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A descriptive study comparing Spanish surnamed and Anglo utilizers of a mental health facility

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A DESCRIPTIVE STUDY COMPARING SPANISH SURNAMED AND ANGLO UTILIZERS OF A MENTAL HEALTH FACILITY

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Chapter 1

THE PROBLEM

The Problem Formulation

Under-utilization of mental health services by the Spanish surnamed population* has been an area of concern for many professionals in the mental health field including administrators, psychologists, psychiatrists, and social workers. The issue is perplexing. Because of the many stress-producing factors that exist within the Anglo society for the Latino, one would think that mental health care would be in more of a demand by this group than is indicated by the literature (see Alvarez, Hoyos, Dieppa, et al., 1974; Padilla, Ruiz, and Alvarez, 1975; Abad, Ramos, and Boyce, 1974; and Abad, Ramos, and Boyce, 1977). Some studies have undertaken the task of attempting to show the reasons behind this dilemma and in the hopes of finding ways to improve mental health services to better accommodate the needs of this group of minorities. However, the approaches have often been to study nonusers and their reasons for nonuse rather than those Spanish surnamed individuals who have chosen the mental health facility as a resource. L. C. Moll and his colleagues (1976) agree that under-utilization is a popular

*This term will be used interchangeably with "Latino" and will symbolize all individuals of Spanish origin in the United States.

subject in the field of mental health and that this focus has diverted attention from those clients who do utilize the facilities.

The purpose of this thesis is to study the problem of under-utilization from a more positive approach, namely, the users of the mental health facility. Although there are research materials that have addressed themselves to the problem of nonuse in this manner, we still do not know how the Latino users compare to the Anglo with regard to demographic characteristics and the type of treatment that is afforded them. It is with the intention of providing such information that the author will conduct a comparative study that takes into consideration demographic characteristics, referral source, presenting problem, mode of treatment, length of treatment, and outcome of therapy.

Objectives of the Study

The special study is based on two major objectives. First, it will serve to compare basic demographic characteristics of Spanish surnamed (SS) and Anglo families who utilize the mental health services provided by the Adult and Child Guidance Clinic of Santa Clara County. The age and sex of the child, sex, marital status, and educational level of the parents, the amount of annual family income, and the number of individuals in the family, are all included in the term "characteristics." Secondly, it provides data as to any differences that may exist in the diagnosis, source of referral, presenting problem, nature of treatment, length of

treatment, and outcome of therapy between the two groups of clientele. Although these terms are operationally defined in Chapter 3, some clarification is needed at this time.

The "presenting problem" differs from the child's "diagnosis" in that the diagnosis denotes the clinical or professional's definition of the problem while the presenting problem is a description of the child's difficulties as the parent(s) sees them. "Source of referral" is designated by the person(s) or institution who recommended that the client contact the clinic. "Nature of treatment" means the mode of intervention; whether individual, group, parent, or family, or a combination of these. "Length of treatment" will be symbolized in terms of the number of visits made to the clinic. The "outcome of therapy" will be measured by the attainment or unattainment of the goals that are specified by therapist in cooperation with the parent(s).

It is not the intent of the author to explore the mental health needs of the SS population nor to propose alternate ways of meeting those needs. The study will, however, provide basic comparative data that may be used as a reference source for the development of programs that may better serve this group of minorities.

Need for the Study

The importance of this study becomes apparent when one considers that there is a lack of knowledge as to who the SS users of mental health services are as compared to the Anglo users. Also, if one is to develop a mental health

program for the SS population, data as to the characteristics of those who actually seek help from this source becomes indispensable.

Social workers are continually faced with the issue of providing the kind of help that will enhance the social functioning of the SS group. Some of these workers have launched community outreach programs in order to approach those who may be in need of help but are not seeking it. Information concerning the majority of users would help clarify what factors are related to current success in outreach and program utilization. Such information would also be beneficial to administrators when making proposals to the state and federal governments for grants related to providing mental health care to this group of minorities.

Description of the Agency

The Adult and Child Guidance Clinic is an outpatient mental health facility situated in San Jose. It serves an ethnically diverse community in catchment area #26 and is bound by Highway 101 and Guadalupe River, and Highway 17 and Capitol Expressway. The clinic itself is split into two distinct sections: the adult and adolescent section (upstairs) and the children's section (downstairs). Whereas the adult and adolescent section handles clients thirteen years and over, the children's section serves only children, twelve years and under, and their families.

The two sections are different from each other in many ways. First, each section is supervised by a different

director such that there is an administrative boundary. A second difference lies within the intake procedure. The children's section requires an initial interview with the parent(s) and an additional visit to the agency for an evaluation of the child by the psychologist. The adult and adolescent section does not require a psychological evaluation and treatment may be based on an initial interview with the individual or the entire family. Whereas long term treatment is more desireable in the children's section, the adult and adolescent portion of the agency does more short-term therapy.

Since the above dissimilarities may influence the length and mode of therapy and, therefore, present confounding variables into the study, the sample will be chosen only from the children's section. Thus, from here on, the author will be referring to this section of the agency when talking about the clinic.

At the present time there is one Spanish-speaking/Spanish surnamed staff member at the clinic. However, this individual was only recently hired by the clinic and was not present at a time when the cases (those that are going to appear in the sample) were closed. Those clients who spoke Spanish only were usually referred to another agency. The effects of the lack of a bilingual/bicultural therapist on the utilization of the clinic by the SS will be discussed in Chapter 5. The Adult and Child Guidance Clinic is now realizing the importance of a bilingual/bicultural program

and is in the process of developing such a program.

Normally, a family comes into contact with the agency by phone. Basic information such as the name of the child, age, address, and phone number are obtained at this time and an appointment is set up for the parent(s) to come in for the initial intake. Other data such as income, race, number of individuals in the family and their ages, education level of parents, occupation, and the amount of fee are all determined by the secretary when the parent(s) shows up for the appointment. The fee is based on a sliding scale (Short-Doyle funding). An intake entails obtaining any relevant information as to the presenting problem, social and medical histories, and the signature of the parent(s) to allow the agency to obtain more information from other sources. The intake worker may or may not be assigned to the case. Another appointment is then made for the child to see the psychologist.

From the psychological evaluation, which includes I.Q., affect, ability of the child to separate from his parent(s), and to relate to the psychologist, and based on the information gathered in the intake, a diagnosis is reached. Symptoms to be focused on and the length and mode of treatment are recommended. A therapist is assigned to the case and the parents are contacted by this person to discuss the evaluation and agree on the treatment plan.

Research Questions

The author would hope to answer the following questions in comparing Anglo and Latino families:

1. What are the demographic characteristics of SS users of the Adult and Child Guidance Clinic as compared to those of the Anglo users?

2. Do the ethnic groups differ from each other with regard to their source of referral?

3. Are there any differences between the two groups in the reasons for why the parents brought their children to the clinic?

4. Are there differences in the frequency with which a diagnostic label is used for one group versus the other?

5. Is the treatment mode different for SS families than for Anglo families?

6. Does the length of treatment differ for the two groups?

7. Is the success of treatment group-related, i.e., whether or not goals and objectives of therapy were reached?

More specific questions can be raised for each one of the above research questions. For example, for question #1, how does level of income differ for the two groups? Or, are there any differences in the level of education for the parents of each group? And so on. These will become more specifically stated as the research methodology is discussed. However, in order to get a picture of some of the variables that will be dealt with in this study, and in order to formulate hypotheses with regard to these variables, one needs to see the data that is already available in the literature. This is the focus of the next chapter.

Chapter 2

LITERATURE REVIEW

This chapter is divided into two sections, the first of which consists of three parts. Part a cites the literature on the utilization of mental health services by the general population. Part b of Section I looks at the current findings on the utilization of mental health services by the Spanish-surnamed population and reasons for their underrepresentation in mental health facilities. The characteristics, presenting problem, and the mode, length, and success of treatment for the SS are depicted in part c. Section II is a brief summary of the information obtained from Section I.

Section I

a. Mental health services utilization by the general population. The National Institute of Mental Health Analytical and Special Study Reports cites that from June of 1970 to July of 1971, there were over 2.5 million admission episodes (an unduplicated count of new cases added during the one-year period) to 3,200 mental health facilities in the United States; an admission rate of 1,327 per 100,000 population. These facilities include psychiatric inpatient and outpatient services but exclude patients utilizing the private practice of psychiatry and general hospital nonpsychiatric services.

The nonwhite admission rate (1,696 per 100,000 in the general population) exceeded the white rate (1,173 per 100,000 in general population) by 45 percent. Overall, 17 percent of the total admissions were accounted for by nonwhites. The smaller percentage, of course, is due to the smaller proportion of nonwhites in the population. These findings indicate that even though nonwhites made up a small percentage of the total number of admissions in 1971, their admission rate per 100,000 population was higher than the white admission rate. It is unfortunate, for the purposes of this study that color, rather than race, was used to differentiate the entry rate into the mental health system. To date, all documented national statistics materials on the utilization of mental facilities break up the population in this manner and fail to look at the SS population as a separate group to determine the extent of their consumption of mental health services. Such statistics, however, do exist on a smaller scale, i.e., on the state level.

For example, Karno and Edgerton (1969), in looking at California census figures, found that although Mexican-Americans made up approximately 9-10 percent of the state's population during 1962-1963, not more than 3.4 percent of them were represented in any one of the categories of psychiatric facilities. Their results suggest that Mexican-Americans are under-represented in the use of mental health services; nonutilization ranging from 6.4 to 9 percent.

Another state-wide report was done in Texas when Jaco (1960) examined the incidence rate of mental disorders in private and public mental hospitals. All inhabitants who were seeking treatment for psychosis for the first time during a two-year period (1951 and 1952) were included in the study. One of the conclusions was that Spanish-Americans exhibited the lowest psychosis rates and the Anglo-Americans the highest.

Statistics from the Connecticut Mental Health Center were used by Abad, Ramos, and Boyce (1974:590) to show that "compared with the black population, a comparable group in terms of poverty and minority status, the number of admissions and readmissions from July 1, 1971 to March 1, 1972 for Puerto Ricans per 10,000 population was at least 3.5 times lower than that of black patients."

From reading the above studies one might think that perhaps Latinos are a mentally healthy group of individuals and, therefore, do not need as much mental health care as the general population. However, the following authors would look at the above information from a different perspective.

Padilla, Ruiz, and Alvarez have stated that the Spanish-speaking/Spanish surnamed actually need more mental health care than the general population since they are only

> . . . partially acculturated and marginally integrated economically and, as a consequence, are subject to a number of "high stress" indicators. These indicators, known to be correlated with personality disintegration and subsequent need for treatment intervention, include (a) poor communication skills in English; (b) the poverty cycle--limited education, lower income, depressed social status, deteriorated

> housing, and minimal political influence; (c) the survival of traits from a rural-agrarian society; (d) the necessity of seasonal migration (for some); and (e) the very stressful problem of acculturation to a society which appears prejudicial, hostile, and rejecting. (1975:2-3)

Abad, Ramos, and Boyce (1977) and Torrey (1969) agree that the need for mental health services are greater for the SS than the population at large. The Latino Task Force has also cited a few unpublished sources to show that "despite the fact that the overwhelming majority of Latinos suffer under conditions which threaten their community mental health, it is well known that Latinos use mental health facilities less frequently than do other groups" (1974:3). There have been many viewpoints as to the reasons for this incongruency and these will be cited next.

b. Reasons for nonuse of mental health facilities by the SS population. One of the most dated yet still prevalent explanations for the nonutilization of mental health services by the SS has been the discriminatory practices of the mental health system. During the past ten years efforts have been made to eliminate or at least minimize such discriminatory practices. Gibson (1977:15) writes, "Title VI of the Civil Rights Act of 1964 prohibits recipients of federal funds from discriminating against patients on the grounds of race, color, or national origin. . .(but). . .more subtle factors may impair the accomplishments of program goals." Among the factors mentioned were (1) limited outreach services to minorites, (2) lower percentage of minority staff members,

minority clients, and minority advisory board members than exist in the catchment area population, (3) inaccessible locations, and (4) lack of bilingual staff members.

Differences in the perception (usually negative) and definitions of mental illness by the SS have also been thought to partially or totally account for their under-representation in the mental health facilities (Burruel and Chavez, 1974). The results of a study conducted by Karno and Edgerton (1969) in East Los Angeles with 444 Mexican-Americans and 224 Anglo Americans, showed no significant differences between the two groups in either perceptual differences nor differences in the definition of mental illness. Fred Crawford did a study in San Antonio, Texas where the mothers of twenty-three SS children were asked to define their child's problems according to a list. He concluded that the "mothers of these children were aware of and could describe, when questioned by the nurses, behavior which was considered by four experts to have serious implications for mental health" (1961:18).

Some researchers (Madsen, 1964; Torrey, 1972) have explained the problem of under-utilization by offering that instead of going to mental health facilities, Curanderos or folk healing methods are used to deal with mental illness. Madsen proposes that acculturation is a threat to the values of the Latino and produces stress and anxiety so that even though the need may be greater for this group, other forms of mental health care are used.

Several other studies, however, have shown that folk psychotherapy or curanderismo are not significantly used by Latinos (Karno and Morales, 1971; Karno, Ross, and Caper, 1969; Karno and Edgerton, 1969; Edgerton, Karno, and Fernandez, 1970) and that family physicians are replacing these traditional methods of mental health care. These studies found that language barriers, the degrading nature of the intake process and the inaccessibility of mental health facilities were also important factors in influencing low utilization.

The discrepancies with regard to the utilization of folk psychotherapy are probably due to the different locations in which these studies were undertaken. It may well be that the SS population in South Texas is more apt to count on the folk healer than are those living in Los Angeles. The year of the investigation is also significant in these findings since acculturation would invariably play a major role in the reliance of the SS on the practices of the Curandero.

Another viewpoint concerning under-utilization is depicted by Abad and his colleagues. They discovered that the Puerto Ricans' lack of utilization were due to the irrelevancy of the psychiatric facilities in serving their needs (1974). Torrey (1970) also explains under-utilization of psychiatric services by the Mexican-American by saying that the services are irrelevant for this group. Several reasons that were given are: inaccessibility of the facilities, language differences, class, caste, and cultural-boundedness,

and the use of their own systems of mental health services.

Sanchez (1971), on the other hand, believes that nonutilization is irrelevant to the Chicano population for another reason; due to the fact that mental health services are planned by institutions that are outside of the barrio and are, therefore, naive about Latino mental health needs. Heiman, Burruel, and Chavez (1975:515) suggest that "a mental health center offering outpatient services to Mexican-Americans should be centrally located in the Mexican-American community, should have a bicultural and bilingual staff, and should have an informal atmosphere with a minimum number of bureaucratic procedures."

As one can see, there are disagreements as well as agreements as to the explanations for Latino underutilization of mental health facilities. The underlying theme, however, has remained constant throughout the different studies, i.e., the Spanish surnamed population is under-represented in the use of mental health facilities. Having firmly established this point, let us begin to look at the literature on studies that have tried to describe the Latino utilizers of mental health services, their reasons for usage or (the presenting problem), and the treatment that is afforded them.

c. The characteristics, presenting problem, source of referral, and the mode, length, and outcome of treatment for SS and Anglo clients. In this portion of the literature review, each variable is individually discussed with regard to current findings that compare SS clients to Anglo clients. Only those

variables that are going to be used in this study will be reviewed in this section of the literature review. For example, literature on the experiences of the Latino client with the therapist will not be presented here since this variable will not be employed in this study even though the importance of such experiences as it relates to drop-out rates and success of treatment is realized.

Before proceeding with the literature review, however, there is one particular study which needs to be discussed in some detail since it will frequently be used as a reference throughout the rest of this section.

Stoker and Meadow (1974) randomly selected case files of Mexican-American and Anglo-American patients (all closed within two years of the investigation) from three child guidance clinics. The cases were carefully matched for income such that the effect of socioeconomic status on possible differences in psychopathology would be minimized. Also, all cases indicating organic pathologies and mental deficiencies were not considered. The final sample consisted of 152 Mexican-American and 152 Anglo-American case files (76 males and 76 females for each ethnic group), matched for income. Among the variables studied were marital status of parents, referral source, presenting problem, staff recommendations (equivalent to the mode of treatment), diagnosis, and case outcomes. Despite the differences existing in the sampling procedure, namely, the matching of annual income, discarding cases with organic pathologies and mental deficiencies, and

the equal distribution of male and female cases, the investigation closely parallels the research that will be undertaken in this paper. Therefore, many of the hypotheses that are to be formulated and tested will be influenced by the Stoker-Meadow report.

Age. Rosen and her colleagues studied the utilization of psychiatric facilities by children and found that among the nation's almost half a million children under care during 1966, almost 2/3 of them were between ten and seventeen years, 1/3 were between five and nine years, and only 6 percent were under the age of five.

In an earlier study, the same author looked at census data obtained from the National Institute of Mental Health report of 1960 to determine termination rates of outpatient psychiatric clinics. Rosen noted that for both boys and girls, the number of terminations increased with age.

> Two distinct periods of increased clinic usage appear: for boys, a decided peak at around age 9 and again at 14; for girls, a slight rise to age 10 and a marked increase at 15. For both sexes the rates were relatively low at 11 and 12 years. (1964:458-459)

A Connecticut study (Novack, et al., 1975) reported on the age differences of children from different ethnic backgrounds. In the youngest age group (those under five years) there were more SS individuals (26 percent) than Anglo (18 percent). In the 5-9 age group 28 percent were Anglos as compared to 19 percent SS. Anglos were more numerous in the 10-14 age group than the SS (25 percent vs. 21 percent). The Stoker-Meadow study, on the other hand, did not show

significant differences between the ethnic groups.

Since adolescents are not being considered in this particular study, the above findings can be modified and summarized as such: Latency-aged children (7-10 years) were represented in mental health agencies more often than pre-schoolers (1-6 years.). Pre-adolescents (11-12 years) made up the smallest portion of utilizers.

Sex. Many studies have addressed themselves to this variable and have shown that boys outnumber girls by a ratio of 2:1 (Rosen et al., 1968). Among these, only one reference to ethnic background related the client's gender (Novack, et al., 1975) with the finding that the 2:1 male predominance existed regardless of ethnic background. It is safe to presume that males will outnumber females for both Anglo and SS groups.

Diagnosis. Several investigations have pointed out the differences that exist for the frequency with which a diagnostic label is used on white vs. nonwhite clients of mental health facilities. In a Thirteen-state Biometry Branch Collaborative Study showing first admissions rates to state mental hospitals during 1960, Rosen, Kramer, Redrick, and Willmer found that schizophrenia admittance rates were about three times as high for nonwhites as the corresponding rates for white children. Outpatient data indicated that "rates for nonwhite children were higher than those of white children but only for the more serious disorders" (1968:49).

Rosen, Bahn, and Kramer (1964) also report such a difference in their nation-wide study. Their results showed that nonwhite male and female children under the age of twelve received a diagnosis of mental deficiency more often than white children of the same sex. Another study revealed that Blacks are overdiagnosed in schizophrenia and underdiagnosed in affective disorders (Simon, et al., 1973). These references suggest that racial background is an important factor in diagnostic labelling. But is diagnosis also influenced by the client's cultural background?

In 1974, Andrulis reviewed closed cases from the Bexar County Mental Health Center in Texas to determine if, indeed, such a difference existed for Anglo and SS clients. The results showed that Anglos received more deferred diagnoses, while Latinos received more transient situational disorder and mental retardation diagnoses. Whereas 30 percent of Latinos between thirty-five and forty-four were diagnosed as neurotic or phobic, none of the Caucasians in the same age category received that diagnosis.

Stoker and Meadow (1976:197) observed a "higher rate of neurotic disorders in the Anglo-American sample, suggesting a basic difference in psychopathology between the two groups."

In summary, cultural background is a factor influencing diagnosis. It can be hypothesized, therefore, that there will be differences between the Anglo and SS groups with respect to this variable.

Educational level. Many investigators have referred to the lower educational levels of the SS relative to the population at large (Galarza, Gallegos, and Samora, 1970; Hernandez, Haugh, and Wagner, 1976; Baker, Wald, and Zamora, 1971). Padilla and Ruiz (1976:5) have indicated that "twenty percent of the SSSS have completed less than 5 years compared to only four percent of general population; and only 48 percent of the SSSS have completed high school, compared to a national frequency of 80 percent."

Since there were no studies which specifically compared the SS and Anglo clients of a psychiatric facility in the number of formal education years completed, it will be assumed that the differences found in the above studies will also apply to the utilizers of a mental health facility. In short, Anglo heads of households will indicate the completion of a greater number of years of schooling than will SS heads of households.

Size and composition of household. In 1960, admission rates of children to all psychiatric facilities in Louisiana and Maryland were recorded by Beatrice Rosen, et al., thus, determining who the utilizers of these facilities were. With respect to the size and composition of the household, they concluded that (1) admission rates were unusually high for families of two (mother absent) and in those having six or more members, and (2) rates for children of single-parent families were unusually high in families of size two (father absent) in Louisiana; in Maryland rates for

single-parent families were twice as high as rates for two-parent families, regardless of family size. Simply stated, single-parent families and those having six or more members found it necessary to use a mental health facility more often than did two-parent families.

Comparing SS, Black, and Anglo families, Novack and his colleagues found that 63 percent of the Black and Anglo children came from one-parent families as compared to 57 percent of the SS families. This implies that for both groups, the majority of the children had single-parent households but that the occurrence of this type of family structure is less frequent in Latino households.

Not only are SS children more apt to have two-parent families, there is reason to believe that they are also from larger families. According to Baker, Wald, and Samora (1971), the average size of the SS family (4.6 persons/household) exceeded its Anglo counterpart (3.4 percent persons/household) by 35 percent. The 1970 Census Report of the Population, in recording the average number of children living within Anglo and SS families, found that SS families tended to have a larger number of children than Anglo families (2.19 versus 1.48, respectively).

Comparative data concerning the number of female heads of households in Anglo and SS families were nonexistent. However, because there is evidence to believe that Latinos have a higher percentage of two-parent families, one might deffer that they will probably show a lower frequency of

female-dominated households than their Anglo counterpart.

Income. Very few investigators have explored the income levels of psychiatric patients from different ethnic backgrounds as a variable for clinic usage. This is somewhat perplexing in the light of the tremendous psychological effects of economic deprivation on the individual and his family. Of the studies that have been undertaken, many are outdated and statistically inferior resulting in a marked reduction in the availability of such data. Nevertheless, there is some evidence showing that there are differences between utilizers and nonutilizers of mental health facilities with regard to income.

In New York City, for example, families of three community social psychiatric services centers were compared with the nonusers of these facilities. The results indicated that clinic utilizers were more apt to be from lower occupational and educational levels than the nonusers, thereby, also suggesting lower income levels for the users of these facilities.

Rosen and her colleagues studied the utilization of psychiatric facilities by children throughout the United States in 1961. While their data supported the above finding, they noted significant differences in income level between white and nonwhite families. As many as 35 percent of nonwhite families had incomes below the poverty level (less than $3,000/year) as compared with only 10 percent of white families.

Alvin Novack did not observe such a difference as he looked at the ethnic background of the individual. His three-year epidemiological investigation in Connecticut showed that "an examination of family income by ethnic group revealed no differences. Approximately 2/3 of the mental health group children, irrespective of their ethnicity, were from families on public assistance" (1975:136). Other writers, however, ascertain that differences in economic status do exist between SS and Anglo groups, both in the general population and in psychiatric settings.

Padilla and Ruiz (1976:5), for example, comment on the economic situation of the SS as it compared to the general population. "The yearly median SSSS family income is almost $3,000 less than the general population ($7,334 vs. $10,246); 25 percent of the SSSS fall below governmental 'low income levels,' compared to only 10 percent of the general population."

Despite the opposing reports, which may again be due to the time and location of the research, two hypotheses may be formulated. First, regardless of the individual's ethnic background, a relatively large portion of the psychiatric patients are going to be from low income families. Secondly, SS families will generally have lower incomes as compared to Anglo families of a mental health facility.

Source of referral. Andrulis (1976) examined the referral patterns of a comprehensive mental health center for different ethnic groups. His results showed that

Mexican-Americans under eighteen years of age were referred to the center by non-medical professionals most often while young caucasians were referred by non-medical professionals and family members.

The Stoker-Meadow study showed that SS patients tended to be referred by the welfare department or a charitable organization whereas the Anglo patients were either self-referred or came under the instruction of a private practitioner or private clinic. It is ironic to note that the child's school was not even mentioned as a possible source of referral especially when one considers the age group with which Stoker and Meadow were dealing.

Alston (1974) looked at the referral source of minority and non-minority college students who utilized the campus mental health center. Differences between the two groups were noted within this setting also.

Source of referral, then, will be expected to differ for the Anglo and SS clients of the Adult and Child Guidance Clinic. There would be a greater tendency for Anglos to be referred by non-medical professionals, family, and self. In contrast, the majority of the SS clientele will be referred by non-medical professionals and charitable organizations.

Presenting problem. The initial problems with which one comes to the mental health facility are relevant in that this is the reason for which the individual has made himself known to the facility. However, the author did not encounter any studies in which the patient's perception of his problems

were noted. Rather, the diagnosis, which actually depicts the professional's description of the individual's difficulty were used by most investigators to represent the presenting problem. However valid this may be, the interest of the author is to determine the specific reasons for which the client has decided to utilize the services of a mental health agency. Only one study was found in which an attempt was made to approximate the gathering of such information.

Stoker and Meadow, whose research has already been referred to several times, have found some very interesting differences between the groups under study with regard to symptomatology. The total SS sample showed the following to be indicative of their presenting problem: Destructiveness, aggressiveness, fighting, impulsivity, hostility, obstinate and defiant attitude, stealing, hallucinations, somatic complaints, suspiciousness and distrust, and depression. The total Anglo sample, in contrast, was marked by anxiety, nail biting, compulsivity, infantalisation, masturbation, flat affect, enuresis, nervousness, nightmares, friendlessness, poor social relationships, thumb sucking, and withdrawal. The authors found these differences to be significant and attributed them to the cultural aspects of family structure, family interaction, role conflicts, and personality structure of the Latino.

Mode and length of treatment. Lubin, Hornstra, Lewis, and Bechtel (1973) investigated initial treatment assignment of Blacks and Anglos at a community mental health center in

Greater Kansas City. Race was found to be a significant factor in deciding the type of treatment that was going to be assigned to the client. Blacks were assigned to individual therapy less frequently than Anglos.

Yamamoto et al. (1968), in comparing the treatment experiences of Caucasians (65 percent), Negros (25 percent), Mexican-Americans (9 percent), and Orientals (1 percent), concluded that ethnic patients received less intensive individual and group psychotherapy and for shorter periods of time than the caucasian patient. Abad et al. (1974) in their review of mental health services for Puerto Rican patients, supported the view that lower socioeconomic groups are underrepresented in outpatient treatment facilities and that their (Puerto Rican) dropout rate was extremely high. Miranda, Andujo and others (1976) reported that Mexican-Americans drop out of therapy at a rate of approximately 60 percent following the initial interview and up to 85 percent drop out of treatment prior to the fifth session. Compared to the non-Mexican Americans, whose dropout rates are 35 percent and 55 percent, the dropout rate for the M-A is overwhelmingly high.

Rosenberg (1976) did an intensive review of the literature concerning the length of stay in psychiatric treatment. Race, income, occupation, and social class were discovered to be quite relevant to dropout rate. Racial factors are, for the most part, difficult to separate from educational and social class variable, therefore, it is hard to say to what extent racial factors influence dropout rate. However, it

was pointed out that nonwhites generally stay in treatment for a shorter length of time than whites.

Another study (Karno, 1966) compared the case files of Mexican-Americans, Negros, and third generation American-born Caucasian patients with regard to social class characteristics and length and mode of treatment. Nonethnic patients were found to be accepted into psychotherapy more often and for longer periods of time than ethnic patients who were of the same social class.

It does not seem unreasonable, then, to assume that SS families will have a shorter length of treatment, whether self-initiated or therapist-determined, than Anglo families.

The Stoker-Meadow study reports considerable differences in treatment mode for the two groups.

> Summing the number of recommendations for therapy for parents without collateral therapy for the child, one finds a rate of 21 percent in the total Mexican-American sample and 38 percent in the total Anglo-American sample. . . . Staff recommendations which terminate services to the patient without recommendations for further treatment or for referral to another agency amount to 27 percent in the total Mexican-American sample as opposed to 19 percent in the total Anglo-American sample. . . . Correspondingly, there is a higher rate of recommendations for direct discharge from the clinic and for termination of clinic services (1976:196).

In summary, Latinos were found to be assigned to individual, group, and parent counseling less often and for shorter periods of time than Anglos.

Outcome of therapy. The question of whether or not treatment goals are ultimately reached is complicated by and very much related to the number of sessions that are attended

by the patient. Obviously, if the client drops out of therapy prematurely the achievement of such goals becomes an impossibility. Thus, solely on the basis of previous observations which show a relatively higher dropout rate for the SS, one might expect to find a larger proportion of the SS clientele to report unsuccessful therapeutic experiences. Also, a greater number of referrals outside of the agency would be expected.

Section II

To summarize, in part a of Section I, it was learned that the SS population is seriously under-represented in mental health facilities even though many stress-producing factors exist in the Anglo society which threaten their community mental health. Some of the reasons for the reluctance to utilize such services were discussed in part b. Among them are racial prejudice, differences in the perception and definition of mental illness by the Latino, and the irrelevancy of mental health treatment to this group. Language barriers seemed to be the most common explanation for non-use. In part c, current findings on the differences between Anglo and SS clients were discussed with regard to each of the variables (age, sex, diagnosis, presenting problem, etc.). Children between the ages of seven and ten were found to be the most likely candidates for therapeutic intervention. More boys than girls utilized the facilities. There were significant differences between Anglos and Latinos with respect to diagnosis, source of referral, presenting problem,

and mode and length of treatment. Anglos tended to have higher income and educational levels than Latinos. SS children tended to come from larger households, were more apt to have two-parent families, and had a lower frequency of female-heads of households than Anglo children. Lastly, Anglos had more successful outcomes of therapy than Latino clients.

The following chapter will identify the research procedures that will eventually lead to further justification of the above findings.

Chapter 3

RESEARCH METHODOLOGY

Research Hypotheses

Even though the context, research approaches, and comparative groups of the above research materials were not similar to the conditions under which this particular study will be conducted, certain speculations can be made such that, if they are found to be true, they would serve to substantiate earlier findings. The following hypotheses are formulated based on the data obtained from the previous studies. Where there is no direct data available from the literature comparing Anglos with Latinos, hypotheses are based on the information obtained from comparisons of whites versus non-whites and/or from personal observations.

1. There will be a greater number of latency-aged children represented in the clinic for both the Anglo and Latino groups.

2. There will be a greater number of male patients represented in the clinic for both the Anglo and Latino groups.

3. There will be differences in the frequency with which a diagnostic label is applied to the child according to his/her ethnic background.

4. Anglo parents will indicate higher levels of formal education than Latino parents.

5. For both groups, there will be a greater number of single-parent families than intact or two-parent families. Latino children, however, will tend to have two-parent families more often than Anglo children.

6. The number of individuals living within Latino households will be larger than Anglo households.

7. The number of female heads of households will be larger for Anglo families.

8. (a) There will be a greater number of clientele from the low income category for both ethnic groups.

(b) Within the low-income bracket, Anglos will report a slightly higher income range than Latino families.

9. (a) There will be differences between the two groups with respect to source of referral.

(b) Anglos will show a higher number of self-referrals and referrals from non-medical professionals while the SS will be referred most often by non-medical professionals and other organizations.

10. There will be differences in both groups with regard to the presenting problem.

11. Length of therapy will be shorter for Latino clients.

12. Anglo children and their families will be assigned to individual and group therapy more often than Latino children and their families.

13. Success of treatment will differ for the two groups with Anglo clients achieving goals more often than Latino clients.

Research Design

The research approach will be of a descriptive nature comparing the Spanish surnamed clients of the Adult and Child Guidance Clinic with the Anglo utilizers of the same outpatient mental health facility. Data will be obtained from closed case files (1974-1977) by way of a simple random sampling procedure.

The Population

The population from which the sample will be chosen is made up of all cases involving children between the ages of 1-12 years whose cases were closed in the three-year period, 1974-1977. Closed cases are filed alphabetically without regard to the year of closure.

Sampling Procedure

The simple random sampling procedure will be implemented as follows: Starting from the first case beginning with the letter "A," and every twentieth case thereafter, closed files will be pulled and placed in one of two piles according to the ethnic background of the client; the Anglo pile or the SS pile. If the file does not fall within either of these categories or if the client is above the age of twelve, the case will be replaced and the next twentieth case will be pulled. This procedure will continue until thirty Anglo and thirty SS children's cases are gathered. If the desired number of cases has not been obtained by the time all of the cases in the filing cabinet have been counted in this fashion,

there will be a return to the beginning of the case file and every tenth case will be considered.

Operational Definitions of Variables

The variables under scrutiny are as follows: Age, sex, and diagnosis of the child, income, educational level, marital status, and sex of the head of the household, presenting problem, source of referral, length of therapy, mode of treatment, and outcome of therapy. The following are operational definitions of the variables and the context in which they will be used.

Child variables. "Age" of the identified patient will be measured according to three age groups; pre-schoolers, 1-6 years, latency, 7-10 years, and pre-adolescent, 11-12 years. "Sex" will be defined in terms of whether the child is a male or female. "Diagnosis" is derived according to the categories in the Diagnostic Statistical Manual, Number 2.

Parent or head of household variables. The head of the household (hh) is defined as the parent who sustains the family finances. In the case where both parents are working, the one who earns the highest wages will be considered as the head of the household. "Educational level" of the parents will be determined by the number of formal school years completed by the hh. "Sex" of hh will be used as an index to measure how prevalent female hh's are in each cultural group. "Marital status" includes only two categories; married and unmarried (divorced, separated, or widowed), and will denote

the composition of the child's family, that is, whether single- or two-parent.

Family variables. The "number of individuals in the household" is self-explanatory and will pertain to the size of the household at the time of application. The amount of yearly "income" will be derived from the parents' stated gross monthly income multiplied by twelve. Averages will then be computed for each ethnic group.

Source of referral. Five classifications will be considered under this variable: Self-referrals, referrals from friends or relatives, referrals from the school (teachers, principles, school nurse, school social worker), referrals from medical professionals (private physicians and psychiatrists), and referrals from other agencies (Department of Social Services, churches, juvenile courts, etc.).

The presenting problem. This is defined as those behavioral terms used by the parents to describe the child's difficulty. This information will be obtained from the intake sheet and will depict parental rather than professional views of their problem. This would allow us to determine whether or not any differences exist between the Anglo and SS parents in their reasons for seeking the help of a mental health facility. The categories of behavior problems are: (1) fears or night fears, (2) disobediance or talking back to authority, (3) temper tantrums, (4) stealing, (5) fighting and destructive behavior, (6) fidgeting and restlessness, (7) wetting and/or soiling, (8) shyness,

withdrawal, (9) masturbation, (10) storytelling, imaginary friends, (11) somatic complaints, and (12) school-related problems such as learning disabilities, acting out, and disruptive behavior. These categories, with the exception of #12, have been derived from Fred Crawford's study in San Antonio, Texas.

Mode of treatment. The mode of treatment is defined as the type of intervention, whether individual, group, parent, medication, evaluation only, or a combination of these services.

Length of treatment. The length of therapy will be measured by the number of sessions attended by either the identified patient or any other member of his/her family.

Outcome of therapy. Successful outcomes will be defined as the completion of therapy after a mutual decision by the therapist and parents has been made to end therapy on the basis of perceived goal achievement. The initiative taken by the family to drop out of therapy prematurely would be an indication of unreached goals and would not be recorded as a success unless such an action is based on the parents' belief that there has been an improvement. Referrals to other agencies would not be tallied as successful nor unsuccessful, but would stand for a third possible outcome of therapy.

Data Collection and Analysis Procedures

Each case will be reviewed and manually coded for the aforementioned variables. The information will then be

subject to either the "t" test or the Chi-square test such that significant in- and between group differences may be detected. The level of significance that will be used throughout the study is .05 and beyond.

Chapter 4

DATA ANALYSIS

The presentation of the results obtained from the present study will be the emphasis of this chapter. As was done previously, each variable will be discussed individually.

Age.

Hypothesis #1: There will be a greater number of latency-aged children represented in the clinic for both the Anglo and Latino groups.

Latency-aged children represented the largest group of the total sample (52 percent), followed by pre-schoolers (33 percent). Pre-adolescents were smallest in number and made up only 15 percent of the sample. Latino children were 7.8 years old as compared to 7.6 years for Anglos. The age differences were not significant and the general impression is that children between the ages of 7-10 will utilize mental health services more often than the other age groups, regardless of the child's ethnic background (see Table 1, p. 38). This confirms the first hypothesis.

Sex.

Hypothesis #2: There will be a greater number of male patients represented in the clinic for both the Anglo and Latino groups.

For both groups, an overwhelming majority of the children were male. There were four times as many males as females for the SS sample and almost three times as many males as females for the Anglo sample (see Table 2, p. 38). The second hypothesis, then, was also confirmed.

Diagnosis.

Hypothesis #3: There will be differences in the frequency with which a diagnostic label is applied to the child according to his/her ethnic background.

With regard to diagnosis, Organic Brain Syndromes (OBS) and Psychoses and Psychophysiologic disorders made up a very small portion of the entire sample (9 percent) and significant differences between the Anglo and SS children in these areas were not indicated. Table 3 (p. 39) presents the entire sample and the various subcategories of major diagnoses for the two groups. Omitting OBS's, psychoses, and psychophysiologic disorders, these categories were combined under (1) personality trait disturbances, including transient situational disturbances and special symptoms such as specific learning disturbances, enuresis, and encopresis, (2) behavior disorders including hyperkinetic reaction, withdrawing reaction, overanxious reaction, unsocialized aggressive reaction, and other reaction of childhood, and (3) conditions without manifest psychiatric disorders and non-specific conditions which includes deferred diagnosis, no mental disorder, and other social maladjustment.

Table 1

Age Differences Between Anglo and SS Samples

	Pre-schoolers 0-6 yrs.	Latency 7-10 yrs.	Pre-adolescent 11-12 yrs.	Total
Anglo	10	15	5	30
SS	10	16	4	30
Total	20	31	9	60

Table 2

Sex Differences Between Anglo and SS Samples

	Male	Female	Total
Anglo	22	8	30
SS	24	6	30
Total	46	14	60

Table 3

Comparisons of SS and Anglo Samples With Regard to Diagnosis According to DM_2

	Diagnosis	Anglo	SS	Total
I.	Nonpsychotic OBS schizophrenia, childhood type	1	0	1
II.	Depressive neurosis	1	0	1
III.	Psychophysiological disorders, cardio-vascular disorder	0	1	1
IV.	Special symptoms			
	a. Specific learning diabilities	0	1	1
	b. Enuresis	2	1	3
	c. Encopresis	2	0	2
V.	Transient situation disturbance, adjustment reaction	6	6	12
VI.	Behavior disorders			
	a. Hyperkinetic reaction of childhood	8	3	11
	b. Withdrawing reaction of childhood	1	3	4
	c. Overanxious reaction of childhood	3	2	5
	d. Unsocialized aggressive reaction of childhood	7	4	11
	e. Other reaction of childhood	3	0	3

Table 3 (continued)

	Diagnosis	Anglo	SS	Total
VII.	Nonpsychotic OBS, with epilepsy	1	1	2
VIII.	Conditions without manifest psychiatric disorder and nonspecific conditions			
	a. Other social maladjustment	1	1	2
	b. No mental disorder	0	3	3
IX.	Diagnosis deferred	0	5	5
	Total	36	31	67

The results revealed significant differences between the Latino and Anglo clientele as shown in Table 4 (p. 42), thus validating the third hypothesis. The Anglo group received behavior disorder diagnoses more often than did the Latino group. On the other hand, the third diagnostic category was more prominant for Latinos. The number of personality trait disturbances was slightly higher for the Anglo children. For both ethnic groups, behavior disorders were used as a diagnostic label more frequently than were the other two diagnoses. Personality trait disturbances, in turn, was applied more often than the third diagnostic category.

Educational level.

Hypothesis #4: Anglo parents will indicate higher levels of formal education than Latino parents.

The majority of the parents had completed 10-12 years of formal schooling, while the second largest group fell in the college level category. Whereas all of the Anglo parents had completed at least ten years of schooling, seven of the Latino parents reported having not reached this level of education. Significant differences were found between the two populations when the total sample was categorized according to those who had completed up to twelve years of school and those parents who had completed more than twelve years of school. Also significant was the average number of years of schooling completed. Anglo parents, on the average, completed 13.2 years of education while SS parents completed 10.4 years of formal education. The results are presented in Tables 5 and

Table 4

Comparison Between Anglo and SS Samples With Regard to Diagnosis

	Diagnosis	Anglo	SS	Total
I.	Personality trait disturbances (transient situational disturbances, special symptom reaction)	10	8	18
II.	Behavior disorders (hyperkinetic reaction of childhood, withdrawing reaction of childhood, overanxious reaction of childhood, unsocialized aggressive reaction of childhood, other reaction of childhood)	22	12	34
III.	Conditions without manifest psychiatric disorders and nonspecific conditions (deferred diagnosis, no mental disorder, other social maladjustment)	1	9	10
	Total	33	29	62

df = 2
$x^2 = 9.26$
$p < .05$

6 (p. 44). Hypothesis #4 is verified.

Size and composition of household.

Hypothesis #5: For both groups, there will be a greater number of single-parent families than intact or two-parent families. Latino children, however, will tend to have two-parent families more often than Anglo children.

Although the hypothesis was true for the Anglo clientele, it did not apply to the SS group who exhibited an equal number of single- and two-parent families (see Table 7, p. 45). Thus, Anglos were significantly different from Latinos in that they had a greater percentage of single-parent households, partially validating hypothesis #5.

Hypothesis #6: The number of individuals living within Latino households will be larger than Anglo households.

There were no significant differences between the two groups with regard to the average number of individuals in the home. However, Latino household size tended to be slightly larger than Anglo households (4.1 and 3.8, respectively). Hypothesis #6 was not validated. (Refer to Table 8, p. 45.)

Hypothesis #7: The number of female heads of households will be larger for Anglo families.

There were no statistically significant differences in sex of primary wage-earner in the household (defined as the head of the household, hh). In general, 63.3 percent of

Table 5

Educational Level

	Elementary Level 1-6	Junior High School level 7-9	High School Level 10-12	College Level 13+	Total
Anglo	0	0	14	10	24
SS	3	4	17	3	27
Total	3	4	31	13	51

Table 6

Average Number of School Years Completed

	Total	Average Number of Formal School Years Completed
Anglo	24	13.2
SS	27	10.4

$t = 4.31$
$p < .05$

Table 7

Marital Status of the Head of Household

	Married (Two-parent Families)	Unmarried (Single-parent Families)	Total
Anglo	8	22	30
SS	15	15	30
Total	23	37	60

$df = 1$
$x^2 = 3.4$
$p < .05$

Table 8

Average Number of Individuals in Household

	Total	Average Household Size
Anglo	30	3.8
Latino	30	4.1
Total	60	

the entire sample consisted of female hh's. Fifty-five percent of these were Anglos. Whereas 70 percent of the Anglo hh's were women, only 57 of the SS households had women as their primary wage-earner (see Table 9, p. 47). Hypothesis #7 was not confirmed.

Income.

Hypothesis #8: (a) There will be a greater number of clientele from the low income category for both ethnic groups. (b) Within the low-income bracket, Anglos will report a slightly higher income range than Latino families.

The computation of average gross annual income for the Anglo and SS households showed no significant differences. This invalidates part b of hypothesis #8; however, hypothesis 8a was upheld as follows. Only five of the fifty-nine families who revealed their annual earnings had incomes over $12,000. The results indicate that the majority of children who come to the clinic (over 91 percent) are from low-income households irrespective of whether or not he/she is Anglo or Latino. Table 10 (p. 47) shows the results for this variable more concisely.

Source of referral.

Hypothesis #9: (a) There will be differences between the two groups with respect to source of referral. (b) Anglos will show a higher number of self-referrals and referrals from non-medical professionals while the

Table 9

Sex of Head of the Household

	M	F	Total
Anglo	9	21	30
SS	13	17	30
Total	22	38	60

df = 1
x^2 = 1.14
p < .03

Table 10

Average Annual Income for SS and Anglo Utilizers

	Number	Income
Anglo	30	7,954
SS	29	7,350

t = .4 (not significant)

SS will be referred most often by non-medical professionals and other organizations.

Table 11 (p. 49) presents the sources of referral for Anglo and SS clients. It is interesting to note that SS parents were self-referred to the clinic more than three times as often as Anglo parents. In fact the majority of the referrals for Anglos were from their physicians (30 percent). These results are completely the reverse of the Stoker and Meadow study as well as hypothesis 9b formulated by the author. Referrals from other agencies represented the second largest referral source for both groups. The third largest source of referral came from schools. These referrals were distributed evenly among Anglos and Latinos. Anglo families were referred by friends and relatives more often than SS families. These results were statistically significant, thereby supporting hypothesis 9a.

Presenting problem.

Hypothesis #10: There will be differences between the two groups with respect to the presenting problem.

Fighting and destructive behavior, disobedience, and talking back to authority, and temper tantrums (with raw frequencies of 27, 23, and 19, respectively) made up 49.3 percent of the total sample. As a category, school-related problems was next, followed by withdrawal, shyness and feelings of sadness, both of which represented another 21.4 percent of all of the presenting problems. A little more than 19 percent of

Table 11

Source of Referral for Anglo and SS Clientele

	Self	Friend or Relative	School	Physician	Other Agencies	Total
Anglo	3	5	6	9	7	30
SS	11	1	6	3	9	30
Total	14	6	12	12	16	60

$df = 3$
$x^2 = 7.47$
$p < .05$

the parents complained of wetting and/or soiling, fidgeting and restlessness, and fears or night fears. The least common complaints were stealing, storytelling and imaginary friends, somatic complaints, and lastly, masturbation which all together made up 10 percent of the entire sample.

As is shown in Table 12 (p. 51) hardly any differences existed between the SS and Anglo samples with respect to the presenting problem. Insignificant divergences appeared in only two of the twelve initial complaints. Disobedience and talking back to authority and school-related problems tended to be more prevalent for Anglo than Latino children. Unlike the previous findings, one is left with the impression that Latinos and Anglos do not differ from each other in the reasons for which they were prompted to seek the help of the facility. This information does not support the tenth hypothesis.

Length of treatment.

Hypothesis #11: Length of therapy will be shorter for Latino clients.

Anglos, on the average, had 8.3 more visits to the clinic than SS families. This finding, shown in Table 13, (p. 51), was statistically significant and served to substantiate the hypothesis.

Mode of treatment.

Hypothesis #12: Anglo children and their families will be assigned to individual and group therapy more often than Latino children and their families.

Table 12

Presenting Problems of Anglo and SS Children

	Anglo	SS	Total
1. Fears or night fears	4	4	8
2. Disobediance, talking back to authority	14	9	23
3. Temper tantrums	10	9	19
4. Stealing	3	3	6
5. Fighting and destructive behavior	13	14	27
6. Fidgeting and restlessness	5	3	8
7. Wetting and/or soiling	6	5	11
8. Shyness, withdrawal	7	7	14
9. Masturbation	0	1	1
10. Storytelling, imaginary friends	1	3	4
11. Somatic complaints	1	2	3
12. School-related problems	10	6	16
Total	74	66	140

Table 13

Mean Length of Treatment for SS and Latino Families

	Number	
Anglo	30	19.1
SS	30	11.4

$t = 2.5$
$p < .05$

Table 14 (p. 53) portrays the treatment mode that was assigned to each ethnic group. Individual therapy and parent counseling were the major modes of treatment and co-occurred most of the time for the total sample. Noticeable differences between the two groups existed in individual therapy only. Although statistically insignificant, Anglo children tended to be assigned to individual therapy more frequently than Latino children. A higher percentage of Latino families as compared to Anglo families (12 percent vs. 6 percent) asked for or received an evaluation of their child without any follow-up treatment or services. The hypothesis was not supported.

Outcome of therapy.

Hypothesis #13: Outcome of treatment will differ for the two groups with Anglo clients achieving goals more often than Latino clients.

Fifty-eight percent of the clients attained "successful" treatment outcomes as measured by agreement between therapist and parents. Sixty-six percent of the Anglos as compared to 50 percent of the SS families "successfully" terminated therapy. A total of thirteen Latino families (43 percent) and seven Anglos (23 percent) dropped out of therapy before the goals of therapy were reached. These results, shown in Table 15 (p. 54), support the hypothesis that Anglos have a higher frequency of "successful" psychotherapeutic experiences than do Latinos. Referrals out of

Table 14

Mode of Treatment for Anglo and SS Clientele

	Individual	Group	Family	Parent Counseling	Medication	Fvaluation Only	Total
Anglo	23	7	7	18	3	4	62
SS	18	6	8	17	0	7	56
Total	41	6	8	17	0	7	56

df = 1
x^2 = 1.35
p > .05

Table 15

Outcome of Therapy for Anglo and SS Clientele

	Successful	Unsuccessful	Referral Out of Agency	Total
Anglo	20	7	3	30
SS	15	13	2	30
Total	35	20	5	60

$df = 2$
$x^2 = 2.76$
$p > .05$

the agency made up a very small proportion of the entire sample (8 percent) and did not signify observable differences between the two groups.

Chapter 5

CONCLUSIONS AND IMPLICATIONS

The focus of this chapter will be on the possible explanations for the results of this study. Also included are the limitations of the study and the implications of the findings for the Adult and Child Guidance Clinic as well as for the utilization of mental health facilities by the Spanish surnamed population.

The study supported nine of the fifteen hypotheses. Many of the findings were not consistent with the conclusions arrived at in the literature review. Some differences that were expected to exist did not prove true. With other variables, unexpected differences were found. To discuss the findings in a comprehensible fashion, the similarities between the two groups will be considered first. The dissimilarities will then follow. Lastly, conclusions as to the characteristics of utilizers, in general, will be drawn.

Similarities Between the Anglo and SS Samples

The Anglo and Spanish surnamed samples were similar with respect to several variables: Age and sex of the identified patient, household size, the number of female heads of households, income, presenting problem, and the mode of treatment. With the exception of the age and sex of the

identified patient, the rest of the variables were not in accordance with earlier findings. That is, the two ethnic groups were similar in five areas where differences were expected to exist. The following paragraphs will suggest possible explanations for why the results of this study did not support current data.

In looking at household composition as a variable, we found that Anglos had as many female heads of households as did the SS. The definition of this variable was based on the main wage-earner in the family and was not necessarily an indicator of the parent's marital status. However, as it turned out, more than 96 percent of all female heads of households were also single parents.

The social work literature on Latino husband-wife roles would lead one to believe that women are usually not expected to work and, thus, do not assume positions in which they are the main wage-earners. The fact that 12 percent of the Latino female heads of households were married could indicate that the distinct and clear-cut allocation of sex roles as indicated in social work literature is weakening and that Latino women are getting out of the home and into the labor market more readily. The author would have to conclude, then, that perhaps Latino utilizers of the Adult and Child Guidance Clinic are somewhat similar to Anglo utilizers regarding husband-wife relations and contribution to household income.

The size of household was another variable pertaining to household composition in which there were no significant differences between the two groups. The review of the literature showed that Latinos have always had larger families than Anglos. The author suggests that this may have to do with the traditional religious and cultural beliefs which warn against the use of contraceptive measures and abortions. Because such differences were not observed, the author would be inclined to think that perhaps traditional Latino values have been modified in a direction which permits the use of birth control techniques. In addition, because of the increasing financial hardship on the family which continues to rise with the cost of living, it is probable that having a large number of children is becoming an economic impossibility such that it is no longer as desireable to as many Latinos.

The results of this study showed no differences between Anglo and SS utilizers with respect to average annual income. This is surprising in the face of economic data indicating that Anglos, in general, have higher earnings than their SS counterpart. Part of the discrepancy may be due to the fact that the literature review compared the economic status of users vs. non-users, whites vs. non-whites, or SS vs. Anglo populations at large--and not SS utilizers vs. Anglo utilizers of a mental health agency. Novack, Bromet, Neill, et al. (1975) were the only ones that compared SS and Anglo utilizers and their results were almost identical to

those of the present study. The data suggests that generalizing the findings of other comparative groups to SS and Anglo utilizers may not be very reliable.

With regard to the presenting problem of the children, it was found that SS and Anglo families were quite similar. This outcome would seem to counteract the notion that Latinos, in general, have a different definition of mental illness as noted by Heiman, Burruel, and Chavez (1975). The writer would agree with Karno and Edgerton (1969) in that there are no differences between the two groups with respect to their abilities to recognize the need for mental health intervention.

The results also contradict the Stoker and Meadow study (1976). They found that acting-out behavior and defiant attitudes are more characteristic of the symptomatology of Latino children. In explaining their results, they referred to the resentment of the SS mother toward her role as an all-giving mother figure and toward her inability to express her own dependency needs. The resentment is consciously or unconsciously displayed through the ultimate rejection of her own children. They go on to say that with an equally threatening and rejecting father figure, the children are fearful of openly expressing their hostilities and act it out outside of the home environment. The present findings refute this speculation in showing that Anglo children are not significantly different from the SS children in their presenting problems. In fact, the raw frequencies indicate that there might even be a reversal of Stoker and

Meadow's predictions in that the Anglo children had a slightly higher frequency of authority- and school-related difficulties. The emphasis that Latinos place on respect for their parents could be generalized outside the household to include other authority figures such as school personnel.

Lastly, the two cultural groups exhibited similarities in the type of intervention offerred them. In this respect, the results contradict those of the Stoker-Meadow study (1976). Although the Anglo groups had a higher frequency of assignments to individual therapy, it was statistically insignificant. The author postulates that the similarities may be due to a decrease in the prejudiced and discriminatory practices of the mental health system. It should be noted that many of the investigations cited in the literature review section referred to the mode of treatment for adults rather than for children and their families. Psychotherapy is a more conventional form of treatment with adults whereas with children, play therapy is the major form of therapy used, especially at the Adult and Child Guidance Clinic. The difference in the form of individual therapy would certainly account for the equal distribution of treatment modes for the two groups.

Dissimilarities Between Anglo and SS Samples

The two populations differed from each other in relation to the following variables: educational level, single-parent families, source of referral, diagnosed problems,

length of treatment, and outcome of therapy. The source of referral and the diagnosed problems were the only variables which did not support the hypothesis and the findings in the literature.

Even though there were significant differences between the two groups which substantiate other findings, the results of this study were the exact opposite of the general knowledge that Anglos come to the mental health agency on their own initiative more often than Latinos (Andrulis, 1976; Stoker and Meadow, 1976). This information might indicate that traditional Latino perceptions of Anglo mental health systems are changing. Perhaps the negative attitudes on the part of the Latino toward the utilization of mental health services, referred to by Heiman, Burruel, and Chavez (1975), are diminishing, and the notion of the utilization of mental health services is becoming more widely accepted by this minority group. If so, one might suggest that the values of the Latino clients of the Adult and Child Guidance Clinic may be approximating the values of the Anglo clients, at least with respect to the utilization of the facility.

Even though there were differences with which a diagnostic label was applied to each cultural group, the data obtained in this study departed from the previous reports in that SS clients did not receive the more serious diagnoses. Several investigators (Rosen, Kramer, Redrick, and Willner, 1968; Rosen, Bahn, and Kramer, 1964; Simon, et al., 1973; Andrulis, 1974; Stoker and Meadow, 1976) had found that

minorities were overdiagnosed in transient situational disorders, and underdiagnosed in deferred diagnoses. The converse appeared to be true in the current study.

In recent years there have been many efforts on the part of researchers to explore the mental health needs of the SS minority. These researchers have been able to uncover some biases that prevail in mental health practices. Workshops and in-service training programs have been constructed in order to increase the level of cultural awareness in those individuals who work for the human services. The importance of such awareness and its relationship to diagnosis has been reviewed in great detail by Padilla and Ruiz (1976). They express concern over the large number of misdiagnoses that occur as a consequence of a lack of knowledge concerning the SS culture. The present data indicate that staff members at the Adult and Child Guidance Clinic possess the level of awareness that is necessary in making a culturally sensitive diagnosis. If so, the previously mentioned programs have been more than successful, at least in this particular setting. The writer speaks from experience when noting that in their staff meetings, special attention is always given to the cultural aspect of the cases being presented. The fact that a considerable number of SS clientele received deferred diagnoses could indicate the resistance on the part of the staff to jump into conclusions prematurely.

With regard to educational level, Anglos, on the average, had completed 2.8 more years of formal education than the

Latino heads of households. This is in accordance with prior data in the literature review. Padilla and Ruiz (1976) refer to the incredible number of barriers that stand in the way of the Latino's achievement of higher education. Among the most obvious are teacher biases, language difficulties, low socio-economic status, and a lack of self-confidence. The results of this study could mean that the barriers are still in existence, at least for the SS utilizers of the clinic, and that there has been little change in their educational achievement as compared to the Anglo utilizers.

The fact that only half of the SS clientele were from two-parent families surprised the author since she was under the impression that the rate of divorce, separation, or desertion would be lower among the SS client families. Many authors have commented on the importance of the family unit in the life of the Latino. This emphasis on the family would lead one to assume that divorces would be relatively infrequent in traditional SS households. In spite of the larger than expected frequency in the sample, there were more two-parent families in SS households relative to the Anglo sample.

Part of the reason for Anglos having lengthier periods of treatment could be due to the greater number of presenting problems indicated for this group. Children having two or three initial problems would require longer treatment periods than those having only one such complaint. A second explanation could be that Latinos are more responsive to treatment and were able to resolve the presenting problem in a shorter

period of time. This answer does not seem probable since more successful treatment outcomes would be implied and the findings did not indicate this possibility. A more probable reason is related to the greater tendency on the part of Latinos to drop out of therapy prematurely. Since there were no bilingual staff members at the Adult and Child Guidance Clinic, SS clients may have felt uncomfortable in having to speak a language which they may not have mastered. In addition, the formation of the therapist-client relationship, which is a crucial element in any successful therapeutic process, may have been hindered since the client did not share the same cultural background as the therapist. The end result for the Latino may have been the feeling that the Anglo therapist was misunderstanding or misinterpreting the facts of the situation and/or was recommending solutions which were against their cultural values. Observations stating that SS individuals require longer periods of time in order to establish a trusting relationship, in combination with the above speculations, would account for the shorter length of treatment, the large number of premature drop outs, and, therefore, the relatively fewer number of "successful" outcomes of therapy for the SS clientele.

Client Characteristics in General

Josselyn (1948) gives us a clue as to why latency-aged children would be expected to utilize a mental health facility more often than preschoolers and pre-adolescents

as she comments on the problems that face the latency-aged child, particularly as he enters school. He is suddenly expected to act as an adult and conform to the unfamiliar and often exhausting and rigid rules and regulations of the school. He is to form satisfying social relationships which require that he give up a part of his individual identity for group acceptance. Simultaneously, he is caught between the conflict of having to emancipate himself from the very persons on whom he is still very dependent--his parents. He is expected to be in control of his impulses and to be actively involved in the process of learning. Demands such as these become even more intolerable to the child if his earlier experiences did not provide him with the skills needed to effectively cope with the added pressure.

Although Novack and his colleagues observed differences between SS and Anglo children with regard to age, the data obtained from the present study supported Stoker and Meadow who did not report such a difference. The similarities between the two populations may point to the universality of the difficulties which face the child at each developmental stage.

The outcomes of other investigations (Rosen et al., 1968 and Novack et al., 1975) which showed that males utilize mental health agencies more often than females were upheld by the present study. We might turn to role theory for a tentative explanation for the discrepancy between the sexes. Despite the effort of the women's movement to abolish the

differences in male/female roles, society still persists in assigning little girls a more conforming role than little boys. The saying "boys will be boys" suggests that males are freer to do as they wish with less constraints while females are thought to be in need of protection and are raised to become obedient, considerate, and nurturing individuals. The importance attached to physical aggressiveness is more prevalent for males than females. Thus, boys would be more apt to display their aggression physically and get caught at it than would girls. As is shown in Table 13, aggressive behavior in the form of defiancy, fighting, and temper tantrums made up close to 50 percent of the presenting problems.

In addition, girls may be able to get away with certain behaviors which would not be tolerated in boys, predominantly because society defines such acts as "cute" for girls and "deviant" for boys.

The psychological and emotional impact of the loss of a parent on the entire family is a well known phenomenon to mental health personnel. Many children can not cope with this loss effectively. This may be reflected in the large percentage of children from single-parent households that found it necessary to use the services of the agency.

An interesting finding was the tremendous number of utilizers that came from low and middle income levels. Only five of the fifty-seven families had incomes above $12,000/year. One explanation for this result is that the Adult and

Child Guidance Clinic receives Short-Doyle funding such that they are able to attract low income families in their catchment area. Also, higher income families probably utilize private psychiatric services more often than psychiatric clinics, accounting for the small number of high income families represented in the sample.

Limitations and Implications of the Study

Many hypotheses were based on reading materials that were irrelevant to the objectives of this study. The fact of the matter is that studies such as this one have not been conducted, save for the Stoker-Meadow study. Thus, the author had to draw from investigations that were only slightly related to each of the variables and to the groups under study. Hopefully, the present investigation will be used as a reference for further studies that would test the findings and conclusions reached by the author.

The lack of bilingual/bicultural personnel at the Adult and Child Guidance Clinic has serious implications for the client population. The indications are that those SS individuals that used the clinic may have values which run parallel to Anglo values. The Latino sample did not include prospective monolingual (Spanish speaking only) clients and, thus, was not representative of clients utilizing other agencies which do provide bilingual/bicultural programs. Also, no comparative sample was drawn of non-users of the clinic services in the Latino community at large with problem children.

Until further research is done along these lines, controlling for non-users and for users of other bilingual/bicultural clinics in Santa Clara County, it will not be possible to generalize about the similarities in the characteristics of SS and Anglo clients. It is recommended that a bilingual/bicultural outreach and therapeutic program be instituted in the Adult and Child Guidance Clinic. Once this is done, a follow-up study could be done to assess possible changes in the types of SS clients attracted to the facility.

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