A CULTURALLY SENSITIVE INTERVENTION IN PAIN MANAGEMENT SETTINGS:

USE OF DICHOS IN MULTI-ETHNIC PAIN GROUPS

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Dissertation Prepared for the Degree of

DOCTOR OF PHILOSOPHY

UNIVERSITY OF NORTH TEXAS

December 2005

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Riley, Celeste Arden, *A culturally sensitive intervention in pain management settings: Use of dichos in multi-ethnic pain groups*. Doctor of Philosophy (Health Psychology and Behavioral Medicine), December 2005, 133 pp., 18 tables, 2 figures, 98 titles.

The present study explored whether use of Spanish language sayings, or dichos, improved group climate within multi-ethnic chronic pain groups. Use of this form of figurative language fits within psychological theory identifying use of metaphor as a means of promoting change and creating new meaning. Further, metaphor use is consistent with the broader aims of experiential therapy.

Group climate was measured by group members' self reports using the Group Climate Questionnaire-Short Form. A pilot study involving Latino Americans in medical and non-medical contexts aided in categorizing dichos as high versus low-relevance. It was anticipated that clients would rate high-relevance sessions as involving greater engagement, and less conflict and avoidance than low-relevance groups.

Participants were recruited from four multidisciplinary pain management clinics offering similar programs. Once every four to six weeks, group leaders were provided with a list of either high or low-relevance dichos, and were blind to the existence of dichos categories. Three hierarchical regression analyses were employed to determine whether dichos relevance, characterized as low, mixed or highly relevant, contributed to variance in group conflict, avoidance and engagement. Dichos familiarity was the last variable entered into the regression equation, with gender, ethnicity and acculturation score entered in sequential fashion. Consistent with predictions, low-relevance groups yielded higher conflict scores than all groups combined. Also, high-relevance groups

predicted lower avoidance when compared to all groups. In contrast to hypotheses, high-relevance groups predicted lower ratings of group engagement when compared to all groups. Post-hoc analysis indicated the mixed-relevance groups yielded significantly higher engagement scores than the low and high-relevance groups. Implications of these findings are discussed in relation to impact on approaches to group therapy with Latino American clients, and within the chronic pain population. Limitations of the study and recommendations for future research are offered.

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CHAPTER 1

INTRODUCTION

Emic versus Etic Treatment Approaches

Historically, literature surrounding how to resolve the health and mental health disparities between minority cultures and the majority culture has been divided along the emic versus etic approaches to therapy. The etic approach to assessment and treatment is delineated as one that focuses on universal themes across cultures. Though some adjustments may be necessary to accommodate clients of other cultures, commonalities are emphasized (Hong, Garcia & Soriano, 2000). Proponents of this perspective caution that the client's cultural background can be overemphasized to the detriment of a full understanding of the client's uniqueness (Daya, 2001).

Emic approaches operate under the contrasting assumption that the context of culture is crucial when planning assessments and interventions. They do not assume that the same techniques or principles apply equitably across all cultures (Hong et al., 2000). Followers of the emic position believe that in the absence of culture-specific knowledge, the therapist would likely go awry in choosing interventions for a client from another culture. Further, this perspective forwards the notion that the current array of theoretic choices available to counselors are primarily Western in origin and may or may not resonate with clients of other non Western cultures (Daya, 2001).

Some discussions regarding this issue seek to move beyond theoretical debate, and move toward an applied resolution (Daya, 2001; Hong et al., 2000). Daya (2001) proposes the principles of change view which criticizes literature surrounding the emic/etic debate for offering theory devoid of applicable guidelines. The crux of this

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approach is that there are existing processes of change that may be common to all cultures. The author posits that the emic/etic stances are resolved within this theory since therapists knowledgeable regarding other cultures would then choose the most appropriate change interventions for specific clients.

Hong et al. (2000) caution that the insistence of developing culturally specific interventions for each culture and subculture, a purely emic approach, may promote future clinicians to serve clients with whom they share a cultural background, avoiding the difficult task of developing multicultural skills altogether. Like Daya (2001), the authors forward the presumably more realistic approach of using the emic and etic approaches in a complementary manner. They contend that clinicians must possess a good command of the etic factors associated with various presenting problems, while striving to understand the client's unique experience of this problem at the emic level.

The present investigation integrates the emic and etic stances by making use of therapy components assumed to be more universal in nature. These therapeutic factors involve use of metaphor and imagery techniques that fit within the framework of experiential therapy. However, these interventions are altered to target a specific subpopulation of Latino Americans involved in a chronic pain management program.

Experiential Therapy

Experiential theory is the synthesis of several theoretical approaches. Experiential theorists have melded classical ideals and practices from Gestalt, person-centered, existential, constructivist, and focusing-oriented therapies to create a collective genre of therapy emphasizing a client's level of experiencing within the session. (Greenberg & Van Balen, 1998; Corey, 2000). Several researchers have

recently offered detailed hypotheses of experiencing, human personality and therapeutic change from an experiential perspective (Greenberg & Van Balen, 1998; Hendricks, 2002; Mahrer, 1996).

The term experiencing does not narrowly refer to a client's emotions within the present moment, but is rather a broader term that also includes bodily sensations, behaviors and cognitions that occur in response to the external world (Greenberg & Van Balen, 1998). From a process-oriented approach, Hendricks (2002) describes experiencing partially as a bodily phenomenon but emphasizes that our bodily sensations occur within the context of what happens around us. The author further explains that when we attach meanings to this experiencing, it is referred to as a felt sense. When a change in this sense occurs, either due to therapy or a person's own response, it is then referred to as a felt shift. Such a shift is often accompanied by feelings of relief in the body. Mahrer (1996) states that all humans have potentials for experiencing, which are described as ways of being rather than particular behaviors. In relating a potential for experiencing to a client, Mahrer suggests therapists "think of the words you might use to give a thumbnail sketch of how an actor is to be in this particular scene" (p. 38). The external world, whether it is one that has been presented or one that has been actively created by an individual, provides a context for experiencing particular potentials or operating potentials. Mahrer sites the example of the operating potential of loving and being close to someone. "This experiencing calls for some kinds of appropriate external contexts. The function of the external world is to provide the situation that is appropriate for this experiencing" (p. 50). Others propose that "experiencing can be understood as the synthesized product of a variety of

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sensorimotor responses and emotion schemes, tinged with conceptual memories, all activated in a situation" (Greenberg & Van Balen, 1998, p. 45). Each of these factors represents a different level of processing and is an element which may become more integrated in therapy.

By this approach, experiencing has a neural and thus biological basis (Greenberg & Van Balen, 1998). Mahrer's (1996) explanation of experiencing complements this proposal, by noting that bodily events may be vehicles for experiencing or may be a sign of experiencing, and may thus be helped with an experiential perspective in therapy. "To the extent that the bodily event enables experiencing, or the bodily event is a manifestation of a deeper potential, the bodily event may be let go" (p. 133).

From an experiential standpoint, personality and resulting human behavior stems from how individuals organize and make meaning of their collective experiences. Greenberg & Van Balen explain that "a person is seen as a symbolizing, meaning-creating being who acts as a dynamic system constantly synthesizing information from many levels of processing and from both internal and external sources into a conscious experience" (p. 42). These levels of processing may be somewhat analogous to what Mahrer (1996) refers to as potentials for experiencing. Mahrer explains that it is the dynamic relationships between these potentials, and whether the relations are integrative or disintegrative that determines an individual's personality. These relationships are also what activate humans into motion. The author describes four ways that individuals may create or construct the external world around them. In the first way, individuals passively receive what the external world presents to them. The

reception of outside events is subject to each person's unique appraisal; however, in this mode individuals have no real impact on their environments. Secondly, individuals may make use of what is presented in the external world. "The person may use the external world by selecting out the aspect to engage with" (p. 47). In the third mode of experiencing the world, individuals and their environment interact to 'co-construct' something entirely new. Lastly humans may actively construct their external worlds. Mahrer explains that people may create worlds that are based upon reality or fantasy, or may even construct external worlds that render them powerless and passive.

Reminiscent of Gestalt therapies, one of the primary goals for experiential therapy involves constructing a more integrated or coherent self. In their description of a 'dialectical constructivist model of experiential therapy,' Greenberg and Van Balen (1998) combine the goals of person-centered and Gestalt therapies. Therapeutic progress is framed in terms of integrating and making meaning of as many aspects of the self as possible. In therapy, the process of integration is co-facilitated by therapist and results in a new coherent view of the self that is ideally based on an individual's strengths. According to Mahrer the appropriate focus for change is the integration of a person's potentials for experiencing, and for unexploited potentials to become operating potentials. Another goal is to facilitate more intense experiencing of operating potentials. In the experiential model this is referred to as actualization. "The change is toward increased amplitude, saturation, strength and fullness of experiencing," which is distinguished from simply feeling something more strongly (Mahrer, 1996, p. 65). Hendricks (2002) contends that the purpose of increasing a client's level of experiencing is to facilitate shifts in the meanings that accompany experiencing, or felt shifts. Though

relief often accompanies shifts, this sensation or feeling is not the purpose of therapy but rather a by-product. The primary purpose is to achieve change, or to 'un-block' the particular process of living that brought the client to therapy. The result is not simply a cognitive reframing of external or internal events, but an entirely new way of being for the client.

Regarding the efficacy of experiential therapy, Hendricks (2002) provides a summary of twenty-seven studies relating level of experiencing to outcome. Only one of these studies showed no relationship with outcome, and another demonstrated an inverse relationship with client satisfaction at the end of therapy. However, the rest of the studies presented yielded results indicating that higher levels of experiencing is linked to better outcomes and may discriminate between cases categorized as successful versus unsuccessful.

In addressing how therapists may facilitate change, Hendricks (2002) proposes that "because a person's experiencing involves language, culture, other human beings, symbols, dreams, actions or interpersonal behavior, any of these avenues may carry blocked experiencing forward" (p. 224). The interpersonal nature of the therapeutic process has also been emphasized as a critical ingredient to successful outcome. Greenberg and Van Balen state that actualization "results not only by means of the self-organization of some type of biological tendency but also through confirming dialogue with another person" (p. 47). In concordance with these recommendations, the present study assesses the impact of a group intervention making use of client language and culture on the relational processes of the group.

Angus and Korman (2002) place metaphor use into the context of experiential psychotherapy by offering metaphors as vehicles for self-construal. The authors promote the idea that metaphors allow clients to map one life experience onto another, and in so doing encourage individuals to integrate the meanings of those experiences. It is this process that is argued to be the basis for change. "Old stories may in turn come to be understood in new ways and new metaphor themes may emerge to represent this different way of seeing and experiencing and aspect of the self" (p. 154). Other theorists echo the relevance of symbolic or figural experiencing in therapy. Greenberg and Van Balen introduce the idea that experiences may be symbolized and that these symbols may also be organized and integrated within the self. This process may enable the client to make new meaning of the self. "People are then viewed as constantly striving toward making sense of their preconceptual experience by symbolizing it, explaining it, and putting it into narrative form" (p. 43).

Metaphors

Bayne and Thompson (2000) offer that a metaphor "suggests a relation between two apparently unrelated notions, a means of transferring significance from one thing to another, a carrying across of similarity whatever the surface dissimilarity of the notions invoked" (p. 38). Though succinct, this linguistic description misses much of the therapeutic function and value of interest to applied psychologists.

In following the evolution of the metaphor, Mair (1976) points out that humankind's consideration of metaphor has moved from that of a verbal decoration to a helpful means of experiencing reality, and one that is even implicated in our psychological processes. Some researchers consider this transition of metaphoric use

to involve a conflict of whether metaphor is an innate and necessary part of speech, or whether it is merely an ornamental device that fails to create additional meaning (Muran & DiGuiseppe, 1990). The former argument aligns with the interactive view of metaphor, which posits that by connecting two previously unrelated subjects, one creates new meaning, thereby generating potential for learning (Muran & DiGuiseppe, 1990).

Available literature points to several advantages and few disadvantages for the therapeutic use of metaphor. One of the benefits mentioned involves the capacity of metaphor to influence the psychological processes of the client and promote change. Mair's (1976) account of metaphoric functions includes its value in describing the unknown with something more familiar, acting as a "filter" through which we view the world. As such, metaphors emphasize some truths, but suppress others. Hence Mair concedes that metaphors may set boundaries on one's perceptions. In keeping with this view, Clark (2001) believes that narrative approaches, which may be inclusive of patient metaphors, enable clients to "re-story" their lives. Owen (1989) contends that use of the client's metaphoric language promotes "a context for self-healing by wrapping the client's symbol with more of the client's words and creating the possibility that the symbol, or its context, could be able to change" (p. 195).

Recent findings support the existence of both the advantage of promoting change, and the disadvantage of limiting one's perspective. One case study suggests that for metaphor to be successfully utilized in therapeutic settings the therapist's attention must be focused on the potential of a metaphor to become static, or to 'filter out' motivation to change (Koetting & Lane, 2001). In this investigation, the authors followed a client through over 80 sessions in which the client's own metaphors initially

promoted a shared understanding between the therapist and client. However, as therapy progressed and the same metaphors were used in an unmodified manner, they served as barriers to change. Specifically, Koetting and Lane emphasize "the insidious capacity of a metaphor, once it has died (i.e., failed to provide new, helpful information about its referent), to both perpetuate negative self-representations and block the realization of more fulfilling self-representations" (p. 249).

At the same time, a shift in metaphor content may provide the clinician with a valuable signal that therapeutic change is occurring (Levitt, Yifaht & Angus, 2000). In one investigation of the influential nature of metaphor, researchers recorded metaphors used in successful process experiential and person-centered therapeutic dyads. Metaphors were then coded according to their content or theme. It was discovered that the percentage rates of themes used by the client reflected content shifts as therapy progressed (Angus & Korman, 2002). For example, the authors contend that in one therapeutic dyad the client's metaphors regarding her relationship with her husband changed fromthose reflecting loss following an argument to those symbolizing 'fighting and winning' after conflicts. The disadvantage of the study is lack of statistical methodology to lend power to the authors' conclusions. Predominance of metaphor themes were reported in terms of percentages, however, no statistical tests were performed to determine whether the difference in theme predominance was significant. In an earlier investigation, Levitt et al. (2000) examined the this same content shift hypothesis by comparing therapeutic sessions categorized as having good and poor outcomes. This classification of outcomes was based upon client response to objective symptom inventories before and after therapy. It was found that frequency of metaphor

usage was no different between the good and poor outcome groups. However, good outcome sessions followed a pattern of shifting the content of the metaphor. In this case, the "burden" of depression was described as being carried, and in later sessions was described as being unloaded.

Otto (2000) sites several advantages for using stories and metaphors in a therapeutic setting, including the increased likelihood that clients will remember therapeutic strategies or information presented in this format due to its use of chunking and evocation of multiple sensory modalities. In cognitive therapies, metaphors function to describe experiences, and create new paradigms while improving memory and recall for the new paradigm (Muran & DiGiuseppe, 1990). In a quantitative test of this proposal, Martin, Cummings and Hallberg (1992) requested therapists who regularly utilized metaphor with clients to offer therapeutic metaphors when appropriate. Client recall of sessions inclusive of metaphor was higher than recall for sessions devoid of metaphor. Researchers also found that of the sessions with highly recalled events, clients rated metaphor-inclusive sessions as most helpful. In another investigation, analysis of the costs and benefits of metaphor yielded evidence that metaphors used in reading materials result in longer reading times in adults and children; however, metaphoric references improved correct response rates to comprehension questions (Noveck, Bianco & Castry, 2001). Hence available literature is supportive of the contention that use of metaphor improves content recall and comprehension, with the possible disadvantage of requiring more time for interpretation.

Further, metaphors may encourage client input and participation, thereby promoting therapist-client communication. Enhanced communication may then facilitate

a shared conceptualization of the referral problem (Otto, 2000), as well as the client's identity and values (Angus & Rennie, 1989). Paulson (1996) notes that this occurs by allowing "abstract ideas that are rooted in sensory processes to be symbolically and experientially understood" (p. 12). Owen (1989) relates that therapists must find a way of communicating with the client that wholly elicits their experiences, further explaining that "each word the client uses for describing their experience is like a code word which has a series of associations, meaning, memories and other experiences attached to it" (p. 189). The increased client involvement may also serve to decrease resistance to change by granting clients an increased sense of self-efficacy in terms of problem solving (Paulson, 1996).

The literature validates the assertions of improved communications and increased client involvement primarily through investigation of client level of experiencing. When Martin et al. (1992) queried clients about why sessions were recalled, participants responded that the sessions inclusive of intentional metaphors fostered understanding and communication of previously nonverbal experiences, promoted rapport with the therapist, and aided in delineation of goals. Levitt, et al. (2000) also note that use of metaphor advances the aim of increased level of experiencing, and connect experiencing to better outcomes for depression treatment. Good outcome sessions, determined by client responses to objective symptom inventories, more frequently consisted of metaphors used in conjunction with an internal or emotional state in the client. According to a client experiencing scale, these sessions were also marked by higher levels of experiencing or emotional involvement. Another investigation used metaphors embedded in guided imagery exercises to promote self-

soothing and self-exploration in bulimia patients. The authors suggested that the

positive effects of the imagery may have been brought about in part by its promotion of

self-experiencing (Esplen, M.J, Gallop, R., & Garfinkel, P.E., 1999).

Otto and others (Zuniga, 1992) also point to the commonly sited benefit of

allowing the therapist to present the client with information that may provoke defensive

responses when given in a more direct manner. The process of deciphering how

metaphors operate in this vein has launched a host of theoretical outlooks. Muran and

DiGiuseppe (1990) review use of metaphor from the standpoints of Freud and Erickson.

Both perspectives relate metaphorical communication to the unconscious. For example,

the Erickson's communicative school believes that "a story provides the conscious mind

with one denotative message which keeps it occupied, while another therapeutic

message can then be slipped to the unconscious mind via implication and connotation"

(p. 75). In contrast, Muran & DiGiuseppe's cognitive perspective proposes that

therapists use metaphors as a means of direct communication, questioning the client

about the implied meaning rather than leaving responsibility of meaning formulation

solely with the client.

Metaphors may also function by combining useful aspects of two distinct forms of

cognition, logical/propositional and imaginative, thereby providing a means for clients to

utilize both reason and creativity in problem-solving (Kopp & Craw, 1998; Paulson,

1996). In an investigation of this link, Gibbs, Strom and Spivey-Knowlton (1997) noted

the consistency of mental imagery elicited by proverbs (e.g. a rolling stone gathers no

moss), compared to literal versions of well-known proverbs and figurative definitions of

familiar proverbs. They provide evidence that understanding of a conceptual metaphor

(life is a journey) is closely related to understanding of the corresponding proverb (a rolling stone gathers no moss). Therefore, the research suggests that comprehension and processing of metaphorical proverbs involves both imagery and a logical understanding of the metaphor's implied meaning. Papagno and Vallar (2001) conducted a case analysis involving a young woman with Down's syndrome. Extensive neuropsychological testing revealed deficits in abilities correlated with right hemispheric functioning, such as visuospatial processing while the client evidenced strengths in phonological abilities and literal language comprehension. Based on their own findings and previous research, the authors concluded that right hemispheric abilities such as visuospatial and executive functions largely determine an individual's ability to interpret metaphors and idioms. Taken together, these studies suggest that hearing a metaphor may simultaneously initiate distinct cognitive processes: visual processes connected with the imagery of the phrase, and language processes that translate the figural saying into a conceptual metaphor.

Regarding the aforementioned proposed benefits of metaphor, researchers do not mention their use within specific client cultures. The previous discussion thus seems to speak to etic benefits, or those that reach across cultural boundaries. However, a few have begun to postulate about the importance of communicating metaphorically in cases of cross-cultural therapeutic relationships. These proposals have come from studies examining psychotherapeutic relationships, as well as those exploring communication in medical contexts. Clark (2001) asserts that within medical contexts patients and physicians represent different cultures, raising the possibility that miscommunication and depersonalization may occur. He further argues that "the major

implication of this cultural chasm is that the patient's 'story' is re-interpreted, repackaged, and re-presented as it is changed to conform to the objective and scientific basis of medicine" (p. 195). From an anthropological perspective, Zeserson (2001) explores how the medical symptoms of menopause are expressed metaphorically in Japanese culture. The article seems to suggest that by considering commonly used metaphors describing an illness or its symptoms, health professionals would in effect carry out the biopsychosocial model. Zeserson explains that "for the person experiencing the sensations, wanting to be rid of them is only part of the motivation for expressing them. Suffering people are motivated also by the desire/need to explain the suffering in the context of who they are" (p. 183).

Again, empirical investigation lends supportive evidence of the proposed benefit of metaphor. Taylor, Wooten Babcock and Hill (2002) reviewed literature outlining the need for therapeutic techniques sensitive to the client's individual and cultural perspective of their problem, and suggest use of metaphors due to their capability to work within the client's own worldview. The authors constructed a metaphorical story designed to improve relational esteem, or appraisals of family members in Mexican American families. It was concluded that the use of this metaphorical story, which was somewhat tailored for each family, was indeed successful in raising relational esteem in adults but not children.

Thus empirical use of metaphor suggests that this approach, grounded by research primarily conducted in mainstream American culture, might be successfully adapted to serve adult Latino populations. A means of altering metaphor use to better

suit Latino Americans in therapy has been recommended and supported anecdotally, but not empirically tested thus far.

<center>Dichos</center>

Zuniga (1992) proposes the use of dichos in individual therapy to improve various aspects of the therapeutic experience for Latino American clients. In this article, dichos are described as Spanish language idioms or proverbs that are often poetic and/or metaphorical in nature, frequently comparing humans to animals. The author, who is Mexican American, suggests that this form of figurative language may serve to decrease client resistance, enhance motivation, facilitate therapist-client communication and stimulate new perspectives. "*Al que no ha usado huaraches, las correas le sacan sangre,*" provides an example of a dicho Zuniga suggests may be utilized when a therapist wishes to convey empathy regarding the difficulty of trying something new. This idiom translates to "He who has never worn sandals is easily cut by the straps." In concordance with the uses offered by Zuniga, Aviera (1996) offers clinical anecdotes on how dichos have built rapport, decreased defensiveness, increased motivation to participate, increased self-esteem, focused attention, aided in emotional exploration and development of new insights, and prompted thought concerning cultural identity.

Altarriba and Santiago-Rivera (1994) suggest that dichos may be used as a means of mixing languages, which purportedly captures the advantages of using either the dominant or non-dominant language of the client. They propose that conducting therapy in both languages enables the client to discuss difficult or painful topics while relying on a broader and more familiar vocabulary. This is consistent with Delgado and Humm-Delgado's (1984) recommendations that use of both languages facilitates self-

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expression in group contexts (Beals, Beals & Cordova de Sartori, 1999; Delgado & Humm-Delgado, 1984). Others concur, posing language switching as a technique that also reduces anxiety (Beals et al., 1999). Zuniga (1992) also suggests use of dichos as an appropriate technique for non-Latino therapists, in that an attempt to study the meaning and pronunciation of the sayings displays respect for the client's culture. The present study attempts to present dichos in a structured activity, another suggestion for Latino/a groups (Delgado & Humm-Delgado, 1984).

Another potential advantage of dichos discussion within groups relates to the metaphorical nature of many of the recommended Spanish-language sayings. Those reviewing techniques appropriate for transcultural therapy highlight the importance of familiarity with clients' language of preference and relevant metaphors in order to accurately understand client presentation of symptoms and goals for therapy (Beals et al., 1999; Bernal, Bonilla, & Bellido, 1995; La Roche, 2002). La Roche argues that motivation to adhere to treatment may be increased if target goals are communicated using the client's metaphors. The author explains that "understanding the cultural scripts that reflect how Latino patients construct or make meaning of their symptoms is helpful in reducing symptoms or understanding chief complaints" (p. 117).

<div align="center">Group Cohesiveness</div>

The emphasis on the interpersonal aspect of experiential therapy (Greenberg and Van Balen, 1998) poses the question of whether altering a therapeutic intervention to enhance cultural sensitivity would positively enhance interpersonal group processes. Though outcome research is imperative if research concerning culturally sensitive treatment is to evolve and support its application, investigation regarding process

variables is also an important component of this research effort. Process-related research seeks to elucidate which therapeutic factors are at work in determining outcomes. A host of research investigations have connected process variables to better mental health outcomes (Orlinsky, Ronnestad, & Willutzki, 2004). One of the factors receiving more consistent support revolves around interpersonal factors in therapy, or therapeutic bond. In reviewing this factor, Orlinsky et al. (2004) stated that over 1,000 studies conclusively make therapeutic bond the most supported therapeutic process in terms of its relation to outcome. The authors further stipulate that the connection is especially strong when the quality of the relationship is considered from the client's point of view.

Three interrelated concepts within the interpersonal group process literature include group climate, cohesion and alliance. Presently much debate exists over conceptual clarity among these therapeutic factors, as well as their measurement (Burlingame, MacKenzie & Strauss, 2004). This recent review describes group cohesion as "a measure of belonging and acceptance at the group level" (p. 677). Despite its widespread use in measuring group cohesion, Burlingame et al. categorize the Group Climate Questionnaire as an instrument emphasizing 'psychological work' or interpersonal learning at the whole group level. Elsewhere, definitions of cohesiveness have overlapped with what Burlingame et al., describe as a distinct concept, or alliance to the group leader. However, Yalom (1995) asserts that cohesiveness is not only the therapist-client relationship in a group context, but also each individual's relationship to the rest of the group. The author argues that in total, cohesiveness may be thought of as "the attractiveness of the group for its members" (p. 48). Wright and Duncan (1986)

also attempted to highlight components of the cohesiveness and, like Yalom, point out

attraction to group leaders and other members as two distinct perspectives, as well as

the notion of an individual's feeling of inclusiveness within the group. Graphorn,

Kaufhold & Overbeck (2002) do not expressly include relationship to the therapist in

their definition of cohesion, but liken the group cohesion construct to therapeutic

alliance in an individual therapy context. The authors offer that cohesiveness is a sense

of "interrelatedness" and "is that force of which it is assumed that it leads the

participants to remain in the group in difficult or conflictual phases" (p. 142). In terms of

measurement, cohesiveness has been rated from multiple perspectives (members,

leaders and observers), and at the individual and group levels (Burlingame et al., 2004).

Though the construct is still somewhat loosely defined, the relative importance of

group cohesion is less disputed within the literature. Yalom (1995) posited that

cohesiveness functions not only as one of the therapeutic factors in a group, but also as

a precursor that must exist for other therapeutic factors to work. He further asserts that

more cohesive groups "have a higher rate of attendance, participation, and mutual

support, and will defend the group standards much more than groups with less esprit de

corps" (p. 48). As a measure of group process, the concept of cohesion has been

repetitively linked to measures of therapeutic outcome. Group cohesion has predicted

therapeutic gain operationalized by participant ratings of therapeutic gain or goal

attainment (Braaten, 1989; Kivlighan & Lilly, 1997; Wright and Duncan, 1986). A more

recent study utilizing a new instrument of cohesion in a group of cardiac patients

examined whether cohesion could predict physical outcomes related to cardiac

functioning (van Andel, Erdman, Karsdorp, Appels & Trijsburg, 2003). Researchers

found that though cohesion was unrelated to vital exhaustion, hierarchical analysis did reveal an association with post-group blood pressure and heart rate after controlling for pre-treatment values of these parameters. Graphorn et al. (2002) were able to use a measure of group climate to differentiate successful versus unsuccessful patients involved in group therapy. Only one recent study did not find a relationship between cohesion as measured by the Group Attitude Scale (Evans & Jarvis, 1986) and outcome variables related to anxiety reduction (Woody & Adessky, 2002). One possible explanation for this finding may involve the nature of the participants who were seeking treatment for social phobia. This particular population may indeed demonstrate different patterns of group cohesion than other group populations.

Pertinence of Culturally-Sensitive Psychotherapy with Latino Americans

Demographic trends.

Given widespread growth in the Latino/a population, development of cultural competence in mental health contexts is clearly an issue that is relevant to mental health professionals not in localized pockets, but across the nation. Twenty-seven U.S. states experienced a growth rate of 60 to 200%in Latino/a populations between 1990 and 2000 (U.S. Census Bureau, 2001). The majority of the states in which Latino/as comprise the largest minority group are located in the Southwest. However, growth trends indicate that other regions are also experiencing a surge in Latino population. Six of the seven states with a growth rate of 200% or more were located in the South, and many Midwestern and even Northeastern states gained approximately 60 to 200% in Hispanic/Latino population (U.S. Census Bureau, 2001).

Disparities in service utilization.

The need for research on and the development of culturally sensitive mental health interventions is further underscored by evidence that discrepancies in service utilization rates and treatment outcomes among ethnic groups reliably indicate lower utilization rates and differential treatment outcomes for Latino/as. Recent studies have investigated socio-economic status factors (i.e. income level, insurance status and education level) that may account for these differences, (Freiman & Cunningham, 1997; Maynard et al., 1997; Padget et al., 1994). The common finding of these studies demonstrates that utilization differences still exist even after controlling for SES variables. This suggests that ethnic and cultural differences are not to be equated with differences in SES when investigating utilization disparities.

Freiman and Cunningham (1997) grouped African Americans and Hispanics together and compared mental health service utilization to a group including Caucasians and other non-whites. The data showed differences in educational level and insurance status between the two groups, with Hispanics having lower educational level and being less likely to have health insurance. African Americans and Hispanics were still less likely to have utilized any type of mental health care after accounting for these discrepancies. Another study demonstrated that even with a sample comprised only of insured, non-poor multi-ethnic participants, Caucasians were still more likely to seek mental health care than African Americans or Hispanics (Padgett et al., 1994). Maynard et al. (1997), surveyed people who accessed mental health services in Washington state through Medicaid and similar publicly funded programs. Out of the 34,000 participants in this study, over 2,000 were Latino/a. Other ethnicities designated in the

data collection were Caucasian, African American, Asian American and Native American. Multivariate analysis indicated that after controlling for covariates such as age, gender, language and income, ethnic differences existed, particularly with regard to the quality and quantity of services used. Caucasians accessed more hours of service and more sessions than the other ethnicities. Hispanics were less likely to receive medication management and crisis management than Caucasians, indicating the existence of qualitative differences in treatment.

Unfortunately the precise culprits for these differences in service utilization have not been completely elucidated due to differences in study populations and design. However, studies including variables that partially address the relative influences of demographic information, the availability of services, and the need for mental health services offer some insight as to why these disparities exist (Peifer, Hu & Vega, 2000; Vega, Kolody, Aguilar-Gaxiola & Catalano, 1999).

In an examination of utilization patterns, logistic regression demonstrated that several demographic factors predicted type of care sought. Living in an urban versus rural setting, having more education, and older age all predicted greater use of mental health services (Vega et al., 1999). In this study, family income was divided into three categories with utilization rates highest in the middle income category. Using a slightly different but overlapping population, another regression analysis (Peifer et al., 2000) yielded discrepant findings. Age, employment and income were unrelated to utilization rates, while women and unmarried individuals were found to be more likely to seek mental health care. However, in this latter study, income was dichotomized as more or

less than $12,000. Therefore, the Vega et. al. (1999) study may more accurately represent income's influence on utilization rates.

Studies have also investigated how service demand among Mexican Americans and Mexican nationals impacts usage by including diagnostic status and level of functioning in regression equations. Greater degree of self-rated impairment was not associated with increased use of mental health services but was correlated to greater utilization of medical and other professional care providers such as chiropractors, religious counselors or nurses (Vega et al., 1999). However, having two or more DSM-III-R diagnoses predicted greater use of all service types tracked, which included mental health specialists. Piefer et al. (2000) found diagnostic status to be unrelated to use of mental health services; however those who did meet criteria for a psychological diagnosis were more likely to utilize medical services.

Thus the unresolved difference between the two studies is the degree to which diagnostic status predicts mental health utilization among Mexican Americans. The consistent finding between the two is that variables thought to indicate level of need for mental health services, such as functional impairment, may be unrelated to Latino/a service use or may instead predict utilization of other service modalities such as medical care.

Availability of services or obstacles to utilization may also be important factors in why ethnic disparities exist in mental health utilization rates. However, some results dispute this common claim. Compared to a group of Caucasians and other non-Latino individuals, Hispanics and African Americans were less likely to show any increase in the usage of mental health care with greater numbers of psychiatrists per capita

(Freiman & Cunningham, 1997). Also, one investigation found insurance status among Mexican American individuals to be unrelated to mental health utilization (Peifer et. al., 2000).

More studies examining the issues of demographic information, need for mental health services, and availability of such services are required across all Latino subgroups. However, a gross summary of the evidence collected thus far is that these factors indeed affect service utilization, but do not seem to explain the entirety of the differences observed. At this stage of research, other explanations must be considered. These alternative interpretations revolve around cultural differences in health beliefs, attitudes regarding seeking mental health care and perceived efficacy of treatment. For example, Romero (2000) notes that it is more acceptable for Latina women and children to present with illness, and less appropriate for Latino men to do so due to the cultural expectation that men remain strong and control their emotions. In explaining the differences in utilization behavior, others have concluded that the rest of the story may lie with factors such as provider attitudes toward diagnosis and treatment of minorities, patients' perceptions that providers are unable to understand their particular problems, as well as cultural beliefs regarding symptoms and treatment seeking (Freiman & Cunningham, 1997).

Disparities in treatment outcomes.

A more complete understanding of these issues necessitates a brief review of treatment outcome data for Latino/as who have sought mental health services. Studies attempting to contribute insight on whether designing more culturally sensitive interventions positively impacts treatment outcomes for Latino/as generally compare a

culturally tailored program to a treatment that is more generic in nature. However, these studies are few in number, yield mixed results and represent great discrepancy in what cultural sensitivity entails.

Results of one study investigating Latino and non-Latino whites involved in Alcoholics Anonymous meetings indicated no differences in treatment outcomes as represented by clients' self-reported frequency, intensity and quantity of drinking (Arroyo, Westerberg & Tonigan, 1998). The Alcoholics Anonymous program was used as a proxy for treatment approaches that are generic in terms of cultural focus. The authors concluded that since no outcome disparity between ethnic groups existed, that particular population of Latino clients does not require culturally specific services. However, for this assertion to be completely supported, data on treatment outcomes with culturally specific sessions for both groups would need to be compared to that of the Alcoholics Anonymous program. The possibility that the treatment outcomes for Hispanics would improve beyond the existing data with culturally specific treatment cannot be ruled out.

One study addressed this concern in an investigation conducted with Latino children. In an experimental design assessing efficacy of culturally sensitive interventions that manipulated the actual intervention, Costantino, Malgady and Rogler (1994) found evidence that the culturally sensitive intervention was more effective than the control intervention along several dependent measures. Since the participants were children, the results may or may not apply to an adult population.

Another investigation qualified culturally specific services not as those that offered a culture-specific intervention, but as those that matched case manager and

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client according to ethnicity (Ortega & Rosenheck, 2002). Analyses showed that Hispanic clients improved less than Caucasians on several dependent variables, but found little evidence favoring ethnicity matching. When the statistical interaction between client and case manager ethnicity was considered, the only significant finding was that the ethnically matched Latino pairs resulted in less improvement in terms of psychotic symptoms when compared to other ethnic pairings. A recent review regarding the effect of ethnic matching on therapeutic outcome suggests that most studies yield favorable results from matching the client and therapist, but that the effect sizes for these studies are small (Zane, Hall, Sue, Young & Nunez, 2004). Thus empirical evidence initially suggests little benefit to ethnic matching between client and therapist, and some improvement in outcome with a culturally tailored therapeutic intervention.

Impact of Acculturation Level

One variable that has been purported to be critical in fully understanding treatment outcomes, treatment preferences, symptom presentation and mental health in ethnic minority populations is acculturation level. Theorists differentiate between the processes of enculturation and acculturation. These processes are described as distinct but interactive in that enculturation occurs as individuals become more socialized into their native culture, whereas acculturation refers to a response to the dominant or second culture (Aponte & Johnson, 2000).

Research related to measurement of acculturation has more recently moved to a multidimensional definition of the construct (Cuellar, Arnold & Maldonado, 1995). This definition, supported by factor analysis and theory (Berry, 1980), proposes that acculturation may occur in one of four modes: assimilation, integration, marginalization

and separation. In a recent extrapolation of this model to health contexts, Kazarian and Evans (2001) pose that health acculturation may be considered from the perspective of the health consumer as well as the health professional. Each individual within this dyad may approach health-related interactions via health assimilation, health integration, health separation and health individualism. A health assimilation strategy requires the health consumer to adopt the health beliefs and behaviors of the host culture, or that of the health professional. When the health professional espouses this view, assimilation on the part of the consumer is the expectation. When either the professional or consumer values both culture of origin and host culture's practices, a health integration strategy of acculturation occurs. When consumers adopt a health separation approach, they do not adopt the practices of the host culture, and continue health behaviors of their culture of origin. From the professional's standpoint, separation allows an appreciation of the choice to maintain former health practices but a simultaneous distancing from individuals oriented to that culture. Health individualism describes consumer health practices that are not associated with the culture of origin or host culture. Health exclusion on the part of the health professional disallows consumers to orient themselves to the host culture or culture of origin.

Using a slightly different collection of acculturation modes, Santiago-Rivera, Arredondo, and Gallardo-Cooper (2002) present manifestations of different responses to a host culture. According to this model, whether a person responds to the dominant culture via assimilation, acculturation or rejection determines their behaviors and cognitive style at the intrapersonal, interpersonal and community levels. For example, an individual assimilating to the mainstream culture would adopt a highly individualistic

style of thinking. At the other extreme, one rejecting American culture would adopt a collectivist manner of thinking which is compatible with Latino cultures. The middle of the continuum is represented by acculturation, in which case the individual would remain "flexible and resourceful with multiple systems to access multiple realities and views" (p. 41). Whether this acculturated individual thought in individualistic versus collectivistic terms might depend upon contextual factors.

In an effort to reflect theories positing multiple modes of acculturation, Cuellar et al., (1995) revised their original scale so that individuals might be measured along two independently scored continuums. One of these continuums reflects degree of acculturation (or enculturation) to the Mexican culture, while the other denotes level of acculturation to the American culture. The authors also emphasize the possibility that the acculturation process is also multidimensional in terms of the behaviors, beliefs and emotions indicative of the process. Factor analysis of scale items indicated three factors including language, ethnic identity and ethnic interaction.

From a humanistic perspective, an individual's degree of acculturation is not solely determined by external forces, but individuals' exertion of choice in determining to which aspects of culture they will adhere (Garza & Gallegos, 1995). These authors propose that individuals successfully coping with a multicultural environment exhibit a flexible construct system, while others may choose to constrict the construct system, or choose to associate with one culture exclusively, "in an effort to overcome the anxiety and uncertainty of a dual existence" (p. 9).

The importance of acculturation as a variable that moderates therapeutic outcomes, and as a possible confound in research, is perhaps the most common thread

among investigations including acculturation as a variable. Gamst et al., (2002) imply that in order for interventions with other cultures to be culturally sensitive and maximally effective, the role of acculturation and its impact on therapeutic outcomes must be better understood. Others forward acculturation as a more superior predictor of belief systems, than demographic variables such as race, language, and citizenship (Beals, Beals & Cordova de Sartori, 1999). Recommendations regarding specific instances in which acculturation ascertainment is especially critical involve bilingual clients (Aponte & Johnson, 2000), and culturally heterogeneous psychotherapy groups since acculturation may influence each client's receptiveness to working in a group format (Han & Vasquez, 2000). Using analysis of variance methodology, one study demonstrated that acculturation status was associated with Latino preferences regarding therapist gender and primary language used during therapy sessions (Gamst et al., 2002). Mexican oriented tended to prefer gender matches with therapists and use of Spanish and English during treatment. Anglo-oriented clients were more likely to have a preference for English or indicate that language did not matter.

Data regarding whether and how acculturation status impacts mental health yields mixed conclusions. One group attempted to conduct a meta-analysis exploring directionality of the relationship between acculturation and mental health (Rogler, Cortes & Malgady, 1991). The authors had observed that studies reported positive, negative and curvilinear associations between the variables, defined in widely different capacities. Due to these variations in measurement and statistical methods, researchers were unable to conduct a meta-analysis. However, researchers did note the pattern that acculturation was positively related to drug and alcohol use in the majority of the studies

dealing with this topic. Also, it was recommended that researchers account for gender when examining the relationship between acculturation and mental health.

More recent investigations attempting to elucidate directionality of the associations between acculturation and mental health only underscore the methodological disparity encountered by Rogler et al. Two studies defined acculturation based on language criteria, and both of these studies indicated a positive relationship between acculturation, or English proficiency, and mental health. Using structural equation modeling, Tran, Fitzpatrick, Berg and Wright (1996) examined the direct and indirect effects of demographic variables and acculturation on several domains of stress and psychological distress in over 2,000 elderly Latino Americans. Psychological distress was assessed by questions tapping feelings of restlessness, boredom and depression, as well as being upset as a result of social criticism. After controlling for the effects of age, gender, marital status and ethnicity, language proficiency was related to subjective physical health, financial stress and social stress. Social stress was defined in terms of loneliness and dependency on others. Though a direct relationship between English proficiency and psychological distress did not emerge, an indirect association was established through the model which linked the various forms of stress and subjective health to psychological distress. The directionality of the findings indicates that less acculturated individuals, defined as those with less of a command of the English language and less education, experience greater higher levels of stress and psychological distress, and poorer subjective physical health.

Escalante, del Rincon, & Mulrow (2000) examined the impact of acculturation level and ethnicity on depression and mental health in a population of rheumatoid

arthritis patients. Acculturation was measured with an instrument composed of questions regarding language only. The effects of disease process on depression were controlled by eliminating questions on the depression questionnaire that might be influenced by worsened functioning or increased pain. Using multivariate technique, they found that acculturation status independently influenced depression levels such that higher acculturation levels were associated with decreased depression scores. This relationship remained after controlling for age, education, income, self-rated pain and disease manifestations including joint tenderness, range of motion and joint alignment. Acculturation did not moderate the relationship between ethnicity and an objective measure of mental health; however, the authors concede that a more sensitive and thorough acculturation instrument may detect different relationships among the variables studied.

One study demonstrated that acculturation was not independently related to any of the mental health variables, but did interact with ethnic identity to influence pre-post GAF scores (Gamst et al., 2002). This investigation measured acculturation using the multidimensional created by Cuellar et al. (1995). The authors utilized analysis of covariance methodology to determine whether acculturation status, dichotomized as either Mexican or Anglo oriented, impacted GAF scores at intake and termination, as well as a total cost of treatment, a pre-post comparison of GAF and number of visits each client received. Covariates included client gender, gender match between client and therapist, referral source, diagnosis, marital status, therapist licensure status, and years of therapist experience. The interaction detected indicated that Anglo-oriented clients with low Latino ethnic identity demonstrated decreases in pre-post GAF scores.

This supports the notion that acculturated Latinos may be experiencing poorer mental health outcomes. The authors conjecture that "although findings indicate that they [Latino clients] may not endorse Latino values, attitudes, or behaviors, their therapists may not make these distinctions" (p. 498). Therefore, research must continue to address the issue of acculturation, as this variable may mask effects of culturally sensitive interventions with Latino/a clients if no distinction is made regarding the beliefs and attitudes they bring to therapy.

Since the present study involves a mental health intervention with a population of chronic pain patients, literature surrounding acculturation and physical health is also relevant. Several studies offer findings supporting the idea that acculturation level influences health behaviors and beliefs. Guinn (1998) used correlational analysis and multiple regression models to examine the relationship between acculturation and health locus of control in Mexican American adolescents. Significant associations between the variables were found such that participants categorized as acculturated to Mexicanism were more likely to orient to 'powerful others' in terms of locus of control. This standpoint describes those who believe that health status is controlled primarily by another more powerful being. Those participants categorized as bicultural or American on the acculturation scale were more likely to yield locus of control scores oriented toward internal control, which describes the belief that respondents control their own health. These findings seem to contrast with studies that find negative associations between acculturation and good health. However, the authors are careful to point out that "internalizing one's health beliefs does not ensure reduced susceptibility to negative health behaviors" (p. 497). Another caveat to these findings relates to the adolescent

population of the study. This age group in particular may have difficulty translating health beliefs into actual health behaviors.

In a population of adult women, Borraryo and Jenkins (2003) employed grounded theory technique to examine relationships among acculturation level, health beliefs and use of preventative health services (mammography and breast self-examination). The findings indicated that acculturation did not significantly relate to preventative service utilization but did seem to be associated with more traditional Mexican health beliefs. From this initial data collection, the authors hypothesized the behavior of seeking health services has less to do with acculturation and more to do with specific health beliefs. This lends support to the connection between acculturation and health attitudes found by Guinn in the adolescent population, as well as his caution that researchers not draw direct links from acculturation level to health behaviors.

However, Hulme et al. (2003) offer evidence that acculturation, measured by language preference, does explain some of the variance in health behavior in Latino adults. This group established differences between those who spoke Spanish only, Spanish more than English, or both equally as frequent in how often they performed certain health-promoting behaviors. These behaviors were assessed with an objective instrument measuring health promotion along several domains: nutrition, physical activity, health responsibility, stress management, interpersonal relations and spiritual growth. In each of these health categories, individuals with greater acculturation levels, or those who spoke English with greater frequency, more often performed the health-promoting behaviors. In a hierarchical regression analysis, acculturation level, defined as a continuous score on an objective measure of acculturation, contributed

independently to five percent of the variance in health-promoting behaviors. These findings are relevant in that they may suggest that more acculturated individuals might be more behaviorally invested in a pain management program and its group therapy components. However, the results do not offer insight into how less acculturated individuals might respond to a more culturally sensitive intervention.

Additional research has explored how acculturation and culture impact pain experiences and expression of physical symptoms. Alarcon et al. (1999), attempted to detect differences in high and low-acculturated groups of lupus patients on illness behaviors and attitudes. The authors created a brief measure of acculturation consisting of place of birth, length of time in the U.S., culture of participants' community or neighborhood, language usage and preferences, ethnic identity and social interactions. Each of these components was assessed with a single item question. Level of social support, illness behaviors, attitudes and disease-related helplessness were determined with objective instruments. After categorizing participants into groups of high and low-acculturated individuals, researchers found no differences between groups on illness behaviors and attitudes, or disease-related helplessness. However, low acculturated individuals reported receiving less social support.

A few studies have examined pain descriptions specifically. These studies seem to unanimously find discrepancies in participant experiences of pain based on ethnicity. Lipton and Marbach (1984) conducted a detailed investigation of how pain experiences differ among African, Irish, Italian, Jewish and Puerto-Rican Americans. Level of medical acculturation was assessed along three domains (skepticism about medical care, dependency in illness and health knowledge). Differences among ethnic groups

were detected for each of the domains. Specifically, Puerto Rican patients displayed more dependency in illness and less health knowledge than other groups. These variables were therefore included as covariates, along with variables related to socioeconomic status, familial values, psychological distress, number of medical contacts and pain duration, in the analysis of covariance to determine the effect of ethnicity on pain experience. Pain experience was assessed along several domains: pain descriptions, behavioral and attitudinal responses to pain and medical interventions. Groups differed on certain descriptive items tapping pain intensity and quality. Regarding attitudinal responses, a difference among groups existed on causal attribution such that Italian and African Americans were more likely to blame pain on something they had done. Some differences in emotional expressivity were also detected. For example, Puerto Rican Americans reported being more likely to 'lose control' when discussing their pain with others.

One dissertation concerning culture and pain experience did include acculturation level based on the original Acculturation Rating Scale for Mexican Americans (Cuellar, Harris, & Jasso, 1980) as a variable (Sardas, 1995). This study contrasted pain experiences and behaviors among Mexican, Mexican-American and Anglo-American women experiencing chronic headache pain. Sardas discovered that differences of pain experience and behavior existed according to cultural group, such as pain intensity, affective experience, verbal expression of pain, number of daily activities inhibited by pain, and number of prescriptions for headache pain. Mexican women tended to score higher on these measures, while Mexican American and Anglo American women scored significantly lower. However, Anglo American women scored

higher than the Mexican women on a measure of pain sensation and reported an increased number of body areas in pain. Descriptions of pain experiences varied qualitatively according to cultural group. Mexican women were more likely to qualify their pain as severe, and used a "pulsating" descriptor more often than the other cultural groups, while Anglo-American women described their pain as mild and more often used "pressing, tightening" descriptors to relate their experience. Mexican American women were found to be in the middle of the language spectrum, using "mild" and a combination of the above descriptors to describe pain.

When acculturation status was also considered, no differences were found among the three levels of acculturation on self-rated pain intensity, but similar discrepancies were detected on measures of pain expression, behavior and sensation. Sardas suggests that acculturation status yields a better understanding of pain experience differences attributable to culture. The author explained this increased accuracy with the multidimensional nature of the acculturation scale used, noting that the language preference portion of the scale explained the most variance on pain measures (Sardas, 1995).

Group Therapy

In addition to client variables, practitioners must also consider which treatment formats have shown greatest efficacy for the specific client populations they intend to serve. The literature surrounding treatment of clients with chronic pain and ethnic minority populations seems to converge in support for the group format. The following presents evidence for use of this format with these clients, and provides recommendations regarding enhancement of group process.

Group therapy within the chronic pain population.

Gentry and Owens (1986) presented a rationale for use of group interventions with chronic pain populations. Since this review, some of the proposed reasons have been supported empirically and some have not been studied adequately for verification. Due to the homogeneity of challenges that pain patients experience, the authors suggest that group therapy is the most cost-efficient method of addressing multiple patients. They also state that groups may provide meaningful social support, which is often lacking in patients' lives. Further, the group format allows clients to hear feedback from others who are in chronic pain, a type of feedback that may be perceived as qualitatively different than that offered by therapists or other well persons. Group contexts also provide the therapist with the opportunity of observing clients in a social setting, which may then offer knowledge about the client that would foster progress in individual counseling sessions. Finally, Gentry and Owens contend that in individual counseling, the therapist might assume more responsibility for curing the patient, while in the group context, clients might assume more responsibility for their own improvement. Herman and Baptiste (1990) support this notion by pointing out the power of social modeling in affecting behavior and pain tolerance in this population.

Investigations documenting the efficacy of group interventions for individuals with chronic pain primarily focus on cognitive behavioral approaches, with intervention conditions consisting of multiple components such as relaxation training, psycho education and physical rehabilitation (Keel, Bodoky, Gerhard & Muller, 1998; Kogstad & Hintringer, 1993; Tuner, 1982). These studies compared interventions with a group

psychotherapy component to groups without this component, and/or to a wait-list control group.

The earliest study found that differences between two forms of group intervention, cognitive behavioral therapy and relaxation training, were not detectable until a one-month follow up. At this time point, those in the cognitive behavioral group reported less pain, increased pain tolerance, increased involvement in normal activities and decreased anxiety. At 18 to 24 months follow-up, no differences between the groups existed, though both groups maintained lowered rates of health care use and lower ratings of pain (Tuner, 1982). Another investigation that assessed outcomes at a later follow-up period found that participants in the intervention group had better outcomes on a global outcome measure than control participants (Kogstad & Hintringer, 1993). Results also found that a greater percentage of the intervention group experienced less social withdrawal, greater life satisfaction, fewer family problems and easier contact with others. However, the authors failed to find significant differences on several other objective outcomes including medication use, sleep disturbance, depression, fatigue, and physical activity. Keel et al., (1998) compared a comprehensive cognitive-behavioral program conducted in a group format to the effectiveness of group relaxation training in relieving symptoms associated with fibromyalgia. Literature suggested that patients meet four of six criteria in order to be categorized as having shown improvement. When the authors used this cutoff, the experimental group was not better than the control group. However, when they lessened the criteria to three of six factors, results indicated that the experimental group was superior to the control group.

Collectively, these studies reveal that relaxation training groups and cognitive behavioral groups both improve certain outcomes, and that these treatment gains are maintained at follow-up. Cognitive behavioral groups may have the advantage of improving emotional and social coping skills beyond what relaxation or other control groups offer (Kogstad & Hintringer, 1993), while any additional gains in physical functioning are more limited (Keel et al., 1998). However, the extent to which group psychotherapy in and of itself contributes to psychological well-being remains undetermined as the group intervention was one of several components in these cognitive-behavioral pain programs.

Few studies examine the issue of whether cognitive behavioral therapy administered in a group format confers any treatment advantage over individual sessions with a cognitive behavioral focus. One such study involved participants with chronic upper limb pain (Spence, 1989) while another studied individuals with chronic headache (Johnson & Thorn, 1989). Both trials involved random assignment of participants to individual conditions, a group condition, or a wait-list control group. These studies indicated little difference in outcomes between the individual and group conditions along several dependent measures of pain, as well as self-ratings and objective measures of psychological functioning. However, one difference did emerge at a six month follow-up in Spence's study. Participants in the group condition experienced greater improvement on the Sickness Impact Profile scores completed by significant others. This is consistent with other findings that group cognitive behavior therapy yielded benefits in social functioning relative to control groups (Kogstad & Hintringer, 1993). This lack of many significant differences in outcome between individual versus

group treatment leads researchers and practitioners to favor group treatments due to their relative cost efficacy.

One of the few empirically-based recommendations for therapeutic process offered by the literature was that of considering the use of psychological interventions earlier rather than later in the course of chronic pain treatment (Keel et al., 1998). This suggestion was based on the evidence that those individuals who had improved on measures of physical functioning had experienced pain for a shorter amount of time than those who had not improved. Herman & Baptiste (1990) contend that regardless of theoretical approach, one particular goal must be present for improvement to occur in this population. "A crucial element responsible for behavioral change is change in conceptualization of the pain problem. All group programs, therefore, are aimed at a 'translation' process during which the patient learns to view his problem in a different way" (pp. 214-215).

Clearly, more studies within and beyond the cognitive behavioral approach are needed to clarify how group treatment is best delivered among specific subpopulations. A finding of interest in one study utilizing a group cognitive behavioral format in a heterogeneous pain population was that the treatment impacted the members differentially according to diagnosis (Basler, 1993). Those members with low back pain and tension type headache improved more than individuals with rheumatoid arthritis and ankylosing spondylititis in terms of subjective pain intensity and overall emotional and physical well-being assessed with objective measures.

Other areas that merit further study include decreasing resistance to various forms of psychotherapy among pain patients (Gamsa, Braha & Catchlove, 1985), as

well as exploration of treatment approaches other than cognitive behavioral therapy. One investigation examined a type of Gestalt therapy focused on emotional expression in this population (Corbinshley, Hendrickson, Beutler & Engler, 1990). The study tentatively concluded that pain patients display a more narrow range of affect, express fewer positive emotions, and tend to utilize only passive coping strategies. In comparison, group members who were depressed but had no diagnosable pain disorder were less tentative about verbalizing negative emotions and made more statements that were future-oriented than the pain group. These findings suggest that pain patients tend to make statements during the group process that are qualitatively different than those of non-pain group members. These discussions highlight the uniqueness of group processes that may occur within the chronic pain population which could feasibly serve as obstacles to change in any group format, cognitive behavioral or otherwise.

Given the prevalence of research examining cognitive behavioral groups involving multiple components in the pain management literature, many of the current guides or practitioner handbooks for group interventions recommend cognitive behavioral approaches (Keefe, Beaupre & Gil, 1996; Paleg & Jongsma, 2000). These references offer a wealth of specific topics for didactic components of therapy, but have a paucity of recommendations or discussion of research on how to accommodate the group process to individuals from varying ethnic backgrounds. Undoubtedly this lack of suggestion is based largely on the lack of research in this area since the authors purport to offer empirically based treatments.

Group therapy with Latino/as.

Recent empirical investigation of how psychotherapeutic treatment with Latino clients within a group context fares relative to individual interventions is sparse. However, in a recent review Organista (2000), promotes group interventions as especially helpful to Latino/as, citing the advantage of discussing themes such as interpersonal relationships and stress related to acculturation and discrimination, issues common to many Latino clients. Fenster (1996) contends that the emergence of such problem themes is more likely in a multiethnic group context because this setting more realistically simulates the outside world. Another potential benefit of group therapy with Latino/a clients is that some Latino/as may not possess the language system for mainstream psychotherapy requiring relatively immediate communication of thoughts, emotions and goals (McKinley, 1987). McKinley further points out that a group setting with other Latino/a individuals from similar backgrounds may provide a means for patients to freely self-express without challenging the authority of the therapist, an inappropriate behavior in many Latino cultures.

The proposed advantages are opposed by some contradictory evidence. A recent summary of group therapy literature indicates that the issue of whether the group format confers any outcome advantage over individual treatment in the Latino/a population is undecided (Zane et al., 2004). One study examined a measure of group process, verbal participation, among clients of various ethnic backgrounds (Shen, Sanchez & Huang, 1984). Results indicated that compared to Native Americans and Mexican Americans combined, Anglo patients made more verbal contributions, and constituted a higher percentage of the patients that were verbal during a multi-ethnic

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group. This study presents evidence that ethnic minorities may be less participatory, and presumably receive less benefit from multicultural group therapy than Caucasian clients. However, those involved in assuring competency in multicultural counseling have offered suggestions that may circumvent this problem in multi-ethnic groups.

Despite recent paucity of group process research in this population, recommendations on how to approach group interventions are abundant. Some of these suggestions are based on earlier empirical works (Delgado & Humm-Delgado, 1984), while others derive support from experiential knowledge and literature review (Fenster, 1996; Organista, 2000). Delgado and Humm-Delgado suggest the use of Spanish during group sessions to promote group cohesion, as well as English to foster flexibility in self-expression. Other approaches cited include use of structured activities to promote a present-oriented focus, therapist demonstration of cultural sensitivity, and facilitation of a cooperative versus a confrontational group format (Delgado & Humm-Delgado, 1984). Similarly, Fenster (1996) advises that therapists approach confrontation respectfully by helping members regulate their level of anxiety before exposing them to feedback or information. The use of an 'engagement strategy' involving personalismo, or the presence of trust within relationships, before focusing on the presenting problems of the group might represent one means of resolving members' anxiety before proceeding therapeutically.

Purpose

More recent conclusions along the emic versus etic debate point toward compromise, or an integration of the two stances. Experiential theory represents a therapeutic approach that has not been aligned with a particular culture and is therefore

consistent with an etic approach. Therapeutic use of metaphor is a technique that complements the experiential aims of facilitating change through relationship and increasing client level of experiencing within session. Evidence regarding experiential therapies and use of metaphor has demonstrated success in improving process and outcome variables in mainstream populations.

Disparities among ethnicities regarding mental health service utilization and treatment outcomes still exist, even after demographic factors are considered in statistical analyses. Latino Americans seek mental health services less often, and some evidence raises the possibility that despite functional impairment caused by mental health problems, Mexican Americans may seek help through other avenues, such as medical services. Techniques touted as being more culturally sensitive, such as ethnic matching between client and therapist yield only small effect sizes in improving outcomes. However, initial work evaluating the efficacy of narrative approaches targeted toward use in Latino cultures demonstrate that this technique shows promise when emic factors are also considered. Therefore, a need for continuing research regarding culturally appropriate interventions with Latino Americans still exists. Recommendations for enhancing results with Latino Americans promote a group format utilizing language switching between Spanish and English. Literature surrounding pain management populations also points to group therapy in cognitive behavioral contexts due to its cost efficacy relative to individual therapy.

The goal of the present study is to determine whether use of familiar and relevant Spanish language sayings, or dichos, in a group therapy context improves group climate among multi-ethnic clients experiencing chronic pain. A measure of group

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climate, discussed by some as a measure of group cohesiveness, was chosen as a means of tracking therapeutic bond and attractiveness of the group. According to review studies connecting process variables with outcome, this particular process variable offers the most consistent connections between process and outcome. This process variable will be measured by patient self-report.

Hypotheses

Groups will be randomly designated to receive dichos categorized as high, low or mixed in dichos relevance, as previously determined by a pilot study. It was predicted that Latino/a American clients in the group sessions receiving high relevance dichos would rate their sessions as having a better group climate than sessions in which participants receive dichos rated as being unfamiliar or having little relevance to life in general. Specifically, it is anticipated that clients will rate high-relevance sessions as having greater engagement, and less conflict and avoidance, according to a group climate measure than low-relevance groups. This difference is expected to occur once differences attributed to therapist, gender, ethnicity and acculturation level are considered statistically.

Data concerning acculturation and mental health are discordant regarding directionality of the relationship between the two variables, making empirical prediction of how acculturation will impact group climate difficult. Since the present investigation is targeted toward Mexican Americans, it is anticipated that increased acculturation will be correlated with less favorable ratings of group climate. Clients whose acculturation scores indicate greater orientation to the Anglo culture will be more likely to rate the session as having less cohesion and greater conflict and avoidance.

CHAPTER 2

METHOD

Participants

Participants were recruited from four multidisciplinary pain management clinics

offering open cognitive behavioral, didactic and experiential groups. The pain

management programs were identical 30-day programs in which patients participate in

multiple therapeutic modalities including individual and group psychotherapy,

biofeedback, massage, yoga, Feldenkrais, aquatherapy, hypnotherapy and physical

rehabilitation. All incoming patients received an individualized weekly schedule. All

group members included adults of varying ethnicities who experienced chronic pain for

three months or longer. The three-month duration was a criterion for entrance into the

pain management program; therefore, all participants had experienced chronic pain.

Site of injury was not measured; however, it was expected that this varied among the

participants.

It was anticipated that the sample size of the experimental phase would include

at least 80 participants. The expected sample size was based on a power analysis. This

procedure was performed with a desired power value of .80, significance criteria set at

alpha = .05, four degrees of freedom, representing the number of independent variable

categories, and 120 degrees of freedom for the denominator of the F ratio. This latter

value was selected according to the recommendation by Cohen (1988) that this value

will yield sufficiently accurate sample size values since lambda values (the noncentrality

parameter) based on the degrees of freedom do not significantly vary. A previous study

(Costantino, Malgady & Rogler, 1994) found that a culturally-specific group intervention

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yielded effect sizes of .11 and .09. These values are closest to Cohen's description of a medium effect size (R^2 = .13). Therefore, this value was used for the present calculation. Using Cohen's Table 9.4.2, the noncentrality parameter was determined to be 12.3. This value was then entered into the formula N = lambda (1- R^2) / R^2, yielding a sample size of 82.

<div align="center">Design</div>

Once every six weeks, I randomly selected either five high-relevance or five low-relevance dichos, and provided the sayings to the therapists via email or fax. Therefore, the group leaders were blind as to which relevance category the expressions belonged. I alternated high-relevance dichos with low-relevance dichos. In this way, participants were randomly assigned to a group format. Therapists were requested to wait four to six weeks, or one length of a pain management program, so that participants were involved in only one dichos group session during the length of their program. However, since some clients experience difficulties with attendance due to their pain or related factors, they could remain in the program longer than a typical 30-day program. These clients could then participate in the dichos group more than once. To simplify statistical analyses, only the first administration was considered for data analysis. Groups were conducted over a 15-month period until the desired number of participants was achieved.

Independent variables were to include the group leader or therapist, participant gender, participant level of acculturation, and group format. Gender was dummy-coded with 0 representing females and 1 representing males, and group format was encoded with 0 representing the low relevance group and 1 as the high-relevance group.

Therapist was similarly dummy-coded. Following power analysis, it was decided that participant ethnicity should be included in the analysis. Dependent variables of interest included subscale scores of the Group Climate Questionnaire (Engaged, Avoiding and Conflict).

<div align="center">Materials</div>

The Acculturation Rating Scale for Mexican Americans-II (Cuellar, Arnold & Maldonado, 1995) assesses the extent to which individuals are behaviorally oriented to the Mexican and Anglo cultures. An individual's acculturation score is determined by totaling the scores from the Anglo Orientation and Mexican Orientation Subscales, and then computing an item average for each subscale. The average from the Mexican Orientation Subscale (MOS) is then subtracted from the Anglo Orientation Subscale (AOS) to obtain a single acculturation score. Scale 2 of the ARMSA-II is described as an optional, experimental scale designed to assess degree of marginality through one's attitudes regarding the Anglo, Mexican and Mexican American cultures. This latter scale was not utilized for the present study.

The normative sample for the ARMSA-II included 379 persons of Mexican, Mexican American and White non-Latino ethnicity. The authors report one-week test-retest reliabilities of the AOS and MOS to be .94 and .96, respectively. Split-half reliability for the AOS was .77, while the MOS yielded a correlation of .84. Another study found these reliability coefficients to be .74 for the AOS and .90 for the MOS (Cuellar, Nyberg & Maldonado, 1997). Concurrent validity for the measure was determined by comparing the scores for a subset of the entire normative sample on the original ARMSA and ARMSA-II. The resulting Pearson product moment correlation

coefficient was .89. The reliability and validity of the ARMSA has been reported elsewhere (Cuellar, Harris, & Jasso, 1980). Other investigations indicate concordance with a measure of ethnic identity, the Multigroup Ethnic Identity Measure such that higher acculturation scores are associated with lower scores of ethnic identity (Cuellar, Nyberg & Maldonado, 1997; Gamst et al., 2002). Lessenger (1997) conducted a study that analyzed correlations among the ARSMA-II, Cultural Lifestyle Inventory (CLSI) and the Cultural Identification Scale (CIS). Significant correlations were reported between the ARSMA-II acculturation score and the CLSI subscale measuring cultural shift, as well as the ARSMA-II AOS score and the CIS Anglo-American identification score. However, the ARSMA-II MOS and CIS Mexican American identification scores were not significantly related.

The Group Climate Questionnaire originated to assess aspects of group environments thought to impact interpersonal functioning within the group and consequently, therapeutic gain (MacKenzie, 1983). The version administered in the present study is the 12-item Group Climate Questionnaire-Short Form (MacKenzie, 1983) based upon the original version published previously (MacKenzie, 1981). Group members are asked to rate the extent to which the 12 statements describe the group session on a seven-point Likert-type scale. Factor analysis of the short form revealed three factors designated as Engaged, Avoiding, and Conflict (MacKenzie, 1983). The Engaged scale, thought to tap group cohesion, correlated positively with scores on the Global Positive Index, a measure of therapeutic goal attainment (Braaten, 1989). Another validation study examined each scale's ability to predict members' self-rated amount learned from group sessions (MacKenzie, Dies, Coche, Rutan & Stone, 1987).

The Engaged scale was the strongest predictor of outcome for all sessions assessed. Permission to translate and use the scale was obtained from the author. The translation of the original survey is presented in Appendix A.

<div align="center">Procedure</div>

A pilot study was conducted to ascertain which Spanish-language sayings were most relevant or familiar to those with a Latino/a American cultural heritage. The Spanish and English language proverbs and their corresponding meanings were collected from various sources (Aparicio, 1998; Basset, 1998; Sellers, 1994; Cobos, 1985), and assimilated into a questionnaire requesting individuals to rate the relevance of 40 sayings on a Likert-type scale (Appendix B).

Data for the pilot study was collected from two categories of participants, and all participants were required to sign an informed consent form (Appendix C). Population type was categorized as medical, or those involved in outpatient work hardening or pain management programs; or non-medical, or those recruited from a local church. Mean ratings of familiarity or relevance for all dichos were obtained by requesting participants to rate the dicho on a Likert-type scale, with a rating of 0 representing the anchor *I am not familiar with this saying*, and 5 representative of the belief that the dicho was *highly applicable or relevant to life in general*. The mean ratings of dichos from the medical and non-medical populations were both ranked ordered (Table 1). Dichos were then divided into low-relevance and high-relevance categories. Dichos were categorized as high relevance if the mean rating was greater than or equal to 4.0. Mean scores greater than or equal to 4.0 corresponded to the anchors *applicable or relevant in many situations*, or *highly applicable or relevant to life in general*. Low relevance dichos

included those with a calculated mean rating less than or equal to 2.0. Such a rating

corresponded with the anchors *not applicable or relevant to life at all*, or *I am not

familiar with this saying*.

Dichos were selected for their use in the experimental portion of the study by

meeting the above high-relevance/low relevance-criteria, and were rated in this manner

consistently between the medical and non-medical groups. For example, those dichos

that fell within the high-relevance category in the medical population but did not meet

these criteria within the non-medical population were excluded for use in the study.

Sayings meeting these criterions for both groups were then utilized in the experimental

portion of the study. Appendix D lists the sayings belonging to the high and low-

relevance categories. It was initially planned that for each group, therapists would be

provided with five high-relevance or five low-relevance sayings, so that all dichos

discussed within one session were either high or low-relevance. However, during the

course of the study therapists, blind to the fact that there were differences among the

dichos they were presenting, mixed some of the high and low-relevance sayings within

some of the group sessions. These groups were therefore coded as mixed as the group

members discussed both high and low-relevance sayings within one session.

For the experimental portion, potential participants were provided with an

informed consent form in their language of preference following their group session,

detailing the general rationale and nature of the study (Appendix E). At this time,

patients were able to decline to participate in data collection. Declining participants still

participated in the group session as it was a scheduled part of their regular pain

management program. However, these individuals did not complete the research

questionnaires. Those signing the informed consent form were informed that they could discontinue involvement at any point prior to or during the investigation. Once voluntary permission had been granted, each participant was asked to complete a questionnaire packet including the demographic survey (Appendix F), Group Climate Questionnaire and ARSMA II. None of the data used for the present study was taken from patients' medical charts.

Licensed professional counselors (one per clinic) led all group sessions, and were blind to the study hypotheses. We provided therapists with a written guide for each group session, which included an orientation to the rationale and methods of this experiential group exercise (Appendix G). The group leaders were informed that the experimental purpose was to assess group dynamics in experiential group therapy in multi-ethnic chronic pain populations. They were also asked to complete a brief survey following the group to identify their clinic location and other details about the group (Appendix H).

Group types followed identical formats, with each session concentrating on the introduction and discussion of Spanish-language dichos. The high-relevance group differed from the low-relevance group in that the dichos presented were chosen from the group of dichos rated to be highly relevant by the pilot study population. Dichos presentation was modeled after a culturally-specific group intervention used with Latino/a children (Costantino, Malgady & Rogler, 1994). The activity involved presentation of pictures with cultural elements and characters to groups of children. Group leaders prompted the children to create a story relating to the picture presented as a group. Leaders then summarized themes found within the group's story and invited

the group members to share personal experiences that might be associated with the group's story. In the present study, a dicho was presented in Spanish and English at the outset of each session. Group leaders then prompted members to share visual images that the dicho elicited, and to develop a literal interpretation of the metaphorical saying as a group. Members were also invited to share specific images and memories elicited by the saying, as well as how the literal interpretation of the dicho applies to living with chronic pain and other resulting life stressors.

<div align="center">Statistical Analyses</div>

Data were examined for assumption criteria including mulitcollinearity, normality, linearity and homoscedasticity. The raw scale scores for the Conflict variable were logarithmically transformed due to a positive kurtosis value. Each group session was analyzed independently due to the open nature of the groups. Hierarchical multiple regression analyses was employed to assess the correlations between the independent variables and the GCQ subscale scores. The independent variables were entered in sequential fashion in the following order: gender, ethnicity, acculturation score and group format or dichos familiarity. Data from multiple clinics (Garland, San Antonio and El Paso) were also excluded from analysis due to insufficient sample sizes from these sites. It was also considered that analysis of data from one only clinic location and therefore one therapist would eliminate the possibility of confounding clinic location and group therapist since the two variables could not be balanced. Since dichos familiarity and ethnicity included more than two categories, the effect coding procedure described by Myers and Well (1995) was employed. Gender was dummy coded. Missing values were deleted in a pairwise manner.

CHAPTER 3

RESULTS

Demographic Data

Participants included in the pilot study included 54 Latino/a adults ranging in age from 20 to 70, $M = 37$, $SD = 10.2$. A total of 18 men (33.3 %), 28 women (51.9%) and eight individuals (14.8 %) who did not identify their gender comprised this portion of the study (Table 1). Participants from the outpatient medical facilities comprised 24.1 % (13 people) of the sample, while the non-medical group included 75.9 % (41 individuals) of the sample (Table 2). The majority of the volunteers choose to complete all questionnaires in Spanish (85.2% Spanish; 14.8% English). Table 3 summarizes this population by country of origin.

Participants for the experimental portion of the study self-selected their ethnicity as follows: 21% White, non Latino/a; 43% African American; 23% Latino/a; 0 % Asian American; 4 % Native American; 0 % Middle Eastern; and 0 % Other (Table 4). Of those who selected Latino/a as their ethnicity 18 (64.3%) endorsed they were first generation Americans, 5 (17.9%) endorsed the second generation category; 1 (3.6%) endorsed third generation; and 1 (3.6%) endorsed fifth generation. The majority of Latino/as (82.1 %) chose to complete their questionnaires in Spanish. Mode level of education for all participants was high school level, or completion of grade 9 or higher (Table 5).The age of the participants ranged from 22 to 80 years old $M = 48.4$, $SD = 11.1$, $N = 115$. In total, 44 women (34.1%) and 75 men (58.1%) participated, along with 10 (7.8%) individuals who did not complete a demographic questionnaire (Table 6). Participants were evenly distributed among the group formats (Table 7).

Using the acculturation categories delineated by Cuellar et al., (1995) the distributions of Latino/as and non-Latino/as were examined. Based on the total ARSMA II score, each individual was categorized into one of five levels of acculturative status. The data for Latino/as yielded a positively skewed distribution, with the greatest frequency of participants producing ARSMA II scores within the Very Mexican Oriented category (Figure 1). All levels of acculturation except for Level 5, denoting Very Assimilated/Anglicized were represented within the Latino/a sample. By contrast, the distribution for non-Latino/a individuals was negatively skewed, with Levels 1 and 2, the categories indicating greatest orientation toward Mexican culture, not represented within this sample (Figure 2).

Dichos Pilot Study

Mean ratings and standard deviations for all 30 dichos were computed and are summarized in Table 8. Eight dichos met the 'High Relevance' criteria for both the medical and non-medical groups, and nine sayings fell within the 'Low Relevance' parameters for both populations. These dichos were then utilized for the experimental portion of the study. The selected dichos and their categories are shown in Appendix F.

Data Screening

Prior to regression analysis, the continuous dependent variables (Conflict, Avoidance, and Engagement) were checked for accuracy of data entry and assumptions of multivariate normality. Normality, linearity and homoscedasticity of residuals were examined by evaluation of residual plots. Predicted values of each of the dependent variables were plotted against their residual values. Values of skewness and kurtosis were also assessed. The variable Conflict showed a significantly positive

kurtosis value, and this was evident on the residuals plot. As a result, this variable was logarithmically transformed. In addition, six cases were identified as multivariate outliers according to the Mahalanobis distance value, χ^2 (4, N = 107) = 18.47, p = .001. These cases were excluded from regression analyses.

<div align="center">Hierarchical Regression Analyses</div>

Three hierarchical regression analyses were utilized to determine whether dichos familiarity characterized as low, mixed or highly relevant dichos, contributed to variance in Conflict, Avoidance and Engagement scale scores as rated by group members. Dichos familiarity was the last independent variable entered into the regression equation, with gender, ethnicity (Latino/a, Caucasian, African American or Native American), and ARSMA II score entered in sequential fashion.

Conflict.

Using the transformed Conflict scores, only dichos familiarity significantly contributed to the variance in group conflict. Table 9 displays the multiple correlation statistic R^2, adjusted (R^2), (sr_i^2), and F change statistics for each step of entry. Table 10 summarizes the standardized and unstandardized beta weights. Following the fifth step, or entry of dichos familiarity, to predict member-rated Conflict (log of), adjusted R^2 = .09, F_{inc} (1, 86) = 3.78, p = .03. The semipartial correlation (sr^2 = .07) for this variable indicates that level of dichos relevance accounts for 7 % of the variance in group conflict with the variance from the other variables parceled out. Group members' gender, ethnicity and ARSMA II scores did not add significantly to the amount of variance in Conflict. Since effect coding was employed for dichos familiarity, two beta coefficients resulted.

The standardized coefficient denoted F2 refers to the difference between the means for the low-relevance group compared to the mean for all groups (high, low and mixed-relevance), β= .31, F = 6.77, p = .01. The positive beta weight indicates that that mean Conflict scores for the low-relevance group were greater than all groups combined. The other beta coefficient generated (F1) was not significant, indicating that mean Conflict scores for the high-relevance group did not differ from the mean score for all groups combined, β= -.09, F = 0.54, p = .46. The third beta coefficient representing the difference between the mean Conflict scores of the mixed-relevance groups and all groups combined was computed by adding the first two beta coefficients and then subtracting the sum of these coefficients from zero. This approach was utilized because the effect coding technique yields only two beta weights, or the number of categories minus one. The third beta coefficient could be determined since the sum of all beta weights for an effect-coded variable equals zero (Table 10).

Post-hoc analysis of variance was employed to determine the nature of the differences in conflict among the three dichos groups. The low-relevance groups (M = 0.58) rated group conflict higher than the mixed-relevance groups (M = 0.45), F (2, 97) = 3.83, p = .03. Table 11 summarizes the descriptive statistics and significant differences by dichos familiarity for all dependent variables. There was no significant difference in Conflict scores between the high and low-relevance groups.

Avoiding.

Using the raw Avoiding scores as the dependent variable, one significant predictor was determined in regression analysis (Table 11). Consistent with findings for Conflict, dichos familiarity significantly predicted Avoiding scores, adjusted R^2 = .05, F_{inc}

(1, 85) = 3.21, p = .05. The semipartial correlation (sr^2 = .07) for therapist indicates that this variable independently contributes to 7 % of the variance in member-rated Avoiding. Group members' gender, ethnicity and ARSMA II scores did not add significantly to the amount of variance in Avoiding.

The standardized coefficient denoted F1 refers to the difference between the means for the high-relevance group compared to the mean for all groups (high, low and mixed-relevance), β= -.31, F = 5.77, p = .02 (Table 12). The negative beta weight indicates that that mean Avoiding scores for the high-relevance group were less than all groups combined. The other beta coefficient generated (F2) was not significant, indicating that mean Avoiding scores for the low-relevance group did not differ from the mean score for all groups combined, β= .09, F = 0.48, p = .49. The final beta weight for the mixed-relevance group is noted in Table 12.

Post-hoc analysis indicated that the mixed-relevance groups (M = 17.43) rated group avoidance as significantly higher than the high-relevance groups (M = 15.59), F (2, 96) = 3.03, p = .05). As with Conflict scores, significant differences did not exist between the high and low-relevance groups (Table 11).

Engaged.

In the final regression analysis, gender predicted member-rated engagement, adjusted R^2 = .06, F_{inc} (1, 86) = 6.04, p = .02. Semipartial correlations indicate that gender explains 6.0 % of the variance in group engagement (sr^2= .06). Post-hoc analysis of variance indicated that females (M = 26.5) rated group Engagement higher than males (M = 23.7), F (1, 103) = 8.84, p = .004 (Table 13).

Neither participant ethnicity nor acculturation level added to predictive variance in the model. However, dichos familiarity again contributed to prediction of Engaged scores after accounting for the variance added by the other predictors, adjusted $R^2 =$ .24, F_{inc} (1, 86) = 11.64, $p < .001$. Of all predictors, dichos familiarity accounted for the largest percentage of variance ($sr^2 = .19$, or 19 %) in the model. The standardized coefficient denoted F1 refers to the difference between the Engaged means for the high-relevance group compared to the mean for all groups (high, low and mixed-relevance), $\beta = -0.42$, $F = 13.50$, $p < .001$ (Table 14). The negative beta weight indicates that that mean Engaged scores for the high-relevance group were significantly less than all groups combined. The other beta coefficient generated (F2) was not significant, indicating that mean Engaged scores for the low-relevance group did not differ from the mean score for all groups combined, $\beta = -0.06$, $F = 0.25$, $p = .62$. The beta weight for the mixed-relevance groups was calculated as described above (Table 14).

Post-hoc analysis of variance indicated that the mixed relevance groups ($M = 27.35$) rated group engagement higher than the high-relevance groups ($M = 22.36$), as well as the low-relevance groups ($M = 24.12$), F (2, 97) = 11.56, $p < .001$. There was no difference between the high and low-relevance groups (Table 11).

Additional analyses.

Among participants of all ethnicities, one-tailed correlational analysis among the dependent variables revealed a significant and positive relationship between the Avoidance and Engaged scales, $r = .39$, $p < .001$ (Table 16). Avoidance was also related to conflict in a positive manner ($r = .27$, $p = .003$). The Conflict and Engagement scales were unrelated ($r = .-08$, $p = .22$.). When patterns among the dependent variables were

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examined for Latino/as alone, only one significant relationship emerged. Avoidance and

Engaged scale scores were positively associated, $r = .47$, $p = .02$. Conflict and

Avoidance were unrelated in this population (Table 17). Table 18 summarizes the

associations among the GCQ scores for non-Latino's only.

CHAPTER 4

DISCUSSION

It was predicted that Latino/a American clients in the group sessions receiving high- relevance dichos would rate their sessions as having a group climate with less conflict and avoidance, and greater engagement than sessions in which participants received dichos rated as being unfamiliar or having little relevance to life in general. This difference was expected to occur once differences attributed to gender, ethnicity and acculturation level were considered statistically.

Conflict

Conflict was described by MacKenzie (1983) as an element of group climate that while generally not desired by group members, may be necessary for change. He argued that this aspect of group culture "forces members to further self-disclosure so that differences can be explored" (p. 166). Consistent with predictions, category of dichos familiarity predicted Conflict scores. Sessions in which only high-relevance dichos were presented did not stand apart from mean Conflict scores of all groups combined, and this was not supportive of the hypothesis. However, the low-relevance group was significantly higher in Conflict scores than all groups combined, and this was consistent with predictions. Post-hoc comparisons afforded further detail, indicating that the low-relevance group yielded higher scores in comparison with the mixed-relevance group. This suggests that mixing high and low-relevance dichos within a session results in diminished conflict, while presenting only low-relevance sayings yields greater conflict. Items loading on the Conflict scale indicate that low conflict sessions involve less friction, anger and distrust among group members than high conflict sessions.

Though a significant predictor, dichos familiarity did leave 93% of the variance in group conflict unexplained. It seems that contextual or individual factors present within a single session do not wholly account for Conflict scores. The group's process over time may provide additional predictive power to the model. Contextual or individual variables in one session may in fact predict levels of conflict in subsequent sessions. MacKenzie postulates that the relationship between group conflict and time is not linear in nature (1983). In describing the course of conflict during one of his ongoing groups, he notes that Conflict scores remain low until the tenth session. In subsequent sessions, Conflict scores returned to baseline levels. Therefore, it is noteworthy that the present data capture group climate at only one point in time.

Another possibility for the small effect of dichos familiarity on conflict is the presence of interpersonal interactions among the group members outside of the group. As described earlier, the participants engage in multiple therapeutic modalities over the course of the 30-day treatment program. Therefore, group conflict may also be explained by events or conversations that occur outside of the dichos groups. The nature of the treatment programs prevented isolation among group members before and after sessions. Therefore, prediction of group climate within this population is likely a complex undertaking. MacKenzie (1893) hypothesized that extreme behavior by one group member may skew ratings. In the present sample, extreme behavior at any point in the therapy day, rather than only within the group session, could potentially skew data.

Avoiding

MacKenzie's (1983) factor analytic results suggest this scale encompasses avoidance of intrapersonal problems and change, as well as avoidance of interpersonal interactions with other group members. In addition, high avoidance scores may represent a group member's belief that all members complied with group norms and strongly depended on the group leader for direction. In the present study, only dichos familiarity predicted avoidance scores.   Examination of the beta weights indicates that participants in the high-relevance groups tended to rate the group sessions as lower in avoiding behaviors when compared to mean Avoiding scores for all dichos categories. This finding was in accordance with predictions. However, post-hoc comparisons show that the differences lay between the high and mixed-relevance groups, with the high-relevance groups yielding less conflict. The lack of difference between the high and low-relevance groups was inconsistent with predictions. As with the dependent variable of conflict, dichos familiarity explained only 7% of the variance in avoidance. The same extra-therapeutic variables that occur outside of the actual session but within the context of the pain management program are likely important factors with this outcome variable as well.

The additional correlational analysis among the dependent variables did indicate a positive relationship between the Avoiding and Engaged scales, which may help account for the ability of dichos familiarity to predict Avoiding scores in the present study. Interestingly, the association between Avoiding and Engaged is similar in strength to that of MacKenzie's (1983) study; however the positive direction is in opposition to his validation study. In the present study, as group avoidance behaviors

increased, engagement also increased. It is possible that within the present study's sample, group members felt that behaviors such as depending on the leader for direction and following unspoken group norms were positive attributes of group climate. Therefore, they may have rated these items avoidance items highly while having an overall positive impression of the group.

The structure of the pain management program and/or exposure to other group formats (e.g. didactic groups) may foster dependence on group leaders and following group expectations. Reports of group members' attendance and participation may be relayed back to third-party insurers, and program participants are usually aware of this. Multi-ethnic groups consisting Latino/a Americans may also be more prone to group members failing to assert their own influence on the direction of the group (McKinley, 1987). Despite the presence of these factors, high-relevance groups yielded less avoidance behaviors. The present results are thus supportive of high-familiarity items being utilized to perhaps moderate the overall climate of pain management as well as cultural influences on avoidance behaviors.

<center>Engaged</center>

MacKenzie's Engaged scale is, of the three scales, most related to goal attainment, and learning and predicting outcome (MacKenzie, Dies, Coche, Rutan & Stone, 1987; Braaten, 1989). It is proposed to include cohesion among group members, a group climate conducive to work and change, as well as attribution of cognitive behaviors that signal work to other group members (MacKenzie, 1983). In the present study, participant gender, and category of dichos familiarity were predictors of Engaged scores.

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Females rated level of engagement more highly than men. The design of the present study prohibits the attribution of this difference to the use of dichos. It is possible that females would rate groups of all formats, including didactic or other types of process groups, as involving a greater level of engagement than males. Comparison of these group formats with dichos groups would be required to determine whether group format impacts perceived engagement according to gender.

Finally, as predicted, level of dichos familiarity was a predictor of participant-rated group engagement. Interestingly, this variable predicted the highest amount of variance (19 %) in engagement when covariances from all other variables were parceled out. In contrast to the hypothesis, the groups presented with highly-relevant dichos rated the sessions as having significantly less engagement than all sessions (high, low and mixed-relevance) combined. Post hoc analysis revealed that the significant difference lay between the high and mixed-relevance groups, with mixed relevance groups rating engagement more highly. It was anticipated that the high-relevance groups would yield the highest Engaged scores. This is consistent with the findings for level of avoidance, in that it was also the mixed-relevance groups that yielded the highest scores on this measure.

These data support the notion that within multi-ethnic groups, presentation of metaphors both high and low in familiarity to one of the ethnic groups may benefit the group climate as a whole. The present evidence suggests that utilizing metaphors that are highly relevant to one ethnic group may be alienating to other ethnic groups, thereby decreasing overall group cohesion or engagement. Inclusion of some low-relevance dichos may have allowed non-Latino/a individuals to help interpret or attribute meaning

to the sayings, rather than relying solely on Latino/as to disclose a figurative meaning. The mixed-relevance groups may thus have afforded a greater collaborative effort among the ethnic groups to create meaning from the sayings, thereby increasing engagement of all group members, regardless of ethnicity.

The mixed-relevance category was created as an add-on to the original study design. Rather than utilizing the dichos provided, it was discovered that some therapists, after several months of involvement with the study, had mixed high and low-relevance dichos without awareness that there was a qualitative difference between them. Therapist rationale for this may have involved self-selection of those sayings that had produced greater participation in past groups. Thus, experience with numerous dichos may have provided the therapists with knowledge about which sayings yielded the most engagement or participation. Alternatively, since these sayings were therapist-selected, they may have represented the therapists' biases about which sayings were most relevant to the population or pain management program. The therapists themselves may have found particular dichos to have more meaning or relevance for their groups, and it is possible that the presentation of these therapist-selected sayings differed in some way than the researcher-selected sayings.

Regardless of the explanation, the amount of variance in engagement explained by the familiarity variable alone provides intriguing results for clinicians. As recommended by Fenster (1996) the data support the use of both high and low-relevance dichos as an 'engagement strategy,' or a means of promoting trust and relieving some anxiety among group members. Clinicians may be wary of promoting both engagement and avoidance behaviors simultaneously. However, the data equip

the clinician with the understanding that level of dichos familiarity explains more variance in engagement (19%) than avoidance behaviors (7 %) in multi-ethnic pain management populations. Busy clinicians may not have the manpower to devote to a pilot study to determine which dichos are most relevant to Latino/a Americans in their area. The present data suggest that a combination of low and high-relevance dichos is most desirable in terms of group cohesion, or engagement. Thus, for clinical use, a pilot study may be unwarranted assuming that a clinician's sources of metaphors afford a collection of both categories. Further, it is possible that experiential expertise with the sayings is more important to achieve an impact on group engagement.

Additional Findings

In MacKenzie's (1983) correlational analyses among the three scales, the Engaged and Conflict scales were not associated, which is consistent with the present study. This suggests that there are some sessions in which the two constructs coexist and some in which they do not. There may be groups in which members are both engaged and experiencing interpersonal conflict, and some in which they are engaged without the experience of tension. MacKenzie also notes that the associations among the scales change over time, with early groups tending to have a negative correlation between Engaged and Conflict, and subsequent groups with a positive relationship between the two scales.

Unlike MacKenzie's sample, a positive correlation between the Avoiding and Engaged scales emerged. A possible explanation for this positive association between is that the dichos group itself fostered intrapersonal avoidance behavior, dependence on the group leader, avoidance of intrapersonal problems and behaviors acceptable to

the group. Though more structured group activities may be recommended (Delgado & Humm-Delgado, 1984) for Latino/a clients, it may be that this approach engages the client simply for the sake of involving the group members in the activity, rather than encouraging group members to assume responsibility for working therapeutically. It is possible that in focusing on the activity, the group members become less aware or interactive with one another. Another possibility for this seemingly discordant finding is that some of the Avoiding items may actually correlate more highly with the engagement construct in the pain management population.

Level of Acculturation

Contrary to hypotheses, level of acculturation did not predict ratings of group climate. However, it should be noted that the Group Climate Questionnaire requests participants to rate the behavior of the group as a whole, rather than just their own thoughts and behaviors associated with the group. Therefore, effects of participant ethnicity and/or acculturation on their own reactions to the group may not be best captured by this questionnaire. It is also noteworthy that descriptive findings indicated that there were disparate distributions of acculturation level between the Latino/a and non-Latino/a groups. Any effect of acculturation level may have been masked by combining all ethnic groups rather than examining acculturative influence on Latino/a Americans alone. However, given that there was no also effect of ethnicity on any of the climate scales this scenario seems to have little support.

Group Therapy with Latino/as

The therapist guidelines for the dichos groups incorporated several recommendations promoted in the group literature. The multi-ethnic format paralleled

the reality of the outside world (Fenster, 1996). Therefore, the previous finding that Mexican Americans tend to be less verbally participatory in multi-ethnic groups was a potentially relevant challenge in this study (Shen, Sanchez & Huang, 1984). Indeed, the post-hoc result that engagement and avoidance behaviors were positively correlated may reflect that this tendency held true.

It is also feasible that the dichos format allowed participants to self-express without directly challenging the therapist, as McKinley (1987) suggested. Two of the four items loading on the Avoiding scale may have tapped not only avoidance of intrapersonal problems and interpersonal interactions, but also challenging the authority of the group leader. These items ask the participants to rate the extent to which "the members depended on the group leader(s) for direction," and "the members appeared to do things the way they thought would be acceptable to the group." Given the considerable proportion of the sample that was Latino/a, the positive correlation between Avoiding scores and Engaged scores may reflect this culture's negative perception of challenge to authority. The dichos format may thus have provided a means for participants to be engaged in the activity while preserving cultural values. To be more certain of this a measure of individuals' own cognitive and behavioral responses to the group format would be required.

Results further indicated that Engaged and Conflict scores were unrelated for the present sample. MacKenzie (1983) contends that rising Conflict scores are indicative of progress over time within an ongoing group. However, in the present chronic pain management setting, groups were open and not ongoing. Fenster (1996) advised that therapists help group members regulate their level of anxiety before exposing them to

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confrontation or feedback. The use of an engagement strategy to foster trust and manage anxiety was recommended before focusing on the presenting problems of the group. Present findings indicate that using mixed-relevance dichos does improve group engagement, but has less predictive power in the existence of conflict. One possibility is that the dichos format would work better in an ongoing group. It may be that this strategy, used alone, is not sufficient to promote therapeutic gain via conflict or confrontation. A group leader might use the strategy as an introduction to an going group to promote trust, and show respect and interest in Latino/a culture. This format might then be followed with more traditional cognitive behavioral or experiential group strategies. Another possibility is that the presence of group conflict is not a necessary condition for therapeutic gain with Latino/a and/or pain management clients. Additional studies involving ongoing groups, and relations between Conflict scores and outcome measures are necessary to answer these questions. Further characterization of the relationships among engagement, conflict and participant anxiety level would also aide in answering these questions.

<center>Relation of Results to Chronic Pain Literature</center>

Presentation of dichos within a group context is consistent with advocation of group versus individual therapy (Gentry and Owens, 1986; Herman and Baptiste, 1990). Though several studies explore the relationship between cognitive behavioral group therapy and psychological and physical outcomes, only one study examined a Gestalt approach (Corbinshley, Hendrickson, Beutler & Engler, 1990). No studies exploring the efficacy of experiential group techniques were found, though Corbinshley et al. elucidated group processes within the chronic pain population that are potentially

<center>69</center>

applicable to several group formats or orientations. The present study adapted use of

metaphor to the aims of experiential therapy, thus providing the chronic pain literature

with information about group processes that vary from cognitive behavioral approaches.

Exploring how this experiential technique impacted group climate was an initial step in

exploring its efficacy within the chronic pain population. The present study is also

among the first to empirically examine how a particular group technique influences

multi-ethnic chronic pain groups, a topic that, given the reality of both demographic

trends and ethnic disparities in mental health service utilization, is deficient in current

literature. Future studies must examine how an experiential orientation relates to

measures of physical and psychological outcome.

<p style="text-align:center">Relationship to Goals of Experiential Therapy</p>

The goals of experiential therapy generally involve deepening a client's level of

experiencing with the intent of facilitating meaning-making of various aspects of the self,

so that a different and more complete view of the self may transpire (Greenberg and

Van Balen, 1998). This change, however, is described as more than cognitive in nature

in that it not only changes they the way a client views internal and external events, but

also manifests as a different way of being, experiencing and behaving (Hendricks,

2002). The finding that level of dichos familiarity impacted group engagement supports

the proposition that this group experiential group process met the aim of increasing

participants' level of experiencing. That the effect occurred even when participant

ethnicity and acculturation level were considered provides more convincing evidence

that finding a means of deepening level of experiencing promotes group engagement.

The engagement construct includes group cohesion, interpersonal and intrapersonal

<p style="text-align:center">70</p>

learning, and self-disclosure (MacKenzie, 1983), processes that are consistent with the experiential goal of facilitating a changed, more coherent view of the self. Engagement and experiencing may be related but different constructs, and future research may address this. However, a previous investigation involving use of metaphors and guided imagery yielded results suggestive that the positive effects of the approach may have been attributable to greater self-experiencing (Esplen, M.J, Gallop, R., & Garfinkel, P.E., 1999).

The vehicle used to facilitate deeper experiencing in this study was therapeutic use of metaphor. The rationale for this involved the capacity of metaphors to allow participants to map one life experience onto another. In this context, group members were encouraged to integrate the meaning of living with chronic pain with the experiences surrounding the familiar sayings. The findings are also concordant with Greenberg and Van Balen's (1998) assertion that self-actualization, or a new view of the self facilitated by greater experiencing, materializes more fully through interpersonal dialogue.

Limitations of the Present Study

The unanticipated combination of low and high-relevance dichos within a session leaves rationale for the effect of mixed-relevance groups on avoidance and engagement unclear. As discussed, the effect may be attributed to the combination of low and high relevance dichos. Alternatively, the effect may be due to the differing selection procedure or in how the therapist presented these self-selected metaphors. For example, since the mixed sayings were therapist-selected, there may have been a difference in therapist affect that promoted greater group engagement.

The measure of acculturation utilized placed individuals on a continuum between Mexican and Anglo-oriented, which may have misrepresented the African American participants that were a significant portion of the sample. Normative data for the ARSMA II included Mexican Americans and Caucasian non-Latino individuals in South Texas. A scale incorporating a third dimension for African Americans simultaneously with the other ethnicities is nonexistent.

Attributes of the client population and group also deserve attention. The groups were conducted by a licensed professional counselor in cooperation with a translator. This was consistent across all groups; however the present results may not be generalizable to groups conducted by a bilingual therapist since accuracy in translation and interruption of group process must be considered when a non-therapist translator is also involved. Further, medication usage was not assessed in the present study. As all clients met chronic pain criteria, it was assumed that most patients were taking one or more pain relief medications and that this was randomized across groups. However, the extent to which dosage and number of medications impacted group climate ratings is unknown, and is a recommended variable for future research in this population.

Suggestions for Future Research

Future investigations pertaining to effect of metaphors on group climate should consider the impact of this approach on closed, ongoing groups. The present data, due to the open nature of the pain management programs capture a 'snapshot' of how this approach influences climate within a single session. The relevance of this approach with other outpatient medical populations would also further research concerning therapeutic use of metaphor.

Factor analytic studies should also be considered. Due to inadequate sample size for Latino/as only, the present study could not evaluate whether the factor structure of the translated scale was consistent with MacKenzie's original scale. Exploration of the structure of the Spanish version, as well as the scale structure within the chronic pain population may provide insight as to why there were disparate relationships among the scales when compared with MacKenzie's original sample.

A measure of participant anxiety, along with surveys more specific to participants' intrapersonal responses to the group exercise would assist clinicians in understanding how the dichos activity impacts personal engagement in the group. The Group Climate Questionnaire primarily asks participants about how they think the group as a whole responds and behaves. Thus, supplemental questionnaires would likely afford more understanding about responses on an intrapersonal level.

Finally, as research involving therapeutic use of metaphor in groups progresses, the impact of how this approach impacts outcome variables should be incorporated. The present study explored how the use of metaphors influences an important process variable, group engagement or cohesion. Though correlated with outcome in other studies (Braaten, 1989; Graphorn et al, 2002; Kivlighan & Lilly, 1997; van Andel, et al., 2003; and Wright and Duncan, 1986), investigation of the efficacy of group cohesion or engagement in predicting outcome should be extended to the chronic pain population. Studies may also address whether this process variable differentially affects outcome for Latino/a Americans.

Table 1

Description of Pilot Study Sample by Gender

Gender	*n*	%
Female	28	51.9
Male	18	33.3
Total	46	85.2
Missing	8	14.8
Total	54	100.0

Table 2

Description of Pilot Study Sample by Recruitment Population

Group	*n*	%
Non-medical	41	75.9
Medical	13	24.1
Total	54	100.0

Table 3

Description of Pilot Study Sample by Country of Origin

Country	n	%
Mexico	38	70.4
Columbia	2	3.7
Native American	1	1.9
Other	1	1.9
U.S.	2	3.7
El Salvador	1	1.9
Total	45	83.3
Missing	9	16.7
Total	54	100.0

Table 4

Description of Dichos Group Sample by Ethnicity

Ethnicity	n	%
Latino/a	30	23.3
African American	56	43.4
White/non-Latino/a	27	20.9
Native American	5	3.9
Total	118	91.5
Missing	11	8.5
Total	129	100.0

Table 5

Description of Dichos Group Sample by Education Level

Level of Education	n	%
Elementary through 6th grade	12	9.3
Grades 7-8	18	14.0
Grades 9-12	54	41.9
1-2 years of college	26	20.2
3-4 years of college	7	5.4
College graduate or more	1	0.8
	118	91.5
Missing	11	8.5
Total	129	100.0

Table 6

Description of Dichos Group Sample by Gender

Gender	n	%
Female	44	34.1
Male	75	58.1
Total	119	92.2
Missing	10	7.8
Total	129	100.0

Table 7

Description of Dichos Group Sample by Level of Dichos Familiarity

Category of Relevance/ Familiarity	*n*	%
High	43	33.3
Low	43	33.3
Mixed	40	31.0
Total	126	97.7
Missing	3	2.3
Total	129	100.0

Table 8

Pilot Study Results: Latino/a Mean Relevance Ratings for Dichos

Item Number	Medical and Non-medical Groups			Medical Group Only		
	n	*M*	*SD*	*n*	*M*	*SD*
23*	53	4.68	0.94	13	4.77	0.83
34*	54	4.59	1.06	13	4.46	1.33
14*	54	4.50	1.16	13	4.38	1.56
33*	54	4.48	1.15	13	4.54	0.97
24*	53	4.38	1.404	13	4.54	1.39
35*	51	4.22	1.514	11	4.73	0.91
9*	52	4.02	1.674	12	4.33	1.61
22*	54	4.00	1.660	13	4.62	1.39
6	53	3.96	1.732	13	3.92	2.06
28	51	3.94	1.630	12	3.75	1.91
38	53	3.77	1.794	12	3.42	2.15
15	51	3.69	1.816	12	3.58	2.02
39	53	3.49	2.063	13	3.54	2.15
20	53	3.25	2.018	13	3.31	2.21
11	53	3.25	2.147	13	3.46	2.18
36	54	3.22	2.098	13	3.23	2.32
37	52	3.15	2.191	13	3.92	2.06
21	52	3.13	1.981	13	2.85	2.15
19	53	2.91	2.022	12	2.58	2.02
29	53	2.58	2.107	13	3.54	1.94
30	53	2.40	2.124	13	2.08	2.10
5	52	2.33	2.017	13	2.54	2.22
16	53	2.26	2.123	12	2.50	2.15
1	48	2.06	2.168	12	2.33	2.50
2	47	2.02	1.961	12	3.00	2.13
26	53	2.02	1.995	13	2.15	2.08
25	51	2.00	2.020	12	2.08	2.11
27	52	1.96	2.019	13	2.92	2.06
31*	52	1.87	1.910	13	1.92	2.06
32	52	1.83	1.968	13	2.46	2.03
17*	52	1.79	1.964	13	1.54	1.98
13*	52	1.75	1.939	13	1.31	1.89
12	52	1.75	2.009	13	2.00	2.12
4	49	1.73	1.857	13	2.08	1.94

(table continues)

Table 8 *(continued).*

Item Number	Medical and Non-medical Groups			Medical Group Only		
	n	*M*	*SD*	*n*	*M*	*SD*
8*	51	1.59	1.910	12	0.92	1.51
7*	52	1.56	1.955	13	1.00	1.87
40*	51	1.47	1.901	13	1.69	2.06
10*	52	1.27	1.805	13	1.38	1.98
18*	53	1.19	1.798	13	1.85	2.08
3*	48	0.87	1.525	12	0.83	1.53

Note. * represents items used in the experimental portion of the study.

Table 9

Hierarchical Regression Analysis for Group Member-Rated Conflict (N = 98)

Variable	R	R^2	Adjusted R^2	sr^2	F_{inc}	p
Gender	.07	.00	-.01	.00	0.39	.53
Ethnicity	.29	.09	.04	.08	2.62	.06
Acculturation Level	.30	.09	.04	.00	0.21	.65
Dichos Familiarity	.40	.16	.09	.07	3.78	.03

Table 10

Regression Coefficients for Variables Predicting Conflict Scores.

Variable		B	β	F	p
Gender		0.01	.02	0.05	.83
Ethnicity					
	R1	-0.05	-.10	0.13	.72
	R2	0.10	.24	1.96	.17
	R3	0.17	.34	3.62	.06
Acculturation Level		-0.01	-.09	0.08	.78
Dichos Familiarity					
	F1	-0.03	-.09	0.54	.46
	F2	0.08	.31	6.77	.01*
	F3	-0.06			

Note. R1 denotes the coefficient generated by the comparison of mean Latino Americans ratings to the mean ratings of all ethnic groups combined. R2 denotes the coefficient generated by the comparison of mean African Americans ratings to the mean ratings of all ethnicities combined. R3 denotes the coefficient generated by the comparison of mean Caucasian ratings to the mean ratings of all ethnicities combined. F1 represents the mean ratings of high-relevance groups to all groups combined, while F2 represents the mean ratings of low-relevance groups to all groups combined. F3 represents the mean ratings of mixed-relevance groups to all groups combined.
*$p < .05$.

Table 11

Descriptive Statistics for Group Climate Outcomes by Dichos Familiarity

Group Climate Scale	Dichos Level of Familiarity	*M*	*SD*	*N*
Conflict (log of)				
	High	.46	.24	28
	Low	.58$_a$	.20	33
	Mixed	.45$_b$	.20	37
Avoiding				
	High	15.59$_a$	2.58	27
	Low	16.73	2.75	33
	Mixed	17.43$_b$	3.36	37
Engaged				
	High	22.36$_a$	5.19	28
	Low	24.12$_a$	4.70	33
	Mixed	27.35$_b$	2.90	37

Note. Means with different subscripts for a particular subscale differ at p<.05 in the Tukey honestly significant difference comparison.

Table 12

Hierarchical Regression Analysis for Group Member-Rated Avoidance (N = 97)

Variable	R	R^2	Adjusted R^2	sr^2	F_{inc}	p
Gender	.00	.00	-.01	.00	0.00	.99
Ethnicity	.22	.05	.01	.05	1.53	.21
Acculturation Level	.23	.05	.00	.00	0.11	.74
Dichos Familiarity	.34	.12	.05	.07	3.21	.05

Table 13

Regression Coefficients for Variables Predicting Avoiding Scores.

Variable		B	β	F	p
Gender		0.06	.01	0.01	.93
Ethnicity					
	R1	2.77	.40	2.09	.15
	R2	0.70	.12	0.46	.50
	R3	0.65	.10	0.28	.60
Acculturation Level		0.20	.14	0.16	.69
Dichos Familiarity					
	F1	-1.14	-.31	5.77	.02*
	F2	0.31	.09	0.48	.49
	F3	0.83			

Note. R1 denotes the coefficient generated by the comparison of mean Latino Americans ratings to the mean ratings of all ethnic groups combined. R2 denotes the coefficient generated by the comparison of mean African Americans ratings to the mean ratings of all ethnicities combined. R3 denotes the coefficient generated by the comparison of mean Caucasian ratings to the mean ratings of all ethnicities combined. F1 represents the mean ratings of high-relevance groups to all groups combined, while F2 represents the mean ratings of low-relevance groups to all groups combined. F3 represents the mean ratings of mixed-relevance groups to all groups combined.
*$p < .05$.

Table 14

Hierarchical Regression Analysis for Group Member-Rated Engagement (N = 98)

Variable	R	R^2	Adjusted R^2	sr^2	F_{inc}	p
Gender	.25	.06	.05	.06	6.04	.02
Ethnicity	.32	.10	.06	.04	1.35	.27
Acculturation Level	.32	.10	.05	.00	0.20	.67
Dichos Familiarity	.54	.30	.24	.19	11.64	.00

Table 15

Regression Coefficients for Variables Predicting Engaged Scores.

Variable		B	β	F	p
Gender		-1.81	-.19	3.76	.06
Ethnicity					
	R1	3.06	.28	1.32	.25
	R2	2.60	.29	3.23	.08
	R3	0.58	.06	0.12	.74
Acculturation Level		0.34	.15	0.24	.63
Dichos Familiarity					
	F1	-2.41	-.42	13.50	.00[*]
	F2	-0.31	.06	0.25	.62
	F3	2.72			

Note. R1 denotes the coefficient generated by the comparison of mean Latino Americans ratings to the mean ratings of all ethnic groups combined. R2 denotes the coefficient generated by the comparison of mean African Americans ratings to the mean ratings of all ethnicities combined. R3 denotes the coefficient generated by the comparison of mean Caucasian ratings to the mean ratings of all ethnicities combined. F1 represents the mean ratings of high-relevance groups to all groups combined, while F2 represents the mean ratings of low-relevance groups to all groups combined. F3 represents the mean ratings of mixed-relevance groups to all groups combined.
[*]$p < .05$.

Table 16

Post-hoc Correlations Among Group Climate Questionnaire Scales for All Ethnicities

Scale	Conflict	Avoiding	Engaged
Conflict	1.0	$.27^{a*}$	$-.08^{b}$
Avoiding		1.0	$.39^{a*}$
Engaged			1.0

[a] $n = 97$. [b] $n = 98$.
[*] $p \leq .01$

Table 17

Post-hoc Correlations Among Group Climate Questionnaire Scales for Latino/as Only

Scale	Conflict	Avoiding	Engaged
Conflict	1.0	.12	-.16
Avoiding		1.0	$.47^{*}$
Engaged			1.0

$n = 21$
[*] $p \leq .05$

Table 18

Post-hoc Correlations Among Group Climate Questionnaire Scales for non-Latino/as

Scale	Conflict	Avoiding	Engaged
Conflict	1.0	$.35^{a*}$	$-.10^{b}$
Avoiding		1.0	$.40^{a*}$
Engaged			1.0

[a] $n = 75$. [b] $n = 76$.
[*] $p \leq .01$

Figure 1. Distribution of Latino/as by acculturation level.
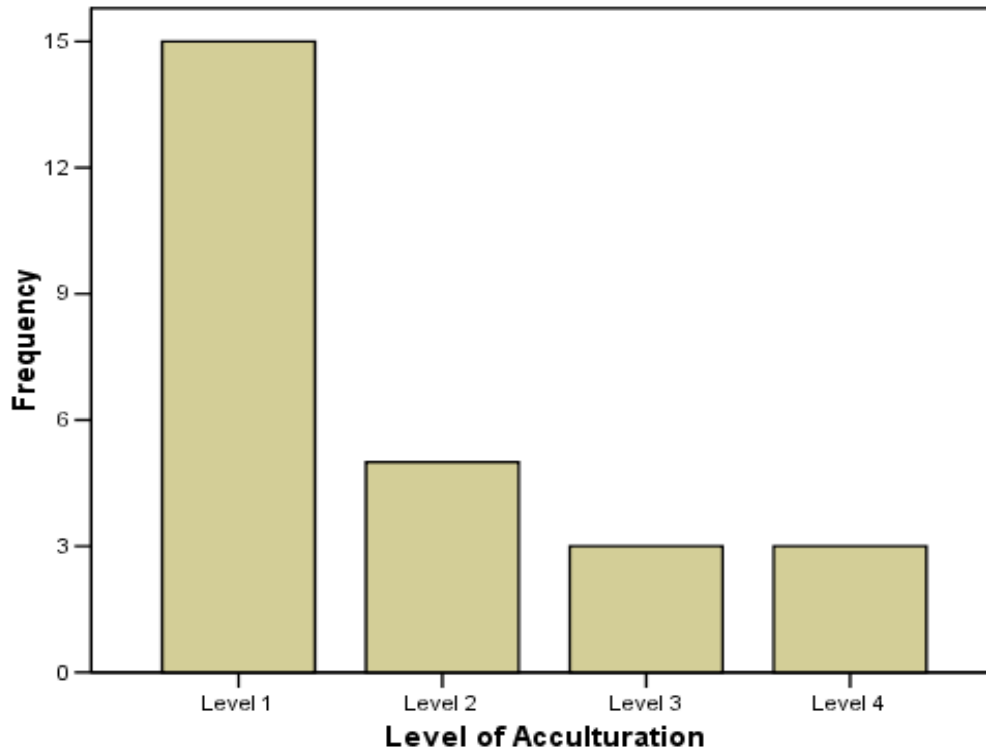
Level 1 = Very Mexican oriented
Level 2 = Mexican oriented to approximately balanced bicultural
Level 3 = Slightly Anglo oriented bicultural
Level 4 = Strongly Anglo oriented

Figure 2. Distribution of non-Latino/as by acculturation level.

Level 3 = Slightly Anglo oriented
Level 4 = Strongly Anglo oriented
Level 5 = Very assimilated Anglicized

APPENDIX A

GROUP CLIMATE QUESTIONNAIRE

SPANISH VERSION

Agrupe Cuestionario De Clima

Por favor evalúe cuánto usted está de acuerdo con las siguientes declaraciones acerca del grupo en una escala del 1-7. Uno representa "de ningún modo" y siete representan "sumamente".

1. Los miembros se gustaban y se apreciaban.
   ①　②　③　④　⑤　⑥　⑦

2. Los miembros trataban de entender por qué ellos hacen las cosas que hacen, trataban de razonarlas.
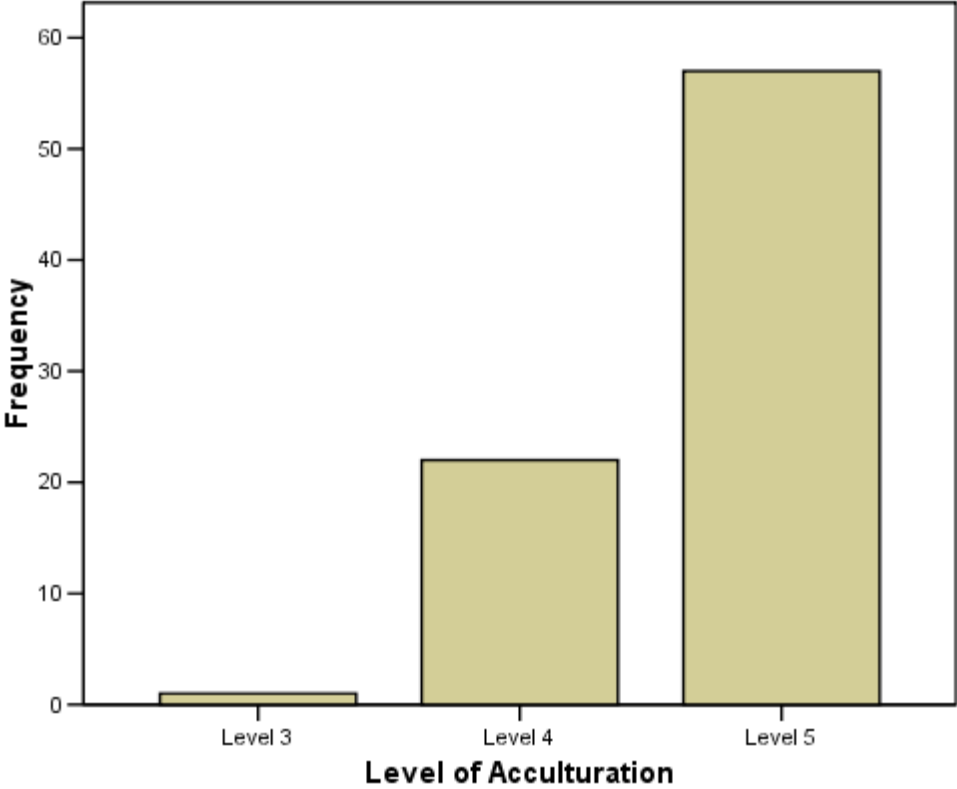   ①　②　③　④　⑤　⑥　⑦

3. Los miembros evitaron considerar asuntos importantes pasando entre ellos mismos.
   ①　②　③　④　⑤　⑥　⑦

4. Los miembros sentían qué lo que sucedía era importante y había un sentido de participación.
   ①　②　③　④　⑤　⑥　⑦

5. Los miembros dependían al líder del grupo para la dirección.
   ①　②　③　④　⑤　⑥　⑦

6. Había fricción y enojo entre los miembros.
   ①　②　③　④　⑤　⑥　⑦

7. Los miembros estaban distantes y retirados de uno al otro.
   ①　②　③　④　⑤　⑥　⑦

8. Los miembros desafiaban y confrontaban uno al otro en sus esfuerzos para ordenar las cosas.
   ①　②　③　④　⑤　⑥　⑦

9. Los miembros parecían hacer las cosas en la manera que pensaron sería aceptable al grupo.
   ①　②　③　④　⑤　⑥　⑦

10. Los miembros desconfían de y rechazaban uno al otro.
    ①　②　③　④　⑤　⑥　⑦

11. Los miembros revelaban información o sentimientos personales y sensitivos.
    ①　②　③　④　⑤　⑥　⑦

12. Los miembros parecían tensos y ansiosos.
    ①　②　③　④　⑤　⑥　⑦

APPENDIX B

DICHOS RATING QUESTIONNAIRE, ENGLISH AND SPANISH VERSIONS

Male_____   Female_____

Age_____

Ethnicity
(Please indicate by circling your answer.)
1. Latin American
2. African American
3. Caucasian
4. Native American
5. Asian American
6. Middle Eastern
7. Other

If you are Latin American, which country are your or your ancestors from? _____

The following phrases are sayings used in Latino cultures. Please rate how applicable/relevant to life you think each saying is as follows:

> 0 = I am not familiar with this saying
> 1 = Not applicable or relevant to life at all
> 2 = Applicable or relevant in a few situations
> 3 = Applicable or relevant in some situations
> 4 = Applicable or relevant in many situations
> 5 = Highly applicable or relevant to life in general

Note: If you have not previously heard the saying or one like it, please mark as a "0." At the end of the questionnaire, there is space to write any sayings that you have heard but were not listed here. Thank you for your participation!

1. Primero sopitas de miel y luego de hiel.   ⓪①②③④⑤
   (First comes the honey then the bile.)

2. Si el vino te tiene loco, déjalo poquito a poco.   ⓪①②③④⑤
   (If wine is driving you crazy, leave it little by little.)

3. En cama angosta, metete en medio.   ⓪①②③④⑤
   (In a narrow bed, get in the middle.)

4. Aguántate tantito y la fruta caerá en tu mano.   ⓪①②③④⑤
   (Wait a little while and the fruit will fall into your hand.)

5. El lobo pierde los dientes pero no las mañas.   ⓪①②③④⑤
   (The wolf loses his teeth but not his ways.)

6. La burra no era arisca, los palos la hicieron.   ⓪①②③④⑤
   (The donkey was not skittish; she is now because of the beatings she got.)

7. Las enfermedades llegan a caballo y se van a pie.   ⓪①②③④⑤
   (Illnesses come on horseback and leave on foot.)

8. Cuando no hay pan, buenas son cemitas.   ⓪①②③④⑤
   (When there's no bread, sweet rolls will do.)

9. El que anda con lobos a aullar se enseña.   ⓪①②③④⑤
   (He who walks with wolves learns to howl.)

10. Ganar un pleito es adquirir un pollo y perder una vaca.   ⓪①②③④⑤
    (To win a dispute is to gain a chicken and lose a cow.)

11. De bajada hasta las piedras ruedan.   ⓪①②③④⑤
    (Downhill even stones roll downward.)

12. De mañana en mañana bien pierde la oveja la lana.   ⓪①②③④⑤
    (From day to day the sheep easily loses her wool.)

13. Casa sin madre, río sin cauce.   ⓪①②③④⑤
    (A house without a mother, a river without a course.)

14. Agua que no has de beber déjala correr   ⓪①②③④⑤
    (Water that you shall not drink, let it run.)

15. Mas vale paso que dure y no que madure.   ⓪①②③④⑤
    (Better a stride that will last than a trot that tires fast.)

16. Niño que no llora no mama.   ⓪①②③④⑤
    (The child who does not cry does not nurse.)

17. Arriba ya del caballo, hay que aguantar los respingos. ⓪①②③④⑤
(Once mounted on a horse, one must hang on when he bucks.)

18. La rana mas aplastada es la que mas recio grita. ⓪①②③④⑤
(The frog squashed the hardest croaks the loudest.)

19. No es lo mismo hablar de toros que estar en el redondel. ⓪①②③④⑤
(Talking about bulls is not the same as facing them in the ring.)

20. Al nopal lo van a ver solo cuando tiene tunas. ⓪①②③④⑤
(The prickly pear has company only when it bears fruit.)

21. No hay que andarse por las ramas estando tan grueso el tronco.
⓪①②③④⑤

 (There's no reason to walk on the branches when the trunk is so thick.)

22. Del árbol caído todos hacen leña. ⓪①②③④⑤
(From the fallen tree everyone makes firewood.)

23. Dios aprieta pero no ahorca. ⓪①②③④⑤
(God squeezes but does not choke us.)

24. Mas vale pájaro en mano que ciento volando. ⓪①②③④⑤
(Better to have a bird in hand than a hundred flying.)

25. El que mal canta, bien la suena. ⓪①②③④⑤
(He who sings badly thinks he sings well.)

26. En tus apuros y afanes, acude tus refranes ⓪①②③④⑤
(In time of need, turn to your proverbs.)

27. Camarón que se descuida, se lo lleva la corriente. ⓪①②③④⑤
(The careless shrimp will be carried away by the current.)

28. Al que le duela la muela que se la saque. ⓪①②③④⑤
(The person whose tooth is causing pain should pull it out.)

29. Al que le aprieta el zapato que se lo afloje. ⓪①②③④⑤

(The person whose shoe is too tight should loosen the shoe strings.)

30. Estabas como perro en barrio ajeno.   ⓪①②③④⑤
(He/she is like a dog in a strange neighborhood.)

31. Al que no ha usado huaraches, las correas le secan sangre
⓪①②③④⑤
(Al que no ha usado huaraches, las correas le secan sangre.)

32. Si queremos la flor, soportamos las espinas.   ⓪①②③④⑤
(If we want the flower we must tolerate the thorns.)

33. En boca cerrada no entran moscas.   ⓪①②③④⑤
(In a closed mouth flies do not enter.)

34. Árbol que nace torcido jamás su tronco endereza.   ⓪①②③④⑤
(A tree that grows bent never straightens its trunk.)

35. No hay ahogarse en un vaso de agua.   ⓪①②③④⑤
(One should not drown in a glass of water.)

36. Como el perro del hortelano, ni come ni deja comer.   ⓪①②③④⑤
(Like the farmer's dog, who neither eats nor allows others to eat.)

37. Al caballo regalado no se le miran los dientes.   ⓪①②③④⑤
(Do not look a gift horse in the mouth.)

38. A la mejor persona se le van las patas.   ⓪①②③④⑤
(The best person can lose his feet.)

39. Farol de la calle y oscuridad de su casa.   ⓪①②③④⑤
(A street lantern and darkness in the home.)

40. Lo que en el capillo se toma con la martaja se deja.   ⓪①②③④⑤
(That which is grasped with a child's cap is laid away with the shroud.)

Masculino_____   Femenino_____

Edad_____

Origen étnico
(Por favor indique con un círculo la respuesta.)
1. latinoamericano
2. americano africano
3. caucáseo
4. americano asiático
5. del oriente medio
6. americano nativo
7. del oriente
8. otro

¿Si usted es latinoamericano, entonces cuál país están usted o sus antepasados de? _____

Las siguientes frases son dichos algunas veces usados en culturas Latino. Por favor evalúe cómo aplicable / pertinente para la vida usted piensa que cada dicho es como sigue:

    0 = No soy familiar con este dicho
    1 = No es aplicable o ninguna relevancia para la vida del todo
    2 = Aplicables o pertinentes en pocas situaciones
    3 = Aplicables o pertinentes en algunas situaciones
    4 = Aplicables o pertinentes en muchas situaciones
    5 = Altamente aplicables o pertinentes para la vida en general

Nota: Si usted previamente no ha oído, entonces el dicho o uno le gusta ello, por favor marcar como uno " 0 ". Al final del cuestionario, hay espacio para poner por escrito cualquier dichos que usted ha oído, pero no estaba listado aquí. ¡Gracias por su participación!

  1. Primero sopitas de miel y luego de hiel.   ⓪①②③④⑤

  2. Si el vino te tiene loco, déjalo poquito a poco.   ⓪①②③④⑤

  3. En cama angosta, metete en medio.   ⓪①②③④⑤

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4. Aguántate tantito y la fruta caerá en tu mano. ⓪①②③④⑤

5. El lobo pierde los dientes pero no las mañas. ⓪①②③④⑤

6. La burra no era arisca, los palos la hicieron. ⓪①②③④⑤

7. Las enfermedades llegan a caballo y se van a pie. ⓪①②③④⑤

8. Cuando no hay pan, buenas son cemitas. ⓪①②③④⑤

9. El que anda con lobos a aullar se enseña. ⓪①②③④⑤

10. Ganar un pleito es adquirir un pollo y perder una vaca. ⓪①②③④⑤

11. De bajada hasta las piedras ruedan. ⓪①②③④⑤

12. De mañana en mañana bien pierde la oveja la lana. ⓪①②③④⑤

13. Casa sin madre, río sin cauce. ⓪①②③④⑤

14. Agua que no has de beber déjala correr. ⓪①②③④⑤

15. Mas vale paso que dure y no que madure. ⓪①②③④⑤

16. Niño que no llora no mama. ⓪①②③④⑤

17. Arriba ya del caballo, hay que aguantar los respingos. ⓪①②③④⑤

18. La rana mas aplastada es la que mas recio grita. ⓪①②③④⑤

19. No es lo mismo hablar de toros que estar en el redondel. ⓪①②③④⑤

20. Al nopal lo van a ver solo cuando tiene tunas. . ⓪①②③④⑤

21. No hay que andarse por las ramas estando tan
grueso el tronco. ⓪①②③④⑤

22. Del árbol caído todos hacen leña. ⓪①②③④⑤

23. Dios aprieta pero no ahorca. ⓪①②③④⑤

24. Mas vale pájaro en mano que ciento volando.   ⓪①②③④⑤

25. El que mal canta, bien la suena.   ⓪①②③④⑤

26. En tus apuros y afanes, acude tus refranes.   ⓪①②③④⑤

27. Camarón que se descuida, se lo lleva la corriente.   ⓪①②③④⑤

28. Al que le duela la muela que se la saque.   ⓪①②③④⑤

29. Al que le aprieta el zapato que se lo afloje.   ⓪①②③④⑤

30. Estabas como perro en barrio ajeno.   ⓪①②③④⑤

31. Al que no ha usado huaraches, las correas le
    secan sangre.   ⓪①②③④⑤

32. Si queremos flor, soportamos las espinas.   ⓪①②③④⑤

33. En boca cerrada no entran moscas.   ⓪①②③④⑤

34. Árbol que nace torcido jamás su tronco endereza.   ⓪①②③④⑤

35. No hay ahogarse en un vaso de agua.   ⓪①②③④⑤

36. Como el perro del hortelano, ni come ni deja comer.   ⓪①②③④⑤

37. Al caballo regalado no se le miran los dientes.   ⓪①②③④⑤

38. A la mejor persona se le van las patas.   ⓪①②③④⑤

39. Farol de la calle y oscuridad de su casa.   ⓪①②③④⑤

40. Lo que en el capillo se toma con la martaja se deja.   ⓪①②③④⑤

APPENDIX C

PILOT STUDY INFORMED CONSENT, ENGLISH AND SPANISH VERSIONS

UNIVERSITY OF NORTH TEXAS COMMITTEE FOR THE PROTECTION OF HUMAN SUBJECTS

RESEARCH CONSENT FORM

Subject Name: Date:

Title of Study: Familiarity of Spanish-language proverbs

Principal Investigator: Celeste Riley

Co-investigators: Joseph A. Doster, Ph.D.

Before agreeing to participate in this research study, it is important that you read and understand the following explanation of the proposed procedures. It describes the procedures, benefits, risks, and discomforts of the study. It also describes your right to withdraw from the study at any time. It is important for you to understand that no guarantees or assurances can be made as to the results of the study.

Purpose of the study and how long it will last:
The purpose of this study is to determine which Spanish-language sayings or proverbs are most familiar to people with Mexican or Mexican American cultural backgrounds. It is anticipated that it will take approximately 30 minutes to complete the survey.

Description of the study including the procedures to be used:
Each participant will be asked to complete a basic demographic information (gender, age and ethnicity), You will then be asked to complete a survey in which you will rate the familiarity or applicability of 40 sayings or proverbs.

Description of the procedures/elements that are associated with foreseeable risks:
It is anticipated that participants will experience negligible discomfort or inconvenience as a result of this study. However, there may be physical, psychological or social risks of the study which were unforeseen by the researchers. If any discomfort does arise during your participation, please notify the researcher assisting you to discuss your continued involvement, or discontinuing the survey. You may decide to discontinue the survey or withdraw participation at any time.

Benefits to the subjects or others:
It is unlikely that you will directly benefit from participating in this survey. Your participation contributes to research with the goal of designing therapeutic interventions that result in positive outcomes for Latino/a clients.

Confidentiality of research records:
You will not be personally identified by participating in this study. Information collected about you will be limited to your age, ethnicity and gender. Your name will not be recorded on any of the surveys. The persons who will have access to the information collected will be limited to those directly involved in the research project.

Review for protection of participants:
This research study has been reviewed and approved by the UNT Committee for the Protection of Human Subjects (940) 565-3940.

RESEARCH SUBJECTS' RIGHTS: I have read or have had read to me all of the above.

_____ has explained the study to me and answered all of my questions.   I have been told the risks or discomforts and possible benefits of the study. I have been told of other choices of treatment available to me.

I understand that I do not have to take part in this study, and my refusal to participate or to withdraw will involve no penalty or loss of rights or benefits or legal recourse to which I am entitled.

In case there are problems or questions, I have been told I can call Celeste Riley at telephone number ******* or Dr. Joseph Doster in the Psychology Departement at (940) *******.

I understand my rights as a research subject, and I voluntarily consent to participate in this study. I understand what the study is about and how and why it is being done. I have been told I will receive a signed copy of this consent form.

_____   _____
                Signature of Participant   Date

**Universidad de Norte Tejas Comité
de La Proteccion de Participantes Humanos**

FORMA DE CONSENTIMIENTO

Nombre de participante: _____ Fecha: _____
Titulo del Estudio: Familiariadad de Refranes Españoles
Investigadora principal: Celeste Riley
Otros investigadores: Joseph A. Doster, Ph.D. _____

Antes de acceder de participar de este estudio de investigación, es importante que usted lee y entiende la siguiente explicación de los procedimientos propuestos. Este forma describe los procedimientos, las beneficias, los riesgos, y las incomodidades del estudio. Tambien describe los tratamientos alternativos que están disponibles a usted y su derecho para retirarse del estudio en cualquier momento. Es importante que usted para tener por entendido que ninguno de las garantías o las seguridades puede estar hecho obre los resultados del estudio.

El propósito del estudio y cuanto tiempo duraran:
El propósito de este estudio es determinar cuales dichos de idiomas españoles o refranes son mas familiares para personas de culturales americanos mejicanos o mejicanos. Es adelantado que tomara aproximadamente 30 minutos completar la encuesta.

La descripción del estudio incluyendo los procedimientos a ser usado:
Cada participante recibira instrucciones de completar información demográfica básica (el género, la edad y la cultura). Usted luego recibirá instrucciones de completar una encuesta en el cual usted evaluara la familiaridad o la aplicabilidad de 40 dichos o refranes.

La descripción del procedimiento/intemperie que es asociado con riesgos previsibles:
Es adelantado que los participantes experimentarán incomodidad insignificante como resultado de este encuesta. Sin embargo, pueden haber reconocimiento médico, psicológica o social se arriesga del estudio que fue imprevisto por los investigadores. Si cualquier incomodidad se levanta durante su participación, entonces por favor notifíquele al investigador ayudando a usted para discutir su envolvimiento mantenido, o discontinuando la encuesta. Usted puede resolver discontinuar el escrutinio o retirar participación en cualquier momento.

Los beneficios para los participantes o los otros:
Es difícil que usted directamente se beneficia de participar de este escrutinio. Su participación contribuye a indagar con la meta de intervenciones terapéuticas de diseño que resultan en resultados positivos para clientes latinos.

La confidencialidad de registros de investigación:
Usted no estará personalmente identificado participando de este estudio. La
información coleccionada alrededor usted estará limitado para su edad, ethnicity y
género. Su nombre no estará registrado en cualquier de los escrutinios. Las personas
que tendrán acceso a la información coleccionaron estará limitado para esos
directamente involucrados en el proyecto de investigación.

Repase para la protección de participantes:
Este estudio de investigación ha sido revisado y aprobado por el UNT Comité para el
Protección del Participantes Humanos *******.

INDAGUE LOS DERECHOS DE TEMAS: Me he leído o me he tenido lectura para mí
todos los citado anteriormente.

_____ me ha explicado el estudio para mí y ha
contestado a todo mis preguntas.   A mí me han sido dichos los riesgos o las
incomodidades y los beneficios posibles del estudio. He sido dado cuenta de otras
elecciones de tratamiento disponible para mí.

Tengo por entendido que no tengo que tomar parte en este estudio, y mi negativa para
participar o abstraer no implicará pena o pérdida de derechos o beneficios o recurso
legal para el cual estoy titulada. A los empleados de estudio les pueden preferir mas
bien detener mi participación en cualquier momento.

En caso hay problemas o preguntas, he sido informado puedo llamar a Celeste Riley en
número de teléfono ******* to Dr. Joseph Doster en el Psychology Departement en
*******.

Entiendo mis derechos como un tema de investigación, y voluntariamente estoy de
acuerdo en participar de este estudio. Entiendo lo que el cuarto de estudio está cerca y
cómo y por qué está siendo hecho. He sido informado recibiré una copia firmada de
este formulario de consentimiento.

La Firma De Participant		La fecha

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APPENDIX D

HIGH-RELEVANCE AND LOW-RELEVANCE CATEGORIES

FOR DICHOS GROUPS

High-Relevance Dichos

Item	Dicho
9	El que anda con lobos a aullar se enseña. (He who walks with wolves learns to howl.)
14	Agua que no has de beber déjala correr. (Water that you shall not drink, let it run.)
22	Del árbol caído todos hacen leña. (From the fallen tree everyone makes firewood.)
23	Dios aprieta pero no ahorca. (God squeezes but does not choke us.)
24	Mas vale pájaro en mano que ciento volando. (Better to have a bird in hand than a hundred flying.)
33	En boca cerrada no entran moscas. (In a closed mouth flies do not enter.)
34	Árbol que nace torcido jamás su tronco endereza. (A tree that grows bent never straightens its trunk.)
35	No hay ahogarse en un vaso de agua. (One should not drown in a glass of water.)

Low-Relevance Dichos

3   En cama angosta, metete en medio.   .
       (In a narrow bed, get in the middle.)

7   Las enfermedades llegan a caballo y se van a pie.
       (Illnesses come on horseback and leave on foot.)

8   Cuando no hay pan, buenas son cemitas
       (When there's no bread, sweet rolls will do.)

10   Ganar un pleito es adquirir un pollo y perder una vaca.
       (To win a dispute is to gain a chicken and lose a cow.)

13   Casa sin madre, río sin cauce
       (A house without a mother, a river without a course.)

17   Arriba ya del caballo, hay que aguantar los respingos
       (Once mounted on a horse, one must hang on when he bucks.)

18   La rana mas aplastada es la que mas recio grita
       (The frog squashed the hardest croaks the loudest.)

31   Al que no ha usado huaraches, las correas le secan sangre
       (Al que no ha usado huaraches, las correas le secan sangre.)

40   Lo que en el capillo se toma con la martaja se deja
       (That which is grasped with a child's cap is laid away with the shroud.)

APPENDIX E

INFORMED CONSENT FOR DICHOS GROUP PARTICIPATION,

ENGLISH AND SPANISH VERSIONS

**UNIVERSITY OF NORTH TEXAS COMMITTEE FOR
THE PROTECTION OF HUMAN SUBJECTS**

RESEARCH CONSENT FORM

Subject Name: Date:

Title of Study: A culturally senstive group intervention with chronic pain patients

Principal Investigator: Celeste Riley

Co-investigators: Joseph A. Doster, Ph.D.

Before agreeing to participate in this research study, it is important that you read and understand the following explanation of the proposed procedures. It describes the procedures, benefits, risks, and discomforts of the study. It also describes your right to withdraw from the study at any time. It is important for you to understand that no guarantes or assurances can be made as to the results of the study.

Purpose of the study and how long it will last:
The purpose of this study is to study how use of Spanish-language sayings during group sessions impacts group climate in sessions focusing on chronic pain. It is anticipated that group involvement and completion of the questionnaires will take one and a half hours total.

Description of the study including the procedures to be used:
Each participant will be asked to complete a basic demographic information (gender, age and ethnicity), and a measure of your cultural practices. Following the group, you will then be asked to complete a questionnaire about the group session.

Description of the procedures/elements that are associated with foreseeable risks:
It is anticipated that participants will experience negligible discomfort or inconvenience as a result of this study. However, there may be physical, psychological or social risks of the study which were unforeseen by the researchers. If any discomfort does arise during your participation, please notify the researcher assisting you to discuss your continued involvement, or discontinuing the survey. You may decide to discontinue the survey or withdraw participation at any time.

Benefits to the subjects or others:
It is unlikely that you will directly benefit from participating in this survey. Your participation contributes to research with the goal of designing therapeutic interventions that result in positive outcomes for Latino/a clients.

Confidentiality of research records:
You will not be personally identified by participating in this study. Information collected about you will be limited to your age, ethnicity and gender. Your name will not be recorded on any of the surveys. The persons who will have access to the information

collected will be limited to those directly involved in the research project. Your group counselor will not have access to your individual responses.

Review for protection of participants:
This research study has been reviewed and approved by the UNT Committee for the Protection of Human Subjects *******.

RESEARCH SUBJECTS' RIGHTS: I have read or have had read to me all of the above.

_____ has explained the study to me and answered all of my questions.   I have been told the risks or discomforts and possible benefits of the study. I have been told of other choices of treatment available to me.

I understand that I do not have to take part in this study, and my refusal to participate or to withdraw will involve no penalty or loss of rights or benefits or legal recourse to which I am entitled.

In case there are problems or questions, I have been told I can call Celeste Riley at telephone number ******* or Dr. Joseph Doster in the Psychology Departement at *******.

I understand my rights as a research subject, and I voluntarily consent to participate in this study. I understand what the study is about and how and why it is being done. I have been told I will receive a signed copy of this consent form.

_____   _____
                    Signature of Participant   Date

**LA UNIVERSIDAD DE COMITÉ DEL NORTE DE TEJAS PARA
LA PROTECCIÓN DE TEMAS HUMANOS**

INDAGUE FORMULARIO DE CONSENTIMIENTO

Subordine Nombre:	La fecha:
El Título De Study: Uno culturalmente senstive agrupa intervención con pacientes crónicos de dolor	
El Investigador Principal: Celeste Riley	
Co-investigator: Joseph A. Doster, Ph.D.	

Antes de quedar de participar de este estudio de investigación, es importante que usted lee y entiende la siguiente explicación de los procedimientos propuestos. Describe los procedimientos, se beneficia, se arriesga, y las incomodidades del estudio. También describe su derecho para retirarse del estudio en cualquier momento. Es importante pues usted para tener por entendido que ninguno de los afianzamientos o las seguridades puede estar hecho en lo que se refiere a los resultados del estudio.

El propósito del estudio y cuánto tiempo durarán:
El propósito de este estudio es determinar ya sea usar de metáforas de idiomas españoles durante sesiones en coro que positivamente los impactos agrupan clima en grupos enfocando la atención en dolor crónico.

La descripción del estudio incluyendo los procedimientos a ser usado:
Cada participante recibirá instrucciones de completar una información demográfica básica (el género, la edad y ethnicity), y una medida de aculturación. Después de la sesión en coro, usted luego recibirá instrucciones de completar un cuestionario de aproximadamente cómo fue el grupo.

La descripción de los procedures/elements que se asoció con riesgos previsibles:
Es adelantado que los participantes experimentarán incomodidad insignificante o incomode como resultado de este estudio. Sin embargo, pueden haber reconocimiento médico, la psicológica o la tertulia se arriesga del estudio que fue imprevisto por los investigadores. Si cualquier incomodidad se levanta durante su participación, entonces por favor notifíquele al investigador ayudando a usted que discuta su envolvimiento continuado, o discontinuando el escrutinio. Usted puede decidirse a discontinuar el escrutinio o abstraer participación en cualquier momento.

Los beneficios para los temas o los otros:
Es difícil que usted directamente se aprovechará de participar de este escrutinio. Su participación contribuye a indagar con la meta de intervenciones terapéuticas de diseño que resultan en resultados positivos para Latino / unos clientes.

La confidencialidad de registros de investigación:
Usted no estará personalmente identificado participando de este estudio. La información coleccionada alrededor usted estará limitado para su edad, ethnicity y

género. Su nombre no estará registrado en cualquier de los escrutinios. Las personas que tendrán acceso a la información coleccionaron estará limitado para esos directamente involucrados en el proyecto de investigación.

Repase para la protección de participantes:
Este estudio de investigación ha sido revisado y aprobado por el UNT Committee para el Protection del Humano Subjects *******.

INDAGUE LOS DERECHOS DE TEMAS: Me he leído o me he tenido lectura para mí todos los citado anteriormente.

_____ me ha explicado el estudio para mí y ha contestado a todo mis preguntas. A mí me han sido dichos los riesgos o las incomodidades y los beneficios posibles del estudio. He sido dado cuenta de otras elecciones de tratamiento disponible para mí.

Tengo por entendido que no tengo que tomar parte en este estudio, y mi negativa para participar o abstraer no implicará pena o pérdida de derechos o beneficios o recurso legal para el cual estoy titulado.

En caso hay problemas o preguntas, he sido informado puedo llamar a Celeste Riley en número de teléfono ******* o Dr. Joseph Doster en el Psychology Departement en *******.

Entiendo mis derechos como un tema de investigación, y voluntariamente estoy de acuerdo en participar de este estudio. Entiendo lo que el cuarto de estudio está cerca y cómo y por qué está siendo hecho. He sido informado recibiré una copia firmada de este formulario de consentimiento.

La Firma De Participant		La fecha

APPENDIX F

DEMOGRAPHIC QUESTIONNAIRE

ENGLISH AND SPANISH VERSIONS

Male _____   **Female** _____

Age ____

Ethnic background
(Circle your choice.)
1. Latino/a
2. White non-Latino/a
3. African American
4. Native American
5. Asian American
6. Middle Eastern
7. Other

Last grade you completed in school
(Circle your choice.)
1. Elementary – 6
2. 7-8
3. 9-12
4. 1-2 years of college
5. 3-4 years of college
6. College graduate and higher

Circle the generation that best applies to you. Please circle only one.
1. 1st generation = You were born in Mexico or another country.
2. 2nd generation = You were born in USA; either parent born in Mexico or another country
3. 3rd generation = You were born in USA; both parents born in USA and all grandparents born in Mexico or other country.
4. 4th generation = You and your parents born in USA and at least one grandparent born in Mexico or other country with remainder born in USA.
5. 5th generation = You and your parents born in the USA and all grandparents born in USA.

Masculino _____   **Femenino** _____

Edad _____

Origen étnico
(Indique con un círculo la respuesta.)
1. Latino o Mexicano
2. Americano
3. Africano Americano
4. Nativo Americano
5. del Oriente
6. del Medio Oriente
7. Otro

Hasta que grado fue a la escuela?
(Indique con un círculo la respuesta.)
1. Primaria -6
2. Secundaria 7-8
3. Preparatoria 9=12
4. Universidad o colegio 1-2 anos
5. Universidad o colegio 3-4 anos
6. Graduado, o grado mas alto de Colegio o Universidad

Indique con un círculo el numero de la generación que considere adecuada para usted. De solamente una respuesta.
1. 1ª generación = Usted nació en México u otro país (no en los Estados Unidos).
2. 2ª generación = Usted nació en los Estados Unidos Americanos (USA), sus padres nacieron en México o en otro país.
3. 3ª generación = Usted nació en los Estados Unidos (USA), sus padres también nacieron en los Estados Unidos, y sus abuelos nacieron en México o en otro país.
4. 4ª generación = Usted nació en los Estados Unidos (USA), sus padres también nacieron en los Estados Unidos y por lo menos de sus abuelos nació en México o algún otro país.
5. 5ª generación = Usted y sus padres y todos sus abuelos nacieron en los Estados Unidos.

APPENDIX G

THERAPIST GUIDELINES FOR DICHOS GROUPS

Thank you for participating in this investigation. I know it takes extra time to try things a little differently, but hope that this intervention is one that you will find useful for your groups.

What is the purpose of this study and what are 'dichos'?
The goal of the present study is to determine how use of familiar, Spanish-language metaphors, or dichos, impacts group dynamics. We will investigate how use of these sayings affect attitudes about the group session from the perspective of Latino/a American clients, clients of other ethnicities and the group leaders. Dichos are described as Spanish language idioms or proverbs that are often poetic and/or metaphorical in nature. Dichos are already in use clinically. It has been suggested that this form of figurative language may serve to decrease client resistance, enhance motivation, facilitate therapist-client communication and stimulate new perspectives. However, these predictions have not yet been tested empirically. This study begins the process of determining how using these familiar sayings therapeutically might affect group dynamics.

Does this intervention fit within any existing psychological theory?
Therapeutic use of Spanish-language metaphors fits within psychological practice identifying use of metaphor as a means of promoting change and creating new meanings for clients. Theorists point out that metaphors make connections between subjects that were previously unrelated, thereby creating new meaning and generating potential for learning. Researchers promote the idea that metaphors allow clients to map one life experience onto another, and is so doing encourage individuals to integrate the meanings of those experiences. It is this process that is argued to be the basis for change.

> *A woman with Lupus resisted her illness and was non-compliant with the treatment regimen. This was self-destructive. With the help of her counselor she came to envision her illness as a wild wolf that she needed to tame. Viewing her illness with the metaphor "wild wolf" she began taking naps with her "pet" rather than fighting the fatigue. The medical regimen she was supposed to followbecame a "map" for taking care of the new pet.*

Metaphor use is one intervention technique consistent with the broader aims of experiential therapy. Experiential therapy emphasizes the clients' depth of self-experiencing. Self-experiencing refers to our deeper awareness of ourselves and others in the present moment, a deeper awareness of our emotions, other bodily sensations, our beliefs and thoughts, and the actions we are taking, or want to take, or are afraid to take. Individuals who are skilled in self-experiencing have an important tool that allows them to more fully appreciate critical choice points of their lives. With a richer, deeper appreciation of personal circumstances, individuals are able to make the kinds of choices they need to make. In experiential therapy, there is a heightened level of

emotional involvement, as well as a deeper relationship between the client and therapist.

How might this intervention help my clients?

Functioning as metaphors, dichos may help clients 'map' a better way of coping with pain. Dichos may enable clients to create a new perspective of their current situation. Also, research has shown that clients have a better memory for sessions in which they experience greater emotional involvement. Some of these sayings may be associated with clients' emotional memories or images; therefore clients may potentially remember these sessions and what they gained from them more than other sessions. Another anticipated outcome is that this kind of intervention will encourage group involvement for all members, but especially for those who are Spanish-speaking or who may be familiar with these sayings. Therefore, all group members are invited to participate in filling out the questionnaires about the group session.

What is my role in leading the session?

The role of the group leader involves:

- Presenting the group with the dichos
- Promoting dialogue about the dichos in a way that is consistent with experiential therapy
- Encouraging clients to relate the meaning of the saying to their present circumstances

Nuts and bolts

- About once every four weeks, I will contact you and we can set a time for you to conduct the next 'dichos' group. This can be a day that is convenient for you and also a day on which we might expect a high patient volume.
- I will then provide you with several dichos for the group session. In keeping with existing clinic practices, either the group leader needs to be bilingual, or a translator needs to be present for the group. I will arrange for an assistant to help collect data following the session.
- On the following page, you will find an example of a dicho and suggestions on how to keep discussion going. This is not meant to be a rigid agenda, but rather a guide so the group does not get 'stuck.' Feel free to follow your typical routine in starting the groups – introducing new members etc.
- The group needs to wrap up in about 45 minutes so they will have time to complete the questionnaires without interrupting other clinic activities.
- I am requesting that you, the group leader, complete the Group Climate Questionnaire after each 'dicho' session you lead. We would like to know how you think the group went.
- A research assistant should be present to collect the data. Just in case you are asked questions about the surveys:
  - They have a choice. They can answer the questions in Spanish, English or orally. They may always decline to participate.
  - I anticipate it will take them about 15-20 minutes to complete the questionnaires after the group is over.

- The study will continue until I reach the desired number of participants. I predict that it will take six months for this to happen. Therefore, you may expect to lead approximately six of these groups before the study ends.
- You may reach me at (248) 549-2123 or hayleste@ev1.net if you have questions. My faculty advisor at UNT for this research is Dr. Joseph Doster. His email is dosterj@unt.edu. His office number is (940)565-2671.

Background about Experiential Therapy
- Usually emphasizes more long-term changes versus providing quick, immediate fixes for specific problems
- Each session may produce change in the client. Often therapists try to facilitate some sort of post-session change by encouraging clients to find ways to experiment or rehearse new ways of thinking, behaving and being.
- Strong feelings (even negative ones) during the session are used for change rather than avoided. Clients are often invited to close their eyes during sessions to experience memories, scenes or feelings more fully.

Guidelines for Group Sessions
The recommended sequence of intervention follows certain steps. Our intervention will be consistent with this but altered to allow discussion of the dichos. A group might follow this process:
o Group instructions and explanation of format that uses sayings to think of things in a new way or with a different perspective. You might explain that we often use sayings in conversation but don't often really think about what they mean to us. The idea for this group is to talk about what some Spanish-language sayings might mean (we'll ask help from our Spanish-speaking members) and maybe how they fit into our lives and situations.

o Introduce the first dicho is Spanish and then ask any Spanish speaking members to translate it (without getting into what it might mean). You might say:
>   ***Could someone tell us what those words are in English?*** (If not you can tell the group yourself.)
At this point we are just trying to get a literal translation of the words, without getting bogged down in a discussion about the meaning of the saying.

o Use of imagery to connect the saying to a mental picture. You might say something like:
>   ***I invite you all to close your eyes. In your mind's eye, you might recall a time when you heard this saying….Picture the person that said it and hear the way they said it….Try to remember how you were feeling and what you were doing at the time. Was it a funny or serious situation?....If this is the first time you have heard the saying, what do you picture when you hear the saying?... Just see whatever comes to mind when you hear me talk (repeat the saying)…It doesn't matter if your image seems silly or makes sense or whether you can***

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describe it in words…Try to imagine the sights, sounds and smells in your scene…

Allow them some time to get an image and then tell them that when they are ready they can open their eyes.

o   Prompting group members to discuss whether the saying is familiar and in what contexts they have heard it used. Invite individuals to share the images they experienced. Feel free to comment on your own feelings that arise as group members describe their images. Welcome whatever images/feelings group members have, even if they are negative.

What did you all see as I was talking? Could anyone remember a time when they have heard those words before? Would you mind telling us about it? Tell us about the feelings that went with the scene.

o   Discussion of the literal meaning of the saying, and exploring whether there is a saying in English with a similar meaning.

What does that saying really mean to us? When you hear those words, what does it make you think of? Are there any sayings in English that mean the same thing?

o   If you see you have plenty of time, or are stalling out, feel free to repeat the above process with another dicho.

o   How the saying might be applied to a problem or current situation of the group members. This is an important part of the group. When you see you are running out of time, try to focus the conversation on this topic. Depending on how much time you have (and how the group responded to the first imagery exercise), you may or may not choose to use imagery to guide the discussion.

I invite you again to close your eyes. This time, I'm asking you to focus on one thing that bothers or troubles you most. It may be something about you or perhaps something that is happening in your life right now. Could be something you don't like and wish would go away… Allow yourself to see whatever comes to mind when this feeling or trouble is strongest…What is the feeling you are getting right when you have this scene in your mind?....Do you have sensations in your body happening? It's okay if you don't quite have a name for it… If the feeling gets stronger, that's okay – you can let it… If you need to laugh or cry or make a face, go ahead. If you don't want to go there today, you can feel free to leave it alone…. If you are feeling pretty quiet and peaceful right now, that's okay too – enjoy it. Give them some time with their thoughts.

Allow your attention to turn back to that saying (or one of the sayings we spoke of today). What would happen if you chose to be more like one of those sayings, or to behave in a way that fits the

meaning of the saying? Or maybe just the opposite of the saying would be better. You decide… Try to picture yourself in this new way…Try it on like a new pair of shoes. Walk around in it and see what it feels like… What would you be saying, doing and feeling?... Would you be different than you are now, the same in a stronger way, or exactly the same?.. Would this way be enjoyable to you or hard to do?... Maybe people would treat you differently, or maybe you would even look different.

Now ask yourself if there is a certain thing you could do, acting in this new way that would help that situation you were thinking of… Maybe there is a way you could just try it out – give it a test drive – and see if it would help…. It could be something as simple as smiling at someone or saying 'no' to someone… Whatever you think the saying is telling you to do. .. It would be a little experiment for yourself… Finally, picture yourself doing this thing or behaving in this new way. I invite you to keep this picture with you when you leave the room. Maybe you will feel like acting on it, maybe not – the choice is with you.

- o Invite everyone to open their eyes and re-orient themselves. They may feel like sharing their images, "experiments" or giving you some feedback about the group. If there is time, that is great. If not, you can opt to invite them to discuss it in individual sessions or with you in your next group.

APPENDIX H

FOLLOW-UP SURVEY FOR THERAPISTS

Date of group _____

Location: Garland_____   Houston _____   D/FW_____

Number of dichos discussed _____

Were the dichos discussed: throughout the group? _____
                                   Mostly toward the beginning? _____
                                   Mostly toward the end? _____

Please complete this survey along with the Group Climate Questionnaire at your earliest convenience after the group. Thank you!

Celeste

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