


9-2014

Simpatia and Negative Interpersonal Emotions in Continuity of Health Care

Andres Gilberto Mendez

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LOMA LINDA UNIVERSITY
School of Behavioral Health
in conjunction with the
Faculty of Graduate Studies

Simpatía and Negative Interpersonal Emotions in Continuity of
Health Care

by

Andrés Gilberto Méndez

A Dissertation submitted in partial satisfaction of
the requirements for the degree
Doctor of Philosophy in Clinical Psychology

September 2014

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

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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 and seeing it through to completion. I am thankful for their guidance, patience, and feedback, all of which were indispensable in completing this dissertation. I would also like to thank Dr. Chavez; his input, perspective, and advice were much appreciated. In addition, I would like to thank Dr. Vermeersch for being a tireless support throughout graduate school.

I would also like to express my deepest thanks to 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 DISSERTATION

Simpatía and Negative Interpersonal Emotions in Continuity of Health Care

by

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Doctor of Philosophy, Graduate Program in Clinical Psychology

Loma Linda University, September 2014

Dr. Hector Betancourt, Chairperson

Past research has demonstrated that continuity of care has positive outcomes for patients. Continuous care has been shown to have positive outcomes for the patient, including increased patient satisfaction, decreased hospitalizations, decreased emergency department visits, and improved receipt of preventive services. Guided by Betancourt's Integrative Model for the Study of Culture, Psychological Processes, and Health Behaviors, the aim of this research was to examine the role of cultural scripts and mistreatment related negative interpersonal emotions on continuity of care among Latin American (Latino) and Non-Latino White (Anglo) women. Specifically, this study examined the effect of simpatía, a cultural script that is common among Latinos that stresses interpersonal harmony and interaction-related personal characteristics (e.g. being likeable, agreeable, and easy going) on negative emotions associated with healthcare mistreatment, and their combined effects on continuity of care. As hypothesized, mistreatment-related negative emotions negatively impacted continuity of care for both Latino and Anglo women. In addition, consistent with the cultural script, the study found that for Latino women simpatía was negatively associated with reported mistreatment related emotions, which was not the case for Anglo women.

CHAPTER ONE

INTRODUCTION

The Institute of Medicine's Report on Primary Care (1996) listed continuity of care as an important component of primary care. Continuity of care has been shown to have positive outcomes for the patient, including increased patient satisfaction, decreased hospitalizations, decreased emergency department visits, and improved receipt of preventive services (Cabana & Jee, 2004). Studies have also shown that continuity of care is affected by the patient's relationship with clinician (Hautala-Jylhä, Nikkonen, & Jylhä, 2005), the physician's actions (Federman et al., 2001), and the patient's disposition (Noyes, Kukoyi, Longley, Langbehn, & Stuart, 2011).

Negative emotions associated with healthcare procedures represent one of the possible negative influences on continuity of care. Research shows that different ethnic groups may express emotions in different ways (Matsumoto, 1993), may have different expectations of emotional expression (Durik et al., 2006), and that cultural values may affect emotional expression (Wong, Bond, & Rodriguez Mosquera, 2008). In the same way, it has been found (Betancourt, Flynn, & Ormseth, 2011) that anger at the health professional negatively influences continuity of care for Latinos, but not necessarily for Anglos. As there are ethnic differences in terms of negative emotions, these emotional variations may affect a group's continuity of care. As such, it would be important to study negative emotions and continuity of care from a cultural perspective.

Betancourt and colleagues have proposed the Integrative Model for the Study of Culture, Psychological Processes, and Health Behaviors as a way to study the role of culture and psychological factors in health disparities. In this model, (see Figure 1)

cultural variables, which are defined as socially shared values, beliefs, norms, and expectations are considered more directly relevant to variations in psychological processes and behavior than race and ethnicity. The study of the cultural script *simpatía*, and its relation to interaction-related emotions in the clinical encounter may therefore contribute to a better understanding of the role of culture and emotions in continuity of care. *Simpatía* is a cultural script that stresses interpersonal harmony through emphasizing the positive and deemphasizing the negative in a given interaction (Triandis, Marín, Lisansky, & Betancourt, 1984). The aim of this study is to examine whether continuity of care, in addition to negative emotions, is associated with variations in *simpatía* among Latino and Anglo women.

Continuity of Care as an Outcome

Continuity of care has been defined in a number of ways. Saultz (2003) described different types of continuity: Informational, as different providers having access to the records of the patient; Chronologic or longitudinal, in which a patient is seen at the same place by the same provider over a period of time; Interpersonal, in which the relationship between the physician and patient develops a personal trust and sense of responsibility; Geographic, in which the patient receives continuity regardless of the location of the patient; Interdisciplinary, in which knowledge of the previous care is available even if the patient requires a wide range of services; and Family, in which multiple family members see the same providers over a period of time. Regardless of the type of continuity of care being studied, it has become apparent that continuity is an important aspect of healthcare delivery.

Continuity of care has been found to be beneficial for patient outcomes. Therefore, it would be useful to understand what variables are related to and influence continuity of care. One study by Hautala-Jylhä, Nikkonen, and Jylhä (2005) conducted interviews and found that a good relationship between psychiatric inpatient clients and their nurses was positively related to continuity of care once they were released for outpatient treatment. Federman and associates (2001) found that returning to the same health care practice was affected by several variables, one of which was “the physician did not listen to what I had to say.” Patients who reported this were more likely not to return. Noyes, Kukoyi, Longley, Langbehn, & Stuart (2011) discussed the effects that continuity of care and patient disposition had on the quality of the relationship between the patient and physician. They found that one dispositional aspect, positive affectivity, significantly affected the relationship. The researchers defined positive affectivity as the “tendency to experience positive mood states such as excitement, interest, and enthusiasm.” They described participants who scored high on positive affectivity as “cheerful, energetic and confident. They tend to be extroverts who are socially active. This is part of a general behavioral system that directs the person towards situations and experiences that are potentially rewarding.” In addition, previous research by Betancourt, Flynn, and Ormseth (2011) found a negative association between negative interpersonal emotions directed towards the healthcare professional after experiencing an incident of healthcare mistreatment and continuity of care. In their study, the authors found that continuity of care was affected by anger at the healthcare professional only for the Latino participants and not the Anglo participants, implying cultural differences between the two.

Influence of Negative Interpersonal Emotions

As continuity of care can be influenced by negative emotions experienced in healthcare interactions, it is important to understand emotions in a cultural context. Research has shown that emotions and emotional expression can vary by ethnic group and culture. Matsumoto (1993) described how different ethnic groups may express emotions in different ways: for example, African-American participants were more likely to express anger than other ethnic groups. Wong, Bond, & Rodriguez Mosquera (2008) discussed the idea that cultural values may affect emotional expression. They found that participants in hierarchical cultures were less likely to non-verbally express negative emotions such as shame, guilt, and fear. Mesquita and Walker (2003) argued similarly, explaining that the expression of emotions in different cultures was tied to cultural models, in which “expressions and behaviors that are consistent with cultural models tend to have a high rate of occurrence whereas responses that are contrary to cultural models tend to be infrequent.” In essence, they argue that emotional expression will reflect what is considered appropriate for the culture. Durik et al. (2006) described different expectations of emotional expression, based on gender and ethnic group. The authors described *simpatía* as a possible influence of emotional expression. The authors found that Hispanic Americans were expected to express more pride and shame than Anglo Americans. Along the same lines, Savani, Alvarez, Mesquita, and Markus (2012) found that Mexican participants were more likely to report experiencing interpersonally engaging emotions and less likely to experience interpersonally disengaging emotions. The authors discussed emotions in the context of Mexican cultural scripts of *simpatía* and *personalismo*, which they took into account when describing their hypotheses.

Considering that Latinos are one of the largest and fastest growing minority groups in the United States, accounting for more than half (15.2 million) of the total population increase (27.3 million) (Ennis, Ríos-Vargas, & Albert, 2011), ensuring effective patient-professional encounters is particularly important to study for this population. According to the U.S. Census Bureau (Humes, Jones, & Ramirez, 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, Latinos are the majority group accounting for 49.8% of the population while Anglos account for 32.5% (Bureau, 2011).

Studying these interactions from a cultural perspective requires research with variables beyond race and ethnicity. Although demographic variables can provide some information and can be related to emotions, unless specific cultural factors are identified and investigated, the applicability of such findings is limited. In an effort to better understand the relationship between continuity of care, negative interpersonal emotions, and culture, it would be reasonable to look at factors 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 López (1993) have argued that the majority of studies examining the effects of culture on psychological processes in fact use ethnicity or race as a proxy for culture to account for variance in psychological processes or behaviors. According to the authors, race and ethnicity are not easily quantifiable and there is as much or more

variation within a given ethnic or a racial group than there is between racial or ethnic groups. The authors argue that instead of race or ethnicity, researchers should use more quantifiable variables such as cultural values, beliefs, expectations, and norms.

Betancourt's Integrative Model for the Study of Culture, Psychological Factors, and Health Behaviors (Betancourt et al., 2011; Flynn, Betancourt, & Ormseth, 2011) provides a framework to study how such cultural factors relate to psychological processes and behavior in addition to explaining how population categories such as ethnicity relate to aspects of culture (see Figure 1).

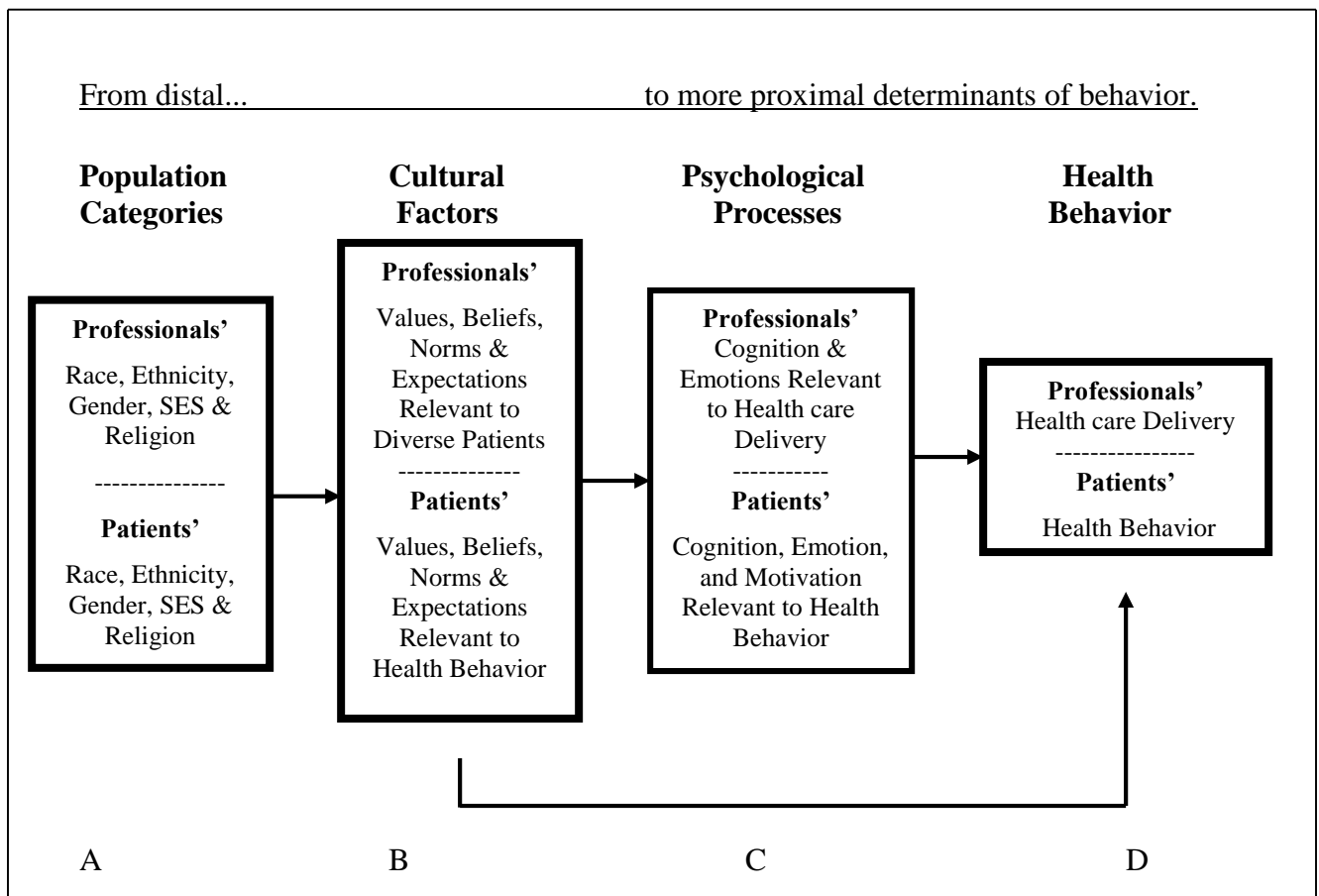


Figure 1. Betancourt's Integrative Model of Culture, Psychological Processes and Behavior adapted for the study of health behavior

The model begins with 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 socially shared values, beliefs, norms, expectations and practices. These cultural aspects are believed to influence psychological processes (C) such as cognitions and emotions directly. In addition, culture may also influence behaviors (D) directly through a route that bypasses the psychological processes. Lastly, psychological processes have the most proximal effect on behavior, as they have a direct relationship to the behavior in question.

Simpatía as a Cultural Script

Triandis et al. (1984) were the first to discuss and empirically test 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 defined *simpatía* as having two parts: as “a permanent personal quality where an individual is perceived as likeable, attractive, fun to be with, and easy-going,” and as a characteristic in which 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 the positive in positive situations and deemphasizes the negative in negative situations (Triandis et al., 1984).

Much of the literature on *simpatía* argues for its importance in understanding interpersonal relations among Latino individuals, though its empirical investigation is less prevalent. Kail and Elberth (2002) 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 and Chávez (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; few scales purport to measure *simpatía*. Research by Triandis et al. (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 less likely to criticize and more likely to show loyalty, admiration and respect for a “target person.” Griffith, Joe, Chatham, and 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. Yu, Lucero-Liu, Gamble, Taylor, Christensen, and Modry-Mandell (2008) developed a scale to examine *simpatía* 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.

A study by Ramírez-Esparza, Gosling, and Pennebaker (2008) found that Latinos scored lower on an 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.

They argued that 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. Previous research (Mendez, 2012) found that simpatía, in particular the expectation of simpatía in others, was found to differ significantly between Latino and Anglo women, in that Latino women had higher expectations of simpatía in others than Anglo women. In addition, the study found that Latinos higher on simpatía experienced less severe mistreatment while Anglos rated their mistreatment more severely.

Simpatía may also influence the relationship between a healthcare professional and their patients and in doing so, affect the patient's continuity of care. A patient's continuity of care may be influenced through negative emotions, as the expression of negative emotions may fall under the domain of a social interaction as prescribed by simpatía. It stands to reason that a person who ascribes to the cultural script may inhibit their expression of negative emotions, as expressing them would be viewed as contrary to one of the basic tenets of simpatía: deemphasizing the negative aspects of an interaction. It does not, however, preclude the participant from experiencing the emotion, but would instead influence the accompanying behavior of expressing or reporting that negative emotion to someone else. While this behavior may be true for groups such as Latinos, other groups may not report similar behaviors, despite having similar ideals and expectations. As previous research has demonstrated, Latinos and Anglos differ on their level of simpatía, which may in turn influence their reported expression of negative emotions.

In sum, continuity of care is an important aspect of primary care, as it positively influences desirable outcomes such as increased patient satisfaction and improved receipt of preventive services. However, negative interpersonal emotions patients experience in their interactions with a healthcare professional can negatively impact their continuity of care. Research with culturally diverse populations suggests that such emotions should be examined in relation to cultural factors, as these cultural factors and associated behaviors may have measureable influence on a person's continuity of care. Guided by Betancourt's Integrative Model for the Study of Culture, Psychological Processes, and Health Behaviors, this study investigated the structure of relations between culture (e.g. the cultural script *simpatía*), psychological processes (e.g. emotions experienced in healthcare interactions) and health behaviors (e.g. patient's continuity of cancer screening). Specifically, this study examined whether continuity of care is influenced by variations in *simpatía* and negative interpersonal emotions among Latino and Anglo women. To this end, the structure of relations among *simpatía* and negative interpersonal emotions as determinants of continuity of cancer screening care was examined using causal modeling techniques for the analyses of structural equations (see Figure 2 for the hypothesized structural equation model).

Hypotheses

1. Higher levels of mistreatment related negative interpersonal emotions will be associated with lower continuity of care for Latino and Anglo women.

- 2a. Simpatía will be positively associated with reported mistreatment-related negative interpersonal emotions for Anglos, and negatively associated with mistreatment-related negative interpersonal emotions for Latinos.
- 2b. The magnitude of the relation between simpatía and reported mistreatment-related negative interpersonal emotions will be stronger for Latinos as compared to Anglos.

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 between 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, SES, and other demographic 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 20 years old, Latino or Anglo American, ability to read English or Spanish), and the risks/benefits for participation. The advertisement listed a time and place where interested individuals could go to participate in the study.

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, reviewed 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 demographic distribution of participants was reexamined and additional data was collected from participants underrepresented in the noted demographics. 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,c,d}	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)) ^{b,c,d}	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 and Anglos who perceived mistreatment.

^c refers to significant differences between Latinos and Anglos who did not perceive mistreatment.

^d refers to significant differences between Latinos and Anglos for the Total Sample

Measures

All instruments were available in English and Spanish.

Simpatía as a Cultural Script

Simpatía was assessed using a newly developed 9 item instrument (Mendez, 2012) based on theoretical definitions provided by Triandis et al. (1984) as well as content included in Griffith et al. (1998) and Yu et al. (2008) simpatía scales. All items were based on a seven point Likert Scale from one, representing “Sometimes”, to seven, representing “Always.”

Exploratory factor analysis of the 9-item scale resulted in two factors. The “Simpatía-Self” factor included five items representing aspects of simpatía valued in oneself: minimize the negative aspects of what people do; be considerate of others’ feelings and needs; emphasize the positive aspects of what people do; get along well with others; and please others even if it means making sacrifices. The reliability of this factor was good: Cronbach’s alphas of .84 (Total), .78 (Latino) and .88 (Anglo). The “Simpatía-Others” factor included four items reflecting aspects of simpatía valued in others: are warm to others; easy going; maintain good relationships with others; and make others feel comfortable. The reliability of this factor was excellent: .87 (Total), .82 (Latino) and .91 (Anglo). The reliability of the total 9-item scale was also excellent, .88 (Total), .82 (Latino), and .92 (Anglo). In order to test the influence of the total simpatía scale on the study variables using structural equation modeling, three parcels were created using three randomly assigned items from the 9-item Simpatía scale.

Mistreatment Related Negative Interpersonal Emotions

Participants were asked to report whether they had experienced 24 different incidents of interpersonal mistreatment in the healthcare setting during routine breast or cervical cancer screening. Participants were then asked to rate the degree to which they had experienced anger, irritation, and rage towards the healthcare professional as a result of the mistreatment incident. The items were scored on a seven point Likert scale, with one representing “Not at all”, to seven, representing “Very Much.” The three-item scale had good reliability (Latinos, $\alpha = .80$; Anglos, $\alpha = .81$; Overall, $\alpha = .80$).

Continuity of Care

Continuity of care following the mistreatment incident was assessed using two items that focused on the participant returning to their healthcare professional or their healthcare facility: “As a result of this incident, did you go to a new health clinic to receive your care (or do you plan to go a new clinic)?” and “As a result of this incident, did you change healthcare professionals (or do you plan to change healthcare professionals)?” Participants marked whether they went to a new clinic or professional, stayed with the same clinic or professional because they did not want to change, or stayed with the same clinic or professional because they had no other option. The third option was recategorized as wanting to discontinue care, as it implied intent to change. The two-item scale had good reliability (Latinos, $\alpha = .87$; Anglos, $\alpha = .86$; Overall, $\alpha = .86$).

In addition, preliminary analyses included an analysis of covariates, including the gender of healthcare provider and insurance status.

Data Analyses

All hypotheses were tested using Bentler's structural equation modeling program (Bentler, 2005) with the maximum likelihood method of estimation. In order to maintain a simplified model without using up model degrees of freedom (Kammeyer-Mueller & Wanberg, 2003), all relevant covariates were partitioned from the indicators of the noted outcomes prior to analyses. Adequacy of fit was assessed using the non-significant χ^2 goodness-of-fit statistic, a ratio of less than 2.0 for the χ^2/df (Tabachnick & Fidell, 2007), a Comparative Fit Index (CFI) of .95 or greater (Bentler, 2005), and a Root Mean Square Error of Approximation (RMSEA) of less than .08 (Browne & Cudeck, 1992).

To test ethnicity-based differences in the relations among the study variables, multi-group structural equation modeling for Latino and Anglo women was also conducted. The LM Test of equality constraints was assessed for evidence of non-invariance (Cheung & Rensvold, 2002) and constraints were released in a sequential manner if doing so improved the model fit ($LM \chi^2 \geq 5.0$ per df) (Scott-Lennix & Lennox, 1995). Since it is necessary in cross-cultural research to establish that differences observed between groups are not due to measurement artifacts (Fons & Kwok, 1997), measurement equivalence was examined prior to invariance testing.

CHAPTER THREE

RESULTS

Preliminary Analyses

Of the 335 women who participated in the study, 225 (107 Latino and 118 Anglo) reported perceiving at least one instance of interpersonal healthcare mistreatment during a routine breast or cervical cancer screening exam. Anglo women who reported healthcare mistreatment were younger ($M = 47.79$, $SD = 16.56$) compared to those that did not ($M = 57.49$, $SD = 19.90$), $t(84.780) = 2.65$, $p = .009$.

A missing variables analysis of the sample that reported healthcare mistreatment identified 17 cases (10 Latino, 7 Anglo) with missing values on one or more of the outcome variables and were therefore excluded from the analyses. These participants reported fewer years of education ($M = 10.21$, $SD = 4.06$) compared to the retained sample ($M = 12.93$, $SD = 3.41$), $t(223) = -3.114$, $p = .002$.

After imputing values for 3 Latino and 9 Anglo women using the expectation-maximization algorithm, the resulting sample of 208 (97 Latino, 111 Anglo) women was used for subsequent analyses. An examination of the demographic variables revealed equal distributions across ethnicity for age, income, and health insurance status, which indicates the effectiveness of the employed multi-stage stratified sampling procedure (Table 1). Anglo participants reported more years of education compared to Latino participants, $t(176.41) = 6.05$, $p < .001$.

Analysis of Covariates, Descriptive Statistics and Correlations

An analysis of covariates revealed that Anglo women mistreated by a male provider as compared to a female provider were more likely to report higher levels of overall negative emotions ($r(111) = -.265, p < .05$), anger ($r(111) = -.214, p < .05$), rage ($r(111) = -.240, p < .05$), and irritation ($r(111) = -.221, p < .05$). Anglo women with a female provider were more likely to return to the same healthcare professional ($r(111) = .189, p < .05$). Anglo women with a greater choice of their healthcare professional were less likely to report overall negative emotions ($r(111) = -.206, p < .05$) and irritation ($r(111) = -.264, p < .05$). They were also much more likely to return to the same healthcare clinic ($r(111) = .315, p < .05$) and healthcare professional ($r(111) = .327, p < .05$).

For Latino women, those with insurance were more likely to continue care with the clinic ($r(97) = .328, p < .01$) and healthcare professional ($r(97) = .243, p < .05$). In addition, those with a female provider were more likely to return to their healthcare clinic ($r(97) = .223, p < .05$) and healthcare professional ($r(97) = .204, p < .05$) after a mistreatment incident.

Table 2 includes the frequencies, means, and standard deviations for the study variables. Table 2 also represents correlations among the study variables after accounting for the covariates of insurance status, the gender of the healthcare professional, and the level of choice the participant had in choosing their healthcare professional. Fischer's *r*-to-*z* test of differences revealed several significantly different correlations based on ethnicity, confirming the need for a test of invariance.

Table 2

Correlations, means, and standard deviations of study variables as a function of ethnicity

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	
1. Simpatía- Total	--																			
2. Simpatía- Self	.882** (.899)***	--																		
3. Get along well with others	.807*** (.848)***	.757*** (.854)***	--																	
4. Minimize negative aspects	.695*** (.607)***	.760*** (.774)***	.551*** (.555)***	--																
5. Emphasize positive aspects	.653*** (.731)***	.803*** (.780)***	.526*** (.700)***	.517*** (.468)***	--															
6. Be considerate of other's feelings	.631*** (.772)***	.774*** (.830)***	.523*** (.777)***	.411*** (.458)***	.638*** (.716)***	--														
7. Please others	.624*** (.649)***	.745*** (.735)***	.411*** (.470)***	.417*** (.490)***	.419*** (.490)***	.489*** (.480)***	--													
8. Simpatía- Other	.821*** (.850)***	.455*** (.534)***	.607*** (.611)***	.393*** (.241)**	.259* (.473)***	.255** (.493)***	.277** (.369)***	--												
9. Are easy- going	.589*** (.704)***	.248** (.416)***	.387*** (.460)***	.255** (.211)**	.110 (.312)***	.099 (.338)***	.133 (.353)***	.813*** (.860)***	--											
10. Maintain good relationships	.734*** (.730)***	.399*** (.456)***	.510*** (.503)***	.391*** (.157)	.186 (.459)***	.164 (.440)***	.295** (.321)***	.903*** (.862)***	.645*** (.663)***	--										
11. Are warm to others	.757*** (.719)***	.446*** (.411)***	.595*** (.527)***	.359*** (.176)	.269** (.367)***	.269** (.399)***	.270** (.240)**	.890*** (.895)***	.592*** (.692)***	.801*** (.678)***	--									
12. Make others feel comfo	.705*** (.809)***	.470*** (.587)***	.585*** (.646)***	.330*** (.304)***	.339*** (.526)***	.364*** (.554)***	.252** (.377)***	.763*** (.856)***	.424*** (.613)***	.597*** (.662)***	.624*** (.727)***	--								
13. Neg. interpersonal emotions	-.086 (.055)	-.037 (-.010)	-.120 (.038)	-.040 (-.006)	.019 (.036)	-.009 (.103)	-.010 (-.147)	-.117 (.122)	-.101 (.047)	-.132 (.165)	-.074 (.133)	-.085 (.079)	--							
14. Anger	-.101 (.058)	-.002 (.010)	-.078 (.056)	-.010 (.020)	.049 (.099)	-.002 (.109)	.015 (-.173)	-.186 (.100)	-.157 (.039)	-.192* (.123)	-.149 (.098)	-.135 (.090)	.901*** (.891)***	--						
15. Rage	-.136 (.069)	-.115 (.036)	-.186 (.071)	-.108 (.052)	-.010 (-.009)	-.050 (.120)	-.098 (-.053)	-.118 (.090)	-.089 (.023)	-.148 (.137)	-.083 (.081)	-.077 (.075)	.795*** (.814)***	.586*** (.595)***	--					
16. Irritation	.010 (.018)	.014 (-.072)	-.052 (-.029)	.008 (-.087)	.007 (-.003)	.026 (.033)	.047 (-.146)	.002 (.121)	-.015 (.057)	-.004 (.162)	.037 (.161)	-.010 (.036)	.867*** (.843)***	.713*** (.662)***	.486*** (.489)***	--				
17. Continuity of care	-.056 (.160)	-.109 (.150)	-.054 (.133)	-.104 (.182)	-.152 (.099)	-.080 (.042)	-.034 (.108)	.030 (.123)	.027 (.030)	-.011 (.175)	.050 (.138)	.038 (.082)	-.270** (-.217)***	-.301** (-.199)*	-.246* (-.064)	-.135 (-.289)**	--			
18. Clinic	.007 (.033)	.009 (.038)	.077 (.011)	.033 (-.048)	-.115 (-.002)	.090 (.032)	-.013 (.136)	.003 (.016)	.013 (-.053)	.061 (-.022)	-.057 (.027)	-.012 (.116)	-.278*** (.422)***	-.320*** (-.339)***	-.200* (-.309)**	-.180 (-.427)***	.265** (.213)*	--		
19. Professional	.049 (.020)	-.051 (.019)	.031 (.012)	-.019 (-.037)	-.144 (-.011)	.002 (-.005)	-.073 (.096)	.157 (.015)	.132 (-.055)	.200* (.002)	.103 (.036)	.093 (.078)	-.355*** (.442)***	-.398*** (-.352)***	-.223* (-.354)*	-.272** (-.421)***	.295* (.225)*	.774*** (.749)***	--	
M	5.70 (5.61)	5.72 (5.73)	6.22 (6.08)	5.50 (5.64)	5.80 (5.81)	6.22 (6.25)	4.88 (4.87)	5.67 (5.45)	5.40 (5.08)	5.62 (5.47)	5.73 (5.54)	6.00 (5.71)	3.29 (3.86)	3.70 (4.33)	2.45 (2.49)	3.72 (4.78)	1.81 (1.85)	1.48 (1.49)	1.46 (1.45)	
SD	.97 (.96)	1.12 (1.08)	1.21 (1.16)	1.54 (1.59)	1.54 (1.33)	1.19 (1.09)	1.79 (1.69)	1.15 (1.12)	1.57 (1.35)	1.37 (1.26)	1.32 (1.36)	1.22 (1.18)	1.93 (1.77)	2.29 (2.17)	2.11 (2.03)	2.34 (2.05)	.66 (.66)	.50 (.50)	.50 (.50)	

* = $p < 0.05$; ** = $p < 0.01$; *** = $p < 0.001$

Boldface indicates groups differ significantly

Structural Equation Modeling

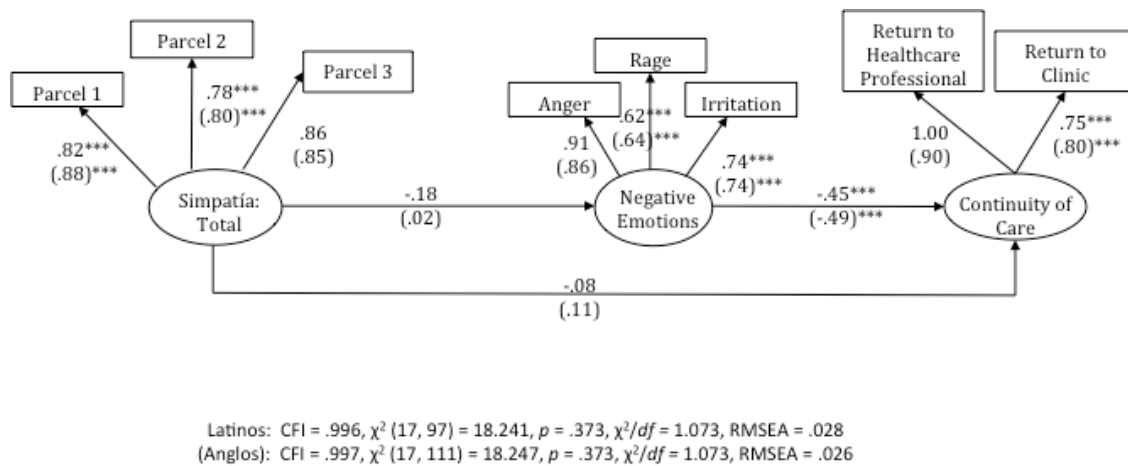


Figure 2. Results of hypothesized SEM predicting continuity of care for Latino and Anglo women. (Note: * = $p < .05$, ** = $p < .01$, *** = $p < .001$)

A test of the causal model including the hypotheses and theory-based relations among the variables of the study as predictors of continuity of care was found to have an excellent fit of the data for both Latino (CFI = 1.00, $\chi^2(24, 97) = 17.872$, $p = .809$, $\chi^2/df = .745$, RMSEA = .000) and Anglo participants (CFI = 1.00, $\chi^2(24, 111) = 18.441$, $p = .781$, $\chi^2/df = .768$, RMSEA = .000). As observed in Figure 2, the first hypothesis was confirmed. For both ethnic groups, higher scores on negative interpersonal emotions were associated with decreased continuity of care (Latinos: $\beta = -.45$, $p < .001$; Anglos: $\beta = -.49$, $p < .001$).

For Latinos, hypothesis 2a was also confirmed. Higher scores on simpatía were related to lower scores on self-reported negative interpersonal emotions. However, for Anglo participants, simpatía was not associated with negative interpersonal emotions. To explore whether the magnitude of the relation between simpatía and negative

interpersonal emotions was moderated by ethnicity, multi-group structural equation modeling was performed. Prior to testing for structural differences, a test for measurement equivalence was conducted to ensure that any identified differences could be interpreted as true cultural differences rather than as a result of measurement issues. Both configural invariance (CFI = .996, $\chi^2(34, n = 208) = 36.487, p = .354, \chi^2/df = 1.073$, RMSEA = .019) and measurement equivalence (CFI = 1.00, $\chi^2(39, n = 208) = 37.962, p = .517, \chi^2/df = .973$, RMSEA = .000) were achieved as determined by the excellent fit indices. In testing for structural invariance (CFI = 1.00, $\chi^2(42, n = 208) = 41.060, p = .512, \chi^2/df = .977$, RMSEA = .000), the LM test did not show any significant between ethnic group differences in the path from simpatía to negative emotions. Although the test of invariance did not reveal any statistically significant differences, a trend is apparent based on the observed path coefficients for Latinos ($\beta = -.18, p = .127$) and Anglos ($\beta = -.02, p = .849$).

Posthoc Analyses

Additional analyses were conducted in order to examine the influence of the simpatía subscales (self and other) on negative interpersonal emotions. The model including Simpatía-Other (Figure 3) fit the data well for both Latino (CFI = 1.00, $\chi^2(24, 97) = 17.872, p = .809, \chi^2/df = .745$, RMSEA = .000) and Anglo participants (CFI = 1.00, $\chi^2(24, 111) = 18.441, p = .781, \chi^2/df = .768$, RMSEA = .000). For Latinas, the effect of simpatía on self-reported levels of negative emotions ($\beta = -.28, p = .011$) was stronger as compared to what was observed in Figure 3 ($\beta = -.18, p = .127$). A slightly stronger

effect was also observed for Anglos ($\beta = .11, p = .311$) as compared to the path observed in Figure 3 ($\beta = -.02, p = .849$).

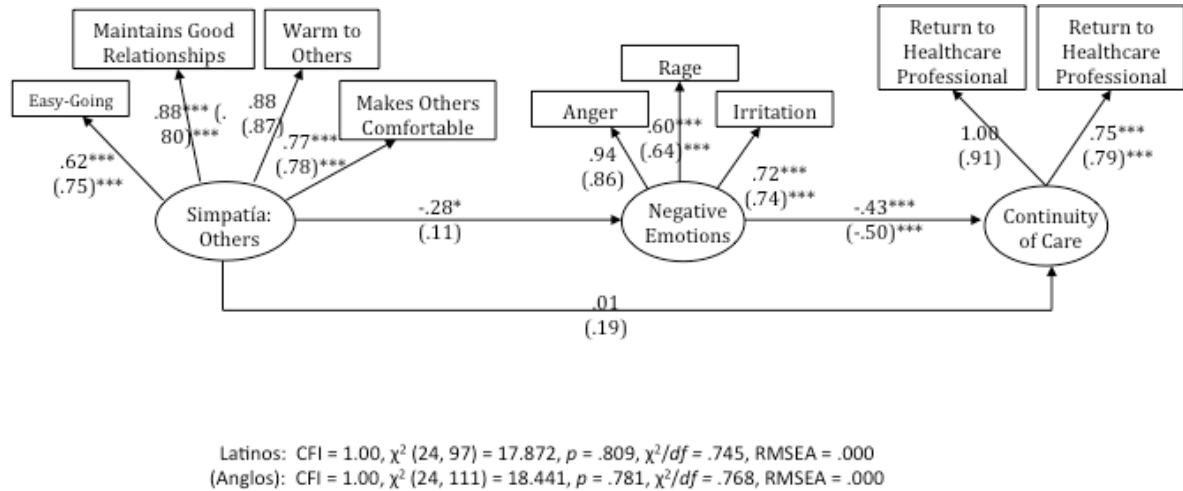


Figure 3. Results of SEM predicting continuity of care for Latino and Anglo women using Simpatía-Other.

In testing for structural invariance, the LM test ($LM \chi^2(1) = 5.36, p = .019$) revealed a significant between ethnic group difference in the path from Simpatía-Other and negative emotions. Based on results from multi-group analyses, the second hypothesis was supported in that the magnitude of the relationship between Simpatía-Other and negative emotions was greater for Latino participants as compared to Anglo participants.

An additional model was tested including Simpatía-Self, however this model did not fit the data well. In order to explore potential reasons for this, the Latino sample was further analyzed based on country of birth. A review of the bivariate correlations (see Table 3) for Foreign-born and US-born Latinos revealed interesting differences. For

instance the relation between Simpatía-Self and negative interpersonal emotions was negative for Foreign-Born Latinos and positive for US-Born Latinos.

Table 3

Correlations between Study Variables

	Negative Emotions	Continuity of Care
Simpatía: Self	-.110/.106/(-.053)	-.057/-.095/ (.051)
Simpatía: Others	-.161/-.072/ (.053)	.043/.163/ (.096)

* = $p < .05$, ** = $p < .01$, *** = $p < .001$
 Foreign-Born Latinos/*US-Born Latinos*/(Anglos)

CHAPTER FOUR

DISCUSSION

Overall, the results of this study lend support to conceptually based expectations concerning the role of *simpatía* as a cultural script of Latinos. Particularly relevant to the aims of the research is the finding that in the case of Latinas, the higher they scored on *simpatía*, the less likely they were to report high levels of mistreatment-related negative emotions. This finding is consistent with the cultural script, which implies minimizing negative aspects of interaction while emphasizing the positive. Equally interesting is the finding that while higher levels of *simpatía* were associated with lower levels of reported negative emotions, the negative impact of mistreatment-related emotions on continuity of care for Latino women was similar to that observed for Anglo women. This further supports the view that while mistreatment does generate high levels of negative emotions in all women, Latinas who score high on *simpatía* are less likely to report those negative emotions than Latinas who score lower on *simpatía*, something not observed in the case of Anglo women. The fact that Anglo women who scored higher on the *simpatía* scale, particularly on items related to expectations of others, reported higher levels of mistreatment related emotions suggests that even though both Anglo and Latino women may score high on *simpatía* related expectations in clinical interactions, only Latino women report the experienced emotions in a manner consistent with the cultural script. This has important implications for the clinical encounter, in which Latino women, particularly those high in *simpatía*, may not report negative emotions as much as Anglo women do, but those emotions may still have the expected negative impact on continuity of care.

In the case of Latinas, consistent with the cultural script, the higher they score on *simpatía* the less likely they are to report high levels of negative emotions associated with mistreatment. However, those under-reported emotions still negatively impacted their continuity of care. In terms of the relationship between culture and emotions, various studies (Mesquita & Walker, 2003; Wong et al., 2008) have alluded to the idea that emotional expression can be significantly influenced and regulated by what is considered culturally appropriate by the individual. As such, it stands to reason that the influence of culture, namely *simpatía* in this example, would influence if the person reports or expresses negative emotions. As mentioned earlier, *simpatía* is a cultural script which regulates the behaviors related to interpersonal interactions: those who are higher on *simpatía* are more likely to emphasize positive aspects of an interaction and deemphasize the negative aspects of an interaction. It would make sense that a person's expectations of others would likely influence their emotional expression and prevent them from voicing those negative emotions, especially if expressing those emotions had the potential to make an interaction more negative.

In this study, Latinas were generally higher on *Simpatía-Others* than Anglo women. While the others-related factor in the *Simpatía Scale (Simpatía-Others)* may capture expectations related to interpersonal relations common to both ethnic groups, the culturally appropriate behavior in response to those expectations of inhibiting the expression of negative emotions would be more prevalent among a Latino population that subscribes to that script. Anglo participants would not necessarily have the same behaviors ingrained in their culture, despite having similar expectations to those of the Latino sample. The Anglo participants would therefore have no problem expressing

negative emotions, regardless of how they respond to items in the Simpatía Scale, particularly those related to expectations of others in interpersonal relations. In a more general view, the cultural script simpatía results in differences in reporting negative emotions between Latina and Anglo women.

In addition to the hypothesized relationships between the study variables, it is also important to consider the pathway between the cultural variable and the behavioral outcome variable, which suggests that for Latina and Anglo women the influence of culture on continuity of care takes place mostly through and indirect influence through mistreatment related negative emotions, as opposed to a direct relationship between simpatía and continuity of care. According to Betancourt's Integrative Model for the Study of Culture, Psychological Processes and Health Behaviors, culture can influence behaviors both through direct and indirect pathways, and this study's findings lend support to the idea of the indirect influence of culture on behavior.

Limitations and Future Directions for Research

In terms of limitations of this study, gender is an important variable to take into consideration. This study's participants were only women, as the study investigated cultural variables that influenced breast and cervical cancer screening behaviors. As such it would be important for future research to include men in the study, as it would improve the generalizability of the findings.

In addition, since this study was very specific to negative emotions, perhaps focusing on positive emotions would produce different results. According to theory, Latino women may express more positive emotions than Anglo women, especially if

simpatía were to play a role in which positive interactions were emphasized in interpersonal encounters.

Future research could also expand the types of variables that are included. Different cultural variables may also influence emotions or how they are reported. In addition to diverse cultural variables, other continuity of care variables may be investigated. Continuity of care is not necessarily solely conceptualized as returning to the same healthcare professional. The length of time before a follow-up appointment and a delay for routine appointments may be another area where cultural variables and negative emotions have a significant impact.

Implications for Practice

Understanding how culture can affect behavior can significantly help a clinician to provide a better service to their patients, improve their health outcomes, and contribute to the reduction of healthcare mistreatment. It may be helpful for the clinician to be aware that their actions may come across as violating a cultural ideal, which would further affect their patient's continuity of care and treatment. In addition, clinicians benefit from understanding that Latino women, particularly those high in simpatía, may be less likely than others to report negative aspects of their experience in the clinical encounter. In a similar manner, based on the Simpatía cultural script, it is possible that these patients perceive as negative aspects of the encounter that are neutral, even though they may not report such negative perceptions.

Previous research conducted on “role induction” within the mental health literature provides a possible method of intervention for other healthcare professionals.

Swift, Greenberg, Whipple, and Kominiak (2012) defined role induction as “the process of providing clients with some education about appropriate therapy behaviors prior to the start of treatment.” Research has shown that role induction provides improved outcomes for outpatient drug therapy retention (Katz et al., 2004) and clinical supervision (Bahrlick, Russell, & Salmi, 1991). In addition, a study conducted by Reis and Brown (2006) found that a pre-treatment therapy orientation video helped reduce therapy dropout. This may prove to be a useful technique for healthcare professionals to employ, in which the possible roles and role expectations of a doctor-patient interaction are explained to the client at the outset of treatment. Healthcare professionals can explain that the clinical encounter is not a typical interaction and that the patient should expect to engage in discussions which may require participation that the client may deem rude or inappropriate. The healthcare professional may emphasize that in order to fully treat the patient, they require the patient’s help, and that any reactions, questions, or problems should be brought to the healthcare professional’s attention. The healthcare professional could also explain to the client that they will not become upset or angry or take offense should the other person voice a negative comment or concern, as it is a normal and expected part of the clinical encounter. This may help delineate what roles each participant should take, and could possibly help the patient feel more comfortable and empowered during the healthcare interactions.

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APPENDIX A
SIMPATÍA SCALE

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

1. Get along well with others.
2. Minimize the negative aspects of a situation.
3. Emphasize the positive aspects of what people do.
4. Be considerate of other's feelings and needs.
5. 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 easy going.
2. maintain good relationships others.
3. are warm to others.
4. make others feel comfortable.