Family systems approaches to wife battering: A feminist critique. *American Journal of Orthopsychiatry, 54,* 558-568.

Bograd, M. (1990). Feminist approaches for men in family therapy: Special issue. *Journal of Feminist Family Therapy, 2,* 314.

Bograd, M. (1992). Values in conflict: Challenges to family therapists' thinking. *Journal of Marital and Family Therapy, 18,* 245-256.

Boyd-Franklin, N. (1989). *Black families in therapy: A multisystems approach.* New York: Guilford.

Braverman, L. (1990). Ethnicity and mothers: Special Issue. *Journal of Feminist Family Therapy, 2.*

Breunlin, D. C., & Schwartz, R. C., & MacKune-Karrer, B. (1992). *Metaframeworks: Transcending the models of family therapy.* San Francisco: Jossey-Bass.

Brislin, R. W. (1970). Back-translation for cross-cultural research. *Journal of Cross-Cultural Psychology, 1,* 185-216.

Bubolz, M. M., & Sontag, M. S. (1993). Human ecology theory. In P. G. Boss, W. J. Doherty, R. LaRossa, W. R. Schumm, & S. K. Steinmetz (Eds.), *Sourcebook of family theories and methods: A contextual approach* (pp. 419-447). New York: Plenum Press.

Buhrke, R. A., & Jorge, M. (1992, August). A Spanish version of the expectations about counseling questionnaire: Translation and validation. *Hispanic Journal of Behavioral Sciences, 14* (3), 363-372.

Burnam, M., Telles, C. A., Karno, M., Hough, R. L., & Escobar, J. I. (1987). Measurement of acculturation in a community population of Mexican Americans. *Hispanic Journal of Behavioral Sciences, 9,* 105-130.

Butcher, J. N. (1982). Cross cultural research methods in clinical psychology. In P. C. Kendall & J. N. Butcher (Eds.), *Handbook of research methods in clinical psychology* (pp. 273-308). New York: Wiley.

Catell, R. B. (1940). A culture free intelligence test. *Journal of Educational Psychology, 31,* 61-179.

Cherbosque, J. (1987). Differences between Mexican and American clients in expectations about psychological counseling. *Journal of Multicultural Counseling and Development, 15,* 110-114.

Cohen, E. (1993, August). Acculturation: A common thread among Latinos. *Family Therapy News, 24*(4), 13-14.

Comas-Diáz, L., & Greene, B. (1994). *Women of color: Integrating ethnic and gender identities in psychotherapy.* New York: Guilford Press.

Cuéllar, I., Arnold, B., & Gonzalez, G. (1995, October). Cognitive referents of acculturation: Assessment of cultural constructs in Mexican Americans. *Journal of Community Psychology, 23,* 339-356.

Cuéllar, I., Arnold, B., & Maldonado, R. (1995, August). Acculturation rating scale for Mexican Americans-II: A revision of the original ARSMA scale. *Hispanic Journal of Behavioral Sciences, 17*(3), 275-304.

Cuéllar, I., Harris, L. C., & Jasso, R. (1980). An acculturation scale for Mexican-American normal and clinical populations. *Hispanic Journal of Behavioral Sciences, 2,* 199-217.

Dienhart, A., & Myers Avis, J. (1994). Working with men in family therapy: An exploratory study. *Journal of Marriage and Family Therapy, 20*(4), 397-417.

Dillworth-Anderson, P., Burton, L. M., & Turner, W. L. (1993, July). The importance of values in the study of culturally diverse families. *Family Relations, 42*(3), 238-242.

Doherty, W. J., & Baptiste, J., D. A. (1993). Theories Emerging from Family Therapy. In P. G. Boss, R. L. W. J. Doherty, W. R. Schumm & S. K. Steinmetz (Eds.), *Sourcebook of Family Theories and Methods: A Contextual Approach* (pp. 505-524). New York: Plenum Press.

Doherty, W. J., & Simmons, D. S. (1996, January). Clinical practice patterns of marriage and family therapists: A national survey of therapists and their clients. *Journal of Marriage and Family Therapy, 22*(1),9-25.

Domino, G., & Acosta, A. (1987). The relation of acculturation and values in Mexican Americans. *Hispanic Journal of Behavioral Sciences, 9,* 131-150.

Eaton, W. W., & Kessler, L. G. (1985). *Epidemiologic field methods in psychiatry: The NIMH Epidemiologic Catchment Area program.* Orlando, FL: Academic Press.

Ekstrand, L. H., & Ekstrand, G. (1986). Developing the emic/etic concepts for cross-cultural research. In L. H. Ekstrand (Ed.), *Ethnic Minorities and Immigrants in a Cross-Cultural Perspective: Selected papers from a Regional Conference of the International Association for Cross-Cultural Psychology* (pp. 52-65).

Falicov, C. J. (Ed.). 1983). Cultural perspectives in family therapy. Rockville, MD: Aspen Systems Corporation.

Falicov, C. J. (1988). Learning to think culturally. In H. A. Liddle, D. C. Breunlin, & R. C. Schwartz (Eds.), *Handbook of family therapy training and supervision.* New York: Guilford Press.

Festinger, L. A. (1957). *A theory of cognitive dissonance.* Evanston, IL: Row, Peterson.

Fine, M. A. (1993). Current approaches to understanding family diversity: An overview of the special issue. *Family Relations, 42,* 235-237.

Fischman, G., Fraticelli, B., Newman, D. E., & Sampson, L. M. (1983). Day treatment programs for the Spanish speaking: A response to underutilization. *International Journal of Social Psychiatry, 29,* 215-219.

Fisher, C. B., Jackson, J. F., & Villarruel, F. A. (in press). The study of ethnic minority children and youth in the U.S. In R. M. Lerner (Ed.), *Theoretical models of human development, Vol. 1 of the Handbook of Child Psychology.* New York: Wiley.

Flaskerud, J. H., & Liu, P. Y. (1991). Effects of an Asian client-therapist language, ethnicity, and gender match on utilization and outcome of therapy. *Community Mental Health Journal, 27*(1), 31-42.

Flores-Oritz, Y., & Bernal, G. (1989). Contextual family therapy of addiction with Latinos. In G. W. Saba, B. M. Karrer & K. V. Hardy (Eds.), *Minorities and family therapy* (pp. 123-142). New York: Haworth.

Franco, J. N. (1938). An acculturation scale for Mexican American children. Journal of General Psychology, 100, 175-181.

Franco, J. N., Malloy, T., & Gonzalez, R. (1984). Ethnic and acculturation differences in self-disclosure. *Journal of Social Psychology, 122,* 21-32.

Globalink Power Translator for Window 3.1. (1996). Fairfax, VA: Globalink, Inc.

Goldberg, J. R. (1993a). Is multicultural therapy in sight? *Family Therapy News, 24*(1), 7-8.

Goldberg, J. R. (1993b). Working with African-American families. *Family Therapy News, 24*(11).

Golding, J. M., & Baezconde-Barbanati, L. A. (1990). Ethnicity, culture, and social resources. *American Journal of Community Psychology, 18*(3), 465-486.

Golding, J. M., & Burnam, M. (1990). Immigration, stress, and depressive symptoms in a Mexican-American community. *Journal of Nervious and Mental Disease, 178*(3), 161-171.

Goldner, V. (1985). Warning: Family therapy may be hazardous to your health. *Family Therapy Networker, 9*(6), 19-23.

Graves, T. D. (1967). Acculturation, access and alcohol in a tri-ethnic community. *American Anthropologist, 69,* 306-321.

Green, S. K., & Bobele, M. (1994). Family therapists' response to AIDS: An examination of attitudes, knowledge, and contact. *Journal of Marriage and Family Therapy, 20*(4), 349-367.

Gregory, M., & Leslie, L. A. (in press). Different lenses: Variation in clients' perception of therapy by race and gender. *Journal of Marital and Family Therapy, 16,* 307-319.

Griffith, J., & Villavicencio, S. (1985). Relationship among acculturation, sociodemographic characteristics and social support in Mexican American adults. *Hispanic Journal of Behavioral Sciences,* 7 (1), 79-92.

Gurman, A. S. (1981). Sources of influence in the family therapy field: Publication trends in three major journals. *Journal of Marital and Family Therapy, 7,* 81-86.

Gurman, A. S., & Kniskern, D. P. (1991). Family therapy outcome research: Knowns and unknowns. In A. S. Gurman & D. P. Kniskern (Eds.), *Handbook of family therapy* (Vol. 1). New York: Brunner/Mazel.

Gutierrez, L., Ortega, R. M., & Suarez, Z. (1990). Self-help and the Latino community. In T. Powell (Ed.), *Working with self-help* (pp. 218-236). Silver Spring, MD: National Association of Social Work Press.

Hardy, K. V. (1989). The theoretical myth of sameness: A critical issue in family therapy treatment and training. In G. W. Saba, B. M. Karrer, & K. V. Hardy (Eds.), Minorities and Family Therapy. New York: Haworth.

Hayes, T. J., & Tinsley, H. E. (1989). Identification of the latent dimensions of instruments that measure perceptions of and expectations about counseling. *Journal of Counseling Psychology, 36,* 492-500.

Herrera, R. S., DelCampo, R. L., & Ames, M. H. (1993, July). A serial approach for translating family science instrumentation. *Family Relations, 42* (3), 357-360.

Herrin, D. A., & Wright, S. C. (1988). Precursors to a family ecology: Interrelated threads of ecological thought. *Family Science Review, 1,* 163-184.

Hurtado, A., & Arce, C. H. (1987). Mexicans, Chicanos, Mexican Americans, or Pochos..Que somos? *Aztlan, 17* (1), 103-130.

Ho, M. K. (1987). *Family therapy with ethnic minorities.* Newbury Park, CA: Sage Publications.

Kagawa-Singer, M., & Chi-Yung Chung, R. (1994). A paradigm for culturally based care in ethnic minority populations. *Journal of Community Psychology, 22,* 192-208.

Kaplan, M. S., & Marks, G. (1990). Adverse effects of acculturation: Psychological distress among Mexican American young adults. *Social Science Medicine?? 31* (12), 1313-1319.

Karrer, B. (1987). Families of Mexican descent: A contextual approach. In R. B. Birrer (Ed.), *Urban family medicine.* New York: Springer-Verlag.

Kaufman, G. (1992). The mysterious disappearance of battered women in family therapists' offices: Male privilege colluding with male violence. *Journal of Marital and Family Therapy, 18,* 233-244.

Keefe, S. E. (1979). Mexican Americans' underutilization of mental health clinics: An evaluation of suggested explanations. *Hispanic Journal of Behavioral Sciences, 1,* 93-115.

Keefe, S. E., & Casas, J. M. (1980). Mexican Americans and mental health: A selected review and recommendations for mental health service delivery. *American Journal of Community Psychology, 8,* 303-326.

Keefe, S. E., Padilla, A. M., & Carlos, M. L. (1979). The Mexican-American extended family as an emotional support system. *Human Organization, 38,* 144-152.

Kluckhohn, F. R., & Strodtbeck, F. L. (1961). *Variations in value orientations.* Evanston, IL: Row Patterson.

Kunkel, M. A. (1990). Expectations about counseling in relation to acculturation in Mexican-American and Anglo-American student samples. *Journal of Counseling Psychology, 37,* 286-292.

Kunkel, M. A., Hector, M. A., Coronado, E. G., & & Vales, V. C. (1989). Expectations about counseling in Yucatan Mexico: Toward a "Mexican psychology." *Journal of Counseling Psychology, 36,* 322-330.

LaFramboise, T., Hardin, L., Coleman, K., & Gerton, J. (1993). Psychological impact of biculturalism: Evidence and theory. *Psychological Bulletin, 114,* 395-412.

Leaf, P. J., Livington Bruce, M., Tischler, G. L., & Holzer, I., C. E. (1987). The relationship between demographic factors and attitudes toward mental health services. *Journal of Community Psychology, 15,* 275-284.

Leslie, L. A. (1995). Psychotherapy: The evolving treatment of gender, ethnicity, and sexual orientation in marital and family therapy. *Family Relations, 44,* 359-367.

LeVine, E., & Franco, J. N. (1981). A reassessment of self-disclosure patterns among Anglo Americans and Hispanics. *Journal of Counseling Psychology, 28,* 522-524.

Levine, E. S., Padilla, A. M. (1980). Crossing cultures in therapy: Pluralistic counseling for the Hispanic. Los Angeles: Brooks/Cole Publishing Co.

Levine, M., Toro, P. A., & Perkins, D. V. (1993). Social and community interventions. In L. W. Porter (Ed.), *Annual review of psychology* (pp. Vol. 44, 525-558). Palo Alto, CA: Annual Reviews Inc.

Lin, K. M. (1982). Social cultural determinates of the helpseeking behavior of patients with mental illness. *Journal of Nervous and Mental Disease, 170,* 78-85.

Manderscheid, R. W., & Sonnenchein, M. A., (Eds.). (1996). *An update on human resources in mental health* [DHHS Pub. No. (SMA)96-3098]. Washington, D.C.: Supt. Of Documents., U. S. Government Printing Office.

Marin, B. V., Marin G., Padilla, A. M., & de la Rocha, C. (1983). Utilization of traditional and non-traditional sources of health care among Hispanics. *Hispanic Journal of Behavioral Sciences, 1,* 65-80.

Marin, G. (1992). Issues in the measurement of acculturation among Hispanics. In K. F. Geisinger (Ed.), APA Science Volume XVII: Psychological testing of Hispanics (pp. 235-251). Washington, D. C.: American Psychological Association.

Marin, G. (1993). Influence of acculturation on familialism and self-identification among Hispanics. In M. E. Bernal & G. P. Knight (Eds.), *Ethnic identity: Formation and transmission among Hispanics and other minorities* (pp. 181-196). New York: State University of New York Press.

Marin, G., & Marin, B. V. (1991). *Research with Hispanic populations.* Newberry Park, CA: Sage Publications.

Marin, G., Sabogal, F., VanOss Marin, B. V., Otero-Sabogal, R., & Perez-Stable E. J. (1987). Development of a short acculturation scale for Hispanics. *Hispanic Journal of Behavioral Sciences, 9,* 183-205.

Marin, G., & VanOss Marin, B. (1991). *Research with Hispanic populations.* Newberry Park, CA: Sage Publications.

Markides, K. S., & Coreil, J. (1986). The health of Hispanics in the Southwestern states: An epidemiological paradox. *Public Health Reports, 101,* 253-265.

Martinez, J. L. (Ed.). (1977). *Chicano psychology.* New York: Academic Press.

Martinez, K. J. (1994, February). Cultural sensitivity in family therapy gone awry. *Hispanic Journal of Behavioral Sciences, 16* (1), 75-89.

McAdoo, H. P. (1993). *Family ethnicity: Strength in Diversity.* Newbury Park, CA: Sage.

McGoldrick, M., Giordano, J., & Pearce, J. K. (1996). *Ethnicity and family therapy.* New York: Guilford Press.

McGoldrick, M., Pearce, J. K., & Giordano, J. (1982). *Ethnicity and family therapy.* New York: Guilford.

McGoldrick, M., Preto, N. G., Hines, P. M., & Lee, E. (1991). Ethnicity and family therapy. In A. S. Gurman & D. P. Kniskern (Eds.), *Handbook of family therapy.* [Vol. 2]. New York: Brunner/Mazel.

Medvene, L. J., Mendoza, R., Lin, K., Harris, N., & Miller, M. (1995, October). Increasing Mexican American attendance of support groups for parents of the mentally ill: Organizational and psychological factors. *Journal of Community Psychology, 23,* 307-325.

Melville, M. B. (1988). Hispanics: Race, class, or ethnicity? *The Journal of Ethnic Studies, 16* (1).

Michigan Census Department of Population & Housing. (1990). *Eaton County* [Electronic data tape, Summary Tape File 3A]. Lansing: Author.

Michigan Census Department of Population & Housing. (1990). *Ingham County* [Electronic data tape, Summary Tape File 3A]. Lansing: Author.

Michigan Jobs Commission. (1988). *Michigan occupational information system index* (pp. 31-34). Lansing: Author.

Mindel, C. H., & Wright, R. J. (1982). The use of social services by black and white elderly: The role of social support systems. *Journal of Gerontological Social Work, 4*, 107-120.

Montgomery, G. T. (1992). Comfort with acculturation status among students from south Texas. *Hispanic Journal of Behavioral Sciences, 14*, 201-223.

Naden, M., Rasmussen, K., Morrissette, P., & Johns, K. (1997). Sources of influence and topic areas in family therapy: Trends in three major journals. *Journal of Marriage and Family Therapy, 23* (4), 389-398.

Neff, J. A., & Keir Hoppe, S. (1993, January). Race/ethnicity, acculturation, and psychological distress: Fatalism and religiosity as cultural resources. *Journal of Community Psychology, 21,* 3-20.

Negy, C., & Woods, D. J. (1992a). The importance of acculturation in understanding research with Hispanic Americans. *Hispanic Journal of Behavioral Sciences, 12*, 224-247.

Negy, C., & Woods, D. J. (1992b). A note on the relationships between acculturation and socio-economic status. *Hispanic Journal of Behavioral Sciences, 14*, 248-251.

Odell, M., Shelling, G., Scott Young, K., Hewitt, D. H., & L'Abate, L. (1994). The skills of the marriage and family therapist in straddling multicultural issues. *The American Journal of Family Therapy, 22*(2), 145-155.

Olmedo, E. L., Martinez, J. L., & Martinez, S. R. (1978). Measure of acculturation for Chicano adolescents. *Psychological Reports, 42,* 159-170.

Orozco, S., Thompson, B., Kapes, J., & Montgomery, G. T. (1993). Measuring the acculturation of Mexican Americans: A covariance structure analysis. *Measurement and Evaluation in Counseling and Development, 25,* 149-155.

O'Sullivan, M. J., Peterson, P. D., Cox, G. B., & Kirkeby, J. (1989). Ethnic populations: Community mental health services ten years later. *American Journal of Community Psychology, 17,* 17-30.

Overmeier, J. B. (1988). *Expectations: From animal laboratory to the clinic.* Paper presented at the meeting of the Midwestern Psychological Association, Chicago, IL.

Padilla, A. M. (1971). Psychology and the Mexican American: An awareness of cultural and social factors. In *Effects of Cultural Variables on the Mexican American.* Symposium conducted at the annual meeting of the American Psychological Association, Washington, D. C.

Padilla, A. M. (1980). The role of cultural awareness and ethnic loyalty in acculturation. In A. M. Padilla (Ed.), *Acculturation: Theory, models and some new findings* (pp. 47-84). Boulder, CO: Westview.

Padilla, A. M. (1995). *Hispanic psychology: Critical issues in theory and research.* Thousand Oaks, CA: Sage.

Padilla, A. M., & Lindholm, K. J. (1984). Hispanic behavioral science research: Recommendations for future research. *Hispanic Journal of Behavioral Sciences, 6,* 13-22.

Phinney, J. (1991). The multigroups ethnic identify measure: A new scale for use with adolescents and adults from diverse groups. Unpublished manuscript.

Piercy, F. P., & Sprenkle, D. H. (1990). Marriage and family therapy: A decade review. *Journal of Marriage and the Family, 52* (4), 1116-1126.

Pike, K. (1954). *Language in relation to a unified theory of the structure of human behavior.* The Hague: Mouton & Co.

Pinderhughes, E. (1982). Afro-American families and the victim system. In J. K. McGoldrick, J. K. Pearce, & J. Giordano (Eds.), *Ethnicity and family therapy.* New York: Guilford Press.

Pinsof, W. M. (1991). Family therapy process research. In A. S. Gurman & D. P. Kniskern (Eds.), *Handbook of Family Therapy* (Vol. 1). New York: Brunner/Mazel.

Pittman, F. S. (1991). The secret passion of men. *Journal of Marital and Family Therapy, 17,* 17-24.

Ponce, F. Q., & Atkinson, D. R. (1989). Mexican-American acculturation, counselor ethnicity; counseling style; and perceived counselor credibility. *Journal of Counseling Psychology, 36,* 203-208.

Ponterotto, J. H. (1987). Counseling Mexican Americans: A multimodal approach. *Journal of Counseling and Development, 65,* 308-312.

Pope B., Seigman, A., Blass, T., & Cheek, J. (1972). Some effects of discrepant role expectations on interviewee verbal behavior in the initial interview. *Journal of Consulting and Clinical Psychology, 39,* 501-507.

Postman, L. (1951). Toward a general theory of cognition. In J. H. Rohrer & M Sherif (Eds.), *Social psychology at the crossroads.* New York: Harper & Row.

Price-Williams. (1987, July). Summary: Culture, socialization, and mental health. *Journal of Community Psychology, 15,* 357-361.

Raymond, J. S., Rhoads, D. L., & Raymond, R. I. (1980). The relative impact of family and social involvement on Chicago mental health. *American Journal of Community Psychology, 8,* 557-569.

Redfield, R., Linton, R., & Herskovits, M. J. (1936). Memorandum for the study of acculturation. *American Anthropologist, 38,* 149-152.

Regier, D. A., Myers, J. K., Kramer, M., Robins, L. N., Blazer, D. G., Hough, R. L., Eaton, W. W., & Locke, B. Z. (1984). The NIMH Epidemiologic Catchment Area Program: Historical context, major objectives, and study population characteristics. *Archives of General Psychiatry, 41,* 934-941.

Roberts, J. (1993). *AFTA resource packet: Honoring and working with diversity in family therapy.* [#273]. Washington, D. C.: American Family Therapy Academy.

Robinson, F. P. (1950). *Principles and procedures in student counseling.* New York: Harper & Row.

Rode, L. T. (1979). *The effects of counselor age, physical attractiveness and attire on subjects' perceptions of counselor characteristics.* Unpublished Master's Thesis, Southern Illinois University.

Rogler, L. H. (1989). The meaning of culturally sensitive research in mental health. *American Journal of Psychiatry, 146,* 296-303.

Rogler, L., Cortes, D., & Malgady, R. (1991). Acculturation and mental health status among Hispanics: Convergence and new directions for research. *American Psychologist, 46,* 585-597.

Rogler, L. H., Malgady, R. G., Constantino, G., & Blumenthal, R. (1987). What do culturally sensitive mental health services mean? The case of Hispanics. *American Psychologist, 42* (6), 565-570.

Rogler, L. H., Malgady, R. G., & Rodriquez, O. (1989). *Hispanics and mental health: A framework for research.* Malabar, FL: Roger E. Krieger.

Rueschenberg, E., & Buriel, R. (1989). Mexican American family functioning and acculturation: A family systems perspective. *Hispanic Journal of Behavioral Sciences, 11* (3), 232-244.

Ruiz, R. A. (1977). The delivery of mental health and social change services for Chicanos: Analysis and recommendations. In J. L. Martinez (Ed.), *Chicano Psychology.* New York: Academic Press.

Ruiz, R. A., & Padilla, A. M. (1977, March). Counseling Latinos. *Personnel and Guidance Journal,* pp. 401-408.

SPSS, Inc. (1994). Statistical Package for the Social Sciences. [computer software]. Chicago: Author.

Saba, G. W., Karrer, B. M., & Hardy, K. V. (Eds.). (1989). *Minorities and family therapy.* Binghamton, NY: Haworth.

Sabogal, R., Marín, G., Otero-Sabogal, R., Marín, B. V., & Pérez-Stable, E. J. (1987). Hispanic familialism and acculturation: What changes and what doesn't? *Hispanic Journal of Behavioral Sciences, 9,* 397-412.

Sabogal, F., Pérez-Stable, E. J., Otero-Sabogal, R., & Hiatt, R. A. (1995, May). Gender, ethnic, and acculturation differences in sexual behaviors: Hispanic and non-Hispanic White adults. *Hispanic Journal of Behavioral Sciences, 17* (2), 139-159.

Saenz, S. (1984). An assessment of the mental health needs of Hispanics in Michigan. Lansing: Michigan Department of Mental Health.

Salgado de Snyder, V. N. (1986). *Mexican immigrant women: The relationship of ethnic loyalty, self-esteem, social support, and satisfaction to acculturative stress and depressive symptomatology*. Unpublished doctoral dissertation, Los Angeles, School of Social Welfare: University of California.

Santiago, A. M., Villarruel, F. A., & Leahy, M. J. (1996). Latino access to rehabilitation services: Evidence from Michigan. *Journal American Rehabilitation, 22,* 10-18.

Schumm, W. R., McCollum, E. E., Bugaighis, Jurich, A. P., Bollman, S. R., & Reitz, J. (1988). Differences between Anglo and Mexican American family members on satisfaction with family life. *Hispanic Journal of Behavioral Sciences, 10,* 39-53.

Sena-Rivera, J. (1976). *Casa and familia: An alternative model of the traditional extended family--A report on exploratory investigation*. Paper presented. annual meeting of the American Sociological Association, New York.

Shortz, J. L., Worthington, E. L., McCollough, M. E., Kurusu, T., Bryant, W., & DeVries, H. (1994). Is there more to counting than what meets the eye? Comment on Snyder and Rice. *Journal of Marriage and Family Therapy, 20,* 197-202.

Snowden, L., & Lieberman, M. (1994). African American participation in self-help groups. In T. J. Powell (Ed.), *Self-help and mutual aid groups: International and multicultural perspectives* (pp. 50-61). New York: Haworth Press.

Snyder, D. K., & Rice, J. L. (1994). There's more to counting than meets the eye: Comment on Shortz et al. *Journal of Marriage and Family Therapy, 20,* 191-196.

Soto-Fulp, S., & DelCampo, R. L. (1994, October). Structural family therapy with Mexican-American family systems. *Contemporary Family Therapy, 16* (5), 349-362.

Starrett, R. A., Todd, A. M., Decker, J. T., & Walters, G. (1989). The use of formal helping networks to meet the psychological needs of Hispanic elderly. *Hispanic Journal of Behavioral Sciences, 11* (3), 259-273.

Subich, L. M., & Hardin, S. I. (1985). Counseling expectations as a function of fee for service. *Journal of Counseling Psychology, 32,* 323-328.

Sue, S. (1977). Community mental health services to minority groups: Some optimism, some pessimism. *American Psychologist, 32,* 616-624.

Sue, S. (1992). Ethnicity and mental health: Research and policy issues. *Journal of Social Issues, 48,* 187-205.

Sue, S., Fujino, D. C., Hu, L., Takeuchi, D. T., & Zane, N. (1991). Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis. *Journal of Consulting and Clinical Psychology, 59*(4), 533-540.

Sue, S., & Morishima, J. K. (1982). *The mental health of Asian Americans.* San Francisco: Jossey-Bass.

Sue, S., & Zane, N. (1987). The role of cultural and cultural techniques in psychotherapy: A critique and reformulation. *American Psychologist, 42,* 37-45.

Szapocznik, J., & Kurtines, W. (1980). Acculturation, biculturalism and adjustment among Cuban Americans. In A. M. Padilla (Ed.), Acculturation: Theory, models, and some new findings (pp. 139-159). Boulder, CO: Westview.

Tinsley, D. J., Holt, M. S., Hinson, J. A., & Tinsley, H. E., A. (1991, October). A construct validation study of the expectations about counseling-brief form: Factorial Validity. *Measurement and Evaluation in Counseling and Development, 24,* 101-110.

Tinsley, H. E., A. (1982). Expectations about counseling [Test manual, Unpublished manuscript]. Southern Illinois University, Department of Psychology, Carbondale, IL.

Tinsley, H. E., A., Bowman, S. L., & Ray, S. B. (1988). Manipulation of expectancies about counseling and psychotherapy: Review and analysis of expectancy manipulation strategies and results. *Journal of Counseling Psychology, 35,* 99-108.

Tinsley, H. E., A., Bowman, S. L., & Westcot Barich, A. (1993). Counseling psychologists' perceptions of the occurrence and effects of unrealistic expectations about counseling and psychotherapy among their clients. *Journal of Counseling Psychology, 40* (1), 46-52.

Tinsley, H. E., A., Brown, M. T., De St. Aubin, T. M., & Lucek, J. (1984). The relationship between expectancies for a helping relationship and tendency to seek help from a campus help-provider. *Journal of Counseling Psychology, 31,* 149-160.

Tinsley, H. E., A., & Harris, D. J. (1976). Client expectations for counseling. *Journal of Counseling Psychology, 23,* 173-177.

Tinsley, H. E., A., Workman, K. R., & Kass, R. (1980). Factor analysis of the domain of client expectancies about counseling. *Journal of Counseling Psychology, 27,* 561-570.

Torres, R. E. (1991). Health status assessment of Latinos in the Midwest. *Latino Studies Journal, 2,* 53-70.

Trevino, F. (1987). Standardized terminology for Hispanic populations. *American Journal of Public Health,* 77, 69-72.

Tropp, L. R., Erkut, S., Alarcon, O., Garcia Coll, C., & Vazquez, H. (1994). Toward a theoretical model of psychological acculturation (Supported by NICHD grant #1 RO1 HD30592-01 entitled, "Normative development among Puerto Rican adolescents).

U. S. Bureau of the Census. (1990). *Social and Economic Characteristics: Michigan.* 1990 Census of the Population [Vol. CP-2-24]. Washington, D. C.: U. S. Department of Commerce.

U. S. Bureau of the Census. (1993). *Current Population Reports: Hispanic Americans Today.* Washington, D. C.: U. S. Government Printing Office.

U. S. Bureau of the Census. (1994). *Current Population Reports: Hispanic Population from the March 1994 Current Population Survey.* Washington, D. C.: U. S. Government Printing Office.

U. S. Bureau of the Census. 1996). *Current Population Reports: Population Projections of the United States by Age, Sex, Race, and Hispanic Origin: 1995 to 2050.* Washington, D. C.: U. S. Government Printing Office.

Varvil-Weld, D. C., & Fretz, B. R. (1983). Expectancies and the outcome of a career development intervention. *Journal of Counseling Psychology, 30,* 290-293.

Vega, W. A., Warheit, G. J., Auth, J. B., & Meinhardt, K. (1984). The prevalence of depressive symptoms among Mexican Americans and Anglos. *American Journal of Epidemiology, 120,* 592-607.

Vega, W. A., Warheit, G. J., & Palacio, R. (1985). Psychiatric symptomatology among Mexican American farm workers. *Social Science and Medicine, 20,* 39-45.

Walonick, D. S. (1988). *Stat Pac Gold, DOS Version 3.0.* [computer software]. Minneapolis: Walonick Associates, Inc.

Wells, B. W., Hough, R. L., Golding, J. M., Burnam, A., & Karno, J. (1987). Which Mexican Americans underutilize health services? *American Journal of Psychiatry, 144,* 918-922.

Wilkinson, D. (1993). Family ethnicity in America. In H. P. McAdoo (Ed.), *Family ethnicity: Strength in diversity* (pp. 15-59). Newbury Park, CA: Sage Publications.

Workman, K. R. (1978). *Client-therapist expectancy congruence and client attraction to the therapist.* Unpublished Master's Thesis, Southern Illinois University.

Yanico, B. J., & Hardin, S. I. (1985). Relation of type of problem and expectations of counselor knowledge and understanding to students' gender preferences for counselors. *Journal of Counseling Psychology, 32,* 197-205.

Yuen, R. K., & Tinsley, H. E., A. (1981). International and American students' expectancies about counseling. *Journal of Counseling Psychology, 28,* 66-69.