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Portuguese-Americans and Mental Health Treatment Client-Therapist Ethnic Match, Ethnic Identity, and Satisfaction with Treatment

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PORTUGUESE-AMERICANS AND MENTAL HEALTH TREATMENT:

CLIENT-THERAPIST ETHNIC MATCH, ETHNIC IDENTITY, AND

SATISFACTION WITH TREATMENT

by

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ABSTRACT

PORTUGUESE-AMERICANS AND MENTAL HEALTH TREATMENT: CLIENT-THERAPIST ETHNIC MATCH, ETHNIC IDENTITY, AND SATISFACTION WITH TREATMENT.

Katherine B. Gamble
Virginia Consortium Program in Clinical Psychology, 2000
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Multicultural issues in psychotherapy have increasingly been recognized as important in the provision of mental health services to our diverse population. Issues such as beliefs about mental health, attitudes toward authority, and even world view affect how clients access and make use of psychotherapy. Cultural views are essential to how one sees the world, and consequently there is much debate about whether clients would benefit from having therapists from the same cultural background. Ethnic identity, or the degree to which a person holds to the beliefs of their culture of origin, consequently plays an important role in psychotherapy. The Portuguese culture is one that has limited areas of settlement, but that accounts for a significant portion of the population in certain areas. They are an understudied population in the literature on multicultural counseling. This study examined the relationships among the variables of client-therapist ethnic match, degree of ethnic identity, and level of satisfaction with therapy. Twenty-four Portuguese-Americans, aged 23 to 58, who were currently in psychotherapy completed questionnaires measuring ethnic identity and satisfaction with therapy. Satisfaction did not differ between those who had ethnically similar therapists and those who had non-Portuguese therapists. However, for those with ethnically matched therapists, satisfaction with therapy was significantly correlated with Portuguese ethnic identity. Clients with

high ethnic identity were more satisfied with therapy than clients with low ethnic identity. Clients whose families had immigrated in more recent generations were confirmed to have a higher ethnic identity than those whose families had been in the United States for generations. There was a trend for clients to be more satisfied if their families were involved in therapy, although this was not statistically significant. Clinical implications of these findings and directions for future research are discussed.

To my family.

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when I felt defeated. He has been my partner in education, as well as in life. To my

family I dedicate my dissertation. To Frank I dedicate my degree.

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CHAPTER I

INTRODUCTION

While multicultural issues in mental health have been the subject of a great deal of research over the last twenty years, such studies have focused on the larger minority groups in the United States such as African-Americans, Asian-Americans, and Hispanic-Americans (Atkinson, 1983). There has been little research on the mental health and treatment of Portuguese-Americans (Moitoza, 1982). The Portuguese culture is rich and full of tradition. A significant number of Portuguese immigrants and descendants live in the United States. Despite their prominence in certain areas, they are a little known and little understood immigrant group. This lack of understanding is especially true in reference to mental health issues.

While some of the research on larger minority groups is relevant to the Portuguese-American client (e.g. issues of acculturation [Berry & Kim, 1988], issues of therapy in a second language [Rozensky & Gomez, 1983]), much of that research is not applicable across cultures. Issues not applicable across cultures include the preference for therapists of the same ethnicity and cultural communication styles. The culture of the Portuguese, the history of Portugal, and the story of Portuguese immigration together create an immigrant population likely to have distinct mental health issues. To create appropriate treatments for this population, more research must be directed toward the treatment of Portuguese-Americans. This study attempts to identify some important issues distinctive to the mental health treatment of Portuguese-Americans, including identifying issues of particular importance to the Portuguese culture, as well as clarifying whether treatment issues common to other cultures apply to this population – such as the benefit of ethnic similarity between therapist and client.

Publication Manual of the American Psychological Association was the style guide for this manuscript.

Portugal, the Portuguese, and Portuguese-Americans

Portuguese-Americans account for a significant number of immigrants to the United States, and while they number about 1.5 million people, they are relatively unnoticed. This is, in part, due to their limited areas of settlement. Significant Portuguese-American populations have settled in California and Hawaii, but the majority of Portuguese immigrants have settled in New England, particularly in Massachusetts. (Cabral, 1978; Leder, 1980; Pap, 1981) Immigration has increased significantly each decade for the latter part of the 20th century (Cabral, 1978; Leder, 1980; Pap, 1981). Since 1972, the Portuguese have been the largest immigrant group in Massachusetts, with Azoreans accounting for over 50% (Moitoza, 1982). Massachusetts also contains 30% of the Portuguese-speaking population of the United States (Carlini-Cotrim & Coelho, 1995).

The Portuguese-American culture has received little attention in the literature of sociology and less in psychology. Leder (1980), in his research of families in a California Portuguese-American community, notes that Portuguese-American communities often are unnoticed by the general public. Leder believed this to be due in part to their quiet acclimation to the majority culture. In contrast, most other researchers and theorists note the tendency of Portuguese-Americans to hold on to their cultural beliefs and their tendency to settle in communities with similar ethnic and geographic backgrounds (Araújo, 1996; Moitoza, 1982). Thus, their lack of visibility is more likely due to their insular tendencies, in addition to a lack of significant clashes between their cultural values and those of the general populace. Such differing opinions of the etiology of their low visibility are reflective of a sea change in the thinking about multiculturalism. As researchers continue to investigate multicultural issues, they no longer assume that a lack of open conflict is an indicator of assimilation.

<u>The Portuguese</u>

Portuguese immigrants to the United States come from the European continent and from three separate island chains: the Azores, the Madeiras, and the Cape Verde Islands (Cabral, 1978; Leder, 1980; Pap, 1981). Pap is one of few investigators who considers Black Capeverdean immigrants as Portuguese, which may be due to the difference in race. Black Capeverdeans may not fit many researchers' concept of the typical light-skinned Portuguese immigrant. Additionally, because they are a visually recognizable minority, their experiences are affected not only by their own culture or ethnicity but by their race. However, they do share many cultural values with other Portuguese populations and are often identified by other Portuguese immigrants as Portuguese.

Although there are many distinct Portuguese groups, all share certain characteristics, especially regarding family values and structure (Moitoza, 1982). The interwoven effects of history, geography, politics, and immigration shaped four major dynamics in Portuguese-American life: fear of loss, fatalism toward life, ambivalence toward authority, and a drive for financial independence (Araújo, 1996). These values are most apparent within the family, and the family unit is of supreme importance to the Portuguese (Moitoza, 1982). Araújo (1996) identified four values of special importance to the Portuguese: <u>honra</u> (honor), <u>respeito</u> (respect), <u>bondade</u> (goodness or generosity), and <u>confiança</u> (trust). Family dynamics and expectations are shaped by these four values.

<u>History of Portugal and the Portuguese Culture</u>

In 1386, Portugal began a program of exploration and conquest. Within 200 years, Portugal was considered one of the great nations (Araújo, 1996; Ribeiro, 1996). During the 15th century, the Crusades led Portugal to the discovery and colonization of parts of South America, Asia, and Africa.

Continental Portuguese explorers landed in and settled the Azores, nine volcanic islands in the North Atlantic about 1000 miles west of Portugal, and slowly colonized them (Araújo, 1996; Moitoza, 1982). The Azores were difficult to cultivate and offered a lean existence. Inhabitants survived centuries of disasters such as volcanic eruptions and earthquakes that repeatedly destroyed their villages, often by complete burial (Almeida, 1968). Additionally, they often had to fight pirates from England. The Azoreans felt at a disadvantage in relation to the mainland and felt both oppressed and ignored by the mainland government (Almeida, 1968; Araújo, 1996; Moitoza, 1982). The red tape involved in immigrating to other Portuguese provinces led Azoreans seeking escape to immigrate to the Americas instead.

In 1910, after several centuries of development as a colonial empire, a republican revolution overthrew Portugal's monarchy (Araújo, 1996; Ribeiro, 1996). The ensuing 15 years of civil uprising created an instability that allowed the country to fall under fascist control in 1925 and military dictatorship in 1926 (Ribeiro, 1996). During this regime, which lasted nearly fifty years, a secret police was established that tortured and killed many Portuguese citizens. People informed on each other to escape punishment; distrust was widespread. In this period, the Azores were essentially abandoned by Continental Portugal: the connection between the two was minimal as the continental government spent little effort governing the Azores (Araújo, 1996). In 1974 a democratic regime was set up via a bloodless revolution (Ribeiro, 1996). Following this, independence was given to the African colonies of Portugal. In 1975, Azoreans successfully pressured the Portuguese government to establish an autonomous government.

The attitudes and values of the Portuguese stem naturally from their history. The Azoreans' lean existence and lack of control over natural disasters led to a fatalistic attitude (Araújo, 1996; Moitoza, 1982). Continental Portuguese became similarly fatalistic both because the mainland was frequently occupied by different invaders

(Araújo, 1996), and because of a rigid two-class structure that did not allow them to improve their status (Moitoza, 1982). There existed a wealthy, educated upper class, and a working class to whom education was neither available nor valued.

The dictatorship led not only to fatalism, but also to profound distrust of authority. The fear of loss often experienced by Portuguese stems, at least in part, from the cultural awareness of the loss of a great empire (Araújo, 1996). Decades of fascism accentuated this fear. For immigrants, loss was re-experienced when leaving their homes, extended family, and culture. Ambivalent feelings toward authority, as well as a drive for financial security, were borne of their wish to have more control over their lives. The drive for financial security is also related to their strong family loyalty, and they will work multiple jobs if necessary to provide for the family.

The Portuguese working class see education as for the rich and aristocratic (Araújo, 1996; Leder, 1980; Pap, 1981), and their children will often work alongside parents rather than attend school. Only in the 1960's was mandatory education in Portugal increased from three to six years, and in 1968 Portugal still had the highest illiteracy rate in Europe (Pap, 1981). Interests of the Portuguese have been mainly economic, and due to their perception of achieving economic success without education, devaluing of education persists throughout generations (Leder, 1980). Most people in Portugal still live in rural villages. Literacy is seen as an excess, valuable only to the upper class, and a necessity only for tradesmen and priests.

In the vastly larger working class, there is a definite reliance on physical labor, with a concentration on practical vocations (Leder, 1980). Self-reliance is prized and more attainable in the American culture due to the ability to acquire financial independence through industrious physical labor. Employers in the United States commonly view Portuguese-American workers as earnest, dependable, and self-sufficient (Moitoza, 1982). Pap (1981) lists a number of epithets most commonly used regarding

Portuguese immigrants in the United States: law abiding, peaceful, orderly, obedient. subservient, docile, lacking initiative, hard working, industrious, thrifty, frugal, sober. honest, loyal, neat, and clean. Leder's (1980) research shows that the public think of Portuguese-Americans as moral and highly ethical. He notes that Portuguese-Americans rarely turn to welfare or charity, supporting themselves independently as soon as they are able. Pap's (1981) description of Portuguese affect is somewhat more diverse: impulsive, quick tempered, melancholy, gentle, generous, hospitable.

Immigration

Most Portuguese immigrants to the United States are from the various Portuguese islands, the vast majority from a farming culture (Cabral, 1978; Leder, 1980; Pap, 1981). Those from the islands do not necessarily define themselves as being "Portuguese," but as Azoreans, etc., with identities distinct from the mainland or other islands (Pap, 1981).

The Portuguese came to America for a variety of reasons. Most have come due to poverty and a lack of economic opportunity at home -- Portugal has been among the poorest of the European countries. Some young men immigrated to escape military service (Leder, 1980; Pap, 1981). Natural disasters often preceded emigration (Leder, 1980; Pap, 1981). Finally, many immigrants came to rejoin family members already relocated within the States.

The first Portuguese to visit America came on expeditions in the 1500's, although there is speculation that the Portuguese preceded Christopher Columbus' arrival (Pap, 1981). There is no evidence of Portuguese settlers in America until the mid-17th century. The Portuguese have long held a high regard for seagoing skill and adventure (Pap, 1981) and this has strongly influenced their immigration patterns. For example, in the United States they have settled exclusively in coastal states. The single highest concentration of Portuguese-Americans in the New England area is in the whaling town of New Bedford, Massachusetts (Cabral, 1978; Leder, 1980; Pap, 1981).

Portuguese immigration to the United States has increased throughout each century (Cabral, 1978; Leder, 1980; Pap, 1981). Immigration has occurred in three major waves, each with different socioeconomic precursors (Araújo, 1996). The first wave, beginning in the 1830's, was in response to a need for whalers. Those oriented to the sea, fishermen and whalers, primarily settled in New England and later in California and Hawaii. (Cabral, 1978; Leder, 1980; Pap, 1981) These immigrants were men, leaving their families until they made enough money either to send for their families or to return to Portugal with enough money to assure a comfortable life. Wives and children remaining at home were supported by older males and extended family members who were crucial for both emotional and financial support (Araújo, 1996).

The second wave began in the late 19th century and continued until the overthrow of the government in 1974 (Araújo, 1996). It began when entire families from the Azores and Madeira islands immigrated and settled as farm workers in California, Hawaii, and New England. Concomitantly, as the need for industrial workers increased, many families began working in textile and leather factories. Fishing, whaling, and textile industries continued to attract Azoreans and Continental Portuguese in great numbers throughout the end of the 19th century, totaling about 64,000 by 1900 (Moitoza, 1982).

In the early 20th century, there was first a shortage of labor and later the Depression. An anti-immigrant stance overtook the U.S. public who felt immigrants were taking jobs from American citizens. This resulted in a gradual throttling of immigration, first with the legal requirement of literacy (strongly affecting the Portuguese, with their high rate of illiteracy), then with quota restrictions from 1921 to 1965 (Cabral, 1978; Moitoza, 1982; Pap, 1981).

Fully twenty-five percent of Portuguese immigrants returned to their homeland - not only first generation but also second generation families who had established a life in the United States. Those who stayed in the U.S. retained their fatalistic sense of passive

resignation to their difficult lot in life, staying in low-level jobs unlike many other White ethnic immigrants who tended to advance in levels of socioeconomic status.

When economic stability resumed in the United States, those second generation immigrants who had returned to Portugal resumed life in America (Araújo, 1996). In 1957, volcanic eruptions, as well as oppression and political instability in the Azores during the fascist regime led to further immigration (Araújo, 1996). After 1965, immigration again steadily increased (Cabral, 1978; Pap, 1981). Because of their limited finances once in the United States and because of the political climate in Portugal, families in this second wave were often separated from extended family in Portugal and left feeling vulnerable. Feeling of dislocation, confusion, and the desire to reaffirm their home culture led these immigrants to become more rigid in their values and to settle in communities already populated with immigrants from their home towns.

The third immigration wave began in 1974, when Portuguese immigrants already numbered about one million (Araújo, 1996). This wave consisted of three sub-groups. One group immigrated from the Azores where they feared a communist takeover, and it included both unskilled laborers and children of the Azorean bourgeoisie. A second group was forced out of the former Portuguese colonies as new rules emerged, and they returned to Portugal where they could not find work. They then immigrated to other countries before arriving in the United States. Because of their experiences, these immigrants were better prepared for the stresses of immigration and urban life. The third group of immigrants came from the Azores during the 1980's following severe earthquakes and from Northern Portugal due to personal financial problems. The third immigrant wave is more diverse and less isolated, and the women have more economic and social mobility. They are more open to the challenges of urbanization, but they are still distrustful of authority (Araújo, 1996).

Portuguese immigrants have demonstrated an uncanny ability to remain invisible as a U.S. ethnic minority. However, the apparent ease with which they disappear into their new surroundings may belie the conflict this creates when the Portuguese ethnic identity is hidden. Although Portuguese immigrants make a great effort to live within and relate to U.S. society, they are strongly tied to their traditional beliefs and life-style (Moitoza, 1982). The pull both ways is intense and potentially alienating. Thus, they are not a particularly assimilated minority, but rather a marginal one. Once in the United States, immigrants from the same area tend to settle together (Pap, 1981). They have set up numerous voluntary associations (Cabral, 1978; Leder, 1980; Pap, 1981) whose membership is generally formed around geographic place of origin.

Immigrant Culture

Many cultural phenomenon, such as Portuguese festivals or festas, also form around local tradition and are based in religious beliefs. Familial ties, new friendships, and the extension of urban social networks are activated and reinforced through the organizing of these festivals (Cabral, 1978; Leder, 1980; Pap, 1981). Minor competition and conflict exists between immigrants from diverse island groups, mostly based upon differences in traditions (Cabral, 1978; Pap, 1981).

Religion. Religion traditionally plays a significant part in the lives of Portuguese-Americans, both socially, and culturally. Although there are Jewish and Protestant Portuguese, the vast majority are Catholic (Pap, 1981). Priests are accorded easy access to the family, normally a closed unit (Moitoza, 1982). The Portuguese rely on assistance and intercession from numerous Catholic saints and religious figures. Folk traditions are incorporated into the Roman Catholic religion (Cabral, 1978; Pap, 1981). These traditions differ according to place of origin, as evidenced in the variety of festas (Cabral, 1978), which, as mentioned above, are a significant social occasion maintaining communality (Moitoza, 1982). However, religion has also been a source of feelings of alienation for

this minority; Immigrants often had to wait for years to be granted a Portuguese speaking priest, or otherwise attend a Protestant church with a Portuguese speaking minister (Pap. 1981).

Family relationships and roles. Strong Portuguese family bonds often exclude outsiders. Although these bonds tend to reach through the extended family, the nuclear family remains the most important (Hollos & Leis, 1985; Leder, 1980; Moitoza, 1982; Pap. 1981). Both children and adults are expected to gratify most of their personal, social, and emotional needs within the family (Moitoza, 1982). Familial needs supersede individual ones. Individuals have a responsibility to their extended family (Leder, 1980; Pap. 1981). The hierarchy of authority goes from the father to the mother to the oldest child. Children continue to consult their parents on decisions throughout their lives (Leder, 1980).

The male is typically the head of the family, and the concept of maintaining honra, which Americans might liken to "saving face," is paramount (Hollos & Leis, 1985; Moitoza, 1982). Thus, even when the woman's role is powerful, it is expressed subtly. There is a history of pride in prolific families, including 15 to 20 children, which represent the male's virility (Moitoza, 1982; Pap, 1981). Men are expected to maintain physical and emotional strength, keeping their feelings to themselves to maintain power (Moitoza, 1982). Men interact almost exclusively with other men, even within the home. The man is the primary emotional and physical protector of the family, and expects respect from his children, expressed by their unquestioning obedience. Corporal punishment is accepted and common (Araújo, 1996; Yoshida & Davies, 1982). Problems leading Portuguese-American men to seek psychological help are often related to alcoholism and physical abuse of children or sometimes of women.

While the family is largely patriarchal (Araújo, 1996; Moitoza, 1982), a great deal of the work "behind the scenes" is done by women. The mother cares for the family and

the household with little assistance at home from her husband (Yoshida & Davies, 1982). The wife's surface role is to love, honor, and obey her husband, and to care for the family (Moitoza, 1982). However, closer analysis reveals her role to be more of an active manager-negotiator and stabilizer. The woman plays a more subtly powerful role involving internal and external familial facilitation, negotiation, and decision making (Hollos & Leis, 1985; Leder, 1980; Moitoza, 1982).

The Portuguese-American wife is typically responsible for providing the family a comfortable blend of the old ways and the new (Pap, 1981). Women are also expected to be virtuous and pure as exemplified by the Virgin Mary (Moitoza, 1982). The family is careful to protect these qualities, especially in younger women. There are well defined sexual double standards and there is strong concern that the family honra remain intact. Female sexuality is seen as powerful and dangerous. Women seek treatment most frequently for anxiety and depressive reactions masked as somatic complaints.

Children are expected to be seen and not heard (Moitoza, 1982). Boys have considerably more freedom from parental control, even through adolescence, and are more easily forgiven for acting out than are girls (Yoshida & Davies, 1982). Girls receive overt attention while boys do not. However, boys have more time outside the family than girls, who are expected to be with their mother, acquiring domestic skills (Moitoza, 1982). Girls are carefully controlled to ensure their marriageability (i.e. perceived virginity) as a matter of family honra (Leder, 1980; Moitoza, 1982; Pap, 1981).

Latency age children are less indulged than majority children in the United States and are expected to contribute to the household. Upon adolescence, children are expected to be financially loyal to the family, which often entails quitting school. They are still subject to the strict demands of parents in contrast to American youth. Adolescents are notably well behaved, both in the family and in public, which has been hypothesized to be a result of parents involving children in numerous adult activities and treating them

with respect (Leder, 1980). As young adults, they are expected to live at home and contribute financially to the family until they marry, in order to repay some of their own child-rearing expenses. Once married, they often live near their parents.

Referrals for therapy are often sought for hyperactive and aggressive boys. Girls are not often referred, but those who are usually present with symptoms of anxiety (Moitoza, 1982). Adolescents seen in therapy are often reacting with frustration and rebellion to the strictness of their family as compared to those of American families. In addition to finding a low level of juvenile delinquency, Leder (1980) found in Portuguese-Americans a low incidence of disorders commonly thought to be of sociocultural etiology. However, his data are limited.

Godparents play a vital role in Portuguese family life. The strongest bonds outside of the nuclear family are those between godparents and godchildren (Leder, 1980). Godparents are integral family members. They are considered sponsors in and for life (Moitoza, 1982). They are especially important in light of Portuguese fatalistic views; parents believe that survival of their children is insured with a second set of parents. Godparents are usually selected from immediate or extended family or chosen for their wealth or power. Godparents are often sought for advice and support throughout life.

<u>Portuguese-American Views of Mental Health</u>

The Portuguese have two prevailing concepts of physical and mental illness, both including biomedical and supernatural components (Moitoza, 1982). The first is that mental illness is biologically determined and expresses itself primarily in somatic symptoms or bizarre behavior. Thus, the Portuguese often believe that mental illness or its somatic equivalent is incurable, or not curable with "mere" words. They feel that they are not responsible for their problems and therefore cannot solve them. Thus, they believe treatment should be actively administered to them. Somatic complaints tend to revolve around the gastrointestinal and circulatory systems. They believe blood or digestive

material can back up and cause mental problems, although such problems usually prove to be rooted in anxiety or depression.

The second concept is that mental illness is caused by supernatural conditions or beings that have to be either negotiated with or appeased (mau-olhado/quebrando = curses; bruxas = witches). Azorean Portuguese place strong credence in folk medicine practices (espiritualistas and curandeiros = curers). Prayers, amulets, teas, herbs. poultices, fumidors, and curers are often used concomitantly with more modern medical treatment. Portuguese-Americans tend to disguise their supernatural beliefs, presenting them indirectly and with reticence. Psychological problems, especially in preadolescents. are seen as punishment for parental weaknesses, sins, or failures. Parents are thus slow to recognize emotional problems in their children and slower yet to seek help for fear of being blamed. Psychiatric problems in an adolescent woman are believed to be result of illicit sexual behavior with marriage as the remedy. In the elderly, problems are attributed to arteriosclerosis or to family inattentiveness.

Portuguese-Americans rarely seek treatment by themselves. They first try to solve their problems within the family (Moitoza, 1982; Yoshida & Davies, 1982). Therapy is more often due to external referrals or court-orders for therapy. These external referrals may be seen as a violation of honra, and thus the client may feel ashamed or embarrassed (Araújo. 1996). Moitoza believes that family therapy is more consonant with Portuguese cultural norms. In individual therapy, the family is likely to try to join in helping with the therapist, and if they are shut out the family may try to withdraw the client from therapy.

Another difficulty in therapy is creating a therapeutic alliance (Moitoza, 1982). Since education in Portugal is only for the rich, educated people such as the therapist are seen as members of this wealthy class and are alternately viewed with envy and mistrust. This ambivalence toward authority may also lead Portuguese clients to seek relationships with various health care providers while not informing the therapist (Araújo, 1996). One

solution is asking the family to obtain the approval of their <u>curandeiro,</u> which allows them to be open with therapists about other sources of help.

The stress of immigration affects all immigrant groups, but due to some of the aforementioned philosophies and cultural beliefs in the Portuguese culture, Portuguese immigrants may be especially likely to suffer. Their fears of loss are realized in leaving their familiar home and extended family. Because of their fatalistic outlook, they do not necessarily anticipate a positive outcome to this major change.

<u>Multicultural Counseling</u>

The beliefs related to Portuguese culture affect both behavior and beliefs about mental health. While fatalism in a majority client may be a symptom of depression, it may be a normal aspect of life for a Portuguese-American client. Such issues can not only affect diagnostic considerations, but also treatment. This understanding has led to a field of theory and research called multicultural counseling.

Multicultural counseling is a field that examines the cultural factors in psychotherapy and counseling with ethnically diverse populations (Vargas & Koss-Chioino, 1992). This includes not only understanding the effect of ethnic minority cultures on counseling, but understanding the Western context in which most psychological theories have been formed. Even something as basic to personhood as the concept of self is culturally constructed and defined by social parameters. Culture defines reality for its members, for example through defining purpose in life, or proper, sanctioned behavior (Kagawa-Singer & Cheung, 1994). Consequently, therapists will function optimally when they understand both their own culture and that of their clients.

"Cultural differences introduce barriers to understanding in those very areas of interaction that are most crucial to the outcome of therapy, through discrepancies between counselor and client experiences, beliefs, values, expectations and goals." (Pederson, 1984, p. 340) Although often ignored, evidence suggests that issues of culture

and race significantly affect therapy (Carter, 1995). If one is to provide culturally

competent care, health must be defined as the ability to achieve one's life objectives

within the beliefs and values of one's own culture (Kagawa-Singer, 1993). Consequently,

for thorough, effective therapy the therapist must understand the context in which the

client's behaviors and problems occur, as well as how to best address the problems given

the client's cultural beliefs. This complex approach requires that studies of the counseling

of ethnic minorities concentrate on a number of issues: ethnic identity, traditional values,

communication in therapy, clinical considerations, matching of therapist and client

ethnicities, and theoretical orientation (Marsella, 1993; Sue, Nolan, & Young, 1994).

Effect of Culture on Mental Health

In different cultures, different factors influence the course of a mental health

problem. For example, in one study lack of perceived social support and poor English

skills were significant predictors of depression in Portuguese women, while

unemployment and low financial status predicted depression for Latin American women

(Franks & Faux, 1990). Thus, knowledge of cultural variables is helpful even very early

in the provision of mental health services, in determining risk factors for minority clients.

Because the self differs significantly between cultures, defense mechanisms or other

methods of self-protection will also differ.

Culture also has an effect on what is seen as pathology. That is, what may be seen

as healthy in one culture may be considered pathological in a different culture. For

example, an individualistic culture, such as the culture dominant in the United States,

values firm boundaries between people, an internal locus of control, and the importance

of the individual (Koss-Chioino & Vargas, 1992). However, some cultures are

collectivist, rather than individualistic, and value the group over the individual, have a

fluid sense of interpersonal boundaries, and rely on the group for a sense of control. To

the individualist therapist, a collectivist client may seem pathologically dependent and

immature despite the fact that they are adhering to their cultural traditions. A culturally informed therapist would interpret the behavior of the client in the light of the relevant cultural context, rather than interpret it as pathology.

Research

Research on the cultural context of mental health treatment is limited. In fact, there has been no rigorous research to determine if psychotherapy is even effective for ethnic minority populations (Sue, 1998). The impetus for researching culturally competent care should be considerable, given the inadequacy of services for ethnic minority members. Investigators have typically found deficiencies in the delivery of mental health services to members of ethnic minority groups, largely related to a lack of cultural competence and the ineffectiveness of traditional mental health services with non-traditional clientele (Sue et al., 1991). Ethnic minority clients are not faring well in the mental health system. One study (Sue, 1977) indicates that ethnic minority groups tend to drop out of treatment quickly; about half terminate after one session (as compared to 30% of White Americans).

Only recently has there been research on groups other than African-Americans, the largest ethnic minority group in the United States (Atkinson, 1983). Gradually, research has also been directed to studies for Asian-Americans, Hispanic-Americans, and, to a lesser degree, Native Americans. As noted before, there are exceedingly few published studies on the counseling of Portuguese-Americans although a number of dissertations and other studies have been undertaken.

Ethnic Identity

Ethnic identity is the degree to which a person's identity is rooted in the values and traditions of their culture of origin. Not all minority members adhere to their traditional culture to the same degree. It is, therefore, important to assess clients' ethnic identity in order to understand their cultural values and thus to treat them as unique

individuals, rather than a homogeneous group. A therapist cannot make the assumption that all minority clients adhere equally to their culture of origin. Similarly, one cannot assume that the only objective of acculturation is assimilation, ignoring the possibility of a bicultural identity, where the minority member identifies both with the ethnic culture and the majority culture. (Kagawa-Singer & Cheung, 1994; LaFromboise, Coleman, & Gerton, 1993)

Acculturation is the way in which a person adapts to having ties to different cultures (Berry & Kim, 1988). While some researchers believe in a linear model of acculturation, where one can only adapt to the new culture by losing the old culture (e.g. Cuellar, Harris, & Jasso, 1980), there is empirical and theoretical support for an alternative model of acculturation (Alvidrez, Azocar, & Miranda, 1996; Zak, 1973). This alternative model, the orthogonal model, does not require that immigrants lose their traditional culture as they adopt values of the new culture. In the orthogonal model, a person can simultaneously be strongly identified with both the new culture and with the old culture (Lanca, Alksnis, Roese, & Gardner, 1994). Thus there are two axes, the new culture and the old culture, and one can be anywhere from strongly to weakly identified with either culture. In counseling an immigrated minority member, it is helpful to know for how many generations a strong sense of ethnic identity is held. Some cultures may assimilate within one or two generations of life in America, while others may maintain traditional values for many generations. The determination of acculturation leads to a fuller understanding of the client.

Communication in Therapy

Culture can also have an effect on the ability to communicate between therapist and client. Difficulty in communication occurs when the therapist interprets information from the therapist's own cultural template (Kagawa-Singer & Chunge, 1994). When a therapist fails to understand or to take into consideration differences in cultural patterns,

the result is a recurrent incongruity between the therapist and the client. Taken out of context, various beliefs or behaviors may be misinterpreted or disregarded as maladaptive or unnecessary if cultural context is not considered. A number of cultural values need to be assessed for counseling: social and family hierarchy, importance of family, respect for tradition, taboo and aversive topics, acceptability of expression of emotions (non-verbal), and acceptability of verbalization of feelings. Other cultural issues important to assess are: metaphors for psychic distress (including somatization), stereotyped roles of therapist and client/patient, proxemics (including hierarchical differences).

Another significant matter is counseling ethnic minority members for whom English is not their first language. The language of therapy is important (Rozensky & Gomez, 1983). Speaking in a second language can be thought of as an intellectual task, versus the emotional task possible when speaking in a mother tongue. Language within therapy can be switched, depending upon the task, but Rozensky and Gomez theorize that the mother tongue is necessary to access emotion, as that may be the language in which those emotional experiences were stored. However, the amount of time each language is used in the client's current life is also important. If the mother tongue is rarely used, the second language may communicate best. Language match in therapy leads to more culturally responsive therapy as well as more sessions of therapy (Sue et al., 1991; Yeh, Eastman, & Cheung, 1994).

When the client and therapist do not share a language, some therapists consider using an interpreter. Many issues arise with the coordination of a therapist, interpreter, and client. The use of interpreters by therapists unable to communicate in the language of clients is subject to distortions involving omissions, substitutions, condensation, and changes in focus from the actual messages conveyed between therapists and clients (Sue et al., 1991). Additionally, dynamics within the therapeutic relationship can be affected. For example, transference and counter-transference can occur among the three

participants, or there may be resistance on the part of the interpreter when the client divulges unflattering information about their shared culture (Freed, 1988). Great difficulties arise in the translation of non-verbal communications, particularly with the interpreter's ability to translate the therapist's non-verbal communications to the client (Freed, 1988).

Many researchers strongly recommend the training of interpreters as paraprofessionals or co-therapists, and advocate their consistent assistance as an official member of the treatment team (Freed, 1988; Sue & Sue, 1990). Thus the interpreter would be trained to understand goals and methods of therapy and the role of the therapist. The interpreter's role would be parallel to that of the therapist. This relationship would require post-session review between the therapist and interpreter, giving the interpreter a chance to communicate if the client is showing culturally appropriate or inappropriate behavior (Freed, 1988). Freed suggests that relatives should be avoided as interpreters, as their feelings regarding the client can interfere with communication.

Cultural or Ethnic Match

Few large scale studies examine in detail the relationship between the adoption of culturally responsive interventions (including matching) and outcomes for minority group clients (Sue et al., 1991). Neither have studies been conducted to examine if the therapist's understanding of the client's culture is related to therapy outcome. One reason for this is that methodological and conceptual problems exist in defining cultural knowledge. In view of these difficulties, most researchers have reformulated the issue into one involving ethnic match. Obviously ethnic match is not identical to cultural match because individuals of the same ethnicity may be culturally different. Nevertheless, ethnicity and cultural knowledge are likely to be highly correlated.

The subject of matching therapist and client ethnicities is a popular subject of debate. Many theorize that if language and/or ethnicity are matched, therapy is more

likely to be helpful because the chances are greater that the world view and cultural definition of the self, the styles of both verbal and non-verbal communication, and the therapeutic objectives will be congruent between the client and therapist (Hymes, 1972; Whorf, 1956). Theorists also question whether a client would be more comfortable with someone of the same ethnicity, whether a therapist of the same ethnicity is better equipped to treat a minority client, and whether matching will improve the outcome of treatment.

Proponents of intracultural counseling argue that counselors who are ethnically similar to their clients are better able to understand their clients' problems, serve as role models for their clients, and resolve their clients' difficulties (Atkinson, 1983). Proponents of cross cultural counseling argue that culturally sensitive counselors should be able to transcend cultural differences just as they must transcend other differences between themselves and their clients. Additionally, there are not enough ethnic minority counselors to meet the demands of minority clients, and therefore all therapists should be trained for cross-cultural work.

Reviews of studies on the topic of counselor-client ethnic match found that African Americans tended to prefer same-ethnicity therapists, but that these findings were not reliably replicated in the limited studies of other ethnicities (Atkinson, 1983; Sue, Nolan, & Young, 1994). A meta-analysis of studies that assessed ethnic minorities' perceptions of and preferences for ethnically similar counselors showed that, in general, minorities tended to prefer either ethnically similar or European-American counselors (versus cross-ethnic minority pairings), although the results were influenced by the cultural affiliation of participants and by the research methods (Coleman, Wampold, & Casali, 1995). Studies often find that ethnic similarity is rated as less important than similarity in attitudes and values. Cultural or ethnic identity has been shown to be a powerful influence accounting for most of the variability within minority groups

(Atkinson, et al., 1998; Gim, Atkinson, & Kim, 1991; Helms, 1985; Ponterotto, Alexander, & Hinkston, 1988). One main difficulty in drawing conclusions from the majority of studies is that they are largely analog (e.g. Bennett & BigFoot-Sipes, 1991; Gim, Atkinson, & Kim, 1991; Ponce & Atkinson, 1989; Ponterotto, Alexander, & Hinkston, 1988), with participants making preference statements assuming all other things are equal (Atkinson & Lowe, 1995). But all things are rarely equal, and ethnic identity cannot be separated from attitudes and values. In addition, preference research has yet to be linked to actual counseling effectiveness (Coleman, et al., 1995). As of 1986, there were still only a few studies using naturalistic settings with actual clients (Atkinson & Schein, 1986).

One way to initially examine the success of treatment with ethnic minority clients is to look at outcome measures. There is more recent research support for the importance of ethnic match in therapy outcome as measured by dropout rates, number of sessions, and length of therapy (Flaskerud, 1990; Flaskerud & Hu, 1994; Fujino, Okazaki, & Young, 1994; Sue et al., 1991; Yeh et al., 1994).

While many studies did not find significant differences in symptom or functioning improvement with ethnic match, ethnic match was a predictor of outcome as measured by ratings of symptoms or functioning, with clients for whom English was not the primary language (Yeh et al., 1994). Additionally, Sue (1998) found that with a number of ethnic minority clients, ethnic match resulted in less dropout, longer treatment, and better functioning. This relationship was particularly strong for clients less acculturated to the majority society. Clients who are matched to ethnically similar therapists have also been shown to use intensive psychiatric services less often, and, despite staying in outpatient care longer, their care is shown to have lower financial cost overall (Jerrell, 1995).

Outcome is a complex and poorly defined construct. The literature reports varied levels of correlation between client and therapist rated measures of outcome (Attkisson &

Zwick, 1982; Larsen et al., 1979). The lack of convergence between therapist and client ratings of outcome has been a continuing controversy in outcome research (Zane, Enomoto, & Chun, 1994). It may merely reflect the different value orientations and different motivations for therapist and client. Consequently, the most culturally responsive measure of change would put emphasis on the client rating of outcome. Perhaps the most easily measured outcome is client satisfaction, which is also often used as a measure of outcome in multicultural psychotherapy studies (Zane, Enomoto, & Chun, 1994). Measures of satisfaction have been shown to be significantly correlated with positive and clinically significant symptom changes (Ankuta & Abeles, 1993). Client satisfaction measures have been found to correlate moderately with therapist ratings of symptom improvement and strongly with self-report measures of symptom improvement (Attkisson & Zwick, 1982; Larsen et al., 1979).

Hypotheses and Research Questions

The United States has a significant population of Portuguese-Americans, yet we have little information about the efficacy of the mental health services they receive. Portuguese-Americans, like other immigrant groups, have a unique set of cultural values that shape their experience of life in the United States. These deeply ingrained values affect how they view and experience psychological problems. Strong family loyalty, unquestioning respect for elders, and a willingness to forego education for the benefit of the family are all examples of cultural values that could be misinterpreted as psychologically unhealthy behavior in the United States. Indeed, a therapist's ignorance of the cultural values of a Portuguese-American client could well lead to treatment failure.

Because there is so little research on Portuguese-Americans in treatment, it is important to develop a base upon which further research can be built. Consequently, it is best to simplify the present study in order to assure maximum participation of the

research population. As efficacy measures are complex and often intrusive in their questioning of symptoms, a simpler measure is called for. Consequently this study focuses on satisfaction with treatment.

Given the limited number of participants available, this study will limit its focus to hypotheses #1 and #2 to assure statistical power. However, the study will also address the additional research questions to examine whether there are other areas bearing investigation in future studies.

Hypothesis #1

One factor that remains unstudied with Portuguese-American clients is that of therapist-client ethnic match. Understanding client cultural values is beneficial to the minority client (Marsella, 1993). However, it is difficult to measure such cultural knowledge (Sue et al., 1991). Thus, research relies upon the assumption that therapists of similar ethnicity will have a better understanding of cultural norms and values, on average, than therapists of a different ethnicity (usually from the majority culture). It is hypothesized that a Portuguese-American client with a Portuguese-American therapist will be more satisfied with therapy than a Portuguese-American client with a non-Portuguese therapist.

Hypothesis #2

Sue (1998) theorized that a stronger ethnic identity would lead to a stronger effect for ethnic match on outcome. The current study will examine how satisfaction is affected by the level of ethnic identity when clients are matched with an ethnically similar therapist. For this study, it is predicted that clients with high Portuguese identity will show more satisfaction in the match condition than clients with low Portuguese identity. The highest ratings of satisfaction are predicted to be from clients with high Portuguese identity who are seeing a Portuguese-American therapist.

Research question #1

Therapists need to understand the cultural values of a client in order to offer effective treatment. Inherent in this issue is the necessity of understanding how strong the client's ethnic identity is, and therefore how important cultural values are to his or her life. Consequently, it can be helpful for the clinician to know for how many generations a strong sense of cultural identity is held. This allows the clinician to be informed early in the process of therapy about the likely level of the client's ethnic identity. This study will examine whether clients from newer generations (e.g. first generation) will have a stronger ethnic identity than those whose families have been in the United States for generations (e.g. third generation). While this is intuitively obvious, there is no research supporting it with Portuguese immigrants.

Research question #2

Portuguese culture espouses strong loyalty to the family (Araújo, 1996; Moitoza, 1982). The family, including godparents, is a strong unit. Moitoza (1982) states that individual therapy may be alienating given the values of the Portuguese culture, and that if family members are discouraged from joining in the treatment, they may make efforts to remove the client from therapy. Thus, family therapy, or therapy that involves the family in some way, is likely to increase compliance as well as satisfaction as it is more consonant with Portuguese-American values. This study will examine the relationship between family involvement and satisfaction, predicting that family involvement will be related to higher satisfaction.

CHAPTER II

METHODS

<u>Participants</u>

Participants in this study were recruited from outpatient mental health centers and private practitioners in Fall River and New Bedford, Massachusetts, and Providence, Rhode Island. Administrators in charge of research procedures were contacted and the study reviewed with them. Administrators then instructed clinicians to present the study to their clients (a script was used; see Appendix A). If they identified themselves as Portuguese-American, they were given an informational sheet in their primary language (Appendixes B-C), asking if they were willing to participate in the study. This included a brief description of the purpose of the investigation, the selection criteria, and investigation procedures, and served as the informed notification form. Clients were offered five dollars for participation in the study.

Individuals had to meet three criteria to be eligible for participation: (1) they had to be Portuguese or Portuguese-American of first or second generation, (2) participants had to have attended at least three sessions of therapy at the given site, and (3) they had to be over the age of 18 years. The criteria for the definition of a Portuguese immigrant was having been born in Portugal or on one of the Portuguese islands (the Azores, the Madeiras, or the Cape Verde islands) and having immigrated to the United States after age five. First and second generations of Portuguese-Americans were defined as being born in America or having moved to America before age five, and having at least one parent or two grandparents, respectively, born in Portugal or on the Portuguese islands.

To determine primary language the client was asked what language they spoke. If they indicate that they are bilingual in English and Portuguese, they were asked in what language they preferred to read. Individuals who agreed to participate in the study

received, in their primary language, an information sheet (Appendixes B-C), a demographic data sheet (Appendixes D-E) and two brief questionnaires (Appendixes F-I) to be filled out and returned in an anonymous envelope. Translation was done by a graduate student bilingual in Portuguese and English, and then reviewed by two Portuguese-English bilingual therapists for accuracy. Human subject review boards at two agencies also reviewed the questionnaires.

The questionnaires, a measure of ethnic identity and a measure of client satisfaction, were presented with the satisfaction measure first, at the suggestion of administrators and clinicians who believed that participant compliance would increase with the perceived relevance of the study to their treatment. As the participants were not to be contacted again for the study, there was no identifying data collected on the demographic sheet. Thus the anonymity of each participant remained protected.

<u>Measures</u>

The demographic sheet required the participants to indicate their age, gender, education, years living in the United States, occupation of self and spouse, and the nationality (birthplace and place of residence) of themselves, their parents, and their grandparents in order to determine their immigrant generation. Additionally they were asked the name of their current therapist, if their therapist is Portuguese-American, and how many sessions of therapy they have attended with this therapist. Participants were asked to indicate their primary language using the following anchors: all English (1), mostly English (2), mostly Portuguese (3), all Portuguese (4).

The Client Satisfaction Questionnaire (CSQ; Larsen, Attkisson, Hargreaves, & Nguyen, 1979) assesses clients' overall satisfaction with mental health treatment. The CSQ is an eight-item measure rated on 4-point Likert-type scales, without a neutral position, indicating satisfaction or dissatisfaction with elements of treatment. Scores range from 1 to 4, and items 1, 3, 6, and 7 are reverse scored. The CSQ score equals the

mean rating. Its internal consistency ranges from .90 to .94. CSQ scores have been found to correlate with client drop-out rates and with therapeutic outcome as rated by both therapist and client (Attkisson & Zwick, 1982; Larsen et al., 1979). An additional item was added to the end of the CSQ to provide a general satisfaction question related to therapy in progress, but was not included in the calculations. There is no evidence to date of this measure being used with a Portuguese-American population, and thus there was no previous data on reliability and validity for the CSQ with Portuguese-Americans.

Cronbach's alpha for the CSQ in this population was .65. If item number five were removed, the alpha would be raised to .76. Internal reliability was also run separately for the questionnaire written in English and the questionnaire written in Portuguese. The English version was reliable at an alpha of .80, but the Portuguese version's reliability was much lower, at .39. For both, removal of item number five raised the reliability, to .82 and .64, respectively. Item number five was "How satisfied are you with the amount of help you received?" It is a vague question, conceivably asking about the number of sessions, the total time served, the number of clinicians on the case, or the amount of benefit perceived. Translation of this item may consequently lean toward some interpretations more than others and therefore cause poorer correlation with other items. Data analyses were run with and without this item, and the direction and statistical significance of results did not appreciably change. Consequently, analyses reported use the original scale, including item five.

The Portuguese-American Identity Scale (PAIS) was adapted by this author from Zak's (1973) Jewish-American Identity Scale. Zak's scale is written such that different ethnic or majority groups can be substituted, and the scale has been successfully used with Arab-Israelis (Zak, 1976), Armenian-Americans (Der-Karabetian, 1980), Turkish-Armenians (Der-Karabetian & Balian, 1992), and Mexican-Americans (Der-Karabetian & Ruiz, 1997). This is a 19-item scale measuring ethnic identity as an orthogonal

concept, with 11 items relating to American identity and 8 items relating to Jewish identity. Items are rated on a 7-point Likert scale ranging from strongly disagree (1) to strongly agree (7). The items are based in cognitive and affective content rather than behavioral content and deal with attitudes related to a sense of belonging, common fate, kinship, and sensitivity to praise and insult of the group. The reliabilities of the Jewish and American identity scales are .88 and .89, respectively (Zak, 1973) and the correlation between them is only .07, supporting the orthogonal conceptualization of ethnic identity.

The PAIS internal reliabilities were run for PI separately from AI. For the sample in this study, reliability was .81 and .72, respectively. Internal reliability of the PI scale was run separately for the English version and the Portuguese version. The English version had an alpha of .79, while the Portuguese version's reliability was again lower at .41. No item's removal raised reliability to any marked degree. American Identity and PI were not related in the current study, supporting the orthogonal nature of the scale ($r=.10$).

The Portuguese Identity score is determined by averaging the scores of the 8 Portuguese identity items (items 1, 2, 5, 8, 12, 13, 16, and 18). The American Identity score is determined by averaging the scores of the 11 American identity items (items 3, 4, 6, 7, 9, 10, 11, 14, 15, 17, and 19).

CHAPTER III

RESULTS

Nine mental health centers and two private practitioners in regions highly populated with Portuguese-Americans were contacted. Seven agencies and two practitioners agreed to participate in the study. Three agencies and one practitioner returned twenty-seven questionnaires of participants eligible to be in the study. One respondent filled out two questionnaires, one in each language, and was removed from the study. One questionnaire was not validly filled out. In running statistics, there was one outlier, who was thus removed from the study. This participant's satisfaction score fell more than four standard deviations below the mean of the sample, and over two standard deviations below the next highest score. She also left a number of responses blank. A total of 24 valid questionnaires were available for review. Seventeen therapists were represented, with none seeing more than two patients in the study.

Data Analyses

This study employed a t-test to evaluate whether the match group showed higher satisfaction with therapy than the no-match group. A Pearson r correlation was used to evaluate the relationship between ethnic identity and satisfaction within the match and no-match groups. Because Cape Verdeans are a more racially distinct portion of the Portuguese immigrant population, as the islands were originally African, their data may differ some from that of the other immigrant populations from the mainland or other islands. Cape Verdean immigrants were included in the study, but analyses were run both including them and excluding them to determine if their results affected the data.

The reliability of the Portuguese version of the PAIS was quite low. The mean education for respondents was the fifth grade. Most respondents had a fourth grade education, which was all that was required and expected of them when they were

schooled in their home country. Consequently, low reading ability may have impacted the reliability of the measure. While participants may be able to read the words, a higher level of reading ability is required to understand what is being communicated. A sixth grade education is considered to be the minimum required for such understanding, although it may vary based on word frequency and length of sentences (Hathaway & McKinley, 1989). Unfortunately, eight of the ten participants who submitted Portuguese version questionnaires had less than a sixth grade education, and therefore analyses could not be run to determine the effect of low education on reliability. Because of the low reliability, analyses were run both with and without the Portuguese version participants.

Another potentially confounding variable could be socioeconomic status (SES). Using the Hollingshead (1957) index of socioeconomic status, correlation with SES was run with satisfaction and with all other variables using a Pearson r correlation. If SES had been found to correlate with any of the relevant data, a step-wise regression analysis would have been run to control for its effects.

A power analysis was conducted to determine the required number of subjects for this evaluation. Using an estimated medium effect size, based on the literature regarding client reported outcomes, an $\underline{N}$ of 64 clients was found to be necessary for power of .80 with a Pearson $\underline{r}$ (Cohen, 1992).

$\underline{T}$-tests were used to determine if there were differences in CSQ scores between participants who had therapy with family involvement versus no family involvement. These were run for all clients, for the match group, and for the no-match group. A one-way ANOVA for three groups was run to determine the relationship between generational status and ethnic identity. Pearson $\underline{r}$ correlation was used to explore for other relationships among the variables.

Demographics

Fourteen females and ten males responded. The mean age was 40, with a standard deviation (sd) of 10, and ranged from 23 to 58. The mean education was 8.9 years (sd = 4.6) and ranged from 2 to 18. Twelve participants were immigrants, six were first generation Portuguese-Americans, and six were second generation. Fifteen clients had Portuguese-American therapists. Five clients were of Cape Verdean descent, six were Azorean, and fourteen were of mainland Portugal descent. (Because Cape Verdeans are a visible ethnic group, which may affect their experience in the United States, statistical analyses were run with and without this population.) One client was of mixed Portuguese heritage. For descriptive statistics by group, refer to Table 1. There were no significant differences in demographic variables between groups.

While approximately half of the participants did not provide a number of sessions attended, the mean number of sessions for those who responded was 14.1 (sd = 11.4). Number of sessions ranged from 4 to "over 40." Other responses included "a lot," "all," "many," "over 10 years," "one month," and "every week." There were 17 therapists serving all participants, with no therapist seeing more than two clients in the study.

Pearson correlations, t-tests, or Chi squared analyses were run on all variables, as appropriate. There were significant relationships indicating that those who filled out the questionnaire in Portuguese tended to have a higher Portuguese Identity (PI), to be older, female, have less education, be more recently from Portugal, to primarily speak Portuguese, and to have their family involved in their therapy. Table 2 provides a summary of these statistics. Table 3 gives descriptive statistics by questionnaire language, and Tables 4 and 5 provide descriptive statistics for each language version by match group. As would be expected from Hollingshead's (1957) formula, SES correlated with years of education. It did not correlate significantly with any other variable. American Identity did not correlate with any other variable. The means and standard

Table 1

Descriptive Statistics by Group

	Match	No-Match
Males	6	4
Females	9	5
Mean Age (sd)	37 (10)	44 (9)
Age Range	23 – 53	26 – 58
Mean Education (sd)	8.8 (4.3)	9.1 (5.1)
Education Range	2 – 16	4 – 18
Immigrant Generation	7	5
First Generation	4	2
Second Generation	4	2
Mainland	8	6
Azores	4	3
Cape Verde	5	0

Note. One client was of mixed heritage in the match group.

Table 2

Statistics by Questionnaire Language (English and Portuguese)

Variable	$\underline{t}$	χ^2
Portuguese Identity	3.38***	
Age[+]	3.20**	
Years of Education	-4.35***	
Primary Language	6.05****	
Gender		7.07*
Generation		17.14****
Family Involvement		8.06**

[+] t-test for unequal variances
*p<.01 **p<.005 ***p<.001 ****p<.0005

Table 3

Descriptive Statistics by Questionnaire Language (English and Portuguese)

	English	Portuguese
Males	9	1
Females	5	9
Mean Age (sd)	35 (11)	47 (6)
Age Range	23 – 58	38 – 58
Mean Education (sd)	11.6 (3.3)	5.2 (3.9)
Education Range	6 – 18	2 - 16
Immigrant Generation	2	10
First Generation	6	0
Second Generation	6	0

Table 4

English Questionnaire Version Descriptive Statistics

	Match	No-Match
Males	6	3
Females	3	2
Mean Age (sd)	32 (10)	41 (13)
Age Range	23 – 46	26 – 58
Mean Education (sd)	10.9 (2.4)	12.8 (4.4)
Education Range	6 - 14	8 – 18
Immigrant Generation	1	1
First Generation	4	2
Second Generation	4	2

Table 5

Portuguese Questionnaire Version Descriptive Statistics

	Match	No-Match
Males	0	1
Females	6	3
Mean Age (sd)	46 (7)	47 (5)
Age Range	42 – 54	42 – 58
Mean Education (sd)	5.7 (5.1)	4.5 (1.0)
Education Range	2 – 16	4 – 6
Immigrant Generation	6	4
First Generation	0	0
Second Generation	0	0

Table 6

<u>List of Means by Group</u>

	Match	No-Match	All
Mean CSQ (<u>sd</u>)			
all participants	3.40 (0.31)	3.50 (0.39)	3.44 (0.35)
all English	3.32 (0.34)	3.43 (0.40)	3.36 (0.35)
Mean PI (<u>sd</u>)			
all participants	5.10 (1.36)	4.59 (1.67)	4.91 (1.47)
all English	4.47 (1.30)	3.57 (1.42)	4.15 (1.36)
Mean AI (<u>sd</u>)			
all participants	5.77 (0.90)	5.41 (1.25)	5.64 (1.03)
all English	5.69 (1.02)	5.54 (1.51)	5.64 (1.16)

deviations for satisfaction, PI, and AI are presented in Table 6. both with and without the Portuguese language questionnaires.

Hypotheses and Research Questions

The first hypothesis was that clients who were placed with a therapist of similar ethnicity (i.e. Portuguese-American) would be more satisfied with therapy than those who were placed with ethnically different therapists. This hypothesis was not supported, and there was no significant difference in mean satisfaction between the groups as measured by a t-test ($t[22]= -0.59$; $p = .28$). This was consistent with analyses run without the Portuguese version questionnaires ($t[10]= 1.08$; $p = .30$).

The second hypothesis, that the match group would have a positive and stronger relationship between ethnic identity and satisfaction than the no-match group, was partially supported. In the group in which clients were placed with ethnically similar therapists, clients with a higher PI were more satisfied than clients with a lower PI (Pearson $r = .78$; $p<.0005$; see Figure 1). This was consistent with analyses run without the Portuguese version respondents ($r = .70$; $p = .03$). When Cape Verdean participants were removed, all of whom were from the match group, the relationship remained significant ($p<.005$). For clients with ethnically dissimilar therapists, there was no relationship between ethnic identity and satisfaction both with ($r = .12$; $p=.76$) and without Portuguese version questionnaires ($r = -.37$; $p=.53$). These relationships were essentially unchanged when controlled for SES (match $r = .78$, $p=.002$; no-match $r = -.12$). However, while the direction of the relationships was as predicted, the correlations of the two groups, .78 and .12, were not statistically significantly different.

Additional research questions were posed. The first was that PI would be related inversely to the generational status. That is, PI would be higher for Portuguese immigrants than for participants of first or second generations. A one-way ANOVA for three groups showed that participants who were of a more recent immigration generation

Figure 1

<u>Correlation Between Satisfaction and Portuguese Identity in Match Group</u>

Hypothesis #2
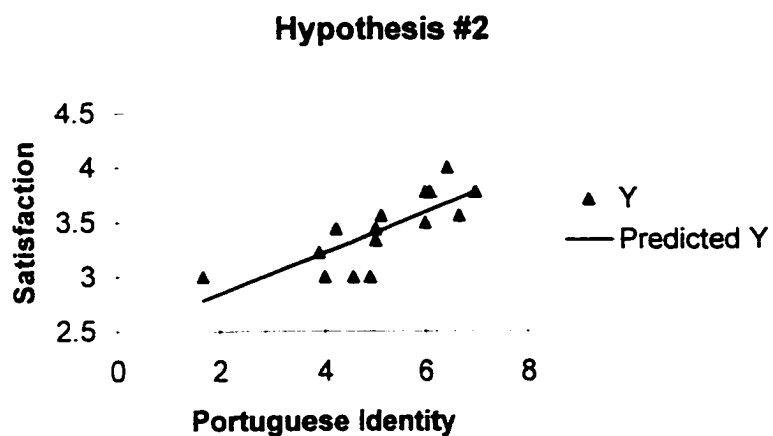
showed a higher PI ($\underline{F}[2,21] = 5.25$; $\underline{p}<.02$). A post hoc Scheffe analysis indicated that there was a significant difference between immigrants and second generation Portuguese-Americans, but not between first generation and other generations. Without the Portuguese version questionnaires, there were only two participants in the immigrant generation group. First and second generations did show the predicted direction of relationship, but there was not enough statistical power to determine significance ($\underline{t}$ [10] = 1.60; $\underline{p}$ = .14) Pearson correlations run across the three generation groups indicated that more recently immigrated generations were more likely to speak primarily Portuguese ($\underline{r}$ = .85; $\underline{p}<.001$) and have less education ($\underline{r}$ = .48; $\underline{p}<.05$). A Chi squared distribution indicated that recent generations were also more likely to have their families involved in their therapy ($\underline{\chi}^2[2,24] = 8.33$, $\underline{p}<.02$).

The second research question predicted family involvement to increase satisfaction with psychotherapy. Mean satisfaction was compared between those with and without family involvement. While there was a difference, it did not reach statistical significance ($\underline{t}[22] = 1.05$; $\underline{p}$ = .15), and was even weaker without the Cape Verdean clients ($\underline{t}[17] = 0.63$, $\underline{p}$ = .26). The match group showed a stronger relationship between family involvement and satisfaction, more closely approaching significance ($\underline{t}[13] = 1.50$; $\underline{p}$ = .06), although when Cape Verdean participants were removed, the relationship did not exist ($\underline{t}[8] = 0.21$; $\underline{p}$ = .41). Only three of the English version questionnaire participants had family involvement, and so analyses could not be run to compare satisfaction.

CHAPTER IV

DISCUSSION

Portuguese-Americans are an understudied population in multicultural counseling research. Consequently, therapy with Portuguese-Americans is not as well informed as it should be. The purpose of this study was to further the understanding of Portuguese-Americans in psychotherapy by studying the relationships among the variables of client-therapist ethnic match, ethnic identity, and satisfaction with psychotherapy. The first hypothesis of the study was that clients who were matched with an ethnically similar, or Portuguese-American, therapist would be more satisfied with their psychotherapy than clients who had non-Portuguese therapists. The second hypothesis was that the satisfaction of clients with an ethnically similar therapist would vary depending upon the clients' ethnic identity. Clients who had a higher Portuguese identity were predicted to be more satisfied with therapy than those who had a lower Portuguese identity when matched with Portuguese-American therapists. Research questions were posed to explore the relationship between generations in the United States and Portuguese identity, predicting that families who had been in America for more generations would have a weaker Portuguese identity. And finally, the relationship between family involvement in therapy and satisfaction with therapy was explored to determine if clients whose families were involved in their treatment would be more satisfied.

Hypothesis #1

The hypothesis that clients who had ethnically similar therapists would be more satisfied with therapy than those with non-Portuguese therapists was not supported. There have long been proponents of interethnic therapy rather than intraethnic matches between counselor and client. Sattler's 1977 review reports that ethnically different, or majority, counselors are capable of being just as effective with minorities. Many reviews of the

literature on preference for ethnic match or beneficial outcome due to ethnic similarity have identified inconsistent results (Atkinson & Schein, 1986; Devereaux, 1991). Atkinson's (1983) review of outcome studies found six studies with a positive effect of ethnic match on outcome, one study with a negative effect for ethnic match, and six studies with no effect on outcome for ethnic match. Atkinson and Schein's (1986) review of dozens of studies was equivocal in findings regarding the benefit of cultural or ethnic similarity in the therapeutic relationship. A meta-analysis of studies of various ethnic groups identified that preferences for ethnically similar counselor varied by cultural affiliation (Coleman, Wampold, & Casali, 1995). Carter (1990) found that the racial identity, rather than the race, of both the client and counselor affected the therapeutic process. Ethnic identity of the counselor was not explored in the current study.

Sue (1998) found that with a number of ethnic minority clients, ethnic match resulted in less dropout, longer treatment, and better functioning. Such outcome measures were not evaluated for this study, although they are generally believed to correlate with successful outcome (Sue, 1998), as is client satisfaction. Another possible explanation for the lack of effect, of course, is the limited sample of both clients and therapists. Further study is warranted, but this specific area of research has a long history of equivocal results, differing across ethnicities, and there may be no effect of ethnic match on satisfaction, overall.

Hypothesis #2

The results did support the hypothesis that, for clients with an ethnically similar therapist, a stronger ethnic identity lead to higher satisfaction with therapy. Clients were predicted to be most satisfied with an ethnically similar therapist if their affiliation to the Portuguese culture was strong. A stronger Portuguese identity, and therefore adherence to Portuguese cultural beliefs, would suggest a client who may tend to feel less comfortable

with outsiders, particularly those in a position of authority. Consequently, such clients were expected to value similarity in culture more than those of lower Portuguese identity.

Another possible explanation for the strong relationship between ethnic identity and satisfaction is the finding that ethnic identity is related to positive self-esteem (Goodstein & Ponterotto, 1997; Lorenzo-Hernandez & Ouellette, 1998), and self-esteem has been found to be a predictor of success with therapy (Vostanis, Feehan, & Grattan, 1998). Given the relationship between self-esteem and ethnic identity, ethnic identity may be a predictor of clients who may be more successful in therapy. However, in this study ethnic identity was not a predictor of satisfaction with therapy when clients were paired with non-Portuguese-American therapists. It may be that ethnic identity does not play as strong a role in the therapeutic process when there is not a match between client and therapist. Conversely, issues of ethnic identity may become more prominent in a matched relationship, and may then play more of a role in outcome. It is also possible that Portuguese identity may be negatively correlated to satisfaction when placed with a non-Portuguese therapist, hypothetically due to the difference in cultural knowledge. If Portuguese identity is also correlated with positive self-esteem and therefore good therapeutic outcome, the relationship between ethnic identity and satisfaction would be counteracted, resulting in no correlation.

<u>Research Questions and Other Findings</u>

Given the small size of this study, further hypotheses were not made. However, so little research exists on therapy with Portuguese-Americans that questions were posed for exploration and to direct future research. Portuguese identity was predicted to be stronger for participants with less family history in the United States. This was found when all 24 participants were included in the analyses. In fact, the mean Portuguese identity predictably decreased for each generation in the United States. Because of limitations in this study, however, the findings are not robust. Ethnic identity is considered to indicate

the degree to which a client holds to the beliefs of his or her culture of origin. Consequently, this study suggests that clinicians would be better informed about the belief system of clients if they inquired into their clients' cultural histories, including what generation American they are. However, even first generation, American-born clients whose parents are from Portugal retain many of the values inherent in the Portuguese culture. This requires that the therapist make a concerted effort to learn the cultural background of every client, as the clients' generational status will not be obvious, nor will their ethnicity necessarily be apparent. Portuguese-Americans may easily be mistaken as majority-Americans or, for Cape Verdeans, African-Americans without studying cultural background, but a wealth of information could be garnered from exploring the clients' culture and understanding their affiliation to Portuguese culture.

The strong family relationship in the Portuguese culture suggests that an individualized therapy will be less successful than family therapy (Moitoza, 1982). Clients whose families were involved in their therapy did show the predicted direction of satisfaction with therapy, although this was not a statistically significant relationship. Additionally, the relationship was lost when Cape-Verdean clients were removed from the sample. These differences in statistics may be due to the limited sample size and the preponderance of Cape Verdeans in the match group. The differences could also be due to a stronger relationship between family involvement and satisfaction for Cape Verdean clients versus those of other Portuguese descent. The relationship between family involvement in therapy and satisfaction with therapy clearly merits further exploration. Should the relationship prove to be predictable, clinicians would benefit by engaging family members of Portuguese-Americans in therapy in order to provide more culturally relevant and more beneficial services.

Limitations

Generalization of the findings from this study is limited by the low number of participants. The population was predicted to be difficult to engage for a number of reasons, such as insulation from those outside the culture and distrust of authority. Additionally, a higher rate of illiteracy for Portuguese-Americans, as predicted by historically limited education, was a known obstacle to the completion of questionnaires. Based on feedback from participating clinicians, that was certainly the case. What was not predicted was that the therapists were equally difficult to engage in the study. This contributed to the low N, sacrificing power, but also external validity. Because the sample is limited, there may be ways in which participants varied from the general Portuguese-American therapy population. Clients, and therapists, may have self-selected for the study in such a way that these results will not generalize to the whole population of Portuguese-Americans in psychotherapy.

It is important, also, to critique the validity and reliability of measures used that were designed for different populations. Both scales showed lower reliabilities than in published research. The CSQ appeared to be most affected by adaptation to a new culture, with a drop in internal reliability for both English speaking and Portuguese speaking participants, although reliabilities without item five are acceptable in both languages. For the PI scale, internal reliability was somewhat higher in English, but not in its translation. Reliability suffered in the Portuguese version, and there are many possible explanations. As in therapy, translation can be complicated and meanings can change. It may be that translation to a different language affected the reliability of the measure. The immigrant population, who responded primarily in Portuguese, had less education, consistent with their cultural norms. Thus, reading ability may have affected reliability. Additionally, measures may not transfer well to a different population, and the Portuguese-American population may be best served by a measure designed expressly for

it. The CSQ, as originally written, may not reliably measure satisfaction for the Portuguese-American population. The PAIS fared much better overall, with only a minor decrease in reliability from previous studies for the PI measure, and it does appear to apply across cultures, as noted in previous studies (e.g. Zak, 1976; Der-Karabetian, 1980). However, the PAIS did not fare well in translation. Ethnic identity is a complex and elusive concept and may be more difficult to translate. Further, ethnic identity is an abstract concept and may be more difficult to comprehend by those with little formal education.

There were also limitations due to the naturalistic format of the study. Clients who spoke only Portuguese inevitably were placed in a match therapy condition. They also naturally tended to be immigrants, to have lower education, and possibly to have higher ethnic identity. Incidentally, they were also nearly all women. Consequently there were many confounds to understanding relationships among variables. However, it should be noted that despite the loading of low education, high PI, and female gender on the Portuguese version of the questionnaire, neither education, PI, gender, nor language of questionnaire were related to satisfaction.

Many theories were statistically supported, some nearly so, and some not at all. Unsupported theories may well have suffered from a lack of power, or may have been incorrect. Supported theories cannot necessarily be reliably applied to the general population of Portuguese-Americans in counseling given such a limited sample. However, all of these results can serve as directions for promising future research, and some of the strong relationships that were found suggest that these theories can provide clinicians with important directions for clinical exploration.

Future research in the area of Portuguese-American mental health treatment will need to overcome many barriers to broad participation. In reviewing with administrators and therapists the reasons for the difficulties in recruiting participants, there seemed to be two

themes. First, clients were often of limited education and therefore had some difficulty

filling out the questionnaires independently. It was suggested that clients would have

benefited from having a facilitator available to help in answering the questionnaire and

assuring that questionnaires were completed on site and turned in to the examiner. The

facilitator must be fluent in Portuguese and English, and given cultural issues, the

facilitator should be of Portuguese ethnicity and not in a position of authority. Measures

will also need to be geared for fourth grade reading ability if immigrant populations are

to participate. Pilot studies for measures would be beneficial to assure the usefulness of

new questionnaires with new populations.

The second area of difficulty in recruitment was the lack of participation by agencies

and clinicians. Most agencies were open to the idea of conducting the research at their

site and were eager to have the results shared with them. However, day to day practice

was not conducive to adding additional steps for clinicians in their work with clients.

Clinicians are busy, with copious paperwork to complete on a daily basis. It would have

been helpful to offer incentives to the clinicians, in addition to clients, for participating in

the study. Additionally, it likely would have been helpful for the researcher to meet with

the clinicians in order to personalize the study and to uniformly explain its purpose.

Clinical Implications

The findings from this study suggest a number of implications for the conduct of

therapy with Portuguese-Americans. First and foremost, clinicians need to be aware of

the ethnic heritage of their clients. With this information, the clinician may better

understand client values about such issues as education and family and avoid

pathologizing the client. This research also suggests that understanding the degree of

ethnic identity in a client can be important, perhaps as early in the process as selecting a

therapist. Ethnic identity can be roughly predicted by generational status, and it may be

beneficial to place immigrants and first generation Portuguese-Americans with

Portuguese-American therapists, rather than with Portuguese-speaking therapists from another culture. These findings also suggest that therapists should regularly consider whether to, and how to, involve the families of these clients in their treatment.

<u>Suggestions for Future Research</u>

While this study was small, it provided many directives for future research. It was able to explore numerous variables in an understudied population. In future studies, it may be helpful to delineate statistics between immigrants from the various Portuguese locations of the Azores, the mainland, and the Cape Verde islands to determine if there are predictable differences that might better inform clinicians. The relationship between ethnic match and satisfaction with therapy appears to be a complex one meriting more exploration. Future studies with more participants can analyze the relationships among the variables of satisfaction, match, and ethnic identity through a multiple regression formula with more statistical power and external validity than the current study. The relationship between family involvement in therapy and satisfaction should be further examined, as well, as current results suggest promising findings with larger samples and more clearly defined variables. Future research may benefit from using multiple measures of outcome, such as symptom measures, drop out rates, and total number of sessions, as well as satisfaction.

Belief systems and views of mental health can affect the willingness to access mental health care. Because both religion (Leder, 1980; Pap, 1981) and folk medicine (Araújo, 1996; Moitoza, 1982) impact mental health beliefs for the Portuguese culture, future research on the roles of religion and folk medicine in mental health care for this population may help clinicians to maintain an open stance and consequently make mental health treatment more acceptable to the Portuguese culture.

Future studies can also examine the issue of language of therapy. Rozensky and Gomez (1983) theorize that speaking in a second language is an intellectual task, and that

the primary language is necessary for accessing emotional material. Following this theory, one would expect therapy in the primary language to be more successful, regardless of fluency in the second language. Determining the importance of therapy in the client's primary language may be a crucial factor in working with truly bilingual clients – often those of first generation status who have been raised in a Portuguese speaking home while growing up in an English speaking world.

Having a better understanding of the Portuguese-American culture and how it relates to therapy can assist clinicians in taking an informed approach to treatment. It cannot substitute for building rapport and gaining an individual understanding of each client, as not every client will fit the general research trend. However, it does provide direction and a basis for interpretation in the initial stages of treatment. Gaining an appreciation for the issues of other cultures takes a two-pronged approach. One must begin with a multicultural philosophy – an awareness of the gap between the Western foundation of most therapies and the diverse belief systems of different cultures. It is important to promote a fuller appreciation of how fundamental, and yet how subtle, these beliefs are to each individual's perspective. Secondly, clinicians need to educate themselves about the specific cultures from which their clients herald. In combining the two approaches, clinicians will be prepared to offer culturally sensitive and culturally relevant treatment. This is a career-long education for all.

REFERENCES

Almeida, C. (1968). Portuguese Immigrants. Hayward, CA: Suburban Press.

Alvidrez, J., Azocar, F., & Miranda, J. (1996). Demystifying the concept of ethnicity for psychotherapy researchers. Journal of Consulting and Clinical Psychology, 64, 903-908.

Ankuta, G. Y. & Abeles, N. (1993). Client satisfaction, clinical significance, and meaningful change in psychotherapy. Professional Psychology: Research and Practice, 24, 70-74.

Araújo, Z. A. (1996). Portuguese families. In M. McGoldrick, J. K. Pearce & I. Giordano (Eds.), Ethnicity and family therapy (2nd ed., pp. 583-594). New York: Guilford Press.

Aponte, J. F., Rivers, R. Y., & Wohl, J. (Eds.) (1995). Psychological interventions and cultural diversity. Boston: Allyn and Bacon.

Atkinson, D. R. (1983). Ethnic similarity in counseling psychology: A review of research. Counseling Psychologist, 11, 79-92.

Atkinson, D. R., Morten, G., & Sue, D. W. (Eds.) (1993). Counseling American minorities: A cross-cultural perspective. Madison, WI: Brown and Benchmark.

Atkinson, D. R., & Schein, A. (1986). Similarity in counseling. Counseling Psychologist, 14, 319-354.

Atkinson, D. R., Wampold, B. E., Lowe, S. M., Matthews, L., & Ahn, H. (1998). Asian American preferences for counselor characteristics: Application of the Bradley-Terry-Luce model for pared comparison data. Counseling Psychologist, 26, 101-123.

Attkisson, C. C. & Zwick, R. (1982). The client satisfaction questionnaire: Psychometric properties and correlations with service utilization and psychotherapy outcome. Evaluation and Program Planning, 5, 233-237.

Bautista de Domanico, Y., Crawford, I., & De Wolfe, A. S. (1994). Ethnic identity and self-concept in Mexican-American adolescents: Is bicultural identity related to stress or better adjustment? Child and Youth Care Forum, 23, 197-206.

Bennett, S. K., & BigFoot-Sipes, D. S. (1991). American Indian and White college student preferences for counselor characteristics. Journal of Counseling Psychology, 38, 440-445.

Cabral, S. (1978). Ritual change among Portuguese-Americans in New Bedford, Massachusetts. Journal of Voluntary Action Research, 7, 75-85.

Carlini-Cotrim, B. & Coelho, G. L. (1995). Identifying risk factors for drug abuse among Portuguese speaking youth in the Boston area: A preliminary assessment using key informant networks. International Quarterly of Community Health Education, 15, 267-277.

Carter, R., T. (1995). The Influence of Race and Racial Identity in Psychotherapy: Toward a Racially Inclusive Model. New York: John Wiley and Sons.

Cohen, J. (1992). A power primer. Psychological Bulletin, 112, 155-159.

Coleman, H. L. K., Wampold, B. E., & Casali, S. L. (1995). Ethnic minorities' ratings of ethnically similar and European American counselors: A meta-analysis. Journal of Counseling Psychology, 42, 55-64.

Cuellar, I., Harris, L. C., & Jasso, R. (1980). An acculturation scale for Mexican American normal and clinical populations. Hispanic Journal of Behavioral Sciences, 2, 199-217.

Dana, R. (1993). Multicultural assessment perspectives for professional psychology. Boston: Allyn and Bacon.

Dana, R. (1996). Assessment of acculturation in Hispanic populations, Hispanic Journal of Behavioral Sciences, 18, 317-328.

Der-Karabetian, A. (1980). Relation of two cultural identities of Armenian-Americans. Psychological Reports, 47, 123-128.

Der-Karabetian, A., & Ballan, N. (1992). Ingroup, outgroup, and global-human identities of Turkish-Armenians. Journal of Social Psychology, 132, 497-504

Der-Karabetian, A., & Ruiz, Y. (1997). Affective bicultural and global-human identity scales for Mexican-American adolescents. Psychological Reports, 80, 1027-1039.

Devereaux, D. (1991). Race and the client-therapist assignment. Issues in mental health nursing, 12, 283-290.

Flaskerud, J. H. (1990). Matching client and therapist ethnicity, language and gender: A review of research. Issues in Mental Health Nursing, 11, 321-336.

Flaskerud, J. H. & Hu, L. (1994). Participation in and outcome of treatment for major depression among low income Asian-Americans. Psychiatry Research, 53, 289-300.

Franks, F. & Faux, S. A. (1990). Depression, stress, mastery, and social resources in four ethnocultural women's groups. Research in Nursing and Health, 13, 283-292.

Freed, A. (1988). Interviewing through an interpreter. Social Work, 33, 315-319.

Fujino, D. C., Okazaki, S., & Young, K. (1994). Asian-American women in the mental health system: An examination of ethnic and gender match between therapist and client. Journal of Community Psychology, 22, 164-176.

Gil, A. G., Vega, W. A., & Dimas, J. M. (1994). Acculturative stress and personal adjustment among Hispanic adolescent boys. Journal of Community Psychology, 22, 43-54.

Gim, R. H., Atkinson, D. R., & Kim, S. J. (1991). Asian-American acculturation, counselor ethnicity and cultural sensitivity, and ratings of counselors. Journal of Counseling Psychology, 38, 57-62.

Goodstein, R. & Ponterotto, J. G. (1997). Racial and ethnic identity: Their relationship and their contribution to self-esteem. Journal of Black Psychology, 23, 275-292.

Harris, H. L. (1998). Ethnic minority elders: Issues and interventions. Educational Gerontology, 24, 309-323.

Hathaway, S. R. & McKinley, J. C. (1989). Minnesota Multiphasic Personality Inventory - 2. Minnesota: University of Minnesota Press.

Helms, J.E. (1985). Toward a theoretical explanation of the effects of race on counseling. The Counseling Psychologist, 12, 131-141.

Holcomb, W. R., Adams, N. A., Ponder, H. M., & Reitz, R. (1989). The development and construct validation of a consumer satisfaction questionnaire for psychiatric inpatients. Evaluation and Program Planning, 12, 189-194.

Holcomb, W. R., Parker, J. C., & Leong, G. B. (1997). Outcomes of inpatients treated on a VA psychiatric unit and a substance abuse treatment unit. Psychiatric Services, 48, 699-704.

Hollingshead, A. B. (1957). Two factor index of social position. Unpublished manuscript, Yale University.

Hollos, M., & Leis, P. (1985). The hand that rocks the cradle rules the world: Family interaction and decision making in a Portuguese rural community. Ethos, 13, 340-357.

Jerrell, J. M. (1995). The effects of client-therapist match on service use and costs. Administration and Policy in Mental Health, 23, 119-126.

Kagawa-Singer, M. & Cheung, R. C. (1994). A paradigm for culturally based care in ethnic minority populations. Journal of Community Psychology, 22, 192-208.

Koss-Chioino, J. D., & Vargas, L. A. (1992). Through the cultural looking glass: A model for understanding culturally responsive psychotherapies. In L. A. Vargas & J. D.

Koss-Chioino (Eds.). Working with Culture: Psychotherapeutic Interventions with Ethnic Minority Children and Adolescents. San Francisco: Jossey-Bass Publishers. pp. 1-22.

LaFramboise, T., Coleman, H. L., & Gerton, J. (1993). Psychological impact of biculturalism: Evidence and theory. Psychological Bulletin, 114, 395-412.

Lanca, M., Alksnis, C., Roese, N. J., & Gardner, R. C. (1994). Effects of language choice on acculturation: A study of Portuguese immigrants in a multicultural setting. Journal of Language and Social Psychology, 13, 315-330.

Larsen, D. L., Attkisson, C. C., Hargreaves, W. A., & Nguyen, T. D. (1979). Assessment of client/patient satisfaction: Development of a general scale. Evaluation and Program Planning, 2, 197-207.

Leder, H. (1980). Cultural Persistence in a Portuguese-American Community. New York: Arno Press.

Lorenzo-Hernandez, J. & Ouellette, S. C. (1998). Ethnic identity, self-esteem, and values in Dominicans, Puerto Ricans, and African Americans. Journal of Applied Social Psychology, 28, 2007-2024.

Marsella, A. (1993). Counseling and psychotherapy with Japanese Americans: Cross-cultural considerations. American Journal of Orthopsychiatry, 63, 200-208.

Miranda, A. O., & White, P. E. (1993). The relationship between acculturation level and social interest among Hispanic adults. Individual Psychology, 49, 76-85.

Moitoza, E. (1982) Portuguese families. In M. McGoldrick, J. K. Pearce & I. Giordano (Eds.), Ethnicity and Family Therapy (1st ed., pp. 412-437). New York: Guilford Press.

Neto, F. (1995). Predictors of satisfaction with life among second generation migrants. Social Indicators Research, 35, 93-116.

Pap, L. (1981). The Portuguese-Americans. Boston: G.K.Hall & Co.

Pederson, P. (1984). The intercultural context of counseling and therapy. In A. J. Marsella & G. M. White (Eds.), <u>Cultural Conceptions of Mental Health and Therapy</u> (p.333-358). Dordrecht, Holland: Reidel.

Phinney, J. S. (1992). The Multigroup Ethnic Identity Measure; A new scale for use with diverse groups. <u>Journal of Adolescent Research, 7,</u> 156-176.

Ponce, F. Q, & Atkinson, D. R. (1989). Mexican-American acculturation, counselor ethnicity, counseling style, and perceived counselor credibility. <u>Journal of Counseling Psychology, 36,</u> 203-208.

Ponterotto, J. G., Alexander, C. M., & Hinkston, J. A. (1988). Afro-American preferences for counselor characteristics: A replication and extension. <u>Journal of Counseling Psychology, 35,</u> 175-182.

Ricker, M., Nystul, M., & Wlado, M. (1999). Counselors' and clients' ethnic similarity and therapeutic alliance in time-limited outcomes of counseling. <u>Psychological Reports, 84,</u> 674-676.

Rotheram-Borus, M. J., Lightfoot, M., Moraes, A., Dopkins, S., & LaCour, J. (1998). Developmental, ethnic, and gender differences in ethnic identity among adolescents. <u>Journal of Adolescent Research, 13,</u> 487-507.

Rozensky, R. H. & Gomez, M. Y. (1983). Language switching in psychotherapy with bilinguals: Two problems, two models, and case examples. <u>Psychotherapy: Theory, Research, and Practice, 20,</u> 152-160).

Sodowsky, G. R. & Plake, B. S. (1991). Psychometric properties of the American International Relations Scale. <u>Educational and Psychological Measurement, 51,</u> 207-216.

Sattler, J. M. (1977). The effects of therapist-client racial similarity. In A. S. Gurman & A. M. Razin (Eds.), <u>Effective psychotherapy: A handbook of research</u> (pp. 252-290). New York: Pergamon Press.

Stüntzer-Gibson, D., Koren, P. E., & DeChillo, N. (1995). The Youth Satisfaction Questionnaire: What kids think of services. Families in Society: The Journal of Contemporary Human Services, 76, 616-624.

Sue, S. (1977). Community mental health services to minority groups: Some optimism, some pessimism. American Psychologist, 32, 616-624.

Sue, S. (1998). In search of cultural competence in psychotherapy and counseling. American Psychologist, 53, 440-448.

Sue, S., Fujino, D. C., Hu, L., Takeuchi, D. T., & Zane, N. W. (1991). Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis. Journal of Consulting and Clinical Psychology, 59, 533-540.

Sue, S., Nolan, Z., & Young, K. (1994). Research on psychotherapy with culturally diverse populations. In A. E. Bergin & S. L. Garfield (Eds.). Handbook of Psychotherapy and Behavior Change (4th edition, pp. 783-817). New York: John Wiley & Sons, Inc.

Sue, D. W., & Sue, D. (1990). Counseling the Culturally Different. New York: John Wiley & Sons.

Tanner, B. A. (1982). A multi-dimensional client satisfaction instrument. Evaluation and Program Planning, 5, 161-167.

van Beek, W. E. A., & Blakely, T. D. (1994). Introduction. In T. D. Blakely, W. E. A. van Beek, & D. L. Thompson (Eds.), Religion in Africa: Experience and Expression (pp. 1-20). Portsmouth, NH: Heinemann.

Vargas, L., & Koss-Chioino, J. (1992). Working with Culture: Psychotherapeutic Interventions with Ethnic Minority Children and Adolescents. San Francisco: Jossey-Bass Publishers.

Vostanis, P., Feehan, C., & Grattan, E. (1998). Two-year outcome of children treated for depression. European Child & Adolescent Psychiatry, 7, 12-18.

Wong-Rieger, D. & Quintana, D. (1987). Comparative acculturation of Southeast Asian and Hispanic immigrants and sojourners. Journal of Cross-Cultural Psychology. 18, 345-362.

Woollett, A., Marshall, H., Nicolson, P., & Dosanjh, N. (1994). Asian women's ethnic identity: The impact of gender and context in the accounts of women bringing up children in East London. Feminism and Psychology, 4, 119-132.

Yeh, M.. Takeuchi, D. T., & Sue, S. (1994). Asian-American children treated in the mental health system: A comparison of parallel and mainstream outpatient service centers. Journal of Clinical Child Psychology, 23, 5-12.

Zak, I. (1973). Dimensions of Jewish-American Identity. Psychological Reports, 33, 891-900.

Zak, I. (1976). Structure of ethnic identity of Arab-Israeli students. Psychological Reports, 38, 239-246.

Zane, N., Enomoto, K., & Chun, C. (1994). Treatment outcomes of Asian- and White-American clients in outpatient therapy. Journal of Community Psychology, 22, 177-191.

APPENDIX A

SCRIPT

Clients previously identified as potentially Portuguese by their therapists will be approached for the study by their therapist as follows:

"Our center is participating in a study on psychotherapy with Portuguese-Americans. Are you Portuguese-American? Would you be willing to fill out a brief questionnaire today?"

If the client declines to take part in the study, the researcher or therapist will say the following:

"Okay. Thank you for your time. May I give you an information sheet on the study in case you should change your mind?"

If the client agrees, the researcher will ask the client if he or she speaks English or Portuguese. If the client indicates both, then the researcher will ask what language he or she prefers to read in. The researcher will then hand the client the brief informational sheet in their preferred language, saying the following:

"Here is some information for you to read about the study. If you are interested, I will give you a questionnaire."

APPENDIX B

INFORMATION SHEET (English)

This questionnaire is part of a study being conducted by Katherine Gamble, M.A. that is looking at what issues might be important for Portuguese-Americans in psychotherapy. The study hopes to find ways that treatment can be more helpful for Portuguese-Americans. Participants in the study will receive $5.00 in cash upon handing in their questionnaire.

To participate in the study, you must be able to answer yes to the following three questions:

Did either you, your parents, or your grandparents grow up in Portugal, including the

Azores, Madeiras, or Cape Verde Islands?

Are you over age 18?

Have you seen your therapist here for at least three sessions?

This questionnaire is completely anonymous, and no information about individual participants will be shared with your therapist, the agency, insurance companies, or others. Please do not put your name on any of the materials in order to keep your responses anonymous. Your answers to this questionnaire will not affect your treatment here, but they may be helpful to therapists working with Portuguese-American clients in the future.

The questionnaire should take less than fifteen minutes to finish, and you may fill it out either before or after your therapy session, as you prefer.

This survey is voluntary, and you are free to refuse to participate. You may refrain from answering any of the questions without forfeiting the monetary reward of $5.00. If you have any questions or concerns about your participation in this study, you may contact the supervisor of this project, Dr. Janis Sanchez, at (757) 683-4209.

APPENDIX C

INFORMATION SHEET (Portuguese)

Este questionário é parte de um estudo que está sendo feito por Katerine Gamble, M.A., com o objetivo de identificar quais são as questões que podem ser importantes para os Portugueses-Americanos na psicoterapia. Através deste estudo nós esperamos encontrar meios de tratamento que podem ser mais eficientes para os Portugueses-Americanos. Os participantes no estudo receberão $5.00 em dinheiro sobre passar em seu questionário.

Para participar neste estudo, você tem que responder "sim" para as três seguintes perguntas:
- Em que parte de Portugal (incluindo as ilhas dos Açores, Madeira) ou Cabo Verde você, ou os seus pais, ou seus avós, cresceu (ou cresceram)?
- Você tem mais de 18 anos?
- Você tem visto seu terapeuta aqui pelo menos três seções?

Este questionário é completamente anônimo, e nenhuma informação sobre os participantes individuais será compartilhada com seu terapeuta, com a agência, com companhias de seguros ou com outras pessoas. Por favor não coloque o seu nome em nenhum dos formulários, de forma a manter suas respostas anônimas. As respostas deste questionário não vão afetar seu tratamento aqui, porém elas podem ser úteis no futuro para terapeutas trabalhando com clientes Portugueses-Americanos.

Este questionário deve levar menos de 15 minutos para ser respondido, e você pode preenchê-lo antes ou depois da sua seção de terapia, como você preferir.

Este questionário é voluntário, e você pode recusar a participar. Pode refrão de responder qualquer das perguntas sem forfeiting a recompensa monetária de $5.00. Se você tiver quaisquer dúvidas ou questões sobre a sua participação neste estudo, você pode contactar o supervisor deste projeto. Dr. Janis Sanchez, em (757) 683-4209.

APPENDIX D

CLIENT SATISFACTION QUESTIONNAIRE (English)

Please help us improve our services by answering some questions about the therapy you have received here. We are interested in your honest opinions, whether they are positive or negative. *Please answer all of the questions.* We also welcome your comments and suggestions. Thank you very much, we appreciate your help.

Please circle one answer under each question.

1. How would you rate the quality of service you received?

Excellent	Good	Fair	Poor

2. Did you get the kind of service you wanted?

No, definitely not	No, not really	Yes, generally	Yes, definitely

3. To what extent have our counseling services met your needs?

Almost all of my needs have been met	Most of my needs have been met	Only a few of my needs have been met	None of my needs have been met

4. If a friend were in need of similar help, would you recommend our counseling services to him or her?

No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

5. How satisfied are you with the amount of help you received?

Quite dissatisfied	Indifferent or mildly dissatisfied	Mostly satisfied	Very satisfied

6. Has the counseling you received helped you to deal more effectively with your problems?

Yes, they helped a great deal	Yes, they helped somewhat	No, they really didn't help	No, they seemed to make things worse

7. In an overall, general sense, how satisfied are you with the counseling you received?

Very satisfied	Mostly satisfied	Indifferent or mildly dissatisfied	Quite dissatisfied

8. If you were to seek help again, would you come back to our center?

No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

9. How much do you think therapy has helped you so far?

It has helped a great deal	It has helped somewhat	It has not helped	It has made things worse

WRITE COMMENTS BELOW:

APPENDIX E

CLIENT SATISFACTION QUESTIONNAIRE (Portuguese)

Por favor, nos ajude a melhorar nossos serviços respondendo algumas questões sobre a terapia que você recebeu aqui. Nós estamos interessados na sua opinião honesta, seja ela positiva ou negativa. *Por favor, responda todas as questões.* Seus comentários e sugestões também serão bem vindos. Muito obrigado, nós apreciamos a sua ajuda.

Por favor, circule uma resposta sob cada questão.

1- Como você classificaria o serviço que você recebeu?

| Excelente | Bom | Mediano | Ruim |

2- Você recebeu o serviço desejado?

| Não, definitivamente não | Não, não exatamente | Sim, no geral | Sim, com certeza |

3- Em que medida os nossos serviços de aconselhamento atenderam as suas necessidades

| Quase todas as minhas necessidades foram atendidas | A maior parte das minhas necessidades foram atendidas | Só poucas das minhas necessidades foram atendidas | Nenhuma das minhas necessidades foi atendida |

4- Se um amigo (a) precisasse de uma ajuda semelhante, você recomendaria os nossos serviços?

| Não, definitivamente não | Não, acho que não | Sim, acho que sim | Sim, com certeza |

5- Está satisfeito (a) com a quantidade de ajuda recebida?

| Bastante insatisfeito | Indiferente, ou um pouco insatisfeito | Satisfeito no geral | Muito satisfeito |

6- Os aconselhamentos que você recebeu te ajudaram a lidar mais efetivamente com os seus problemas?

| Sim, ajudou muito | Sim, ajudou um pouco | Não, não ajudou | Não, pareceu ter piorado as coisas |

7- No geral, está satisfeito com os nossos conselhos?

| Muito satisfeito | Satisfeito no geral | Indiferente ou um pouco insatisfeito | Bastante insatisfeito |

8- Se você fosse procurar ajuda de novo, você voltaria para o nosso centro?

| Não, definitivamente não | Não, acho que não | Sim, acho que sim | Sim, com certeza |

9- A terapia que você recebeu ajudou-lhe?

| Acho que ajudou muito | Acho que ajudou | Não ajudou um pouco | Fez as coisas piorarem |

ESCREVA SEUS COMENTÁRIOS ABAIXO:

APPENDIX F

DEMOGRAPHIC QUESTIONNAIRE (English)

Please fill out the following information:

Age: _____

Gender: __ Male __ Female

Years of education: _____ (This should equal your last grade of high school completed, plus
any additional education after high-school.)

What do you do for a living?: _____

What does your spouse do for a living: _____ __ I am not married.

Years living in the United States: _____

Country you were born in: _____

Country your mother was born in: _____

Country your father was born in: _____

Countries your mother's parents were born in: _____

Countries your father's parents were born in: _____

Language you speak:

__ All Portuguese   __ Mostly Portuguese   __ Mostly English   __ All English

Who is your therapist here? _____

Is your therapist Portuguese or Portuguese-American? __ Yes __ No

How many appointments have you attended with your therapist? _____

Has your family been involved in your treatment? __ Yes __ No (please note who of your family has
been involved _____)

Have they attended therapy with you?

__ Yes __ No   How many times?_____

Have they met your therapist?

__ Yes __ No   How many times?_____

Have they spoken with your therapist on the phone?

__ Yes __ No   How many times?_____

APPENDIX D

DEMOGRAPHIC QUESTIONNAIRE (Portuguese)

Por favor, complete as seguintes perguntas:

Idade: ____

Sexo: ___ Masc. ____ Fem.

Educação (ano): _____ (Deve ser igual ao seu último ano completo de segundo grau, mais qualquer educação adicional completada depois).

Tipo de trabalho: _____

É casado (a)? Sim ___ Não ____ Aonde sua esposa (o) trabalha?_____.

Anos de residência nos EUA: _____

Seu país de nascimento: _____

País de nascimento da mãe: _____

País de nascimento do pai: _____

País de nascimento dos avós maternos: _____

País de nascimento dos avós paternos: _____

Lingua falada:

__Somente português ___Principalmente português ___Principalmente inglês __Somente inglês

Quem é seu terapeuta? _____

O seu terapeuta é Português-Americano? ___ Sim ___Não

Quantas consultas você teve com o seu terapeuta? _____

Sua família foi envolvida no seu tratamento? ___ Sim ___ Não (por favor diga quem da sua família foi envolvido _____).

Os seus familiares estiveram na terapia com você?

__ Sim __ Não   Quantas vezes? _____

Os seus familiares encontraram-se com o seu terapeuta?

__ Sim __ Não   Quantas vezes? _____

Os seus familiares falaram com o seu terapeuta pelo telefone?

__ Sim __ Não   Quantas vezes? _____

APPENDIX D

PORTUGUESE-AMERICAN IDENTITY SCALE (English)

Please circle the number under each question that best describes how you feel.

1	2	3	4	5	6	7
Completely Untrue	Mostly Untrue	Somewhat Untrue	Neither True nor Untrue	Somewhat True	Mostly True	Completely True

1. When an important newspaper insults the Portuguese people, I feel that it is insulting me.

   1   2   3   4   5   6   7

2. My fate and future are bound up with that of Portuguese people everywhere.

   1   2   3   4   5   6   7

3. If a stranger were to meet me and mistake me for a non-American, I would correct his mistake, and tell him that I am an American.

   1   2   3   4   5   6   7

4. My fate and future are bound up with that of the American people.

   1   2   3   4   5   6   7

5. Portuguese the world over are as "one family".

   1   2   3   4   5   6   7

6. My destiny is bound up with the destiny of the Portuguese in the United States.

   1   2   3   4   5   6   7

7. The mixture of many races and cultures in America contributes to its greatness.

   1   2   3   4   5   6   7

8. It is necessary to take an active interest in the fate of Portuguese people everywhere in order to be a good Portuguese person in America.

   1   2   3   4   5   6   7

9. I regard Americans everywhere as "one family".

   1   2   3   4   5   6   7

10. Being an American plays an important part in my life.

    1   2   3   4   5   6   7

11. When an important newspaper insults the American people, I feel that it is insulting me.

    1   2   3   4   5   6   7

12. Being Portuguese plays an important part in my life.

        1   2   3   4   5   6   7

13. When an important newspaper praises the Portuguese, I feel that it is praising me.

        1   2   3   4   5   6   7

14. One of my most important duties as an Portuguese-American is loyalty to the United States.

        1   2   3   4   5   6   7

15. My destiny is closely connected to the destiny of the United States.

        1   2   3   4   5   6   7

16. If I were to be born all over again, I would wish to be born Portuguese.

        1   2   3   4   5   6   7

17. When an important newspaper praises the American people, I feel that it is praising me.

        1   2   3   4   5   6   7

18. If a non-Portuguese person were to meet me and mistake me as being non-Portuguese. I would correct his misperception and tell him that I am Portuguese.

        1   2   3   4   5   6   7

19. If I were to be born all over again, I would wish to be born an American.

        1   2   3   4   5   6   7

APPENDIX D

PORTUGUESE-AMERICAN IDENTITY SCALE (Portuguese)

Por favor, circule em cada questão o número que indica melhor como você se sente:

1	2	3	4	5	6	7
Totalmente falso	Majoritariamente falso	Um pouco falso	Nem verdadeiro nem falso	Um pouco verdadeiro	Majoritariamente verdadeiro	Totalmente verdadeiro

1- Quando um jornal importante ofende o povo Português, eu sinto que ele está me ofendendo.

    1   2   3   4   5   6   7

2- Meu destino e meu futuro estão ligados com o destino e futuro dos Portugueses em todos os lugares.

    1   2   3   4   5   6   7

3- Se um desconhecido te disser que você não é Americano (a), você o corrigiria e diria que você é Americano (a):

    1   2   3   4   5   6   7

4- Meu destino e futuro estão ligados com o destino e futuro do povo Americano.

    1   2   3   4   5   6   7

5- Os Portugueses em todo o mundo são como "uma família".

    1   2   3   4   5   6   7

6- Meu destino está ligado com o destino dos Portugueses nos Estados Unidos.

    1   2   3   4   5   6   7

7- A mistura de várias raças e culturas nos Estados Unidos contribui para a sua grandeza.

    1   2   3   4   5   6   7

8- É necessário ter um interesse ativo no destino dos Portugueses em todos os lugares para ser um bom Português nos Estados Unidos.

    1   2   3   4   5   6   7

9- Eu considero os Americanos em todos os lugares como "uma família".

    1   2   3   4   5   6   7

10- Ser Americano (a) tem uma grande importância na minha vida.

    1   2   3   4   5   6   7

11- Quando um jornal importante ofende o povo Americano, eu sinto que ele está me ofendendo.

    1   2   3   4   5   6   7

12- Ser Português (a) tem uma grande importância na minha vida.

    1   2   3   4   5   6   7

13- Quando um jornal importante elogia o povo Português, eu sinto que ele está me elogiando.

    1   2   3   4   5   6   7

14- Uma das minhas mais importantes obrigações como Português-Americano (a) é a lealdade aos Estados Unidos.

    1   2   3   4   5   6   7

15- Meu destino é intimamente ligado ao destino dos Estados Unidos.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

16- Se eu fosse nascer de novo, eu gostaria de nascer Português (a).

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

17- Quando um jornal importante elogia o povo Americano, eu sinto que ele está me elogiando.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

18- Se um estranho me encontrasse e me confundisse com um Americano (a), eu o corrigiria e lhe diria que eu sou Português (a).

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

19- Se eu nascesse de novo, eu gostaria de nascer Americano (a).

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

VITA

Katherine Gamble was raised in Northern New Jersey where she lived until attending college at Oberlin. She received her Bachelor of Arts in Psychology from Oberlin College of Arts and Sciences in May of 1991. She then moved to Boston, Massachusetts where she worked on the inpatient psychiatric units at The Cambridge Hospital and was first made familiar with the Portuguese-American population of Massachusetts. During her time at the Cambridge Hospital, she completed her Master's Degree in Counseling Psychology at Boston College, which she received in May of 1995. She began her doctoral studies at the Virginia Consortium Program in Clinical Psychology the following September. She completed her third year concentration in Neuropsychology at Eastern Virginia Medical School and Virginia's Eastern State Hospital. Her internship year, ending in August of 1999, was spent at Seacoast Mental Health Center in Portsmouth, New Hampshire, with a specialty in neuropsychology at the Center for Learning and Attention Disorders. She is currently training in neuropsychology at HealthSouth Braintree Rehabilitation Hospital.

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