6-1-2013

Simpatia and Perceptions of Healthcare Mistreatment among Latino and Anglo Women

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Simpatía and Perceptions of Healthcare Mistreatment among Latino and Anglo Women

by

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A Thesis submitted in partial satisfaction of
the requirements for the degree
Master of Arts in General Psychology

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June 2013

Each person whose signature appears below certifies that this thesis in his/her opinion is adequate, in scope and quality, as a thesis for the degree Master of Arts.

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ACKNOWLEDGEMENTS

I would like to express my deepest gratitude to Dr. Betancourt and Dr. Flynn, who have both been instrumental in mentoring me throughout my graduate school career. I am thankful for their guidance, patience, and feedback, all of which were indispensible in completing this thesis. I would also like to thank Dr. Chavez; his input and perspective were much appreciated.

I would also like to thank my parents, without whose support none of my education would have been possible. They are fantastic role models and motivators; I would not be where I am today without them.

Lastly, a special thank you is reserved for my friends and fellow lab members, both of whom have kept me sane throughout graduate school.

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ABSTRACT OF THE THESIS

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Masters of Arts, Graduate Program in Clinical Psychology
Loma Linda University, June 2013
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Past research has examined perceptions of mistreatment in the context of healthcare professional-patient relationships, but the majority of the literature has focused primarily on racial and ethnic differences. Guided by Betancourt's Model for the Study of Culture, the aim of this research was to examine the role of culture and its association with perceptions of healthcare mistreatment among Latino and Anglo women. Specifically, this study investigated ethnic differences in perceptions of healthcare mistreatment through the investigation of simpatía, a cultural script that stresses interpersonal harmony and personal characteristics such as being likeable and easy going. The study also found ethnic differences in the level of reported simpatía between Latino and Anglo participants. The study found that simpatía was related to specific instances of mistreatment, in that Simpatía was positively correlated with communication related instances of mistreatment for Anglos and negatively correlated for Latinos. This study could inform healthcare interactions and provide a better understanding for healthcare providers researching appropriate ways of communicating with their patients.

CHAPTER ONE

INTRODUCTION

According to the Kaiser Family Foundation, perceptions of healthcare mistreatment are prevalent among various ethnic and socioeconomic groups. For example, 15% of Latino Americans in the U.S. (Latinos) felt that their doctor or health professional judged them unfairly or treated them with disrespect because of their race/ethnicity, while only 1% of non-Latino Whites (Anglos) reported the same (Collins et al., 2002). Perceptions of healthcare mistreatment can have consequences for the patient-healthcare professional relationship, such that it could affect keeping future appointments (Freed, Ellen, Irwin, & Millstein, 1998), filling prescriptions (Van Houtven et al., 2005), following doctor's advice (Blanchard & Lurie, 2004), and treatment compliance (Perloff, Bonder, Ray, Ray, & Siminoff, 2006).

One important factor that may contribute to the aforementioned differences in perceptions of healthcare mistreatment is the possible cultural divide between healthcare professionals and their culturally diverse patients (Betancourt & Flynn, 2009). This cultural divide reflects differences in the cultural background of the patient and the healthcare professional. As a result, culture can have a direct bearing on the way a person perceives an interaction with their healthcare professional. Therefore, culture is an important factor that needs to be studied when considering diverse patients' perceptions of healthcare mistreatment.

One method to study culture has been put forth by Betancourt and colleagues based on the Model for the Study of Culture (Betancourt & Lopez, 1993; Betancourt & Fuentes, 2001; Betancourt, Hardin, & Manzi, 1992). In this model, cultural variables

such as values, expectations, norms and beliefs are considered more relevant factors when studying variations in behavior and related psychological processes than are race and ethnicity. The cultural script, simpatía, therefore may contribute to a better understanding of the role of culture in relation to perceptions of healthcare mistreatment. Simpatía is a cultural script that revolves around interactions that stress interpersonal harmony by emphasizing the positive and deemphasizing the negative in a given situation (Triandis, Marin, Lisansky, & Betancourt, 1984). The aim of this study is to examine whether perceptions of healthcare mistreatment are associated with variations in simpatía among Latino and Anglo women. In addition, this study will explore potential sources of variation in simpatía, such as population categories like ethnicity.

Perceptions of Healthcare Mistreatment

The perception of healthcare mistreatment is subjective and varies from person to person (Klassen, Smith, Shariff-Marco, & Juon, 2008). The term implies the perception of differences in care and mistreatment as stemming from biases, prejudice or stereotyping (Crawley, Ahn & Winkleby, 2008). Perceptions of healthcare mistreatment suggest that patients perceive that they are being treated differently during the healthcare encounter on the basis of some personal quality, be it because of their race or ethnicity, gender, sexual orientation, or religion; however, this does not necessarily mean that the person is actually mistreated or discriminated against. In this instance, perceptions may also arise from a cultural incongruence found between the healthcare professional and the patient.

Research indicates that perceptions of healthcare mistreatment can have consequences for the patient and their future healthcare interactions. For instance, one study found that adolescent patients who were less satisfied with their healthcare professional were more likely to perceive healthcare mistreatment and were less likely to keep future appointments (Freed et al., 1998). Data from the 2001 Commonwealth Fund found that African, Latino, and Asian Americans who thought that they would have received better care if they were of a different race or ethnicity were less likely to follow the healthcare professional's advice or put off care (Blanchard et al, 2004). Another study investigating pharmaceutical use found that the odds of delaying prescriptions were significantly higher (OR = 2.02) if the participant perceived unfair treatment, regardless of race (Van Houtven et al, 2005).

As indicated earlier, perceptions of healthcare mistreatment may vary based on the individual. In fact, research suggests that ethnic minority groups perceive more instances of healthcare mistreatment. For instance, Latinos are more likely to report differential treatment from healthcare providers (21%) as compared to Anglos (13%), (Hobson, 2001), as well as lower quality care (56% Latinos vs. 27% Anglos), (Lillie-Blanton, Brodie, Rowland, Altman, & McIntosh, 2000). Latinos are also more likely to report being treated with disrespect because of their race/ethnicity (18%) compared to Anglos (9%) (Collins et al., 2002). One study found that on different measures of healthcare treatment, Latin Americans, Chinese and Korean Americans felt that their care was worse than their Anglo American counterparts because of their ethnicity (Blendon et al., 2008). Immigration status also appears to play a role in perceptions of discrimination. Research indicates that second generation Latino immigrants are more likely to perceive

discrimination than first generation Latino immigrants (43% vs. 25.3%) (Perez, Fortuna, & Alegria, 2008).

Considering that Latinos are the largest and fastest growing minority group in the United States, ensuring effective patient-professional encounters is particularly important to study for this population and healthcare system. According to the U.S. Census Bureau (2011), Latinos represent 50.5 million individuals or 16% percent of the population. By the year 2050, Latinos are projected to account for 29% of the total US population (Passel & Cohn, 2008). In San Bernardino County, where this research was conducted, Latinos are the majority group, accounting for 46.8% of the population while Anglos account for 36.2% (2010 Census Bureau American Community Survey).

The Role of Culture and Perceptions of Healthcare Mistreatment

Betancourt, Flynn and Ormseth (2011) have suggested that health disparities are likely to occur as the result of differences with a health care system that is based upon Anglo-American culture. One explanation for the noted disparities in perceptions of healthcare mistreatment among Latino and Anglo patients may have to do with the cultural divide between healthcare professionals and their patients. In the US only 4.9% of physicians in 2008 are from Latino backgrounds (American Medical Association, 2009). As a result, healthcare professionals treating Latino patients may not be aware of the cultural values, beliefs, expectations and norms relevant to Latino patients. These negative perceptions may in turn predispose the minority patients to view any misstep on the part of the healthcare professional as mistreatment. Perceptions of mistreatment, especially in the context of patient-healthcare professional relationships are likely to be

influenced by culture. However, the idea of studying it from a cultural perspective requires something more than just research that solely address race and ethnicity. Although these categories can inform the study of perceptions of healthcare mistreatment, the applicability of such findings are only generalizable to a limited extent. In an effort to better understand the relationship between culture and perceptions of mistreatment, it would be advisable to look at factor beyond race and ethnicity such as cultural values, beliefs, expectations, norms and practices.

An Integrative Model for the Study of Culture, Psychological Factors and Health Behaviors

Betancourt and Lopez (1993) argue that the majority of studies examining the effects of culture on psychological processes use ethnicity or race to account for variance in psychological processes or behaviors. However, according to the authors, race and ethnicity are not easily quantifiable, and there is as much or more variation within a given ethnic or racial group as there is between racial or ethnic groups. Rather than race or ethnicity, researchers should focus on variables such as cultural values, beliefs, expectations and norms that are more easily quantifiable. An Integrative Model for the Study of Culture, Psychological Factors and Health Behaviors (Betancourt & Flynn, 2009) explains how such cultural factors relate to psychological processes and behavior as well as how population categories such as ethnicity are associated with aspects of culture (see Figure 1).

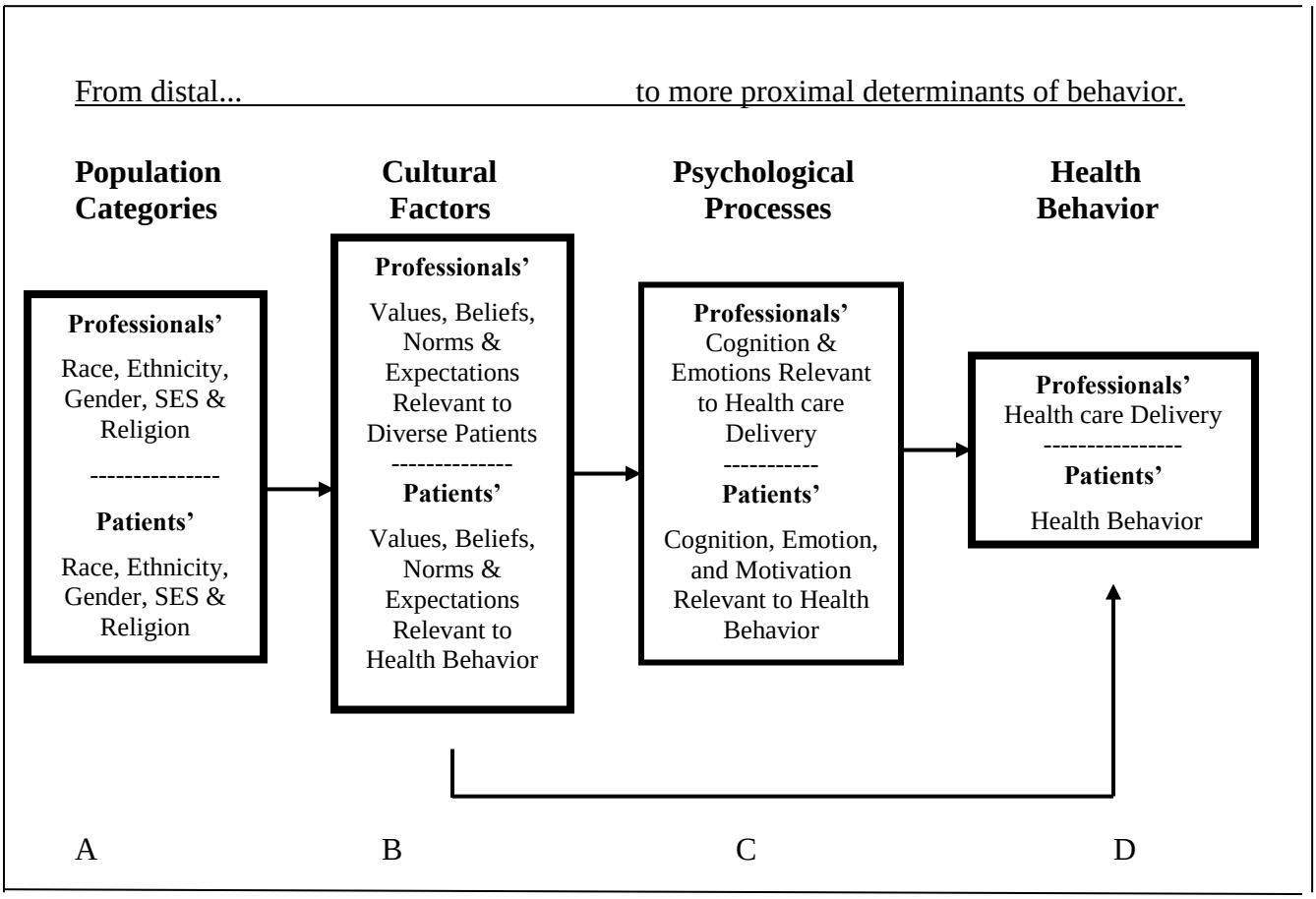

Figure 1. Betancourt's Integrative Model of Culture, Psychological Processes, & Health Behaviors.

At the front of the model are the basic population categories (A), such as ethnicity, race, socioeconomic status, gender and religion. These are more "distal" to psychological processes (C) and behavior (D). Culture (B), on the other hand is more proximal to psychological processes and behavior and includes values, beliefs, norms, expectations and practices. These cultural aspects are believed to influence psychological processes (C) such as cognitions and emotions directly. On the other hand, the population categories influence psychological processes indirectly through mediating cultural factors.

Simpatía as a Cultural Script

Examining the role of culture on perceptions of healthcare mistreatment moves beyond the comparative analysis of ethnic group differences such as those reported earlier. Simpatía is an important cultural script relevant to Latino populations which may shed some light on the role of culture and perceptions of healthcare mistreatment; it stresses interpersonal harmony and personal characteristics such as being likeable and easy going.

Triandis and colleagues (1984) were the first to discuss and empirically test for the cultural script of simpatía. Triandis and colleagues defined a cultural script as a "pattern of social interaction that is characteristic of a particular group." The authors further explained simpatía as "a permanent personal quality where an individual is perceived as likeable, attractive, fun to be with, and easy-going." Another key aspect of simpatía is that individuals strive for harmony in their interpersonal interactions. In essence, a person who is *simpático* would be viewed by others as easy-going, as well as someone who avoids interpersonal conflict, emphasizes positive behaviors in positive situations and deemphasizes negative behaviors in negative situations (Triandis et al., 1984). In addition to the personality and interactional components, it is also important to recognize that the interaction includes two parties: the individual and the person they are interacting with. As such, simpatía takes on another aspect, the properties of simpatía in the individual and the expectation that other person also ascribes to similar personal characteristics.

Much of the literature on simpatía argues for its importance in understanding interpersonal relations among Latino individuals, though its empirical investigation is

less prevalent. For instance, in a discussion of parenting styles among Puerto-Rican and Dominican mothers, Guilamo-Ramos and colleagues (2007) suggested that simpatía could play a role in family interactions. Kail and Elberth (2003) have also suggested that counselors should keep simpatía in mind when working with substance abusing Latinas, especially since confrontational techniques could violate simpatía. Simpatía has also been mentioned in the context of mental health counseling and the emergence of misunderstandings due to the differences in interactive style (Altarriba & Santiago-Rivera, 1994). Furthermore, Shultz & Chavez (1994) have suggested that simpatía may explain differences between Spanish and English social desirability scales.

To a lesser extent, simpatía has also been investigated as a cultural variable in empirical research. Research by Triandis and colleagues (1984) found that Latino American naval recruits were more likely to express agreement with statements that were representative of a simpatía cultural script than their Anglo American counterparts. For example, the Latinos were more likely to show loyalty, admiration and respect for a "target person" in the study, while criticizing less. Varela (2004) investigated the relationship between anxiety and simpatía in Mexican, Mexican American, and Anglo American children, and found a positive correlation between the two. In another study, the same authors examined repressive adaptation style and levels of simpatía in a similar population, although they did not find any association (Varela, Steele & Benson, 2007). Griffith, Joe, Chatham, & Simpson (1998) developed a simpatía scale that focused primarily on the relationship between drug users and their treatment counselors. The 17-item scale looked at simpatía from the patients' perspective with regards to the counselor. Simpatía was also studied by Yu and colleagues (2008) in relation to its effects in

Mexican-origin couples and their partner relationships and parenting relationships. The study found that higher levels of simpatía in the father were associated with the mother's report of greater parental agreement on child rearing. Lastly, a recent study by Ramirez-Esparza, Gosling, & Pennebaker (2008) found that Latinos scored lower on a agreeableness questionnaire which the authors equated to simpatía, but scored higher on a social interaction task than Anglo-Americans. The authors suggest that modesty associated with simpatía was the reason for the lower scores on the scale; the more a participant demonstrated outwardly to be simpatico, the more modest they were, and as a result answered the questionnaire in a more modest manner than other participants. A study by Sotomayor-Peterson, Figueredo, Christensen, and Taylor (2012) found that simpatía, in conjunction with familismo, positively influenced the concept of shared parenting. A study conducted by Varela, Sanchez-Sosa, Biggs and Luis (2009) found that simpatía, in combination with other cultural variables, explained a significant amount of variance related to anxiety, in which a stronger family oriented cultural background produced lower anxiety. Davis, Resnicow and Couper (2010) described simpatía as being associated with higher instances of extreme and acquiescent response styles among Mexican-American participants.

The role of simpatía in the context of healthcare has not been studied in great detail, although researchers have pointed to its conceptual relevance in patient-healthcare professional relations. Findings from focus groups with African, Latino and Anglo Americans revealed that minority patients perceived ethnicity based discrimination; particularly among the Latinos of the study (Nápoles-Spring, Santoyo, Houston, Pérez-Stable & Stewart, 2005). Participants felt that healthcare professionals should adopt a

"humanistic approach" by demonstrating their interest in the patient, sitting down during the interaction, maintaining eye contact, and putting the patient at ease before an examination or a procedure. The participants' suggestions reflect some of the basic components of simpatía.

Betancourt, Flynn, & Ormseth (2011) examined cultural factors associated with attributions for healthcare mistreatment and cancer screening behaviors among Latino and Anglo women. The study found that continuity of care was affected by attributions of healthcare mistreatment. In addition, the study also found that attributions of mistreatment were influenced by the patients' negative cultural beliefs about healthcare professionals. The authors suggested that simpatía might play a role in terms of patients' sensitivity to the healthcare professionals treatment in that they may be more likely to perceive neutral interactions as negative. The authors indicated that some of the items included in the cultural beliefs scale may be associated with violations of simpatía such as the belief that healthcare professionals are not sensitive and compassionate.

Patients who perceive healthcare mistreatment, regardless if any mistreatment actually occurs, are still at risk for adverse outcomes stemming from those perceptions. One way to study perceptions of healthcare mistreatment would be to examine the influence culture has on perceptions of healthcare mistreatment. As such, Betancourt's Integrative Model for the Study of Culture, Psychological Processes, and Health Behaviors will be used to study the interaction between culture and psychological processes, with simpatía as a cultural variable and perceptions of healthcare mistreatment examined as the psychological process. Simpatía provides a good cultural variable to study in the context of patient-healthcare professional relations, as it provides a

qualitative variable that focuses primarily on the way people interact with one another. Guided by the Model for the Study of Culture, this study will examine whether perceptions of healthcare mistreatment are associated with variations in simpatía among Latino and Anglo women. In addition, potential sources of variation in simpatía such as ethnicity will also be examined.

Hypotheses

1. On the average, Latino women will score higher than Anglo women on "simpatía."
2. Scores on "simpatía" will be positively correlated with scores on perceptions of health care mistreatment.
3. Between ethnic-group differences in perceptions of health care mistreatment will be in part accounted for by variations in "simpatía."

CHAPTER TWO

METHODS

This study was part of a larger research program funded by the American Cancer Society to examine the role of cultural beliefs about health care professionals and psychological factors as determinants of cancer screening behavior among Latino and Anglo women.

Participants and Procedures

Multi-stage, stratified sampling was conducted in an effort to obtain nearly equal proportions of participants in terms of ethnicity and other socioeconomic variables. Participants were recruited from universities, churches, markets, and free/low-cost health clinics in Southern California. U.S. Census tract data from the Federal Financial Institutions Examination Council was used to examine projections regarding SES, ethnicity, and age for each recruitment setting prior to data collection. A research assistant first contacted the person in charge of the potential recruitment sites and obtained permission for data collection. Once permission had been obtained, a research assistant posted advertisements at the sites, explaining the purpose of the study, eligibility for participation (at least 18 years old, Latino or Anglo Americans, ability to read in English or Spanish), and the risks/benefits for participation. The advertisement listed a time and place where interested individuals could go to fill out the survey.

Bilingual research assistants were present at a particular time at the recruitment sites for data collection. The research assistant explained the purpose of the study to the participants, verbally explained eligibility criteria, and provided a consent form in

English and Spanish. Once consent was obtained participants were given a questionnaire in either English or Spanish that took approximately thirty to forty-five minutes to complete. Participants received a small monetary gift of $15 for their participation. Once data had been collected from the sites, the distribution of the participants was reexamined and additional data was collected from participants underrepresented in the noted demographic. As a result of the multi-stage stratified sampling efforts a total of 335 women (164 Latino, 171 Anglo) from various socioeconomic backgrounds participated in the study (see Table 1).

Table 1

Demographics

	Total Sample			Experienced Mistreatment			No Experienced Mistreatment		
	Total Sample (N = 335)	Anglo Sample (N = 171)	Latino Sample (N = 164)	Total Sample (N = 225)	Anglo Sample (N = 118)	Latino Sample (N = 107)	Total Sample (N = 110)	Anglo Sample (N = 53)	Latino Sample (N = 57)
Age (M(SD))[a,d,e]	48.35 (16.78)	50.93 (18.31)	45.73 (13.89)	47.09 (15.02)	47.79 (16.56)	46.32 (13.17)	51.04 (18.92)	57.94 (20.17)	44.62 (15.22)
Education (M(SD))[c,d,e]	12.52 (3.60)	13.81 (2.50)	11.18 (4.06)	12.73 (3.53)	14.01 (2.51)	11.31 (3.95)	12.10 (3.71)	13.36 (2.45)	10.93 (4.29)
Income (%)									
$0 - $14,999	30.1	32.2	28.0	27.1	28.0	26.2	37.3	41.5	31.6
$15,000 - $24,999	22.1	22.9	23.7	19.4	18.6	21.4	25.5	24.5	28.1
$25,000 - $39,999	14.7	12.9	15.8	15.9	15.2	16.8	11.8	9.5	14.1
$40,000 - $59,999	14.6	12.3	14.6	15.4	16.0	14.0	12.7	9.4	15.8
$60,000 - $79,999	8.1	10.5	5.5	9.8	11.9	7.5	4.5	7.5	1.8
$80,000 - $100,000	4.2	2.3	6.1	4.9	2.5	7.5	2.7	1.9	3.5
$100,000+	6.3	7.0	5.5	6.7	7.6	5.6	5.5	5.7	5.3
Insured (%)	77.2	84.7	69.0	77.1	82.2	71.4	77.4	90.4	64.8

Note: [a] refers to significant differences between Anglos who perceived vs. did not perceive mistreatment.
[b] refers to significant differences between Latinos who perceived vs. did not perceive mistreatment.
[c] refers to significant differences between Latinos and Anglos who perceived mistreatment.
[d] refers to significant differences between Latinos and Anglos who did not perceive mistreatment.
[e] refers to significant differences between Latinos and Anglos for the Total Sample

Measures

All instruments were available in English and Spanish. Those instruments not currently available in Spanish (simpatía scale) were translated by two bilingual Spanish speakers using the double back translation procedure.

Simpatía

Simpatía was assessed using a newly developed instrument based on the theoretical definitions provided by Triandis and colleagues (Triandis et al., 1984). The instruments developed by Griffith (1998) to study the level of simpatía of substance users and Yu's (2008) scale to identify the level of simpatía in couples were also reviewed for additional content. The newly developed 24-item scale included two sections, with 12 items assessing the participant's own level of simpatía and 12 items assessing their expectations of simpatía in other people. All items were based on a 7-point Likert Scale from 1, representing "Sometimes", to 7, representing "Always." Please see Appendix A for a list of the items.

An expert panel reduced the original 24 Simpatía questions to 12 items. The 12 items that were removed from the scale were considered to be redundant by several evaluators. Twelve questions measuring the participant's level of simpatía were factor analyzed using principal axis factor analysis with Direct Oblimin rotation. The 12 questions yielded two factors for the Total sample, Latino sample and Anglo sample; three items were removed for cross-loading on both factors. The remaining 9 items were factor analyzed and explained a total of 60.22% (Total), 51.49% (Latino) and 69.01% (Anglo) of the variance. Factor 1 was labeled "Simpatía: Self" since these items

represented aspects of Simpatía which they valued in themselves: minimize the negative aspects of what people do; be considerate of others' feelings and needs; emphasize the positive aspects of what people; get along well with others; and please others even if it means making sacrifices. These items explained 48.90% (Total), 38.39% (Latino), and 59.05% (Anglo) of the variance. The second factor was labeled "Simpatía: Others", as these items reflected aspects of simpatía which participants found important in others: are warm to others; are easy going; maintain good relationships with others; and make others feel comfortable. The second factor explained 11.32% (Total), 13.10% (Latino) and 10.02% (Anglo) of the variance. The reliability of the 9-item scale was excellent, .88 (Total), .82 (Latino), and .92 (Anglo). The reliability of the Simpatía: Self factor was good; Cronbach's alphas of .84 (Total), .78 (Latino) and .88 (Anglo) and the reliability of the Simpatía: Others factor was excellent; .87 (Total), .82 (Latino) and .91 (Anglo).

Perceived Interpersonal Healthcare Mistreatment and Stress Emotion Scale (PIMS)

Perceptions of healthcare mistreatment was developed using a bottom-up, mixed methods approach to instrument development. This approach uses mixed methodologies to develop psychometrically sound instruments that can be used with culturally diverse populations. The approach begins with observations in a particular area of research, taken from interviews with specific populations. These observations are then used to develop quantitative measures.

With relation to this study, 20 qualitative interviews were conducted with 10 Latino and 10 Anglo-American women to identify instances of healthcare mistreatment

during routine breast and cervical cancer screenings and the participants' level of stress experienced as a result of the mistreatment. Participants were asked about any negative experiences they had with a healthcare professional during a cancer screening exam. These responses were content coded and analyzed to identify the most frequent instances of healthcare mistreatment.

The bottom-up approach resulted in 13 items representing instances of interpersonal healthcare mistreatment during breast and cervical cancer screening. Eleven additional items were included from a previous study (Tucker, 2008) in which items were developed or adapted from previous quality of care scales. Participants were asked to mark a box if they had never experienced the specific mistreatment incident. Sample items included "The healthcare professional treated me like object" and "The healthcare professional did not treat me with respect." This scale can be found in Appendix B. To assess the participant's level of stress emotions associated with each mistreatment incident, participants were asked to rate how much each particular incident had bothered them. Participants responded by indicating to what extent each item bothered them on a scale of one to seven, with one being "not at all a problem" and 7 denoting "definitely a problem."

Perceived Mistreatment score was calculated based on an individual reporting at least once instance of mistreatment. Cumulative Mistreatment Exposure score was calculated based on the sum of all instances of perceived mistreatment. Lastly, the variable Stress Emotions was calculated by using the highest score for any mistreatment item.

CHAPTER THREEE

RESULTS

Preliminary Analyses

Of the 335 women who participated in the study, a total of 225 (107 Latinos, 118 Anglos) reported at least one instance of healthcare mistreatment. Anglo women who reported mistreatment were more likely to be younger (M = 47.79, SD = 16.56) than those who did not report mistreatment (M = 57.94, SD = 20.17), t (84.70) = 3.21, p = .002. There was also a significant difference between Anglo and Latino women who did not perceive mistreatment; Latino women tended to be younger (M = 44.62, SD = 15.22) than Anglo women (M = 57.94, SD = 20.17), t (96.53) = 3.89, $p < .001$. Latino women also tended to be less educated (M = 10.93, SD = 4.29) than Anglo women (M = 13.36, SD = 2.45), t (90.25) = 3.67, $p < .001$. Anglo women who experienced mistreatment tended to be more educated (M = 14.01, SD = 2.51) than Latinos (M = 11.31, SD = 3.95), t (176.41) = 6.05, $p < .001$. The same trends were reflected in the Total sample, in that Anglo women were older (M = 50.93, SD = 18.31) and more educated (M = 13.81, SD = 2.50) than Latino women (M = 45.73, SD = 13.89; M = 11.18, SD = 4.06). Please see Table 1 for a list of the demographic differences.

In addition to the demographic information, the difference instances of mistreatment were tabulated. Please see Table 2 for more information.

Table 2

Perceived Interpersonal Healthcare Mistreatment and Stress Emotion Scale: Frequencies, Means, Standard Deviations

	Mistreatment Exposure N (%)			Stress Emotion M (SD)		
	Total	Latino	Anglo	Total	Latino	Anglo
1. Did not listen to me	103 (46.6)	49 (45.8)	54 (47.4)	2.44 (2.93)	2.18 (2.74)	2.68 (2.91)
2. Used words I did not understand	123 (56.2)	63 (60.6)	60 (52.2)	2.25 (2.49)	2.34 (2.44)	2.16 (2.80)
3. Did not perform the exam correctly	46 (21.2)	24 (23.3)	22 (19.3)	.94 (2.04)	.88 (1.92)	.99 (2.98)
4. Touched me inappropriately during the exam	23 (13.0)	16 (15.0)	13 (11.2)	.58 (1.75)	.51 (1.57)	.64 (2.85)
5. Did not pay attention to me	78 (35.5)	34 (33.0)	44 (37.6)	1.74 (2.65)	1.34 (2.27)	2.10 (2.44)
6. Did not ask me any questions	94 (42.5)	43 (41.0)	51 (44.0)	1.89 (2.57)	1.48 (2.24)	2.26 (2.91)
7. Did not give me a chance to say all of the things I wanted	118 (53.2)	49 (46.7)	69 (59.0)	2.60 (2.83)	1.95 (2.50)	3.19 (2.79)
8. Did not provide me with enough information	117 (52.9)	51 (49.0)	66 (56.4)	2.46 (2.71)	2.02 (2.49)	2.85 (2.91)
9. Was not totally honest with me	61 (27.4)	29 (27.1)	32 (27.6)	1.20 (2.24)	1.00 (1.99)	1.38 (2.88)
10. Did not answer my questions	88 (40.2)	39 (37.1)	49 (43.0)	1.97 (2.70)	1.56 (2.39)	2.35 (2.38)
11. Was not clear when explaining my test results	90 (40.5)	42 (39.6)	48 (41.4)	1.93 (2.65)	1.72 (2.48)	2.11 (2.10)
12. Rushed or hurried when they treated me	128 (57.4)	49 (46.2)	79 (67.5)	2.91 (2.89)	2.07 (2.62)	3.67 (2.76)
13. Was rough while performing the screening exam	86 (38.6)	34 (31.8)	52 (44.8)	1.92 (2.72)	1.45 (2.46)	2.34 (2.90)
14. Started the examination without any introduction or conversation	57 (25.7)	24 (22.6)	33 (28.4)	1.07 (2.09)	.77 (1.68)	1.35 (2.77)
15. Did not respect my need for privacy	45 (20.1)	20 (18.7)	25 (21.4)	.87 (1.96)	.72 (1.78)	.99 (2.76)
16. Kept me waiting too long	167 (74.9)	80 (75.5)	87 (74.4)	3.61 (2.70)	3.53 (2.64)	3.69 (1.87)
17. Jumped to conclusions about my health without having all of the details	77 (35.0)	36 (34.3)	41 (35.7)	1.80 (2.70)	1.55 (2.46)	2.02 (2.26)
18. Did not treat me with respect	70 (31.4)	26 (24.3)	44 (37.9)	1.46 (2.47)	.90 (1.95)	1.96 (2.78)
19. Did not return my calls in the appropriate time	80 (35.9)	32 (30.2)	48 (41.0)	1.63 (2.47)	1.12 (1.99)	2.10 (2.25)
20. Made offensive comments	36 (16.3)	17 (16.0)	19 (16.5)	.62 (1.61)	.47 (1.24)	.76 (2.53)
21. Did not explain what they were doing	65 (29.5)	28 (27.2)	37 (31.6)	1.19 (2.13)	1.01 (1.98)	1.36 (2.91)
22. Treated me like an object	64 (28.7)	27 (25.2)	37 (31.9)	1.38 (2.43)	.93 (1.90)	1.78 (2.80)
23. Did not warn me that the exam may be painful	72 (32.3)	38 (35.8)	34 (29.1)	1.30 (2.20)	1.33 (2.15)	1.28 (2.98)
24. Was not very thorough and careful	73 (33.0)	34 (32.4)	39 (33.6)	1.39 (2.28)	1.13 (1.95)	1.64 (2.85)

Missing Variable Analysis

A Missing Variable Analysis (MVA) was conducted to determine the amount of missing data in the data set. After running an MVA, a number of subjects failed to provide an answer for the Demographics and Simpatía section; the missing data ranged from two missing responses to 15. An Expectation Maximization (EM) was run to account for the missing data. Using Betancourt's Model for the Study of Culture, the first variables imputed were the Demographic variables, those farthest from the study's outcome variables. The imputed Demographic variables were used to impute the data for the Simpatía items, which in turn were used to impute the data for the perception of mistreatment items.

Ethnicity and Simpatía

A t-test was conducted to compare Latino participants (n = 164, M = 5.784, SD = 1.073) to Anglo participants (n = 171, M = 5.76, SD = 1.182) on their level of simpatía, in particular their beliefs and expectations of themselves and of others. It was expected that there would be significant differences between the two ethnic groups, as per the first hypothesis. The homogeneity of variance attempt was not significant, p = .414. Ethnicity and the level of Simpatía: Total was not significant, t(333) = -.196, p = .845. This result suggests that there is no significant difference for Latino participants versus non-Latino participants in terms of their beliefs and expectations of themselves and of others.

A t-test was conducted to compare Latino participants (n = 164, M = 5.737, SD = 1.129) to Anglo participants (n = 171, M = 5.458, SD = 1.244) on their level of simpatía,

in particular Simpatía Others. The homogeneity of variance attempt was not significant, p = .449. Ethnicity and the corresponding level of simpatía was significant, t(333) = -2.148, p = .032. This result suggests that there is a significant difference between Latino participants and non-Latino participants in terms of their beliefs and expectations of others, such that Latino participants scored higher on the Simpatía: Others subscale than the Anglo participants.

A t-test was conducted to compare Latino participants (n = 164, M = 5.763, SD = .926) to Anglo participants (n = 171, M = 5.626, SD = 1.099) on their level of simpatía, in particular Simpatía: Self. The homogeneity of variance attempt was not significant, p = .091. Ethnicity and the corresponding level of simpatía was not significant, t(333) = -1.236, p = .217. This result suggests that there is no significant difference for Latino participants versus non-Latino participants in terms of their beliefs and expectations of themselves.

Correlations between Study Variables

Demographic variables were correlated with Simpatía: Overall, Simpatía: Self, Simpatía: Others and Perceptions of Healthcare Mistreatment (Tables 3 and 4) using those participants that had been mistreated (N = 225). Correlations with Perceived mistreatment were conducted using the entire sample. Overall, Simpatía: Overall, Simpatía: Self and Simpatía: Others subscales were not significantly correlated with any of the composite mistreatment variables. However, when the individual mistreatment items were correlated with the Simpatía: Overall, Simpatía: Self and Simpatía: Others

scales, a number of significant correlations emerged. Please refer to Table 3-5 for a list of the significant correlations.

Table 3

Correlations between Demographics, Simpatía and Mistreatment Variables, Total Sample, Experienced Mistreatment

	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.
Demographics												
1. Age	1											
2. Education	-.151*	1										
3. Income	.012	.450***	1									
4. Birthplace	.032	.464***	.348***	1								
5. Survey Language	-.060	-.519***	-.281***	-.687***	1							
Simpatía												
6. Total Simpatía	-.022	-.014	.010	.150	-.018	1						
7. Simpatía, I Subscale	-.012	.022	.026	.134	-.006	.890***	1					
8. Simpatía, Other Subscale	-.026	-.052	-.012	.120	-.027	.835***	.492***	1				
Mistreatment												
9. Perceived Mistreatment	-.113*	.082	.127*	.079	-.129*	-.059	-.057	-.045	1			
10. Cumulative Exposure	.128	-.091	-.119	-.154	.071	.026	.046	-.005	.554***	1		
11. Stress Emotions	.060	.164*	.152*	.113	-.202**	.015	.041	-.021	.802***	.408***	1	
Covariates												
12. Social Desirability	.227**	-.284***	-.163*	-.229*	-.317***	.234***	.236***	.163*	-.169*	-.088	-.146*	1
M	47.09	12.73	3.00	--	--	5.65	5.73	5.56	--	8.78	5.42	7.95
SD	15.02	3.53	1.83	--	--	.96	1.10	1.14	--	7.05	1.84	2.87

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

Table 4

Correlations between Demographics, Simpatía and Mistreatment Variables, Latino Sample, Experienced Mistreatment

	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.
Demographics												
1. Age	1											
2. Education	-.122 (-.277**)	1										
3. Income	-.039 (.048)	.598*** (.353***)	1									
4. Birthplace	.032 (--)	.464*** (--)	.348*** (--)	1								
5. Survey Language	-.065 (--)	-.483*** (--)	-.481*** (--)	-.687*** (--)	1							
Simpatía												
6. Total Simpatía	-.089 (.031)	.075 (-.093)	.022 (.000)	.150 (--)	-.078 (--)	1						
7. Simpatía, I Subscale	-.051 (.016)	.117 (-.118)	.078 (.022)	.134 (--)	-.006 (--)	.882*** (.899***)	1					
8. Simpatía, Other Subscale	-.106 (.041)	.000 (-.037)	-.054 (.027)	.120 (--)	-.139 (--)	.821*** (.850***)	.455*** (.534***)	1				
Mistreatment												
9. Perceived Mistreatment	.059 (-.257**)	.045 (.121)	.110 (.144)	.079 (--)	-.183* (--)	-.092 (-.027)	-.081 (-.036)	-.073 (-.011)	1			
10. Cumulative Exposure	.089 (.151)	-.134 (-.130)	-.111 (-.127)	-.154 (--)	.192* (--)	-.059 (.107)	-.016 (.101)	.092 (.086)	.542*** (.565***)	1		
11. Stress Emotion	-.012 (.113)	.214* (-.059)	.288* (.006)	.113 (--)	-.187 (--)	-.012 (.062)	.065 (.012)	-.103 (.105)	.748*** (.858***)	.300*** (.517***)	1	
Covariates												
12. Social Desirability	.213* (.285*)	-.218* (-.166)	-.221* (-.126)	-.229* (--)	.281** (--)	.227* (.233*)	.271** (.230*)	.100 (.174)	-.172 (-.177*)	-.121 (-.027)	-.115 (-.034)	1
M	46.32 (47.79)	11.31 (14.01)	2.99 (3.01)	--	--	5.70 (5.61)	5.72 (5.73)	5.68 (5.45)	--	8.26 (9.26)	5.12 (5.70)	8.87 (7.10)
SD	13.17 (16.55)	3.95 (2.51)	1.82 (1.84)	--	--	.97 (.96)	1.11 (1.08)	1.15 (1.12)	--	6.88 (7.20)	2.00 (1.65)	2.66 (2.81)

Intercorrelations, means and standard deviations for Latino participants (n = 107) are presented in the upper portion of the cell, and values in parentheses represent Anglo participants (n = 118).

** = $p < .05$, ** = $p < .01$, *** = $p < .001$*

Table 5
Correlations between Simpatía and Stress Emotions; Experienced Mistreatment

	Total Sample			Latino Sample			Anglo Sample		
	Simpatía: Overall	Simpatía: Self	Simpatía: Expectations of Others	Simpatía: Overall	Simpatía: Self	Simpatía: Expectations of Others	Simpatía: Overall	Simpatía: Self	Simpatía: Expectations of Others
1. Did not listen to me	.112	.147	.049	-.104	.080	-.259	.247	.206	.254*
2. Used words I did not understand	.053	.070	.020	-.178	.044	-.284*	.283*	.197	.318**
3. Did not perform the exam correctly	.154	.176	.095	.012	.085	-.085	.339	.286	.291
4. Touched me inappropriately during the exam	.255	.170	.270	.023	.026	.014	.551*	.347	.488*
5. Did not pay attention to me	.080	.028	.115	-.041	-.040	-.035	.205	.090	.265
6. Did not ask me any questions	.013	.017	.005	-.246	-.203	-.251	.288*	.228	.289*
7. Did not give me a chance to say all the things I wanted	.150	.116	.155	-.149	-.112	-.165	.405***	.308**	.410***
8. Did not provide me with enough information	.022	.042	-.009	-.218	-.153	-.253	.275*	.244*	.225
9. Was not totally honest with me	.091	.111	.050	-.133	-.105	-.156	.330*	.317*	.235
10. Did not answer my questions	.097	.096	.075	-.064	-.010	-.123	.250	.195	.238
11. Was not clear when explaining my test results	.019	.071	-.049	-.302**	-.184**	-.397**	.383**	.349**	.288**
12. Rushed or hurried when they treated me	.120	.108	.101	-.112	-.037	-.183	.330**	.238**	.331**
13. Was rough while performing the screening exam	.085	.067	.079	-.253	-.088	-.364*	.332**	.180	.415**
14. Started the examination without any introduction or conversation	.249*	.170	.282*	.136	.048	.217	.364*	.287	.255*
15. Did not respect my need for privacy	.154	.120	.149	-.029	-.085	.056	.292	.272	.226
16. Kept me waiting too long	.052	.045	.044	-.107	-.059	-.132	.225*	.157	.230*
17. Jumped to conclusions about my health without having all the details	.102	.121	.046	-.085	.037	-.240	.275	.205	.267
18. Did not treat me with respect	.135	.101	.139	-.197	-.174	-.192	.375**	.287*	346*
19. Did not return my calls in the appropriate time	.087	.162	-.023	-.024	.095	-.192	.221	.217	.159
20. Made offensive comments	.040	.115	-.059	-.028	-.016	-.034	.210	.233	.132
21. Did not explain what they were doing	.004	.115	-.137	-.096	.032	-.270	.105	.206	-.017
22. Treated me like an object	.278*	.231*	.256*	-.061	-.106	-.001	.444**	.402**	.412**
23. Did not warn me that the exam may be painful	.072	.143	-.026	-.047	.054	-.155	.215	.259	.118
24. Was not very thorough or careful	.173	.128	.183	.087	.048	.119	.238	.177	.231

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

Logistic Regression

To test the hypothesis that higher levels of simpatía would cause an increase in the perception of healthcare mistreatment, a hierarchical logistic regression and hierarchical multiple regressions were conducted.

For the Total sample, the hypothesis was not confirmed based on the results from a logistic regression. The overall model was significant, $F(7, 335) = 15.782$, $p = .027$; however, simpatía did not significantly impact the perception of mistreatment. The different variables were entered in different steps, based on Demographics (Age, Education Level, Income Level) and Social Desirability as a covariate, followed by Ethnicity, followed by Expectations of Self and Expectations of Others. The first step was significant, in that Age, Education Level, Income Level and Social Desirability significantly predicted Perceptions of Healthcare Mistreatment ($F(4, N=335) = 15.233$, $p = .004$). Social desirability was significant (OR = .90, $p = .019$). The next step, in which Ethnicity was included, was also significant, $F(5, 335) = 15.317$, $p = .009$. In addition to the overall model, the variable Social Desirability (OR = .90, $p = .033$) was again significant. The last step included Expectations of Self and Expectations of Others; the final step was significant $F(7, 335) = 15.782$, $p = .027$. . Please refer to Table 6 for a complete list of both significant and non-significant variables.

Table 6

Logistic Regression with Demographics, Social Desirability, Ethnicity and Simpatía on Perceived Mistreatment, Total Sample

	β	Wald	df	*p*	OR	CI
Step 1						
Age	-.009	1.438	1	.230	.991	.977-1.006
Education	-.004	.010	1	.922	.996	.927-1.071
Income	.137	3.202	1	.074	1.147	.987-1.332
Social Desirability	-.110	5.479	1	.019	.896	.818-.982
Constant	1.756	6.234	1	.013	5.789	
Step 2						
Age	-.010	1.508	1	.219	.990	.975-1.006
Education	-.008	.042	1	.837	.992	.916-1.073
Income	.142	3.271	1	.071	1.152	.988-1.343
Social Desirability	-.105	4.534	1	.033	.900	.817-.992
Ethnicity	-.082	.084	1	.772	.921	.527-1.608
Constant	1.922	4.490	1	.034	6.832	
Step 3						
Age	-.010	1.656	1	.198	.990	.974-1.005
Education	-.007	.032	1	.857	.993	.917-1.075
Income	.142	3.297	1	.069	1.153	.989-1.344
Social Desirability	-.099	3.785	1	.052	.906	.820-1.001
Ethnicity	-.079	.076	1	.783	.924	.527-1.620
Expectations of Self	-.033	.062	1	.803	.968	.750-1.250
Expectations of Others	-.048	.161	1	.688	.953	.754-1.205
Constant	2.335	4.501	1	.034	10.325	

Logistic regressions were also run using the same variables, but focusing on each ethnic group. As such, Ethnicity was removed from the analyses and only the Demographic variables, Social Desirability and Simpatía variables were included in the analyses. For the Latino sample, the overall model was not found to be significant, $F(6, 164) = 7.211$, $p = .302$). In the first step, the demographic variables Age, Education, Income and Social Desirability were regressed on Perceived Mistreatment, which was not significant, $F(4, 164) = 6.848$, $p = .144$. Social Desirability was a significant predictor

(OR = .866, p = .049). The second step included Expectations of Self and Expectations of Others; this step was also not significant $F(6, 164) = 7.211$, p = .302). Please see Table 7 for a list of the significant and non-significant variables.

Table 7

Logistic Regression with Demographics, Social Desirability and Simpatía on Perceived Mistreatment, Latino Sample

	β	Wald	df	*p*	OR	CI
Step 1						
Age	.016	1.487	1	.223	1.016	.991-1.042
Education	-.011	.051	1	.822	.989	.898-1.089
Income	.118	1.034	1	.309	1.125	.896-1.413
Social Desirability	-.143	3.879	1	.049	.866	.751-.999
Constant	1.048	1.184	1	.276	2.853	
Step 2						
Age	.015	1.335	1	.248	1.015	.989-1.042
Education	-.007	.019	1	.890	.993	.901-1.095
Income	.115	.956	1	.328	1.121	.891-1.411
Social Desirability	-.133	3.097	1	.078	.876	.755-1.015
Expectations of Self	-.083	.197	1	.657	.920	.638-1.328
Expectations of Others	-.033	.039	1	.844	.967	.695-1.346
Constant	1.612	1.300	1	.254	5.012	

For the Anglo sample, the overall model was significant $F(6, 171) = 14.919$, p = .021. The first step included demographic variables (Age, Education and Income) and Social Desirability regressed onto Perceived Mistreatment. This step was significant, $F(4, 171) = 14.828$, p = .005. In addition to the overall model, the Age variable was significant (OR = .973, p = .014). In the next step, the overall model was significant $F(6, 171) = 14.919$, p = .021. Age was again significant (OR = .973, p = .013). Please refer to Table 8 for a list of the significant and non-significant variables.

Table 8

Logistic Regression with Demographics, Social Desirability and Simpatía on Perceived Mistreatment, Anglo Sample

	β	Wald	df	*p*	OR	CI
Step 1						
Age	-.027	6.048	1	.014	.973	.952-.994
Education	-.014	.032	1	.859	.986	.841-1.156
Income	.158	2.063	1	.151	1.171	.944-1.453
Social Desirability	-.055	.595	1	.440	.947	.824-1.088
Constant	2.437	3.101	1	.078	11.439	
Step 2						
Age	-.028	6.115	1	.013	.973	.952-.994
Education	-.016	.037	1	.847	.984	.839-1.155
Income	.161	2.121	1	.145	1.174	.946-1.458
Social Desirability	-.051	.509	1	.476	.950	.825-1.094
Expectations of Self	-.031	.025	1	.873	.969	.659-1.425
Expectations of Others	-.015	.007	1	.932	.985	.689-1.408
Constant	2.701	2.694	1	.101	14.897	

In addition to the Logistic regressions, t-tests were run on each individual perceived mistreatment item comparing their level of Simpatía with the Total, Latino and Anglo samples. The item "did not warn me that the exam may be painful" was significant for Simpatía: Overall (t (158) = 2.049, p =.042) and for Simpatía: Others(t (158) = 2.341, p = .020) for the Total sample.

Multiple Regressions

The Demographic variables, Social Desirability Ethnicity, and the Simpatía variables were all regressed onto two mistreatment composites: Stress Emotions and Cumulative Exposure. Each of these analyses was run three times, testing each regression with the Total sample, Latino Sample and Anglo sample. Of the total 6

regressions that were run, three produced significant results. In the first regression, Age, Education, Income, Social Desirability, Simpatía: Self, and Simpatía: Otherswere regressed in a hierarchical multiple regression onto Stress Emotions using the Latino sample of participants who had perceived mistreatment. The model was significant at the first step, $F(4, 102) = 2.753$, $p = .032$. The second step was also significant, $F(6, 100) = 2.256$, $p = .044$. Please see Table 9 for more information.

Table 9

Hierarchical Multiple Regression of Demographics and Simpatía Regressed onto Stress Emotions, Latino Sample

	B	SE B	β
Step 1			
Constant	4.628	1.124	
Age	.004	.015	.028
Education	.027	.060	.054
Income	.252	.129	.231
Social Desirability	-.087	.074	-.115
Step 2			
Constant	4.867	1.514	
Age	.004	.015	.026
Education	.020	.060	.040
Income	.232	.130	.213
Social Desirability	-.111	.078	-.149
Expectations of Self	.269	.200	.150
Expectations of Others	-.246	.185	-.142

** = $p < .05$*

In the second regression, Age, Education, Income, Social Desirability, Ethnicity, Simpatía: Self, and Simpatía: Otherswere regressed onto Stress Emotions for the Total sample of those participants who had perceived mistreatment. The model was significant at the first step, $F(4, 219) = 3.175$, $p = .015$. The model was also significant on the

second step, $F(5, 218) = 2.867$, $p = .016$. The third step was also significant, $F(7, 216) = 2.184$, $p = .037$. Please see Table 10 for more information.

Table 10

Multiple Regression of Demographics, Social Desirability, Ethnicity and Simpatía on Stress Emotions, Total Sample

	B	SE B	β
Step 1			
Constant	4.508	.751	
Age	.013	.008	.104
Education	.056	.040	.107
Income	.083	.074	.083
Social Desirability	-.081	.045	-.126
Step 2			
Constant	5.215	.935	
Age	.011	.008	.087
Education	.034	.043	.064
Income	.106	.076	.105
Social Desirability	-.064	.046	-.101
Ethnicity	-.354	.280	-.096
Step 3			
Constant	4.742	1.149	
Age	.011	.009	.091
Education	.032	.044	.062
Income	.101	.077	.101
Social Desirability	-.077	.048	-.120
Ethnicity	-.326	.282	-.089
Expectations of Self	.129	.131	.077
Expectations of Others	-.037	.123	-.023

** = $p < .05$*

In the third regression, Age, Education, Income, Social Desirability, Ethnicity, Simpatía: Self, and Simpatía: Otherswere regressed onto Cumulative Exposure for the Total sample of those participants who had perceived mistreatment. The model was

significant at the first step, $F(4, 219) = 3.110$, $p = .016$. The model was also significant on the second step, $F(5, 218) = 2.571$, $p = .028$. The third step was also significant, $F(7, 216) = 2.121$, $p = .043$. Please see Table 11 for more information.

Table 11

Multiple Regression of Demographics, Social Desirability, Ethnicity and Simpatía on Cumulative Exposure, Total Sample

	B	SE B	β
Step 1			
Constant	11.291	2.878	
Age	.074	.032	.157*
Education	-.116	.152	-.058
Income	-.465	.285	-.121
Social Desirability	-.390	.171	-.159*
Step 2			
Constant	12.720	3.593	
Age	.070	.033	.148*
Education	-.161	.167	-.081
Income	-.419	.293	-.109
Social Desirability	-.357	.179	-.146*
Ethnicity	-.716	1.076	-.051
Step 3			
Constant	10.092	4.405	
Age	.073	.033	.155*
Education	-.169	.167	-.085
Income	-.442	.294	-.115
Social Desirability	-.425	.185	-.173*
Ethnicity	-.569	1.083	-.040
Expectations of Self	.688	.501	.107
Expectations of Others	-.176	.472	-.028

* = $p < .05$

CHAPTER FOUR

DISCUSSION

The factor analysis revealed a two-factor structure for the Simpatía scale, in which one factor focused on the person's own behaviors and their expectations of other people that they interact with. This factor structure reflects the underlying theory of the cultural script, in that the script is based on a person's interactions. It stands to reason that the items would fall into behaviors of both the individual and of the other person. Each factor included expectations based on personality characteristics and interactional characteristics, which also reflects the underlying theory.

A t-test was conducted to compare levels of simpatía between the two ethnic groups. Surprisingly, there was no significant difference between the two groups on the Total Simpatía scale and Expectations of Self subscale. However, there was a significant difference between the two groups on the Expectations of Others subscale, in which the Latino participants scored higher than the Anglo participants; this confirmed the first hypothesis. There could be a number of explanations for these findings. In regards to the lack of significant difference with the Total scale and Expectations of Self subscale between the two groups, it could be that simpatía or expectations similar to simpatía are found in more than just the Latino culture. In addition, as the study focused solely on female participants, the simpatía script may be capturing an interpersonal script that is not necessarily ethnically specific but gender specific.

The correlations did not find that neither the total level of simpatía nor the two subscales were significantly related to the mistreatment variables; this was true for the Total sample, the Latino sample and the Anglo sample, which would appear to disprove

the second hypothesis. However, an analysis of the individual items correlated with the simpatía variables found significant results. Interestingly, significant correlations for the Total and Anglo sample were positive, while significant correlations for the Latino sample were negative. In other words, Latinos higher on simpatía experienced less severe mistreatment while Anglos rated the mistreatment more severely. This stands to reason, especially if considering that Latinos higher in simpatía may be minimizing the amount of mistreatment they have experienced in order to maintain harmonious interpersonal interactions.

The logistic regression showed that the demographic variables proved to be more predictive of mistreatment than the cultural variables of simpatía. The first regression that included the total sample of both Latino and Anglo women was significant at each step until the simpatía variables were included. This seems to indicate that overall, the demographic variables predicted whether or not the participant perceived mistreatment. Looking at each variable individually, however, the regression showed that age and income were significant. The regression found that for every year that the participant aged, they were 15% less likely to perceive mistreatment. Conversely, the more money the participant made, they were 17% more likely to perceive mistreatment. The Latino sample did not produce any significant results as opposed to the Anglo sample.

Along the same lines, the hierarchical multiple regressions showed similar results for the Total and Latino samples. In each regression, the regression was significant at the steps that included demographic variables, but was no longer significant once the simpatía variables were included in the model. Again, this seems to indicate that

demographic variables were more predictive of perceptions of healthcare mistreatment as compared to Simpatía.

The results of the factor analysis of the simpatía scale, the t-test comparing the levels of simpatía between the two sample groups, and the correlations of simpatía with social desirability seems to imply that the simpatía scale does indeed seem to be measuring simpatía. The simpatía scale was positively correlated with Social Desirability, which the literature has suggested are related (Shultz & Chavez, 1994. It also appears that although the simpatía scale is measuring simpatía in the participants, it is not related to mistreatment as hypothesized. One possible explanation may be that the script was measured accurately and influenced the results in an unintended way. The script values interpersonal harmony above all else; if the person was possibly mistreated, it stands to reason that they might not report the mistreatment as they do not want to be disharmonious. As such, they may have censored themselves when discussing possible mistreatment. This effect was found by Ramirez-Esparza, Gosling and Pennebaker (2008), in which participants scored lower on self-report scales of simpatía but behaviorally were judged to be higher on simpatía; it may be possible that this effect may have also occurred with this study with both the simpatía and mistreatment items.

Limitations and Future Research Directions

There were a number of limitations to the study that should be rectified in future studies. As mentioned earlier, this study used a sample of women. Future studies should include men as well, as gender may have an effect on the results. The gender effects

might throw the cultural effects into sharper relief, as there could possibly be stronger differences between Latino and Anglo men.

In addition to possible gender effects, the Simpatía scale is a new scale and needs to be refined and tested further to further establish validity. The Simpatía scale was developed using previous research and a scale previously developed by Yu et al. (2008). As such, cultural variables in addition to social desirability would be helpful in establishing validity. Other sources of variation in simpatía would also be important to understand, including immigrant generation and acculturation level. It would also be important to analyze simpatía in relation to healthcare professionals in particular, as opposed to general interpersonal expectations as was originally measured; this would provide further insight into the patient-healthcare professional relationship. It may be that patients who would normally have higher expectations for others in general may have a different set of expectations for healthcare professionals. Individuals may have lower expectations of healthcare professionals given the professional relationship and brief amount of time during a healthcare interaction. Interestingly, a post hoc analysis of the relationship between simpatía and ethnic concordance between the patient and the healthcare professional proved not significant. This perhaps speaks to the idea that doctors are held to different standards than the general public with regards to expectations of simpatía. Since simpatía is primarily a cultural script revolving around interactions, it would be advisable for future research to look at behavioral outcomes in addition to self-report outcomes. In the context of this study and healthcare behaviors, it would interesting to see how simpatía would be related to behavioral outcomes such as continuity of care with their healthcare professional.

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APPENDIX A

SIMPATÍA SCALE

When I interact with other people, it is important for me ….

1. Be likeable and nice to others.
2. Get along well with others.
3. Minimize the negative aspects of a situation.
4. Emphasize the positive aspects of what people do.
5. Be considerate of other's feelings and needs.
6. Please others even if it means making sacrifices.

When it comes to other people that I interact with, it is important to me that others …

1. are nice and likeable as a person.
2. are easy going.
3. always maintain good relationships with their friends, family, and co-workers.
4. are always warm to others.
5. are nice to others when there is a conflict or argument.
6. are not critical or harsh to others.
7. always recognize and praise others for their accomplishments or positive actions.
8. are always respectful.
9. make people feel at ease.
10. are sympathetic to what people may be going through.
11. keep thoughts and feelings to themselves that could anger others.
12. make others feel happy even if they have to do something they do not want to.

APPENDIX B

PERCEPTIONS OF MISTREATMENT IN

HEALTHCARE SCALE

The following are examples of negative experiences that patients have had with their health care professionals. If any of these has happened to you, please indicate the extent to which this has been a problem.

The health care professional….

1) Did not listen to me.
2) Used words that I did not understand.
3) Did not perform the exam correctly.
4) Touched me inappropriately during the exam.
5) Did not pay attention to me.
6) Did not ask me any questions.
7) Did not give ma chance to say all the things I wanted.
8) Did not provide me with enough information.
9) Was not totally honest with me.
10) Did not answer my questions.
11) Was not clear when explaining my test results.
12) Rushed or hurried when they treated me.
13) Was rough while performing the screening exam.
14) Started the examination without any introduction or conversation.
15) Did not respect my need for privacy.
16) Kept me waiting too long.

17) Jumped to conclusions about my health without having all the details.

18) Did not treat me with respect.

19) Did not return my calls in the appropriate time.

20) Made offensive comments.

21) Did not explain what they were doing.

22) Treated me like an object.

23) Did not warn me that the exam may be painful.

24) Was not very thorough or careful.