ABSTRACT

Title of Dissertation: COPING, SOCIAL SUPPORT, BICULTURALISM, AND RELIGIOUS COPING AS MODERATORS OF THE RELATIONSHIP BETWEEN OCCUPATIONAL STRESS AND DEPRESSIVE AFFECT AMONG HISPANIC PSYCHOLOGISTS

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This study investigated the degree to which coping behaviors, social support, biculturalism, and positive religious coping moderate the relationship between occupational stress and depressive affect. Research survey packets were sent to doctoral level Latino/a counseling and clinical psychologists with residence in the U.S., members of national or state psychological associations. Usable surveys were received from 580 participants for an overall return rate of 50%. Participants responded to the following instruments: Mental Health Professionals Stress Scale, Center for Epidemiologic Studies Depression Scale short form, Multidimensional Scale of Perceived Social Support, Job Content Questionnaire, Brief COPE, Brief RCOPE (religious coping), and the Abbreviated Multidimensional Acculturation Scale for Latinos short form.

Analyses indicated that 13% of the variance in depressive affect is predicted by occupational stress. Coping strategies, positive religious coping, social support, and biculturalism collectively explained 13% of the variance in depressive affect. Specifically, coworker support ($\beta = -.21$, $p < .001$), total non-work support ($\beta = -.20$, $p < .001$), biculturalism ($\beta = -.12$, $p < .01$), and positive religious coping ($\beta = .10$, $p < .05$) made a statistically significant contribution to the variance in depressive affect scores.

Analyses showed that interactions terms between occupational stress and coping strategies, work and non-work social support, biculturalism, and positive religious coping did not moderate the relationship between occupational stress and depressive affect. No increments in variance attributed to the product terms above and beyond main effects were found. Results revealed significant main effects for the predictor variables, except for positive religious coping, beyond occupational stress. Coping behaviors, work and non-work social support, and biculturalism were negatively associated with depressive affect regardless of the level of occupational stress.

Results of the present study suggested that on average participants employed more problem-focused coping strategies than emotional-focused coping strategies. Analysis of participants' self-reported coping strategies indicated a wide variety of coping responses. The most frequently mentioned coping strategies were; social support, planning and active problem solving, work support, recreational or disengagement activities, and sports and exercise. Among the least endorsed or mentioned coping strategies were; acceptance, humor, and personal psychotherapy or counseling.

# COPING, SOCIAL SUPPORT, BICULTURALISM, AND RELIGIOUS COPING AS MODERATORS OF THE RELATIONSHIP BETWEEN OCCUPATIONAL STRESS AND DEPRESSIVE AFFECT AMONG HISPANIC PSYCHOLOGISTS

by

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# DEDICATION

To my family, mentors, and friends
whose physical and/or spiritual presence fill my life with joy,
serenity, enlightenment, and strength to carry on.

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# CHAPTER I

## INTRODUCTION

The United States workforce is becoming increasingly more racially and ethnically diverse, mirroring changes in the general population. Until very recently these changes were almost ignored by occupational stress researchers, who now realize that not enough data are available on the particular stresses, coping behaviors, and variables influencing the occupational stress experienced by individuals from ethnic and racially diverse groups (Keita & Hurrell, 1994). This study attempts to help fill that gap in the literature by investigating the degree to which coping behaviors, social support, biculturalism, and positive religious coping moderate the relationship between occupational stress and depressive affect in a national sample of counseling and clinical Latino/a psychologists.

The National Institute for Occupational Safety and Health reported that Hispanic workers accounted for 10.9% of the 135 million workers employed in 2001 and the Bureau of Labor Statistics projects that the Hispanic labor force will number 30.3 million by 2010, representing a 13.3% of the U.S. civilian labor force (NIOSH, 2005). Thus, research advancing our knowledge and understanding about the influence of psychosocial factors on stress and health outcomes in Latinos/as would help to (a) identify particular sources of stress, strain, and coping in this ethnic group, (b) identify ways to protect their health and well-being, (c) redesign jobs, (d) create healthier workplaces, and (e) integrate multicultural psychology with occupational stress theories (Cox & Nkomo, 1990;

Fernandez, 1981; Ford, 1985; Keita & Hurrell, 1994; Moure-Eraso & Friedman-Jiménez, 2001; NIOSH, 2005; Slavin, Rainer, McCreary, & Gowda, 1991).

**Occupational Stress and the Multicultural Model of the Stress Process**

Contemporary occupational stress research investigates the interaction among job conditions, individual differences, health problems, organizational consequences, and interventions designed to reduce the effects of stress on individuals. Identification of occupational factors that may be perceived as stressors, understanding of individuals' reactions to these, and exploration of variables that may either moderate or exacerbate the stressor-strain relationship is key to a better understanding of the dynamic nature of the stress-coping process. Stressors common to most jobs such as (a) factors intrinsic to the job, (b) roles in the organization, (c) relationships at work, (d) career development issues, (e) organizational factors, and (f) home-work interface have been correlated with different psychological and behavioral reactions (for reviews, see Arnold, Cooper, & Robertson, 1998; Baker & Karasek, 1995; Beehr, 1995; Buunk, de Jonge, Ybema, & de Wolff, 1998; Cooper, Dewe, & O'Driscoll, 2001; Ganster & Schaubroeck, 1991; Hatfield, 1990; Holt, 1993; Jex & Beehr, 1991; Kahn & Byosiere, 1992; Le Blanc, de Jonge, & Schaufeli, 2000; Quick, Murphy, & Hurrell, 1992; Sauter, Murphy, & Hurrell, 1990; Schabracq, Winnubst, & Cooper, 1996).

There is considerable interest in the role of coping strategies, perceived social support, personality, and cultural variables as possible moderator variables that attenuate the effects of stressors on personal well-being (Bowers, Weaver, & Morgan, 1996; Cervantes & Castro, 1985; Cooper et al., 2001; Cox & Ferguson, 1991; Fernandez, 1981;

House, 1981; Jex & Beehr, 1991; Keita & Hurrell, 1994; Marsella, 1994; McMichael, 1978; Nelson & Simmons, 2003; Parkes, 1994; Payne, 1988; Slavin et al., 1991; Thomas & Alderfer, 1989). The study of moderator variables or interaction effects (Baron & Kenny, 1986; Frazier, Tix, & Barron, 2004) helps to clarify differences in peoples' behavior by showing the systematic influence one variable exerts in the relationship of two other variables. In occupational stress research, moderator variables have important implications for understanding the way in which their presence can alter an individual's perception of or response to, stressors, thereby reducing the potential negative effects of psychological stress.

The transactional approach to the stress process is one of several models available for understanding the relationship between occupational stress and health (Cooper et al., 2001; Kahn & Byosiere, 1992). It posits that individuals participating in the same job environment will not experience the same stressors to the same degree, exhibit identical reactions, or cope with the stressful situation in the same way. Lazarus' cognitive phenomenological stress model (Lazarus, 1991, 1993; Lazarus & Folkman, 1984) represents an important contribution to the study of psychosocial stress and coping in the workplace (e.g., Barone, 1995; Harris, 1995).

Lazarus and Folkman (1984, p. 21) defined psychological stress as "a relationship between the person and the environment appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being." In this model, stress refers to the overall subjective experience or transactional process. Lazarus' model distinguishes between potential sources of stress, the appraisal of stressfulness, coping resources, and

strain, or the emotional reactions evoked when the person is not able to cope with the threatening stressor (Lazarus, 1991). For the purposes of this study, stressors are work-related events, situations, and demands encountered by individuals. A variety of occupational stressors are usually experienced with variable frequency and intensity. Strain is defined as the person's psychological and behavioral reactions to stressors (e.g., depressive affect) (Cooper et al., 2001).

Depression and anxiety are two of the most frequently used variables to represent psychological strain in occupational stress research (Beehr, 1995; Karasek & Theorell, 1990; Schuler, 1980). Bootzin, Acocella, and Alloy (1993, p.250) reported that there is increasing empirical evidence of the co-occurrence of depressive and anxiety disorders and showed that symptoms of both disorders overlap considerably. Relatedly, Karasek and Theorell (1990) pointed out that depression of workers in high-strain jobs is much more common than the symptoms of heart disease in the U.S. and Swedish populations. Moreover, Quillian-Wolever, and Wolever (2003) argued that chronic levels of elevated stress can contribute to the development of depression and Tennant (2001) concluded that chronic workplace stress is related to the development of depression. For the purposes of this study, depressive affect (which includes sub-clinical levels of depressive symptomatology) was chosen as an indicator of psychological strain.

Individuals confronting a variety of occupational stressors that exceed their adaptive skills and resources can experience depression (Beehr, 1995; Cooper et al., 2001; Arnold et al., 1998; Holt, 1993; Kahn & Byosiere, 1992; Le Blanc et al., 2000; NIOSH, n.d.). Depressive disorders are among the most prevalent forms of

psychopathology in the adult population in the U.S. (Brantley, Mehan, & Thomas, 2000). Epidemiological research suggests that the Latino population has higher prevalence of affective disorders and comorbidity of depression compared with non-Latino White and Black people (Kessler, McGonagle, Zhao, & Nelson, 1994; Malgady & Rogler, 1993; Moscicki, Rae, Regier, & Locke, 1987; Rogler, Malgady, & Rodriguez, 1989).

Depressive disorders are one of the most prevalent mental health problems in the workplace (Eaton, Anthony, Mandel, & Garrison, 1990; Grosch & Murphy, 1998; Roberts & Lee, 1993). Depression has been associated with several occupational stressors such as evaluation of job performance, role ambiguity, factors intrinsic to the job, poor interpersonal relationships, organizational structure, workload, unfair treatment, and job loss (e.g., Bennett, Evans, & Tattersall, 1993; Farley, 1991; French, Caplan, & Van Harrison, 1982; Israel, House, Schurman, Heaney, & Mero, 1989; Kawakami, Haratani, & Araki, 1992; Mallinckrodt & Fretz, 1988; Martin, Blum, Beach, & Roman, 1996; Revicki & May, 1985; Revicki, Revicki, Whitley, & Gallery, 1993; Revicki & Whitley, 1995; Snapp, 1992).

There is increasing interest in understanding the interaction among workplace stress, psychological well-being, coping behaviors, social support, and other culturally relevant variables in different ethnic groups (Keita & Hurrell, 1994). However, explicit attention to the role of cultural-relevant variables of individuals from different ethnic groups is rare in contemporary occupational stress models. The Multicultural Model of the Stress Process (MMSP) (Slavin et al., 1991) is an expanded formulation of Lazarus' cognitive phenomenological stress model (Lazarus, 1991, 1993; Lazarus & Folkman,

1984). The MMSP explicitly incorporates specific culturally relevant dimensions suggested by the literature and research in multicultural psychology into each of the components of Lazarus' model. At the core of the MMSP is the recognition that both culture and ethnocultural identity influence and guide a person's interaction with his or her environment, including stress appraisal, coping, and adaptational efforts (e.g., Lazarus, 1999a; Marsella, 1994; Marsella & Dash-Scheuer, 1988).

According to Slavin et al. (1991), belonging to a visible racial or ethnic group (e.g, Hispanic) influences perceptions about the availability of resources, expectations for successful coping, and the coping options available. Evaluation of the availability of internal and external coping options and resources for dealing with stressful events depends on cultural definitions of behavioral options, roles, and belief systems. Thus, besides problem and emotion-focused coping efforts, coping behaviors may include religious or spiritual beliefs and rituals and biculturalism.

Lazarus and Folkman (1984, p. 141) defined coping as "constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands appraised as taxing or exceeding the resources of the person." Accordingly, coping is a process that evolves from the use of personal, social, material, and environmental resources to deal with stressful circumstances that, in turn, change the relationship between stressors and strain. Problem-focused coping consists of efforts to alter the person-environment relationship, change the behavior or the environment, or remove or reduce the stressor in circumstances appraised as controllable or amenable to change. Emotion-focused coping consists of efforts to reduce, regulate, or remove the emotional

distress caused by the stressful situation, particularly when people believe that nothing can be done to change the situation. In both models, personal characteristics (e.g. bicultural identity) and belief systems (e.g., religious beliefs) strongly influence the appraisal process and perception of coping resources (Lazarus & Folkman, 1984; Slavin et al., 1991).

The transactional approach to occupational stress conceptualizes social support as a coping strategy. Thoits (1986) argued that social support facilitates coping by assisting the person to change the situation, the meaning of the situation, his or her emotional reaction to the situation, or all three. Thus, social support refers to the appraisal that, in stressful situations, others (family, friends, supervisors, or co-workers) can be relied on for information, empathic understanding, guidance, or material aid (Buunk, et. al., 1998). Abundant empirical evidence suggests that support from superiors, coworkers, family, and friends helps to reduce life stress (e.g., Cohen & Wills, 1985; House & Kahn, 1985; Newman & Beehr, 1979; Sarason, Pierce, & Sarason, 1994; Thoits, 1982; Turner, Frankel, & Levin, 1983) and occupational stress (e.g., Beehr, 1985, 1995; Buunk et al., 1998; Cooper et al., 2001; Holt, 1993; Kahn & Byosiere, 1992; Winnubst, Buunk, & Marcelissen, 1988; Winnubst & Schabracq, 1996).

Slavin et al. (1991) argued that individuals from different ethnic and racial groups are constantly confronted with the need to adapt and function in multiple cultural settings. They defined biculturalism as "the acquisition of skills to negotiate both minority and majority cultural settings" (p. 159). Biculturalism entails a dual socialization process in which new cultural customs coexist with native cultural identity, beliefs, traditions, and

behaviors (Berry, 1980, 1990, 1998; Mendoza & Martinez, 1981; Padilla, 1980; Ramirez, 1983, 1984; Ramirez & Castañeda, 1974; Szapocznik & Kurtines, 1980). Biculturalism has been correlated with psychological well-being (Kurilla, 1998; Lang, Muñoz, Bernal, & Sorensen, 1982), leadership (Garza, Romero, Cox, & Ramirez, 1982), achieving styles (Gomez & Fassinger, 1994), and effective functioning in bicultural environments (Rivera-Sinclair, 1997; Szapocznik, Kurtines, & Fernández, 1980; Szapocznik & Kurtines, 1980).

Religious or spiritual beliefs and rituals are proposed by Slavin et al. (1991) as relevant coping behaviors in dealing with a stressful event. Religious coping is defined as the extent to which persons use their religious beliefs and practices to facilitate problem solving to prevent or alleviate the negative emotional effects of stressful circumstances and to help them to adapt to difficult life events (Koenig, Pargament, & Nielsen, 1998; Pargament, 1997). According to Pargament (1990, 1997), religious beliefs and practices provide a frame of reference that influence one's understanding of life situations, guide in selecting solutions to problems, provide emotional support, and safeguard one's self-esteem and general psychological well-being throughout difficult times. From his perspective, the complementary nature of religious and non-religious methods expand people's repertoire of coping behaviors that may be mobilized to deal with difficult circumstances. Available studies have shown that religious and spiritual activities are frequently used to cope with stress, facilitating better adjustment to traumatic life experiences or health conditions (e.g., Beehr, Johnson, & Nieva, 1995;

Koenig, 1997; Koenig, McCullough, & Larson, 2001; Koenig et al., 1998; Levin & Chatters, 1998; Pargament, 1997; Pargament et. al., 1990).

**Occupational Stress Research among Latinos**

The terms "Latino/a" and "Hispanic" are used interchangeably throughout this study when referencing existing literature. The use of these terms reflects the new terminology in the Standards for the Classification of Federal Data on Race and Ethnicity issued by the Office of Management and Budget (OMB, 1997). According to the OMB, a Latino or Hispanic is "a person of Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race" (p. 21). Latinos are the second largest and fastest growing ethnic population, comprising 13 percent of the people living in the U.S. (Cohn, 2003, June 18; Grieco & Cassidy, 2001; Therrien & Ramirez, 2001).

Theoretical and empirical contributions suggest that Latino/a professionals are besieged by multiple stressors at work. Some stressors frequently identified by Latino/a professionals include (a) issues inherent to their professional practice, (b) discrimination, (c) stereotypes, (d) non-supportive work environment, (e) balancing family and work demands, (f) performance pressure, (g) lack of reward and recognition, (h) lack of role models and mentoring, and (i) professional isolation (Amaro, Russo, & Johnson, 1987; Arellano, 2000; Bermudez, 1988; Cervantes, 1992; Comas-Díaz, 1997; Comas-Díaz & Greene, 1994; Fernandez, 1981; Gant & Gutierrez, 1996; Tafolla, 1985; Valtierra, 1989; Vasquez, 1994). Reported levels of occupational stress have been related to generalized

distress, depression, and multiple health concerns (Amaro et al., 1987; Arellano, 2000; Cervantes, 1992; Salgado de Snyder, Cervantes, & Padilla, 1990).

Multiple coping strategies have been reported useful for reducing occupational stress. Some of these are cognitive reframing, humor, planning, optimism, exercise, time management, self-care, and leisure activities (e.g., Arellano, 2000; Gomez, 1996). Reduced stress and increased psychological well-being have been related to spiritual and religious beliefs and practices (Arellano, 2000; Gomez, 1996; López, 2000) and social support from family, spouse, friends, or co-workers (Amaro et al., 1987; Arellano, 2000; Gandara, 1982; Gant & Gutierrez, 1996; Gomez, 1996; Llerena-Quinn, 1987; Valtierra, 1989). Findings also suggest that biculturalism may have an important stress-coping role for Latino/a professionals in the workplace. Biculturalism has been related to educational achievement (Gandara, 1982), lessened occupational stress (Arellano, 2000; Gant & Gutierrez, 1996; Llerena-Quinn, 1987; Rojas & Metoyer, 1995), and increased career development (Gomez, 1996). Contemporary research about occupational stress among Latinos suggests an increasing interest in identifying potential sources of stress and coping strategies frequently used by this population. Results of these studies are encouraging. However, findings are inconclusive regarding the relationship among occupational stressors, sociocultural variables, coping strategies, and mental health status of Latino/a professionals in the workplace. There is a need for research (a) testing specific models of occupational stress in this population (e.g. interactive effects) and (b) clarifying the role of specific culturally relevant variables (e.g., spiritual or religious beliefs and biculturalism) as moderators of the occupational stress-strain relationship.

**Occupational Stress Research among Psychologists**

Research on occupational stress among counseling and clinical psychologists suggests that these professionals are vulnerable to variable levels of stress that can affect their job performance, relationship with clients, colleagues, and their own psychological and physical health (e.g., Book, 1989; Casas, Furlong, & Castillo, 1980; Cushway & Tyler, 1994; Cushway, Tyler, & Nolan 1996; Deutsch, 1984, 1985; Farber & Heifetz, 1981, 1982; Hellman, Morrison, & Abramowitz, 1986; Nash, Norcross, & Prochaska, 1984; Sherman & Thelen 1998). These studies showed that certain client behaviors, factors related to therapeutic work, and working conditions are frequently reported as important sources of stress. For many psychotherapists, the consequences of occupational stress are manifested in several physical and psychological reactions, including depression (e.g., Book, 1989; Deutsch, 1985; Guy, 1987; Mahoney, 1997; Pope & Tabachnick, 1994). Often, experiencing depressive affect has interfered with their job performance and personal relationships (Gilroy, Carroll, & Murra, 2001, 2002).

However, psychologists, like most people, cope with their difficulties through their own adaptive capacities or with help and support from different relevant sources (e.g., Coster & Schwebel, 1997; Cushway & Tyler, 1994; Kramen-Kahn & Hansen, 1998; Mahoney, 1997; Medeiros & Prochaska, 1988). Religion and spirituality are frequently reported by psychologists as a coping strategy to manage stress (e.g., Coster & Schwebel, 1997; Mahoney, 1997; Shoyer, 1999). However, a study about the effect of spiritual practices on psychologists' well functioning found that spiritual practices do not appear to ameliorate the impact of distress (Case, 2001). Further research is needed to

clarify the role of psychologists' self-care behaviors as moderators of the occupational stress-strain relationship.

Despite the contribution of this research literature to our knowledge of psychologists' occupational stress and coping, there are important limitations to its generalization. Two important limitations of this literature are: (a) most of the studies have been conducted with Caucasian samples, omitting participants from visible racial and ethnic groups (e.g, Hispanics), and (b) very few studies have been designed to test specific models of occupational stress (e.g., interactive effects). The virtual absence of studies assessing the experience of occupational stress and coping of Hispanic professionals in psychology impedes the development of a comprehensive understanding of the phenomena. There is a need for research that frames this inquiry within a model that integrates theoretical concepts of stress with ethnicity and culture.

**Significance of the Study to the Field of Counseling Psychology**

Among the most distinguishing features of counseling psychology are its focus on personal strengths, attention to the role of culture, multiculturalism, and diversity issues, emphasis on effective occupational functioning, and development of healthy work environments (Gelso & Fretz, 2001). This study heeded the call of leading figures in the field encouraging counseling psychologists' contributions to the field of occupational health psychology by investigating occupational stress and health issues and developing interventions to promote healthy work environments (Dawis, 1992; Gerstein & Shullman, 1992; Keita & Jones, 1990; Osipow, 1979; Osipow & Toomer, 1982; Ross & Altmaier, 1994; Watkins, 1994). Hansen (1995) encouraged counseling psychologists to assume a

more active role in contributing their theoretical knowledge, research, and counseling skills to the field of occupational health psychology. This study also followed earlier research contributions of counseling psychologists to the study of occupational stress, strain, and coping of different populations (e.g., Bowman & Stern, 1995; Casas, Furlong, & Castillo, 1980; Decker & Borgen, 1993; Driscoll, Kelley, & Fassinger, 1996; Osipow & Davis, 1988; Osipow, Doty, & Spokane, 1985; Osipow & Spokane, 1984).

This study can advance the field by providing needed information and insight regarding work-related events contributing to occupational stress in a Latino/a professional group. The findings would provide descriptive information on this group's professional and employment situation, their personal strengths, and coping strategies. Such information might be useful for developing counseling services to individuals experiencing stress and consultation to organizations interested in addressing cultural issues in the workplace.

**Statement of the Problem**

The growth of the Hispanic population in the U.S. and their increasing presence in professional settings accentuate the need for studies exploring the reality of Latino/a professionals in the workplace. The stressful reality faced by Latino/a professionals in their work environments may increase their distress and vulnerability to psychological problems such as depression. Therefore, research is needed on specific work-related issues with Hispanics to understand this population's particular sources of stress, coping behaviors, and strengths. This study builds upon previous studies of occupational stress among Hispanics and psychologists and attempts to test MMSP (Slavin et al., 1991)

assumptions regarding the moderating effect of several coping behaviors in the relationship between occupational stress and depressive affect.

**Research Hypotheses**

This study is designed to address the following hypotheses.

**Hypothesis 1:** Depressive affect will be significantly predicted by occupational stress.

**Hypothesis 2:** Coping strategies, social support, biculturalism, and positive religious coping will, individually and collectively, explain significant variance in depressive affect.

**Hypothesis 3:** Coping strategies will moderate the relationship between occupational stress and depressive affect, such that the relation of stress to depressive affect will be weaker under conditions of high versus low use of coping strategies.

**Hypothesis 4:** Social support will moderate the relationship between occupational stress and depressive affect, such that the relation of stress to depressive affect will be weaker under conditions of high versus low use of job social support or non-work social support.

**Hypothesis 5:** Biculturalism will moderate the relationship between occupational stress and depressive affect, such that the relation of stress to depressive affect will be weaker under conditions of high versus low biculturalism.

**Hypothesis 6:** Positive religious coping will moderate the relationship between occupational stress and depressive affect, such that the relation of stress to depressive affect will be weaker under conditions of high versus low religious coping.

**Hypothesis 7:** Social support will moderate the relationship between occupational stress and depressive affect above and beyond coping strategies.

**Hypothesis 8:** Biculturalism will moderate the relationship between occupational stress and depressive affect above and beyond coping strategies and social support.

**Hypothesis 9:** Positive religious coping will moderate the relationship between occupational stress and depressive affect above and beyond coping strategies, social support, and biculturalism.

# CHAPTER II

# LITERATURE REVIEW

This comprehensive review of the literature is divided into five major sections. The section on Latinos in the United States addresses ethnic self-identification, demographic characteristics, and ethnocultural values. The second section summarizes findings on occupational stress, strain, and coping among Hispanics and psychologists. The section on social support addresses conceptual and empirical issues related to sources of support in studies with Latinos and psychologists. Current conceptualizations and correlates of biculturalism are addressed in the fourth section. The fifth section addresses the role of religion and spirituality in coping with stressful life situations.

## Latinos in the United States

### Ethnic Self-Identification: Hispanic or Latino/a

According to the Office of Management and Budget (OMB, 1997), a Latino or Hispanic is "a person of Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race." In this definition, individuals indicating they are "other Spanish/Hispanic/Latino" include those whose origins are from Spain, the Spanish-speaking countries of Central or South America, the Dominican Republic or people identifying themselves generally as Spanish, Spanish-American, Hispanic, Hispano, Latino or other similar term. Origin refers to the heritage, nationality, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the U.S. (U.S. Census Bureau, 2000). It is important to note, however, that individuals with Hispanic ancestry may reject these universal labels, preferring other

forms of ethnic self-identification that better reflect their notions of group identity, sociopolitical ideology, and preference (González, 1997; Marín & Marín, 1991). Most Latinos prefer to identify their cultural heritage or ethnic identity by making reference to their specific national origin (e.g., Puerto Rican, Mexican, Cuban) (De la Garza, DeSipio, Garcia, & Falcón, 1992) or self-identify as Latino (males) or Latina (females) (Hayes-Bautista & Chapa, 1987).

**Demographic Characteristics**

Because of the possible underestimation of the true size of the Hispanic population (Cohn, 2001), the Census information presented here may reflect certain trends and not absolute statistics. Latinos are the second largest ethnic group and the fastest growing population in the U.S. (Cohn, 2003), comprising a population of 35,305,818 or 13% of the people living in the U.S. (Grieco & Cassidy, 2001; Therrien & Ramirez, 2001). Including the 3,808,610 Puerto Rican U.S. citizens on the island of Puerto Rico (U.S. Census Bureau, 2001) the total Latino population becomes 39,114,428. Of the Latinos living in the U.S., 51% are male, with a median age of 25 years. The median age of Latinas is 26 years and represents 49% of the Hispanic U.S. population. Thirty-three percent of the population is between 25 to 44 years of age and 36% are less than 18 years of age (U.S. Census Bureau, 2002).

According to Therrien and Ramirez (2001), the Latino population in the U.S. represents more than twenty different nations. In 2000, the distribution of the Latino population was 66% Mexican, 9% Puerto Rican, 4% Cuban, 15% Central and South American, and 6.4% "Other Hispanic." According to the 1990 Census, 78% of Hispanics

spoke Spanish at home, and half of those reported speaking English "very well," whereas 22% reported speaking no Spanish (U.S. Census Bureau, 1993). Although not all Latinos are fluent and literate in Spanish, a majority identify themselves as Spanish-speaking or bilingual (English/Spanish) (González, 1997; Macías, 1993).

The Latino population is composed of multiracial individuals reflecting great variation in racial self-identification across the different subgroups. Hispanics in the U.S. have a common ethnicity but do not share a common race. Latinos might be categorized as Caucasian, Black, Asian, Mestizo (i.e., persons of mixed ancestry), and perhaps other racial types depending on country of origin or combinations of these categories (Amaro & Zambrana, 2000; Casas, Vasquez, & Ruiz de Esparza, 2002; Jones & Smith, 2001; Marín & Marín, 1991; U.S. Census Bureau, 1991).

Latinos comprise a very small fraction of practicing psychologists in the U.S. Data on degrees awarded in psychology show that 5% of master's degrees and 3.8% of doctorates were awarded to Latinos in 1996-97 (HACU, 2000). Statistical information from the U.S. Bureau of Labor (2002) shows that in 2001 there were 268,000 employed psychologists, of which 3.7% ($n$ = 9,916) are of Hispanic origin. Results of a national survey of licensed psychologists members of the American Psychological Association (APA) showed that 96% identified themselves as White, whereas only 1% identified themselves as Hispanic (Williams & Kohout, 1999). Data from the Center for Mental Health Service revealed there were 29 Latino mental professionals for every 100,000 Latinos in the U.S. (CMHS, 1999 cited in DHHS, 2001). According to the APA's Research Office, in 2002, Latinos comprised 1.86% ($n$ = 1,740) of the APA membership

(*N* = 93,431). Of these 937 identified themselves as clinical psychologists and 188 as counseling psychologists. Latinos represented two percent of the APA membership in clinical and counseling psychology areas respectively (M. Wicherski, personal communication, May 28, 2003; June 17, 2003). Latinos are clearly underrepresented in the profession of psychology when compared with their proportion in the U.S. population.

**Ethnocultural Values**

The Latino population is characterized by its heterogeneous nature. Today, Mexican Americans, Puerto Ricans, and Cubans are the three largest single national groups that make up the U.S. Latino population. Individuals from Hispanic groups differ in such aspects as national origin, racial ascription, generational status, reasons for immigration, citizenship status, length of time in the U.S., educational attainment, acculturation status, and language preference. In addition, Latino culture includes elements of Spanish culture and Indigenous and African influences. These three Hispanic groups are also strongly influenced by the dominant cultural views of the U.S. Anglo-European society (Martinez, 1986; Zea, Quezada, & Belgrave, 1997). This diversity prevents any attempt to address the population as a singular entity (Casas et al., 2002). Vasquez (1994) recognizes that findings for a particular Latino group may not generalize to other groups or to all individuals within a group and cite the need for research involving separate analyses for participants of diverse Latino origins.

According to Marín and Marín (1991), the shared cultural values of Latinos help define them as members of a particular ethnic group despite their demographic variations.

Several authors have argued that cultural values including "simpatía," personalism, collectivism, fatalism, familism, and spirituality and religiosity are prevalent and typical of Latino groups (Bernal, 1982; Bernal & Gutierrez, 1988; Canino & Canino, 1993; Comas-Díaz, 1989, 1997; Fouad, 1994; Garcia-Preto, 1982; Martinez, 1986, 1988, 1993; Ramos-McKay, Comas-Díaz, & Rivera, 1988; Sandoval & De La Roza, 1986). Cultural values are among the personal-internal factors believed to influence the process of whether a situation will be perceived as stressful and the ability to cope with stress (Argueta-Bernal, 1990; Arrellano, 2000; Cervantes & Castro, 1985; Slavin et al., 1991). Ethnocultural values have been proposed as potential moderators of the health status of Latinos (Castro, Coe, Gutierrez, & Saenz, 1996). Elder, Apodaca, Parra-Medina, and Zuñiga de Nuncio (1998) asserted that Latino cultural beliefs influence Hispanics' perception of health, illness, prevention, and treatment of illness. Becoming familiar with Latino cultural values is also important because of their potential influence on the results of studies (Marín & Marín, 1991), and their understanding may help to describe, explain, and predict behavior in this cultural group (Fouad, 1994).

Familism is perhaps one of the most salient and empirically supported characteristics of the Latino culture (Guarnaccia, Parra, Deschamps, Milstein, & Argiles, 1992; Sabogal, Marín, Otero-Sabogal, Marín, & Perez-Stable, 1987; Valle & Vega, 1980; Vasquez, 1994). Marín and Marín (1991), defined familism as a strong identification with and attachment of individuals to their nuclear and extended families, and strong feelings of loyalty, reciprocity, and solidarity among members of the same family (p. 13). For many Latinos, the extended family includes relatives and non blood "relatives" such

as godparents, in-laws, and close friends who are respected, supported, and treated as part of the family. Relationships with extended family and friends are also influenced by personalism (i.e., a tendency to relate in personal, respectful, and caring emotional fashion with other people) and simpatía (i.e., a tendency to develop and maintain smooth and harmonious social relationships) (Comas-Díaz, 1989; Sandoval & De La Roza, 1986).

A critical function of the family is to develop, maintain, and nurture a large network of interpersonal relationships. This extended family structure fosters collectivism, interdependence, and cooperation. From this perspective, people who care for each other are always dependent on each other despite age (Sandoval & De La Roza, 1986). It also provides its members emotional and material support, opportunities for social interaction, and enculturation (i.e., relatives serve as behavioral and attitudinal models of identity) (Sabogal et al., 1987). The family has great potential to influence individual health beliefs and behaviors (Elder et al., 1998), and is frequently the first and only source of support sought to buffer stress (Canino, 1982; Sue & Sue, 2003).

## Occupational Stress, Strain, and Coping among Hispanics and Psychologists

### Occupational Stress and Coping among Hispanic Professionals

Only a handful of studies have investigated different aspects of the occupational functioning of Latinos and how their bicultural identity and adherence to cultural values may influence their behavior at work. Research reviews suggest that Latino/a professionals face a stressful reality at work (e.g., Arellano, 2000; Comas-Díaz, 1997; Comas-Díaz & Greene, 1994). Generalized distress, depression, and multiple health

concerns have been attributed or related to occupational stress in this population (e.g., Arellano, 2000; Comas-Díaz, 1997; Comas-Díaz & Greene, 1994; Gomez, 1996).

Salgado de Snyder et al. (1990) revealed that U.S. born Mexican-American males had higher levels of occupational stress and generalized distress compared with Anglo-American males. Several sources of occupational stressors appear related to Latinos/as minority or solo status (being the only one or one of a few of a given race or ethnicity in a larger group in which the majority are of a different category membership) in educational and professional worlds (e.g., Fernandez, 1981; Gomez, 1996). For example, a group of Mexican-American professional women felt that social stereotypes of Mexican-Americans interfered with their ability to function at full capacity and that their cultural strengths were often misinterpreted and used against them (Tafolla, 1985). Gutierres, Saenz, and Green (1994) argued that small proportional representation of Latinos in the workplace and other social considerations (e.g., a stigma of token status) may engender differential and stereotyped behaviors toward Latinos that may exacerbate stress and possibly impair their health.

Other relevant sources of stress for these professionals are balancing family and professional roles, professional isolation, minimal or no peer support, issues of acculturation, overt or covert ethnic or racial discrimination, tokenism, sexism, ageism, lack of role models and mentors, fragmentation, role conflict, hostile work environment, lack of sufficient income, concern about ability to care for the family's well-being, sexual harassment, pressure to prove their competence, and homophobia (Amaro et al., 1987;

Arellano, 2000; Cervantes, 1992; Gomez, 1996; Salgado de Snyder et al., 1990; Tafolla, 1985; Valtierra, 1989).

Concerning the psychological and physical reactions to occupational stressors, Arellano (2000) found that her sample of professionals had experienced a variety of health, physical, and psychological problems or concerns due to stress. These multiple health concerns included headaches, muscle tension, gastrointestinal problems, sleep disturbance, weight gain, anxiety, high blood pressure, depression, rashes, and ulcers. A group of notable Latinas experienced severe health problems (e.g., high blood pressure) attributed to stress, over-commitment to work, and exhaustion (Gomez, 1996). Cervantes (1992) found a negative correlation between stress and self-esteem in a sample of Hispanic immigrants and second or later generation Mexican Americans. His findings also suggested that as stress appraisal ratings increased, so do reported symptoms of anxiety, depression, somatic complaints, and generalized distress. On the other hand, lower levels of stress were associated with fewer unwanted job demands, increased access to financial rewards, and increased availability of social support (Llerena-Quinn, 1987).

**Coping**. Latinos/as report multiple emotion and problem focused coping strategies for reducing occupational stress. For example, coping efforts of Latina professionals include sports and physical exercise, artistic and literary activities, alternative therapies, direct action-problem solving, yoga, meditation, recreational activities, relaxation, moderate use of alcohol or cigarettes, selective decision making, endurance, humor, cognitive reframing, optimism, time management, planning, self-care,

self-soothing talk, psychotherapy, and getting involved in community service (Arellano, 2000; Gomez, 1996). Findings also suggest that the continuous interaction with both Latino and Anglo-European cultures have influenced the development of a bicultural identity that in turn has diversified their repertoire of behaviors, making their interaction in work settings both adaptable and efficacious (Arellano, 2000; Bermudez, 1988; Fernandez, 1981; Gandara, 1982; Gant & Gutierrez, 1996; Gomez, 1996; Llerena-Quinn, 1987; Rodriguez-Charbonier & Burnette, 1994; Rojas & Metoyer, 1995; Valtierra, 1989). Religious or spiritual beliefs and practices were also revealed as potentially important coping strategies (Arellano, 2000; Gomez, 1996; López, 2000; Rodriguez-Charbonier & Burnette, 1994; Valtierra, 1989).

**Occupational Stress among Counseling and Clinical Psychologists**

A growing body of empirical literature suggests that, health service providers in psychology (e.g., counseling and clinical psychologists) are vulnerable to variable levels of occupational stress that can affect their job performance, relationship with clients, colleagues, and their own psychological and physical health (e.g., Guy, 1987; Sherman & Thelen, 1998). Researchers have identified stressors, strains (e.g., depression), and coping strategies of counseling and clinical psychologists experiencing work stress.

Studies have focused on identifying specific sources of stress, their intensity, frequency, and consequences for professional practice. Empirical evidence suggests that psychologists' occupational stress result from a frequent confrontation with a set of particularly intense stressors. Cushway and Tyler (1994), Deutsch, (1984), and Vagg and Spielberger (1998) argued that only by evaluating both the severity and frequency of

occurrence can one adequately assess the overall impact of a particular stressor and develop a better understanding of the overall stress experienced in a profession. Ratings of the perceived intensity provide information regarding the impact of a particular stressor on an individual's emotional state at the moment of encounter, whereas the frequency of occurrence supplies data on how often the individual has responded to that stressor. Disregarding the frequency of occurrence "may underestimate the full impact of a moderately stressful event that frequently occurs while overestimating the effect of highly stressful events that are never experienced in a work setting" (Vagg & Spielberger, 1998). Thus, experiencing particularly stressful situations weekly has different implications than experiencing the same event yearly (Deutsch, 1984).

**Occupational stressors.** Different sources of stress have been identified with relevance for a broad range of psychotherapists working in different settings. These stressors have been organized in seven categories or factors: (a) workload, (b) client-related difficulties, (c) organizational structure and processes, (d) relationships and conflicts with other professionals, (e) lack of resources, (f) professional self-doubt, and (g) home-work conflict (Cushway & Tyler, 1996; Deutsch, 1984, 1985; Farber, 1983; Farber & Heifetz, 1981, 1982; Hellman et al., 1986; Shinn, Rosario, Morch, & Chestnut, 1984).

Workload stressors refer to situations where psychologists encounter too much work to do (Boice & Myers, 1987; Cushway & Tyler, 1994; Farber & Heifetz, 1981, 1982; Hellman et al., 1986; Nash et al., 1984) too many different things to do (Boice & Myers, 1987; Book, 1989; Culbertson et al., 1992; Cushway & Tyler, 1994; Ross,

Altmaier, & Russell, 1989; Shinn et al., 1984); not enough time to complete all tasks satisfactorily (Boice & Myers, 1987; Book, 1989; Cushway & Tyler, 1994; Nash et al., 1984; Shinn et al., 1984); variable caseload size (Book, 1989; Kramen-Kahn & Hansen, 1998; Nash et al., 1984; Rodolfa, Kraft, & Reilly, 1988; Sherman & Thelen, 1998); and working too-long hours (Book, 1989; Hellman et al., 1986, 1987a).

Client-related difficulties include stressors such as ending treatment with clients (Rodolfa et al., 1988); no change or slowness of progress in clients (Deutsch, 1984, 1985; Farber & Heifetz, 1981, 1982; Kramen-Kahn & Hansen, 1998; Nash et al., 1984; Sherman & Thelen, 1998; Shinn et al., 1984); demanding, difficult, or apathetic clients (Book, 1989; Cushway & Tyler, 1994; Deutsch, 1984, 1985; Rodolfa et al., 1988; Ross et al., 1989; Shinn et al., 1984); physically threatening clients (e.g., suicidal or hostile expressions) (Book, 1989; Deutsch, 1984, 1985; Farber & Heifetz, 1981, 1982; Hellman et al., 1986, 1987a, 1987b; Rodolfa et al., 1988; Ross et al., 1989); managing therapeutic relationships (Book, 1989; Cushway & Tyler, 1994; Deutsch, 1984, 1985; Farber & Heifetz, 1981, 1982; Hellman et al., 1986, 1987a, 1987b; Hellman & Morrison, 1987); susceptibility to emotional overload or depletion (Book, 1989; Deutsch, 1984, 1985; Farber & Heifetz, 1981, 1982; Hellman et al., 1986); and sense of responsibility for clients' lives (Deutsch, 1984, 1985; Hellman et al., 1986; Rodolfa et al., 1988).

Stressors related to organizational structure and processes refer to lack of recognition and support from administrators or supervisors (Boice & Myers, 1987; Book, 1989; Culbertson et al., 1992; Cushway & Tyler, 1994; Deutsch, 1984, 1985; May, Corazzini, & Robbins, 1990; Shinn et al., 1984); business aspects of practice (Culbertson

et al., 1992; Kramen-Kahn & Hansen, 1998; Nash et al., 1984; Sherman & Thelen, 1998); restrictions imposed by managed care companies (Kramen-Kahn & Hansen, 1998; Sherman & Thelen, 1998); and poor communication and access to information at work (Culbertson et al., 1992; Rodolfa et al., 1988).

Relationships and conflicts with other professionals concern situations characterized by conflicting roles with other professionals (Cushway & Tyler, 1994; Deutsch, 1984, 1985; Farber & Heifetz, 1981, 1982; Shinn et al., 1984); difficulty of working with certain colleagues (Boice & Myers, 1987; Book, 1989; Cushway & Tyler, 1994; Deutsch, 1984, 1985; May et al., 1990; Rodolfa et al., 1988); and feelings of isolation from colleagues (Book, 1989; Farber & Heifetz, 1981, 1982; Nash et al., 1984; Rodolfa et al., 1988; Shinn et al., 1984).

Lack of resources refers to stressors where there are inadequate working conditions (Cushway & Tyler, 1994; Farber & Heifetz, 1981, 1982). Professional self-doubt implies feeling inadequately skilled to deal with client's needs or difficult clients (Deutsch, 1984, 1985; Cushway & Tyler, 1994; Farber & Heifetz, 1981, 1982), uncertainty about one's own capabilities (Book, 1989; Deutsch, 1984, 1985; Farber & Heifetz, 1981, 1982; Hellman et al., 1986, 1987a, 1987b; Hellman & Morrison, 1987; Shinn et al., 1984), and doubts about therapeutic efficacy (Deutsch, 1984, 1985; Farber & Heifetz, 1981, 1982; Hellman et al., 1986, 1987a, 1987b; Hellman & Morrison, 1987; Nash et al., 1984; Rodolfa et al., 1988). Home-work conflict refers to situations where psychologists report not having enough time with family (Culbertson et al., 1992; Farber

& Heifetz, 1981, 1982) and inability to separate personal from professional roles (Rodolfa et al., 1988).

**Sex differences.** Research has also revealed that female therapists appear to experience higher levels of personal depletion (Farber & Heifetz, 1981, 1982), more stress from job design (e.g., excessive workload, role conflict) and helping role (e.g., self doubts, pressure to help clients), and higher levels of somatic symptoms (Deutsch, 1984, 1985; Shinn et al., 1984). In addition, Cushway et al. (1996) found that female psychologists reported more general distress associated with client difficulties, self doubt, home-work conflict, and lack of resources.

**Experience level differences.** Overall, older and more experienced psychologists report less stress than younger professionals (Cushway & Tyler, 1994). More experienced therapists reported lower levels of personal depletion than inexperienced therapists (Farber & Heifetz, 1981, 1982). Deutsch (1984, 1985) found that therapists with more years of experience reported lower stress than younger inexperienced therapists regarding client emotionality, responsibility for client, emotional control, and competency doubts. Hellman et al. (1987a) found that older, more experienced therapists reported less stress than inexperienced therapists regarding maintenance of therapeutic relationship, scheduling problems, professional doubts, work over-involvement, and personal depletion. As in Farber (1983), Hellman et al. (1987a) found that years of experience did not affect therapists' reactions to stressful client behaviors. Cushway and Tyler (1994) revealed that more experienced psychologists were more likely stressed by supervision, and those involved in supervision reported higher workload stress.

Professionals with less experience were more stressed by self-doubts and client-related difficulties.

**Work setting differences.** Shinn et al. (1984) reported that therapists in mental health and counseling centers reported experiencing more psychological symptoms and less satisfaction than therapists in private practice. Staff at mental health and counseling centers reported more stress from agency membership and job design, whereas private practitioners experienced more stress from clients and helping role. In Deutsch's (1984, 1985) studies, agency therapists were much more stressed than private practitioners by the need to control their emotions in sessions. According to Hellman and Morrison (1987), psychologists in institutional settings reported more stress from greater feelings of personal depletion than therapists in private practice. Therapists in private practice experienced more stress from clients' psychopathological symptoms than those in institutional settings.

In a study comparing practitioners from university counseling centers and VA medical center internship sites, therapists from counseling centers reported feeling more "stressed or burnout" than VA therapists. Respondents from counseling centers reported more stress from blatantly psychotic speech, severely depressed clients, premature termination, demand by family for information, client apathy or lack of motivation, bizarre gestures or postures, and agitated anxiety. Counseling center therapists also experienced stress from not liking a client, sexual attraction to a client, and sexual attraction between supervisor and supervisee. (Rodolfa et al., 1988). Boice and Myers (1987) suggested that psychology professors (academicians) may experience higher

levels of job stress, health, and mental health problems than psychologists in private clinical practice (practitioners). Their study found that neither group reported markedly high levels of pathology. They concluded that compared to academicians, psychologists in private practice report low levels of job stress and low levels of physical and mental health problems.

**Visible racial and ethnic groups.** In the past two decades individuals from visible racial and ethnic groups and Latinos in particular have been almost completely overlooked by researchers investigating work-related stress among psychologists. Two exceptions to this situation are the studies of Casas et al. (1980) and Llerena-Quinn (1987). Casas et al. (1980) investigated stress and coping among minority counselors, and Llerena-Quinn (1987) investigated the relationship between cultural support, job stress, and perceived social support among Hispanic and non-Hispanic female psychologists working in non-Hispanic work settings.

Casas et al. (1980) are among the first to acknowledge the lack of studies about the experiences, needs, and problems of visible racial and ethnic psychotherapists. Information on socio-cultural variables, situational variables, and personal strengths that visible racial and ethnic psychologists use to cope with occupational stress is of concern to the field of counseling psychology and is needed to advance the knowledge base on this topic (Casas et al., 1980). They surveyed a group of counselors working at college counseling centers at predominantly Anglo institutions of higher education. Latino counselors represented 38% ($n$ = 27) of the sample. The limited sample size of racial and ethnic groups precluded exploration of inter and intra group differences.

Casas et al. (1980) reported their results based on whether counselors felt they had an adequate or an inadequate support system to meet their needs and help them cope with stress. Counselors both with and without adequate support systems experienced stress from (a) lack of sensitivity of the non-minority staff, (b) expectations that visible racial and ethnic counselors can speak for and to all problems of people of color, (c) the lack of institutional support for diversity and multicultural programs, and (d) the value that the institution places on the role of visible racial and ethnic counselors. In addition, counselors with adequate support reported serious occupational stress from the expectations of clients from visible racial and ethnic groups, organizations, and the community.

Counselors with an inadequate support system experienced more stress than those with an adequate social network, experienced the institution as a less supportive work environment, and were more likely to spend most of their time providing direct services to clients from visible racial and ethnic groups. Therapists with inadequate support felt occupational stress from lack of contact with other visible racial and ethnic professional peers, lack of contact with a personal self-help network, lack of opportunity for job advancement, and conflicts with their employer or supervisor (Casas et al., 1980).

**Personal Distress and Depression among Psychologists**

Besides exploring the sources, frequency, and intensity of stressors, researchers have identified physical and mental effects of stress in psychologists' health. Among these manifestations are hypertension, headaches, gastrointestinal problems, coronary difficulties, sleep problems, muscle pains, fatigue, distress, depression (e.g., Book, 1989;

Mahoney, 1997), and burnout (e.g., Ackerley, Burnell, Holder, & Kurdek, 1988; Vredenburgh, Carlozzi, & Stein, 1999). Though no consensus has been reached regarding the distinction between distress and impairment (Guy, 1987; Kilburg, Nathan, & Thoreson, 1986; Sherman, 1996), Nathan, Thoreson, and Kilburg, (cited in Hall, 1986, p. 276) defined a distressed psychologist as a practitioner whose work is adversely affected by physical, emotional, legal, or job related problems. According to Nathan (1986), a distressed professional has a subjective sense that something is not well, whereas an impaired professional may not recognize experiencing personal distress or impairment. Norcross, Prochaska, and DiClemente (1986) defined nonspecific psychological distress as the experience of nervousness, depressed moods, physical complaints, low self-esteem, and feelings of confusion and helplessness about a personal problem.

Several surveys have increased the profession's awareness about the prevalence of psychologists' personal distress regarding depression as a serious professional problem (e.g., Skorupa & Agresti, 1993; Thoreson, Miller, & Krauskopf, 1989; Wood, Klein, Cross, Lammers, & Elliott, 1985). Guy, Poelstra, and Stark (1989), Prochaska and Norcross (1983), Norcross et al. (1986), and Norcross and Prochaska (1986a) found that a substantial amount of therapists experience psychic distress at least once in their lives. Pope, Tabachnick, and Keith-Spiegel (1987) reported that 62% of their sample of psychotherapists admitted to "working when too distressed to be effective" though 85% believed that doing so was unethical. Cushway et al. (1996) and Sherman and Thelen (1998) found that psychologists with high general distress also had high work stress, low

job satisfaction, and poorer quality of social support. A reduction in family support correlated with psychological distress, and home-work conflict was the strongest contributor to general distress (Cushway et al., 1996).

Depression is one of the most frequently addressed problems by psychotherapists in their own therapy (Deutsch, 1985; Gilroy et al., 2001; 2002; Mahoney, 1997; Norcross, Strausser-Kirtland, & Missar, 1988; Pope & Tabachnick, 1994; Thoreson et al., 1989). Other problems addressed in their personal therapy include marriage dissatisfaction, divorce, self esteem, self-confidence, anxiety, irritability, emotional exhaustion, concerns about severity of caseload, sleep disturbance, professional doubts, interpersonal problems, chronic fatigue, loneliness, and feelings of disillusionment about their work (Deutsch, 1985; Mahoney, 1997; Pope & Tabachnick, 1994; Thoreson et al., 1989). In Thoreson et al. (1989) and Gilroy et al. (2001, 2002), women reported more depression than men. However, Deutsch (1985) found no sex differences in the occurrence of depression. Deutsch (1985) also reported doctoral level therapists were less likely than master's level therapists to experience depression. Depression was more prevalent among private practitioners than agency therapists (Deutsch, 1985).

Personal distress and depression have been found to interfere with professional work and affect the quality of patient care (Book, 1989; Gilroy et al., 2001, 2002; Guy, Poelstra, & Stark, 1989; Sherman & Thelen, 1998; Wood et al., 1985). For some therapists, depression affected their clinical work by reducing their energy, ability to be emotionally present, productivity, and concentration. Others reported that depression helped them to be more empathic with their clients and have greater insights into client's

depression, and still others reported no impact on their clinical work (Gilroy et al., 2001, 2002). Taken together, these studies suggest that psychologists can be at risk for depression. However, many of these studies did not clearly assess the link between occupational stress and psychologists' symptoms of depression.

**Psychologists Coping and Self-Care Behaviors**

Most studies suggest that psychologists who had experienced many highly stressful work-related events were particularly susceptible to develop psychological, physical, and behavioral problems. In addition, some of these studies show that certain personal characteristics and behaviors tend to moderate the magnitude of the relationship between occupational stress and strains. Such findings suggest that how much stress a psychologist experiences, and perhaps the extent to which harmful effects occurs, depends on how and how well he or she copes in stressful situations (Latack, 1986). Similarly, Coster and Schwebel (1997) argued that psychologists can maintain a normal state of well functioning if they can manage the inevitable stressors of their professional and personal lives. Individuals with a variety of coping strategies may be less vulnerable to stress than those with a more limited repertoire. In this regard, Cowen (1982) stated that the vast majority of distressed individuals cope with their difficulties through their own adaptive capacities or with the help of family, friends, clergy, or others who may provide counsel.

This view is further supported by the findings of a research program investigating the self-change processes psychotherapists use to overcome their own distress (Book, 1989; Norcross et al., 1986; Norcross & Prochaska, 1986a, 1986b; Prochaska &

Norcross, 1983). These authors noted that therapists do not appear to follow their theoretical orientations when faced with their own psychological distress compared with when they treat their clients' distress. They concluded that therapists may have a larger coping repertoire, seem more pragmatic, selective, and knowledgeable in their coping strategies, and that effective coping may involve a wide repertoire and selective use of coping processes. Coster and Schwebel (1997) further argued that professional impairment is primarily a deficiency of adequate coping resources to deal with stressors that overwhelm the psychologist and not necessarily a deficiency in professional skills.

Findings of exploratory studies suggest that psychologists use many coping strategies rather than one predominant strategy to deal with stressful work events (e.g., Guy & Norcross, 1998; Medeiros & Prochaska, 1988). Frequently used self-care behaviors include both problem and emotion focused coping behaviors (e.g., active problem solving, planning, time management, cognitive restructuring, humor, optimistic perseverance) (Boice & Myers, 1987; Coster & Schwebel, 1997; Cushway & Tyler, 1994; Deutsch, 1985; Hellman et al., 1987; Hoeksma, Guy, Brown, & Brady, 1993; Kramen-Kahn & Hansen, 1998; Macran & Shapiro, 1998; Mahoney, 1997; Medeiros & Prochaska, 1988; Norman & Rosvall, 1994; Pope & Tabachnick, 1994; Sherman & Thelen, 1998; Shoyer, 1998; Thoreson et al., 1989; Wood et al., 1985).

## Social Support

The psychological literature on social support suggests that support from superiors, co-workers, family, and friends helps to reduce or moderate life stress (e.g., Cobb, 1976; Cohen & Wills, 1985; House & Kahn, 1985; Newman & Beehr, 1979;

Sarason et al., 1994; Thoits, 1982; Turner et al., 1983) and organizational stress (e.g., Beehr, 1985, 1995; Buunk et al., 1998; Cooper et al., 2001; Holt, 1993; Kahn & Byosiere, 1992; Winnubst et al., 1988; Winnubst & Schabracq, 1996).

The transactional approach to occupational stress conceptualizes social support as a coping strategy. Coping assistance refers to the active participation of significant others in an individual's stress management efforts. Thoits (1986) argued that social support facilitates coping by assisting the person to change the situation, the meaning of the situation, his or her emotional reaction to the situation, or all three. Social support refers to the appraisal that, in stressful situations, others (family, friends, supervisors, or co-workers) can be relied on for information, empathic understanding, guidance, and material aid (Buunk et al., 1998).

Beehr (1985) argued that supervisors and co-workers are among the primary sources of social support at the workplace whereas family, spouse, and friends are extra-organizational primary sources of support. According to Caplan (1976), the family becomes the main source of support when individuals find their work environment less important than their family, and find the quality and quantity of help provided much better or effective than that provided at work. Pearlin and Turner (1987) argued that the family is the system or context where coping behaviors are learned and developed. Social support from family has been found to decrease the likelihood of experiencing depressive symptoms and to moderate the effect of occupational stress on depression in a sample of physicians (Revicki & May, 1985). In addition, studies have shown that family support has been most effective in reducing work stress for women, whereas

workplace support has been more effective for men (e.g., Dunahoo, Geller, & Hobfoll, 1996; House, 1981).

Studies in organizational psychology have shown several types of effects of social support in relation to occupational stress. These effects include the direct or main effects of social support on stressors and strains, and interaction (or moderating) effects of social support on the relationships between stressors and strains (for reviews see, Beehr, 1985, 1995; Buunk, et. al., 1998; Cooper et al., 2001; House, 1981; Kahn & Boysiere, 1992; Payne & Jones, 1987). The moderating hypothesis states that individuals with a strong support system should be better able to cope with stressful events than those with little or no social support (Thoits, 1982).

Empirical support for these effects is mixed. For example, Caplan, Cobb, French, Van Harrison, & Pinneau (1975) found that social support from supervisors, co-workers, friends, and family alleviated perceived stressors and strains. They also reported that work support tends to be more powerful than home support. Pinneau (1975, 1976) found negative relationships of support to stress and depression. Support from supervisors and co-workers was associated with low level of stress. Pinneau found evidence for direct effects but none for the moderating hypothesis. House and Wells (1978) reported evidence for main and interactive effects, whereas LaRocco and Jones (1978) found no evidence of the moderating hypothesis. LaRocco, House, and French (1980) found that perceived social support did not moderate the relationship between job stress (e.g., role conflict, ambiguity, workload) and job strain, such as job satisfaction and boredom with work. However, they found that perceived social support did buffer the effects of job

stress and job strain on overall mental health (e.g., depression, anxiety). Their study also emphasized that work stress and strain are affected primarily by work support and in particular by co-worker support. Although all three sources of support yielded buffering effects, in contrast to supervisor and home support, co-worker support seemed more influential in buffering employees from the impact of stress on depression.

**Social Support and Hispanics**

Emotional, spiritual, and material support and encouragement provided by parents, spouses or partners, family, friends, and co-workers has been found to be central for Hispanics' educational and professional achievement (Gandara, 1982; Gomez, 1996), family-work stress reduction (Amaro et al., 1987), and occupational stress coping (Amaro et al., 1987; Arellano, 2000; Gant & Gutierrez, 1996; Llerena-Quinn, 1987; Rojas & Metoyer, 1995; Valtierra, 1989). More specifically, these professionals reported that their families are the first and most dependable source of support (Gandara, 1982; Gomez, 1996; Llerena-Quinn, 1987). It is interesting that family support seemed either to balance or outweigh the family as a source of stress for most of these participants.

Family or significant others' support is followed in importance by perceived support from peers and co-workers, particularly in settings with increased availability and accessibility to other Hispanic co-workers (Amaro et al., 1987; Gant & Gutierrez, 1996; Llerena-Quinn, 1987). It also seems that work support may be a source of personal competence and well-being (Amaro et al., 1987; Gant & Gutierrez, 1996). However, some studies in predominantly White work settings have found that highly acculturated Latinas report a greater degree of social support at work, whereas bicultural Latinas

experienced less support at work than at home (Arellano, 2000; Rojas & Metoyer, 1995). These findings suggest that in some work environments Hispanics may experience pressure to acculturate to Anglo-American culture, traditional Latino values may be less welcomed or accepted, or that support from family or community networks is preferred over work support.

**Social Support and Psychologists**

Most studies with psychotherapists report that support from supervisors, colleagues, family, or friends is essential to cope with the effects of stress (Casas et al., 1980; Coster & Schwebel, 1997; Culbertson et al., 1992; Cushway & Tyler, 1994; Cushway et al., 1996; Deutsch, 1985; Farber & Heifetz, 1981, 1982; Gilroy et al., 2001, 2002; Kahill, 1986; Kramen-Kahn & Hansen, 1998; Sherman & Thelen, 1998; Shoyer, 1998; Turnipseed & Turnipseed, 1991). Psychologists with minimal or no support appear more likely to experience occupational stress and burnout (Casas et al., 1980; Kahill, 1986; Persing, 1999; Ross et al., 1989). Studies have shown that the composition, adequacy, and accessibility of social support are important for visible racial and ethnic therapists (e.g., Casas et al., 1980; Llerena-Quinn, 1987). These authors reported that therapists with an adequate support system experienced less occupational stress or burnout.

In Casas et al. (1980), therapists from visible racial and ethnic groups with either adequate or inadequate support systems first try to cope on their own. Their second preference is a professional friend, then a family member, and finally a work associate. Sixty-four percent of the therapists surveyed by Shinn et al. (1984) reported focusing on

family, friends, and social support as coping strategies. Women reported higher levels of social support than men. Social support was negatively correlated with strain but the study provided no evidence favoring the hypothesized buffering (i.e., moderating) role of social support. Findings of Ross et al. (1989), like those reported by Shinn et al. (1984), showed that support from supervisors, co-workers, spouse, and friends did not serve to buffer the effects of occupational stress on burnout.

## Biculturalism

The assessment of acculturation and biculturalism plays an important role in counseling psychology theory, research, and practice (e.g., Arbona, 1990, 1995; Atkinson, Thompson, & Grant, 1993; Atkinson & Thompson, 1992; Knight, Bernal, Garza, & Cota, 1993; Casas & Pytluk, 1995; Fouad, 1994, 1995; La Fromboise, Coleman, & Gerton, 1993; Padilla, 1994; Ruiz, 1990; Ruiz-Rodriguez, 1998). Ethical and cross-culturally sensitive practice and research with Latinos requires the assessment of acculturation and biculturalism because of the influence of these variables on individual performance and assessment outcomes (APA, 1993; Comas-Díaz & Ramos-Grenier, 1998; Dana, 1993; Keitel, Kopala, & Adamson, 1996; Marín, 1992; Moreland, 1996; Negy & Woods, 1992; CNPAAEMI, 2000; Padilla & Medina, 1996).

Measurement of acculturation and biculturalism as moderator variables serves several important purposes. In particular, such measurement makes it possible to (a) explore the relative influence of acculturation and biculturalism on the strength and direction of the relationship between a predictor and a criterion variable (Cuéllar, 2000), (b) understand the contribution of cultural variance to an assessment procedure, and

(c) interpret results of psychological instruments (Dana, 1993). It is also helpful for ascertaining the usefulness of existing non-Latino norms for a particular instrument (Cervantes & Acosta, 1992), and for the exploration of intra group differences (Marín, 1992; Ponterotto & Casas, 1991) as well as between-group differences when using measures designed for and standardized on the Anglo culture (Dana, 1993, 1996). It is relevant to the replicability of research findings (Berry, Trimble, & Olmedo, 1986), and to the investigation of moderators in stress and coping research (Cervantes & Castro, 1985; Slavin et al., 1991).

**Theoretical Models**

Theoretical conceptualizations of acculturation have increased in number and complexity (Birman, 1994; Kim & Abreu, 2001; Ward, 2001). These conceptualizations have shifted from a unidimensional linear model to more contemporary multidimensional and orthogonal models (Atkinson & Thompson, 1992; Berry et al., 1986; Domino, 1992; Keefe & Padilla, 1987; Olmedo, 1979; Ramirez, 1977, 1984; Ward, 2001). Traditional models employed to explain the experience of Latinos when in contact with the Anglo-European culture explained acculturation as a unidimensional linear process typically resulting in assimilation to the dominant culture (Ramirez, 1977, 1984). In the 1970s, the assimilation model was challenged by bicultural theories of acculturation emphasizing the idea that individuals can identify with native and host cultures, function effectively in both, develop a bicultural identity, and experience minimum conflict and a healthy adjustment. This alternative conceptualization promoted the proliferation of self-report measurements designed to assess biculturalism.

Bicultural models view the process of acculturation involving the development of a sense of belonging in two cultures as part of a process of affective, cognitive, and behavioral adjustment. Early models conceptualized biculturalism as the midpoint in a unidimensional continuum between two cultural poles suggesting that as individuals acculturate, they lose some of their original ability while developing different abilities from the host culture. In this model either cultural pole represents a form of monoculturalism (Marín, 1992).

A recent conceptualization of acculturation assumes a dual socialization process on two separate cultural continua, representing low to high levels of commitment to the native and host culture. This model does not imply the gradual loss of one's cultural identity while adapting to another culture because different cultures occupy separate and independent axes. It also allows the possibility of identification with two or more cultures, and incorporates the assumptions of the multidimensional model (Berry et al., 1986).

Several models have been proposed to explain the acculturation process of Latinos; each one provides a particular conceptualization of biculturalism (Berry, 1980, 1990, 1998; Mendoza & Martinez, 1981; Padilla, 1980; Ramirez, 1983, 1984; Ramirez & Castañeda, 1974; Szapocznik & Kurtines, 1980). According to Ramirez and Castañeda (1974) and Ramirez (1983, 1984), a bicultural-multicultural person has had extensive socialization and life experiences in two or more cultures and participates actively in these cultures. They argue that bicultural persons show different problem solving, coping, communication, and motivational styles. The behavior of a bicultural person

appears flexible or adaptable, being able to adjust to a variety of environments and life demands. Bicultural persons show a positive attitude toward the customs, beliefs, and values fostered by the two or more cultural communities with which they are in contact, and they possess competent skills for dealing with members of the contact groups. Also, Padilla (1994) posited that biculturalism allows individuals to succeed in the dominant culture, gives them positive ethnic related coping responses, and represents an important source of social support.

Szapocznik and Kurtines (1980) viewed acculturation as a complex process of accommodation to a cultural context that may be either unidimensional or bidimensional. In their model, the degree to which the cultural context within which acculturation takes place is monocultural or bicultural and the relative impact each culture makes on the larger social context are two important elements in the acculturation process. Szapocznik (personal communication, July 17, 2003) defines a bicultural environment as one with plentiful access to both cultures.

According to Szapocznik and Kurtines (1980), how much time the individual has been in contact with the dominant culture influences the individual's accommodation to it, whereas the degree and availability of community support for the culture of origin influences the individual's retention of the characteristics of the native culture. They concluded that for individuals living in bicultural environments, effective adjustment requires an acceptance of both cultural worlds, and skills to live and interact with both cultural groups (Szapocznik & Kurtines, 1980; Szapocznik et al., 1980).

A well-known and empirically supported model of acculturation was proposed by Berry and his colleagues (Berry, 1980, 1990, 1998; Berry, Kim, & Boski, 1988; Berry & Sam, 1997; Berry et al., 1986). His model conceptualizes native and host culture identities as independent or orthogonal, and the acculturation process as involving types of psychological adaptation or strategies that individuals can choose from to reduce the experience of conflict (Berry, 1980). Berry argues that acculturating individuals are faced daily with two central questions regarding the retention of their native culture (Is it of value to retain my cultural identity?) and the extent of their contact and participation in the host culture (Is it of value to become involved with other groups?).

These two questions are considered simultaneously and invoke positive or negative attitudinal responses. The result is a conceptual framework distinguishing four different acculturation strategies: assimilation, integration, separation, and marginalization. Individuals who respond "yes" to both questions are identified as integrated or bicultural, which implies retention of one's identity and active involvement in the host culture. Berry and his colleagues have shown that integration or biculturalism is the most preferred strategy by immigrants in multicultural societies (Berry, 1980, 1990, 1998; Berry et al., 1988; Berry & Sam, 1997; Berry et al., 1986).

Bicultural models have guided researchers' interest in exploring the role of biculturalism in behavior and psychological functioning. Biculturalism is positively related to several variables such as psychological adjustment (Fernández-Barillas & Morrison, 1984; Lang et al., 1982; Rivera-Sinclair, 1997; Szapocznik et al., 1980; Szapocznik & Kurtines, 1980), leadership (Garza et al., 1982), and achieving styles

(Gomez & Fassinger, 1994). It also has been proposed as an influential variable in Latina professional educational achievement (Gandara, 1982), career development (Gomez, 1996), psychological well-being (Kurilla, 1998), and occupational stress (Arellano, 2000; Fernandez, 1981; Llerena-Quinn, 1987; Rojas & Metoyer, 1995; Valtierra, 1989).

## Religion and Spirituality in Coping with Stressful Life Situations

A growing body of popular, empirical, and theoretical literature recognizes the influence of religious and spiritual beliefs on human psychological and behavioral functioning, particularly when coping with stressful life events (e.g., Goldman, 1991; Hoge, 1996; Pargament, 1997). Pargament (1997) defined (a) religion as a process, a search for significance in ways related to the sacred (p. 32), and (b) spirituality as the central function of religion, the search for the sacred (p. 39). Religious coping is defined as the extent to which persons use their religious beliefs and practices to facilitate problem solving to prevent or alleviate the negative emotional effects of stressful circumstances and to help them to adapt to difficult life events (Koenig et al., 1998; Pargament, 1997). More specifically, positive religious coping refers to an expression of a sense of spirituality, a secure relationship with God, a belief that there is meaning to be found in life, and a sense of spiritual connectedness with others.

### Religiosity, Spirituality, and Coping among Hispanics

Like other ethnic and racial groups, Latinos are a religiously diverse population, some members of whom are strongly influenced by their spiritual and religious beliefs and practices (Fukuyama & Sevig, 2002). Spiritual and religious beliefs appear to influence their views of health, illness, treatment, and health seeking behavior (Comas-

Díaz, 1989; Elder et al., 1998; Purdy, Simari, & Colón, 1983; Zea, Mason, & Murguía, 2000). Latinos' reliance on spirituality, faith, prayer, invocation of saints or spirits, and religious institutions provides them a means of coping with psychological stress, resolving problems, and a sense of security and well-being (Argueta-Bernal, 1990; Bach-y-Rita, 1982; Guarnaccia et al., 1992; Martinez, 1986; Perez y Mena, 1977; Plante, Manuel, Menendez, & Marcotte, 1995).

Puerto Ricans, Mexican Americans, and Cubans are a religiously diverse population. Their religious affiliations include Catholic, Christian, Protestant, Pentecostal, Jehova's Witness, Islam, and other evangelical and fundamentalist faiths (Comas-Díaz, 1989; Jenkins, 2001; Kosmin, Mayer, & Keysar, 2001; Zea et al., 2000). Eleven percent of Hispanics surveyed in the American Religious Identification Survey indicated that they have no religion (Kosmin, Mayer, & Keysar, 2001). Most Latinos are affiliated with the Catholic church (Bach-y-Rita, 1982; Kosmin, Mayer, & Keysar, 2001; Sandoval & De La Roza, 1986; Sue & Sue, 2003). In addition to their active involvement in organized religion, Latinos have strong spiritual beliefs and some sectors of the population believe in folk healing traditions, including "santería," "espiritismo" or "curanderismo" (Bernal & Gutierrez, 1988; Comas-Díaz, 1981; Garcia-Preto, 1982; Martinez, 1993; Ramos-McKay et al., 1988; Robinson, 2000, November 20; Zea et al., 2000; Zea et al., 1997).

Studies with immigrants and bicultural Latino/a professionals in the U.S. suggest that religion and spiritual beliefs may influence appraisal of and coping with stress. For example, Plante et al. (1995) examined psychosocial stress factors and coping strategies

of a group of Salvadoran immigrants to the U.S. Participants reported a firm reliance on their strong religious faith for coping. Plante et al. (1995) argued that church and community support gave these immigrants a sense of community, which served to buffer the experience of isolation. Guarnaccia et al's. (1992) study with Hispanic families discovered that spiritual and religious factors influenced these families' conceptions of mental illness and gave them a way to understand their problems. In addition to family support, religious beliefs, practices, and involvement in community sources of spiritual help (e.g., churches, spiritist centers, and "santeros") were a major source of comfort and support. For these families, strong religious beliefs were not an impediment to seeking professional health care.

Lang et al. (1982) investigated the mental health status of a group of bicultural Latinos in California. Participants' satisfaction with their religious and spiritual activities was second only to their satisfaction with family relationships. Llerena-Quinn (1987) suggested that for Latina psychologists, support provided by social networks such as family and religious institutions may be more relevant in moderating occupational stress than work support. Valtierra's (1989) study with highly acculturated-bicultural Latina physicians revealed that spiritual support helped them to cope and reduce work-related stress. Rodríguez-Charbonier and Burnette (1994) found modest levels of stress in a sample that was predominantly Adventist. Gómez (1996) reported that most women in her study of notable bicultural Latinas felt strong bonds with their religious and spiritual groups, experienced a deep sense of spirituality and religiosity, and used religion and spirituality in coping with stressful times. López (2000) found that Hispanic faculty

affiliated with the Catholic religion reported lower levels of depersonalization. Arrellano (2000) revealed that her sample of bicultural Latina professionals used alternative therapies, folk healers (talking to a curandera), and eastern and western spiritual or religious traditions as coping behaviors.

These findings suggest that, for Latinos, active religious involvement and biculturalism may be among the factors that contribute to quality of life and general psychological well-being. Biculturalism entails a dual socialization process in which new cultural customs coexist with native cultural identity, beliefs, traditions, and behaviors. In this sense, it seems possible that bicultural Hispanics maintain their religious and spiritual beliefs and practices as these are central to their ethnic/cultural identity. Thus, as religiosity appears to represent a core ethnic or cultural characteristic for many Hispanics, it also becomes an important personal and social coping resource when facing stressful situations (e.g., acculturation process, occupational stress). It may also be that some individuals seek out religion during the process of acculturation (e.g., spiritual support, prayer), becoming involved in a religious community and relying on their spirituality as part of their continued adjustment to different demanding situations. These studies support further exploration of the additive contribution of religious coping as a moderator of the relationship between occupational stress and strain above and beyond of the contribution of family and work related social support.

**Religiosity, Spirituality, and Coping among Psychologists**

Almost 27 years ago, Beit-Hallahmi (1977) concluded that American psychology considered religion marginal. Ragan, Malony, and Beit-Hallahmi (1980) found that

psychologists were less religious and tended to have less involvement with worship services than does the general academic population. Recent investigations show that psychologists (a) report a variety of religious affiliations (Bergin & Jensen, 1990), (b) apprehend religious and spiritual issues in a highly individualistic manner (Bergin & Jensen, 1990; Shafranske & Gorsuch, 1985; Shafranske & Malony, 1990b), (c) describe their religious orientation as part of an alternative spiritual path (Shafranske & Gorsuch, 1985; Shafranske & Malony, 1990a, 1990b), (d) are relatively uninvolved in organized religion (Bergin & Jensen, 1990; Brossart et al., 2000; Shafranske & Gorsuch, 1985; Shafranske & Malony, 1990a, 1990b), (e) endorse a personal, transcendent God orientation (Shafranske & Malony, 1990a), (f) appear to regard religious and spiritual beliefs as valuable and relevant to their personal life and professional work (Brossart et al., 2000; Lannert, 1992; Shafranske, 1996; Shafranske & Malony, 1990a, 1990b), and (g) respect religious beliefs of others (Shafranske & Malony, 1990b). It appears that psychologists hold an attitude toward religion that may be similar to that of the general population, address spiritual and religious issues in their personal lives, view religious beliefs in a positive and valuable light, identify themselves as involved in more personal spiritual beliefs and practices, and are less likely to affiliate and become involved in organized religion than is the general population (Shafranske, 1996).

Religion, spirituality, prayer, and attending church or spiritual services are among the most frequently reported self-care behaviors used by psychologists to manage stress (Coster & Schwebel, 1997; Guy & Norcross, 1998; Mahoney, 1997; Norcross & Prochaska, 1986; Sherman & Thelen, 1998; Shoyer, 1998). Stark (1990) investigated

whether a psychotherapist's intrinsic or extrinsic religious orientation was correlated with burnout. Stark proposed that psychologists with an intrinsic orientation toward religion would experience less occupational stress and burnout, whereas those with an extrinsic orientation would experience increased vulnerability to stress and strain. Results suggested that religious orientation was not a significant variable in predicting the experience of burnout. Intrinsic religious orientation did not account for much variance in burnout variables.

In a study of the relationship between spiritual involvement, work environment, and psychologists' burnout, participants revealed a reliance on faith as a source of support and sustenance, reported firm spiritual convictions, and had high tolerance for a variety of beliefs (Persing, 1999). Results suggested that a majority made conscious efforts to live according to their faiths or spiritual beliefs. Seventy-nine percent agreed that their faith helps them to confront or cope with suffering and painful life events. Spiritual support and spiritual involvement were highly associated with psychologists' feelings of accomplishment. Female psychologists relied on spiritual beliefs more than males.

Case (2001) examined the effect of spiritual practices on psychologists' well functioning (i.e., the enduring quality in one's professional functioning over time and in the face of professional and personal stressors). The sample was divided into two groups, more religious and less religious, based on the extent to which involvement in a church or synagogue had contributed to their ability to function well. Most participants reported

minimal distress during the previous three years and no group differences were found regarding their global distress score.

Religious psychologists reported using spiritually oriented means of coping, particularly prayer or meditation, and attended religious services. Relaxation, diversity of professional roles, meditation or prayer, guidance from clergy, and relationship with family were important contributors to religious psychologists' sense of well functioning. No significant correlation was observed between positive religious coping and distress after controlling for negative religious coping. According to Pargament, Smith, Koenig, and Perez (1998) the pattern of positive religious coping behaviors represents an expression of a sense of spirituality, a secure relationship with God, a belief that there is meaning to be found in life, and a sense of spiritual connectedness with others. The pattern of negative religious coping represents an expression of a less secure relationship with God, a tenuous and ominous view of the world, and a religious struggle in the search for significance (Pargament et al., 1998).

Though Case (2001) found that spiritual practices do not appear to ameliorate the impact of distress, he cautioned about the interpretation of these results and argued that the small amount of variance accounted for by negative religious coping should not lead to conclusive interpretations about the relationship between religious coping and distress. It is important to point out that religious coping seems more common in dealing with stressful situations (Bickel et al., 1998; Pargament, 1997). He argued that for some psychologists, their faith is at the center of their life, and spiritual practices are among their first resources for coping with the stresses of professional work. Studies have

addressed psychologists' religiousness, but there has been little exploration of their use of religious coping with stress in their professional lives. Some limitations of previous studies include lack of adequate sample sizes and omission of participants from visible ethnic or racial groups. In spite of the relatively high percentage of Latino professionals and psychologists who report maintaining some degree of religiosity or spirituality and using religious and spiritual coping behaviors, no known studies have investigated the effect of religious coping on the relationship between occupational stress and strain among Latino/a psychologists.

Pargament (1997) argued that both religious and non-religious coping behaviors can be potentially useful when dealing with stressful circumstances and in buffering the effects of stress. Research should therefore explore whether religious coping adds something unique to the coping process above and beyond the contribution of non-religious coping behaviors when dealing with difficult life experiences. These studies should also be conducted with individuals from different ethnic and racial groups (e.g., Latinos) to help identify the helpfulness and/or harmfulness of various religious coping methods among specific populations (Pargament & Brant, 1998).

# CHAPTER III

# METHOD

This chapter introduces the design, participants, instruments, procedure, and data analysis of this study. This study uses a non-experimental or passive observational design to investigate the role of coping, social support, biculturalism, and positive religious coping as moderators of the relationship between occupational stress and depressive affect in a national sample of counseling and clinical Latino/a psychologists.

## Participants

Research survey packets were sent to 1,200 doctoral level counseling and clinical psychologists with residence in the United States, members of national or state psychological associations, who identified themselves as "a person of Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race." This included individuals whose origins are from Spain, the Spanish-speaking countries of Central or South America, the Dominican Republic or people identifying themselves generally as Spanish, Spanish-American, Hispanic, Hispano, Latino or other similar terms (OMB, 1997). Psychologists who lived in a country other than the United States were not part of this study.

## Power Analysis and Determination of Return Rate

To determine an adequate sample size for this study a power analysis was conducted using a range from small to medium effect sizes based on Cohen (1992), Cohen and Cohen (1983), and Green's (1991) suggested guidelines for multiple correlation analysis. Conventional values for small, medium, and large $R^2$ are .02, .13,

and .26 respectively. Assuming an effect size from .02 to .13 for an analysis including up to four independent variables, results of the power analysis indicate that a minimum of 602 (small effect) to 85 (medium effect) participants were necessary to achieve a statistical power of .80 with an alpha equal to .05.

The following equation was used to determine the survey response rate. According to Dillman (1978), the response rate is calculated as the percentage of contacts with eligible respondents that resulted in completed questionnaires. This method allows for the exclusion of unmade and non-eligible contacts. Of the 1,200 packets that were mailed, 37 were returned as undeliverable and 4 were unusable, thus reducing the number of potential eligible respondents to 1,159. Usable surveys were received from 580 participants for an overall return rate of 50%. The current sample of 580 participants seemed reasonably close to the required sample size, providing the study with adequate power to reliably detect even small effects.

$$\text{Response rate} = \frac{[580]\ \text{number returned}}{[1{,}200]\ \text{number in sample} - ([4]\ \text{non-eligible} + [37]\ \text{non-reachable})} \times 100$$

Tables 1 and 2 provide demographic, professional, and employment statistics for the participants in the study. Frequencies and percentages on sex, Hispanic identity, marital status, and religious-spiritual preferences of participants are presented in Table 1. Of the 580 Latino psychologists who participated in the study, 62.20% ($n$ = 361) were females. The average age was 47.25 with a standard deviation of 10.21 and a range from 26 to 90 years ($n$ = 575). In terms of ethnicity or Hispanic heritage, 28.84% ($n$ = 167) identified themselves as Mexican or Mexican-American Chicano, 18.30% ($n$ = 106) as

Puerto Rican, 17.80% (*n* = 103) as Central or South American, and 17.60% (*n* = 102) as Cuban. A complete list of categories and combination of categories regarding ethnic heritage is presented in Appendix A. Sixty-nine percent (*n* = 397) were married and 54% (*n* = 311) were born in the United States. The average number of years lived in the United States for those who were not born in the U.S. was 31.28 with a standard deviation of 11.26 and a range from 3 to 57 years (*n* = 246).

Participants resided in forty states throughout the United States. Participants' geographic location was divided according to the categories developed by the U.S. Census (see Therrien & Ramirez, 2000; Appendix B). Respondents were predominantly from the West (34.65%, *n* = 201) and South regions (32.24%, *n* = 187), followed by the Northeast (22.06%, *n* = 128), and Midwest regions (11.03%, *n* = 64). The regional distribution of participants in this study resembled the distribution of the Hispanic population in 2000 according to the U.S. Census (Therrien & Ramirez, 2000)

In terms of religious-spiritual preference 48% (*n* = 277) identified themselves as Catholic. A complete list of categories and combination of categories regarding religious-spiritual preferences is presented in Appendix C. Participants were asked to rate on a scale from 0 (not at all) to 10 (very important) how important religion or spirituality was for them. Five hundred and seventy-seven participants responded to this item. The average score in this scale was 6.94 with a standard deviation of 3.13 suggesting a high degree of importance. Sixty six percent (*n* = 379) rated this item between 7 and 10. Of the total, 30% (*n* = 173) rated religion or spirituality very important. Religion or spirituality was rated as more important by Hispanic female

psychologists ($M$ = 7.20, $SD$ = 3.03) than male psychologists ($M$ = 6.51, $SD$ = 3.26), $t(575) = 2.59$, $p = .01$ (two-tailed) (effect size $r = .11$). Fifty-seven participants (38 females and 19 males) distinguished spirituality from religion and based their rating on how important spirituality was for them.

Table 1

Demographic Characteristics of Participants

| Characteristic | *n* | % |
|---|---|---|
| Sex | 579 | |
| Male | 218 | 37.60 |
| Female | 361 | 62.20 |
| Hispanic Identity | 579 | |
| Puerto Rican | 106 | 18.30 |
| Mexican or Mexican American-Chicano/a | 167 | 28.84 |
| Cuban | 102 | 17.60 |
| Central or South American | 103 | 17.80 |
| Latino/a | 31 | 5.30 |
| Hispanic | 38 | 6.60 |
| Other | 32 | 5.52 |
| Marital Status | 577 | |
| Never Married | 59 | 10.20 |
| Married | 397 | 68.80 |
| Separated-Divorced or Widowed | 71 | 12.30 |
| Partnered-committed relationship | 50 | 8.70 |
| Religious-Spiritual Preference | 579 | |
| Catholic | 277 | 47.80 |
| Protestant | 59 | 10.20 |
| Jewish | 37 | 6.40 |
| Eastern | 25 | 4.30 |
| Agnostic | 32 | 5.50 |
| None | 69 | 11.90 |
| Other | 80 | 13.82 |

Frequencies and percentages on academic degree, major field, primary job position, employment status, and employment setting of participants are presented in Table 2. Four hundred and thirty-eight (77%) participants reported a Ph.D. degree and 80% ($n$ = 462) identified clinical psychology as their major field. Of the female psychologists who participated, 18.90% ($n$ = 66) are counseling psychologists and 81.10% ($n$ = 284) are clinical psychologists. The average number of years of experience as a psychologist was 16.14 with a standard deviation of 9.36 and a range from 1 to 47 years ($n$ = 550).

Fifty percent ($n$ = 286) identified themselves as a direct human services practitioner. Eighty-two percent ($n$ = 472) are employed full-time (30 or more hours per week). In terms of employment setting for their primary position, 35.25% ($n$ = 202) hold consulting and independent practice, and 21.29% ($n$ = 122) work in a university or college setting. Participants reported an average of 11.71 years of work experience in their primary job position with a standard deviation of 8.76. Participants were asked to rate on a scale from 0 (not at all) to 5 (very) the extent to which they considered their work setting a bicultural environment. Five hundred and seventy-three participants responded this item. The average score on this scale was 2.46 with a standard deviation of 1.81. Thirty-four percent ($n$ = 192) rated this item between 4 and 5. Of the total, 21% ($n$ = 124) rated their work setting very bicultural. No statistically significant differences were found between males ($M$ = 2.54, $SD$ = 1.78) and females ($M$ = 2.42, $SD$ = 1.84) regarding the degree to which they considered their work setting bicultural, $t(570) = .81$, ns. Participants' current work setting seemed characterized by a moderate degree of

biculturalism or showing a modest availability or accessibility to key elements of Latino and Anglo-American cultures.

Data from the APA's Research Office (T. Washington, personal communication, July 14, 2004) indicated that in the year 2004 there were 177 (16.40%) Hispanic counseling psychologists and 905 (83.60%) Hispanic clinical psychologists for a total of 1,082 Hispanic members in these areas. Of these, 55.60% ($n$ = 602) were females and the average age was 50.20 with a standard deviation of 10.80. In terms of highest degree, seventy five percent ($n$ = 811) reported a Ph.D. degree and sixteen percent ($n$ = 174) a Psy.D. degree. The average number of years since degree was 16.90 with a standard deviation of 9.70. The characteristics of participants in this study resembled the characteristics of the APA Hispanic counseling and clinical psychologists' membership according to the 2004 APA Directory Survey.

The "typical" participant in this study is a 47-year-old married Mexican-American Chicana who was born in the United States and resides in the West region of the country. She identifies herself as Catholic and considers religion or spirituality important. Professionally, she holds a Ph.D. degree in clinical psychology, identifies herself as a direct human service practitioner, has 16 years of experience, is employed full-time, combines consulting and independent practice with work at a university or college, and considers her work environment to be characterized by a moderate availability or accessibility to key elements of Latino and Anglo-American cultures.

Table 2

Professional and Employment Characteristics of Participants

| Characteristic | *n* | % |
|---|---|---|
| Academic Degree | 567 | |
| Ph.D. | 438 | 77.20 |
| Psy.D. | 114 | 20.10 |
| Ed.D. | 15 | 2.60 |
| Major Field | 562 | |
| Counseling Psychology | 100 | 17.20 |
| Clinical Psychology | 462 | 79.70 |
| Employment Status | 575 | |
| Full-time | 472 | 82.00 |
| Part-time | 92 | 16.00 |
| Unemployed | 2 | .34 |
| Retired | 9 | 1.60 |
| Primary Job Position | 575 | |
| Faculty | 90 | 15.65 |
| Administrator | 61 | 10.60 |
| Consultant | 38 | 6.60 |
| Researcher | 8 | 1.39 |
| Direct Human Services-Practitioner | 286 | 49.74 |
| Faculty-Human Services Practitioner | 20 | 3.47 |
| Faculty-Administrator | 11 | 1.91 |
| Consultant-Human Service Practitioner | 34 | 5.91 |
| Administrator-Human Service Practitioner | 15 | 2.60 |
| Other combinations | 12 | 2.09 |

(table 2 continues)

Table 2 (continued)

| Characteristic | *n* | *%* |
|---|---|---|
| Employment Setting | 573 | |
| University or college | 122 | 21.29 |
| Human services setting | 99 | 17.28 |
| Consulting and independent practice | 202 | 35.25 |
| Private sector organization | 38 | 6.63 |
| Public sector organization | 61 | 10.65 |
| Human services setting-consulting and independent practice | 15 | 2.61 |
| University-consulting and independent practice | 13 | 2.27 |
| Other combinations | 23 | 4.01 |

**Instruments**

Participants responded to seven instruments. Sources of strain or stressors were measured by the Mental Health Professionals Stress Scale. Depressive affect, a psychological response to stressors (i.e., strain), was measured by the Center for Epidemiologic Studies Depression Scale short form. Moderator variables were assessed with the Multidimensional Scale of Perceived Social Support (family & significant other support), the Job Content Questionnaire (job social support), the Brief COPE, the Brief RCOPE, and the Abbreviated Multidimensional Acculturation Scale for Latinos short form. A demographic questionnaire was developed by the researcher to gather personal background and profession-related information; it included three sections: (a) demographic information, (b) professional information, and (c) employment information.

**Mental Health Professionals Stress Scale (MHPSS).** The MHPSS is a research instrument designed to identify and assess specific sources of job stress for mental health

professionals (Cushway et al., 1996). The self-report scale contains 42 items each describing a typical source of stress that is likely to be encountered by mental health professionals in different job settings. Each of the items is answered on a four-point response scale, scored from "does not apply to me" (0) to "does apply to me" (3).

Internal consistency analysis of the MHPSS subscales based on a sample of British clinical psychologists indicated a Cronbach alpha coefficient for the total scale of .87 (Cushway et al., 1996). Similar analyses were conducted with a sample of clinical psychologists in India, revealing a Cronbach alpha for the total scale of .89 (Mehrotra, Rao, & Subbakrishna, 2000). Cushway et al. (1996) reported content-related validity based on an exploratory factor analysis using principal components analysis with varimax rotation. The seven factors extracted accounted for 55 percent of the variance. Evidence of concurrent and discriminant validity was reported by Cushway et al. (1996, p. 290) and Mehrotra et al. (2000).

For the purposes of this study minor modifications were introduced in the wording of items and in the format for responding to them. The wording of items was revised to conform to contemporary English language usage in the United States (e.g., organizational instead of organisational). Other item modifications included: in items 4 and 25 the terms "physician, psychiatrist" replaced "doctor, nurse" and in item 10 the term "immediate supervisor" replaced "line manager."

The current response format of the MHPSS does not permit a clear evaluation of the perceived intensity of stressors. In addition, the format provides no information on how often each of the stressors was encountered. For the purposes of the present study,

the format for responding to the MHPSS was modified to assess perceived stressor severity and frequency of occurrence, following the procedures used by Hellman et al. (1987a), Ross et al. (1989), Vagg and Spielberger (1998), and Spielberger, Reheiser, Reheiser, and Vagg (2000). The latter two studies involved the Job Stress Survey.

Adapting the procedure proposed by these authors, respondents were asked first to rate on a 7-point scale, ranging from 1 ("least stressful") to 7 ("most stressful"), the relative amount of stress (severity) that they perceived to be associated with each of the job stressors. This indicated whether each of the stated situations was a source of stress in their practices and how stressful the situation was perceived. Respondents were asked to base their ratings on personal experience. If a particular situation was not experienced, respondents were asked to base their rating on an estimation of how stressful the situation would be if encountered. In addition to rating the perceived severity of each stressor, respondents were asked to report how frequently each stressor was encountered during the preceding six months by indicating, on an 8-point scale ranging from 0 to 7 or more, the number of days on which each stressor was experienced. A rating of 0 indicated that the situation did not occur whereas a rating of 7 or more indicated that the situation was experienced on 7 or more days during the past six months. These modifications yield a severity score, a frequency score, and a total job stress score for each respondent based on the average rating for all items.

Following the scoring and interpretation procedures proposed by Vagg and Spielberger (1998), the severity score for each respondent was computed by summing the ratings for each item for the severity scale and then dividing the resulting total by 42.

This produced a severity score range of 1.00 to 7.00. The frequency score for each respondent was computed by summing the ratings for each item for the frequency scale and then dividing the resulting total by 42. This produced a frequency score range of 0.00 to 7.00. The total job stress score for each respondent was computed by multiplying the severity rating for each item by its frequency rating, summing these products, and dividing by 42. The minimum possible total job stress score for an individual who reports experiencing none of the situations in the past six months would be 0.00. The maximum possible total job stress score is 49.00: (7x7x42)/42.

**Center for Epidemiologic Studies Depression Scale (CESD).** The CESD was developed at the Center for Epidemiologic Studies of the National Institutes of Mental Health (Radloff, 1977) and was recently revised by Eaton et al. (in press). The CESD is a 20 item self-report measure used to estimate depressive symptom prevalence within the last week for adults in the general population.

The original version of the CESD demonstrated good psychometric properties for the general population and when used with Hispanic adults. In Radloff (1977), Cronbach alpha and Spearman Brown coefficients were .85 and .87 for normal groups. Eaton et al. (in press) reported that the CESD internal consistency coefficients among community samples ranged from .80 to .90. Cervantes et al. (1991) reported a Cronbach alpha coefficient of .87 in a sample of Latin American immigrant and U.S. born Mexican Americans. Areán and Miranda (1997) reported alphas of .89 and .96 for older and younger Hispanics, respectively. Temporal reliability for intervals from two weeks to one year was reported to range between .40 and .70 (Eaton et al., in press). Concurrent

validity was reported by Radloff (1977) and Santor, Zuroff, Ramsay, Cervantes, and Palacios (1995). Analyses of the factor structure of the CESD with Hispanic samples indicated a 4-factor structure that was fairly similar to that obtained by Radloff (Golding & Aneshensel, 1989). A recent study indicated gender differences in the factor structure with a sample of urban Latinos (Posner, Stewart, Marín, & Perez-Stable, 2001).

For the purposes of this study a short form of the CESD was used to measure current depressive symptoms (Andresen, Malmgren, Carter, & Patrick, 1994). The short form consists of 10 items focusing on depressed mood, irritability, concentration, anhedonia, hopelessness, anxiety, sleep disturbance, loneliness, lethargy, and unhappiness. Respondents were asked to rate the frequency of occurrence of each of the items on a four-point scale ranging from "Not at all or less than one day" (0) to "Nearly every day for 5 to 7 days" (3). The CESD - 10 is scored by adding the ratings for all the items after reversing the positive affect items (5 & 8), with higher scores indicating more symptom presence, weighted by frequency of occurrence. Total scores range from 0 to 30. Scores at or above 10 mean probable depression.

The CESD - 10 was derived from an analysis of item-total correlation (Andresen et al., 1994). Two separate principal component factor analyses yielded two factors named positive affect and negative affect similar to factors in the original version (Andresen et al., 1994; Boey, 1999; Radloff, 1977). The short form showed adequate predictive validity at .97 when compared to the original CESD version. Overall test-retest stability was also adequate at .71 at an average time interval of 22 days. According to Andresen et al. (1994) depressed mood as measured by the CESD - 10 was correlated

in a predicted fashion with poor health and physical pain. Self -reported stress was associated with depressive symptoms. The Cronbach alpha coefficient of the CESD - 10 with two different samples was .78 and .79 (Boey, 1999).

**Brief COPE.** The Brief COPE is a multidimensional coping inventory designed to assess a broad range of people's coping strategies and responses to psychological stress (Carver, 1997). This measure is a brief form based on the COPE inventory (Carver, Scheier, & Weintraub, 1989). The COPE inventory was derived from an integration of the literature of coping, the transactional model of psychological stress and coping (Lazarus & Folkman, 1984), and a model of behavioral self-regulation (Carver et al., 1989).

The Brief COPE comprises 28 items, two items in each of the 14 subscales. Respondents were asked to indicate the extent to which (e.g., how much or frequently) they used a particular method of coping to deal with a stressful situation on a four-point Likert scale ranging from "not at all" (1) to "a great deal" (4). High scores on the scale indicate relatively greater use of a particular coping strategy. The Brief COPE showed marginal to adequate internal consistency among community (Carver, 1997) and undergraduate samples (Perczek, Carver, Price, & Pozo-Kaderman, 2000). Cronbach alpha reliability coefficients for the subscales in these samples ranged from .50 to .90 and .57 to .93 respectively. Arellano (2000) reported subscale alpha coefficients ranging from .41 to .85 and .86 for the total instrument. Estimates for test-retest reliability of the COPE inventory ranged from .46 to .86 and .42 to .89 (Carver et al., 1989). Information about the COPE inventory's convergent and discriminant validity was reported by Carver

et al. (1989). An exploratory factor analysis with oblique rotation of the Brief COPE yielded a factor structure consistent with the structure of the COPE inventory (Carver, 1997). The COPE inventory was found to be weakly correlated with a measure of social desirability and was therefore assumed to be relatively free of such response bias (Carver et al., 1989).

For the purposes of the present study only subscales that have demonstrated a Cronbach alpha reliability coefficient of .70 or higher in previous studies were used. According to Nunnally (1978), alpha coefficients of .70 or higher may be judged as adequate levels of reliability for research purposes. Subscales meeting this standard are active coping, planning, use of instrumental support, humor, positive reframing, and substance use. In order to avoid possible unreliability of two-item coping subscales, items of the first three subscales were combined for use as an indicator of problem-focused coping. The items of the latter three subscales were combined for use as an indicator of emotion-focused coping responses (e.g., Ingledew, Hardy, & Cooper, 1997; Lowe & Bennett, 2003).

**Multidimensional Scale of Perceived Social Support (MSPSS)**. The MSPSS was designed to assess the perceived adequacy of social support from family, friends, and significant others (Zimet, Dahlem, Zimet, & Farley, 1988). The instrument taps the individual's perception of socioemotional support from these sources. The MSPSS comprises 12 items, four items in each of three subscales. Items for each source are scored on a seven-point Likert-type scale ranging from "very strongly disagree" (1) to "very strongly agree" (7).

Each set of items provides an index of support from each source. The subscale score for each respondent is computed by summing the ratings for each item for each support scale and then dividing the resulting total by 4. For the total score, ratings are summed and divided by 12. Total and subscale scores range from 1 to 7, with high scores indicating a heightened perception of available social support. For the purposes of this study only the Family and Significant Other subscales were used. Subscale intercorrelations have shown that the Significant Other and Friend subscales are moderately to highly correlated with one another suggesting some overlap between these two scales (Dahlem, Zimet, & Walker, 1991; Kazarian & McCabe, 1991; Zimet et al., 1988). Respondents were asked to base their family and significant other subscale ratings on their family of origin (i.e., parents and siblings) and current spouse or partner, respectively.

The MSPSS family, friends, and significant other subscales have demonstrated adequate internal consistency among undergraduates (Dahlem et al., 1991; Kazarian & McCabe, 1991; Zimet et al., 1988), pregnant women (Zimet, Powell, Farley, Werkman, & Berkoff, 1990), adolescents (Kazarian & McCabe, 1991; Zimet et al., 1990), pediatric residents (Zimet et al., 1990), psychiatric outpatients (Cecil, Stanley, Carrion, & Swann, 1995), and older adults with and without psychiatric disorders (Stanley, Beck, & Zebb, 1998). Cronbach alpha coefficients in these samples ranged from .81 to .90 (family), .85 to .94 (friends), .83 to .98 (significant other), and .84 to .92 (total). Estimates of test-retest reliability at 2 to 3 months ranged from .72 to .85 for the subscales and .85 for the total MSPSS (Zimet et al., 1988).

Information about the convergent, concurrent, and construct validity of the MSPSS was reported by Cecil et al. (1995), Kazarian and McCabe (1991), Stanley et al. (1998), and Zimet et al. (1988, 1990). Several exploratory factor analyses using principal components analysis with varimax and oblique rotation have confirmed the subscale item groupings as proposed by the authors in the original study (Cecil et al., 1995; Dahlem et al., 1991; Kazarian & McCabe, 1991; Stanley et al., 1998; Zimet et al., 1988, 1990). The MSPSS was found to be weakly correlated with measures of social desirability (Dahlem et al., 1991; Kazarian & McCabe, 1991).

**Job Content Questionnaire (JCQ - JSS).** The JCQ is a self-administered instrument designed to assess social and psychological characteristics of jobs (Karasek, 1985; Karasek et al., 1998). The JCQ is based on Karasek's demand-control-support job stress model (Karasek, 1979; Karasek & Theorell, 1990). The full questionnaire focuses on five dimensions including (a) psychological work demands, (b) physical work demands, (c) decision-making opportunities, (d) job insecurity, and (e) job social support (Karasek, 1985).

Only the job social support scale was used in this study. The job social support scale was designed to measure overall levels of "helpful" social interaction available on the job from both coworkers and supervisors (Karasek, Schwartz, & Pieper, 1983). Both subscales include items measuring instrumental support, socioemotional support, and interpersonal hostility or social support deficit. The coworker scale also includes an item measuring teamwork encouragement. Items measuring interpersonal hostility were not used in this study. The coworker support scale consisted of five items and the supervisor

support scale consisted of four items. The scale uses a 4-point Likert response format ranging from "strongly disagree" (1) to "strongly agree" (4). Respondents can also indicate if they have no supervisor. Responses to coworker and supervisor support scales are summed and averaged to produce a total work support score (Karasek, 1985).

The reliability and validity of the JCQ scales was examined in several international studies (Karasek & Theorell, 1990; Karasek et al., 1998). The average Cronbach alpha internal consistency coefficient for women was .84 for supervisor support and .75 for coworker support. The average alpha for men was .84 for supervisor support and .76 for coworker support. Data from the three Quality of Employment Surveys (QES) indicated a Cronbach alpha for the total scale of .83 for men and .84 for women (Karasek & Theorell, 1990; Karasek et al., 1998). The supervisor and coworker support scales are correlated at .40 (Karasek et al., 1998). Predictive validity of JCQ scales was established in many studies of heart disease, mental strain, and musculoskeletal disorders (Karasek & Theorell, 1990; Karasek et al., 1998). Test-retest reliability at a one year interval of JCQ scales using occupation as the unit of analysis in QES national surveys was consistently at or above .90 (Karasek & Theorell, 1990). Confirmatory factor analysis in the U.S. and Canada generally revealed factor patterns consistent with the proposed JCQ scales (Karasek & Theorell, 1990; Karasek et al., 1998).

**Brief RCOPE**. The Brief RCOPE is a short form of religious coping derived from a comprehensive, theoretically based, and functionally-oriented instrument known as the RCOPE (Pargament et al., 1998, 2000). The Brief RCOPE was designed to assess

the degree to which individuals use a wide range of religious coping methods in dealing with major life events or stressful situations they have experienced. The scale distinguishes between positive and negative religious coping patterns. According to Pargament et al. (1998), the pattern of positive religious coping behaviors represents an expression of a sense of spirituality, a secure relationship with God, a belief that there is meaning to be found in life, and a sense of spiritual connectedness with others. In contrast, the pattern of negative religious coping represents an expression of a less secure relationship with God, a tenuous and ominous view of the world, and a religious struggle in the search for significance.

The scale consists of 14 items, seven positive religious coping items and seven negative religious coping items. Respondents are asked to indicate the extent to which (e.g., how much or frequently) they used a particular religious method of coping to deal with a stressful situation on a four-point Likert scale ranging from "not at all" (1) to "a great deal" (4). Responses to subscale items are summed and averaged to produce an average positive religious coping score and an average negative religious coping score. High scores on the scale indicate relatively greater use of a particular pattern of religious coping.

Internal consistency and validity analysis of the Brief RCOPE subscales were conducted with a sample of college students and with a hospitalized elderly sample. Cronbach alpha coefficients with the college student sample were .90 and .81 for the positive and negative scales, respectively. Cronbach alpha coefficients estimates with the hospitalized sample were .87 and .69 for the positive and negative scales, respectively.

To determine the validity of the scale, a Confirmatory Factor Analysis of the 14 items from the two scales was conducted using LISREL VII (Pargament et al., 1998). Results from college student and hospital elderly samples indicated that the two-factor solution offers a reasonable fit to the data. Available studies have shown that religious and spiritual activities are frequently used to cope with stress, and facilitate adjustment to traumatic life experiences or health conditions. For the purposes of this study, only the positive religious coping scale was used. Because of this modification, the scale was shortened to 7 items with possible total scores ranging from 7 to 28.

**Abbreviated Multidimensional Acculturation Scale for Latinos (AMAS).** The AMAS was developed by Zea et al. (2003) to assess acculturation in different Hispanic groups. The AMAS uses an orthogonal, bilinear, and multidimensional approach for assessing acculturation which measures an individual's orientation toward the U.S. American culture (Americanism), orientation toward the participant's own culture (e.g., Puerto Rican) (Hispanicism), and the simultaneous acculturation to both U.S. American and Hispanic cultures (biculturalism). The AMAS consists of 42 items which assess three areas: ethnic identity, language competence, and cultural competence. These areas are assessed separately (orthogonally) for each culture.

The questionnaire uses a 4-point Likert response scale ranging from "strongly disagree" (1) to "strongly agree" (4) for the identity scale, and from "not at all" (1) to "extremely well/like a native" (4) for the language and the cultural competence scales. The sum of each subscale for each cultural frame (e.g., identity-Hispanicism) is averaged and the sum of the averages is divided by three. This provides a score for Hispanicism

and a score for U.S. Americanism. Biculturalism is computed by multiplying the U.S. Americanism and Hispanicism averaged scores together. The resulting scores could range from 1 to 16, with higher scores indicating higher identification with both cultures (Zea et al., 2003; M. C. Zea, personal communication, November, 16, 2000), that is, higher biculturalism. Birman (1991), Gomez and Fassinger (1994), Suarez, Fowers, Garwood, and Szapocznik (1997), and M. C. Zea (personal communication, November 16, 2000, April 9, 2005) suggested the use of the product term (A x H) as an index of Biculturalism because it allows optimal discrimination between participants scoring high on either cultural frame measure but low on the other. This procedure avoids confounding participants scoring equally high and equally low on the two independent measures (Birman, 1991).

The AMAS Cronbach alpha internal reliability coefficients ranged from .90 to .97 in a sample of Hispanic college students from different Latin countries (Zea et al., 2003). Rivera (2003) reported Cronbach alpha reliability coefficients ranging from .87 to .98 in a sample of Hispanic higher education administrators. Her exploratory factor analysis findings reproduced the factor structure proposed by Zea et al. (2003). Preliminary data on the convergent and discriminant validity of the AMAS were reported by Zea et al. (2003). Convergent and discriminant validity of the AMAS was obtained by correlating the scale with the Bicultural Inventory Questionnaire-Form B (BIQ-B). The BIQ-B Americanism scale was positively correlated with the AMAS U.S. American identity scale ($r$ = .40, $p$< .01), English language competence ($r$ = .48, $p$< .001), U.S. American cultural competence ($r$ = .31, $p$< .05), and overall AMAS American dimension ($r$ = .48,

$p < .001$). The BIQ-B Americanism scale was not correlated with any of the AMAS Latino subscales. The BIQ-B Hispanicism scale was positively correlated with AMAS Latino ethnic identity ($r = .47$, $p < .01$), Spanish language ($r = .46$, $p < .01$), and overall AMAS Latino dimension ($r = .41$, $p < .01$) but was weakly and negatively related to Latino cultural competence ($r = -.17$, n.s.). The BIQ-B Hispanicism scale was not correlated with U.S. cultural competence or English language. The scale was negatively correlated with U.S. American identity ($r = -.45$, $p < .01$) and with the overall AMAS U.S. American dimension ($r = -.36$, $p < .05$).

For the purposes of this study a short form of the AMAS was used to measure biculturalism (personal communication, M. C. Zea, May, 13, 2004). The short form was derived from an analysis of item-total correlation and consists of 20 items, eight items to measure ethnic identity, four items to measure language competence, and eight items to measure cultural competence. Item-total correlations ranged from .40 to .70. The short form Cronbach alpha internal reliability coefficient of the Americanism and Hispanicism scales were .87 and .78 respectively in a sample of Latino gay and bisexual men from different Latin countries (personal communication, M. C. Zea, May, 21, 2004). The short form retain several modifications introduced by Rivera (2003) to the original AMAS. Additional modifications include: in items 17, 18, 19, and 20 the phrase "your country" was changed to "Latino/Hispanic." For example, item 19 originally read "How well do you know the history of your country?" the revision reads, "How well do you know Latino/Hispanic history?"

**Procedure**

In order to obtain respondents' cooperation, maximize the return of accurately completed questionnaires, and attain a high final usable response rate, the mail survey procedure was conducted following many of the guidelines and suggestions found in Dillman (1978, 1983), Hackett (1981), Vaux (1996), and Weathers et al. (1993). A list of names and postal addresses of all doctoral-level, Hispanic counseling and clinical psychologists was requested from the APA Research Office, the National Latino Psychological Association (NLPA), California Latino Psychological Association (CLPA), and the Florida Psychological Association (FPA). A one-page cover letter was prepared explaining the purpose of the study, requesting their participation, stating the anonymity and confidentiality of individual responses, explaining participation consent, how to contact the researcher for questions, and how to obtain a summary of the results (see Appendix D). The letter was printed on university departmental stationary and signed by the researcher and his advisor.

Questionnaires were designed as a booklet containing the seven instruments (see Appendix E). To minimize questionnaire order effects two forms were developed. Sections of the survey were counterbalanced so that the questions appeared in a different order for different participants. Each booklet had a number printed on the upper right-hand corner that was used for mail tracking purposes only in order to avoid sending follow-up reminders unnecessarily. The names of the participants did not appear anywhere on the measures. A master list of numbers and participants' names was kept separate from survey results and only the researcher had access to the list. The list of

names and corresponding numbers was locked in a private file cabinet and destroyed at the completion of the study. Only those who did not return the survey received reminder post cards. This procedure helped to monitor the level of return rate while protecting participants' anonymity. Results were not attached to participant names.

The research survey packet consisting of a cover letter, the booklet, a pen, a post card to request survey results, and a stamped, self-addressed return envelope was mailed out unfolded in a manila envelope. Participants interested in receiving a summary of the study's results completed a post card enclosed in the survey package which was returned along with the completed questionnaire in the self-addressed envelope (see Appendix F). The post card was separated from the questionnaire to protect participant's anonymity. Two weeks after the initial mailing, a follow-up postcard was mailed to all participants whose survey packet had not been received, reminding them to complete the instruments and return them if they had not yet done so, thanking them if they had, and providing them with a means for obtaining an additional packet if necessary (see Appendix G). A second reminder postcard was mailed two weeks after the first follow-up. Participants' consent to participate in this study was implied by their filling out and returning the survey packet. Participants did not receive monetary compensation for their time. Participants were offered a summary of the results and received a bookmark listing 101 ways to achieve wellness in appreciation for their time and consideration in responding to this survey. The bookmark was included in the survey packet sent to all potential participants.

**Statistical Analysis**

First, descriptive statistics including frequencies, means, standard deviations, and correlational analyses were computed to aid in the interpretation of results. A series of correlational analyses were computed between demographic variables and scores on the independent, moderator, and dependent variable measures to examine for possible significant relationships.

Independent sample t-tests were used to discern differences between male and female respondents on their demographic characteristics and scores on independent, moderator, and dependent variables. Findings of t-tests also were used to determine the need for separate analyses for male and females. The absence of significant differences between males and females across the set of variables would suggest the use of combined data in subsequent analyses. To control for the probability of a Type I error for the set of comparisons, the experimentwise alpha level was computed. Reliability estimates of all the instruments used in this study were analyzed using the Cronbach alpha coefficient of internal consistency to aid in interpreting the results. The Statistical Package for the Social Sciences for Windows version 9 (SPSS 9; 1998) was used for all analyses.

Moderated multiple regression analyses (Baron & Kenny, 1986; Frazier, Tix, & Barron, 2004) were performed to assess the relation of occupational stress and moderator variables to depressive affect among counseling and clinical Hispanic psychologists. The predictor variable was occupational stress. The proposed moderator variables included problem and emotion-focused coping, work and non-work social support, biculturalism, and positive religious coping. The dependent variable was depressive affect.

To reduce potential problems with multicollinearity between main effect variables and interaction terms, the independent and moderator variables were centered prior to testing the significance of the product terms (Aiken & West, 1991; Cohen, Cohen, West, & Aiken, 2003). This process entails subtracting the sample mean value from each participants' scores on the variable to form deviation scores with a sample mean of zero. Centering scores has no adverse effect on the correlation among variables and yields meaningful interpretations of the relation of predictors to dependent variables (Cohen et al., 2003).

The presence of a statistically significant interaction was determined by (a) observing the increment to $R^2$ due to the contribution of the product term over and above the main effects predictors and (b) the results of the hierarchical regression $F$ test of the step containing the interaction term. Further insight into statistically significant interaction effects may be obtained by generating graphs plotting simple regression lines at different levels of the moderator variable (Aiken & West, 1991).

**Hypothesis Tests**

Hypothesis one stated that depressive affect would be significantly predicted by occupational stress. A correlation analysis was performed to test this hypothesis. Depressive symptom scores were used as the strain criterion and total occupational stress scores as the predictor. The $r^2$ indicated the proportion of variance in depressive symptoms accounted for by occupational stress.

Hypothesis two stated that coping strategies, social support, biculturalism, and positive religious coping would, individually and collectively, explain significant

variance in depressive affect. To test this hypothesis two separate statistical analyses were conducted. The zero-order relationships of coping strategies, social support, biculturalism, and positive religious coping, to depressive symptom were examined separately with Pearson product-moment correlations. A multiple regression analysis was then conducted to explore the collective contribution of predictor variables to the variance in depressive affect. Continuous scores of coping strategies, social support, biculturalism, and positive religious coping were entered together into the regression equation. The regression *F*-statistic indicated whether the relationship between moderator variables and depressive affect is significant. The significance of change in $R^2$ was examined to determine the proportion of variance in depressive affect accounted for by moderator variables.

Hypothesis three indicated that coping strategies would moderate the relationship between occupational stress and depressive affect, such that the relation of stress to depressive affect would be weaker under conditions of high versus low use of coping strategies. Moderated multiple regression analyses were performed to test this hypothesis. Scores of total occupational stress, problem-focused coping, and emotion-focused coping were entered first to test the relation of the individual predictors to depressive affect. Items from subscales including active coping, planning, and use of instrumental support were combined for use as an indicator of problem-focused coping. Items from subscales including humor, positive reframing, and substance use were combined for use as an indicator of emotion-focused coping. Occupational stress, problem-focused coping, and emotion-focused coping scores were entered as separate

continuous measures. Separate interaction terms between occupational stress and problem-focused coping and occupational stress and emotional-focused coping were obtained by computing a product term between these variables. These product terms were entered at the second step of the regression equation to test for a possible interaction between occupational stress and coping strategies. The significance of change in $R^2$ was examined. If the interaction term significantly increased the variance explained by the predictor, the moderating role of coping strategies would be suggested, and the resulting interaction would be graphed to determine the specific form of the interaction.

Hypothesis four stated that social support would moderate the relationship between occupational stress and depressive affect, such that the relation of stress to depressive affect would be weaker under conditions of high versus low social support. Two different sources of social support are included in this study to reflect support from work (coworker & supervisor) and non-work (family & significant other) social networks. Moderated multiple regression analyses consisted of the following sequence. Scores of total occupational stress, work support, and non-work support were entered first to test main effects. Scores of total occupational stress and work and non-work social support were entered as separate continuous measures. Interaction terms between (a) occupational stress and sources of work support and (b) occupational stress and sources of non-work support were obtained by computing product terms between each set of variables. These product terms were entered at the second step of the regression equations to test for possible interactions between occupational stress and work and non-work support. If the interaction terms significantly increased the variance explained by

the previously entered predictors, the moderating role of social support would be suggested and graphed.

Hypothesis five indicated that biculturalism would moderate the relationship between occupational stress and depressive affect, such that the relation of stress to depressive affect would be weaker under conditions of high versus low biculturalism. This moderated multiple regression analysis consisted of the following sequence. Scores of total occupational stress and biculturalism were entered first to test main effects. Scores of occupational stress and biculturalism were entered as separate continuous measures. An interaction term between occupational stress and biculturalism was obtained by computing a product term between these variables. This product term was entered at the second step of the regression equation to test for possible interactions between occupational stress and biculturalism. If the interaction term significantly increased the variance explained by the previously entered predictors, the moderating role of biculturalism would be suggested and graphed.

Hypothesis six stated that positive religious coping would moderate the relationship between occupational stress and depressive affect, such that the relation of stress to depressive affect would be weaker under conditions of high versus low positive religious coping. This moderated multiple regression analysis consisted of the following sequence. Scores of total occupational stress and positive religious coping were entered first to test main effects. Scores of occupational stress and positive religious coping were entered as separate continuous measures. An interaction term between occupational stress and positive religious coping was obtained by computing a product term between

these variables. This product term was entered at the second step of the regression equation to test for possible interactions between occupational stress and positive religious coping. If the interaction term significantly increased the variance explained by the previously entered predictors, the moderating role of positive religious coping would be suggested and graphed.

Hypothesis seven indicated that social support would moderate the relationship between occupational stress and depressive affect above and beyond coping strategies. In this moderated multiple regression analysis, scores of occupational stress, coping strategies, and social support were entered first to test main effects. Scores of total occupational stress, coping strategies, and sources of social support were entered as separate continuous measures. Interaction terms between (a) occupational stress and coping strategies and (b) occupational stress and sources of social support were obtained by computing product terms between each set of variables. These product terms were entered at subsequent steps of the regression equations to test for possible interactions between occupational stress and moderator variables. Examination of the unstandardized *B* coefficients (based on centered data) of the key interaction terms would suggest whether the interaction of interest made a unique and significant contribution above and beyond the other predictors. If the interaction term between occupational stress and social support significantly increased the variance explained by the occupational stress-coping interaction, the role of social support as a moderator above and beyond coping strategies would be suggested and graphed.

Hypothesis eight stated that biculturalism would moderate the relationship between occupational stress and depressive affect, above and beyond coping strategies and social support. This moderated multiple regression analysis consisted of the following sequence. Scores of total occupational stress, coping strategies, social support, and biculturalism were entered first to test main effects. Scores of total occupational stress, coping strategies, sources of social support, and biculturalism were entered as separate continuous measures. Interaction terms between (a) occupational stress and coping strategies, (b) occupational stress and sources of social support, and (c) occupational stress and biculturalism were obtained by computing product terms between each set of variables. These product terms were entered at subsequent steps of the regression equations to test for possible interactions between occupational stress and moderator variables. Examination of the unstandardized *B* coefficients (based on centered data) of the key interaction terms suggested whether the interaction of interest made a unique and significant contribution above and beyond the other predictors. If the interaction term between occupational stress and biculturalism significantly increased the variance explained by the previously entered predictors, the role of biculturalism as a moderator above and beyond coping strategies and social support would be suggested and graphed.

Hypothesis nine indicated that positive religious coping would moderate the relationship between occupational stress and depressive affect above and beyond coping strategies, social support, and biculturalism. In this moderated multiple regression analysis, scores of total occupational stress, coping strategies, sources of social support,

biculturalism, and positive religious coping were entered first to test main effects. Scores of total occupational stress, coping strategies, social support, biculturalism, and positive religious coping were entered as separate continuous measures. Interaction terms between (a) occupational stress and coping strategies, (b) occupational stress and sources of social support, (c) occupational stress and biculturalism, and (d) occupational stress and positive religious coping were obtained by computing product terms between each set of variables. These product terms were entered at subsequent steps of the regression equation. Examination of the unstandardized *B* coefficients (based on centered data) of the key interaction terms suggested whether the interaction of interest made a unique and significant contribution above and beyond the other predictors. If the interaction term between occupational stress and positive religious coping significantly increased the variance explained by the previously entered predictors, the role of positive religious coping as a moderator above and beyond coping strategies, social support, and biculturalism would be suggested and graphed.

# CHAPTER IV

# RESULTS

This chapter presents the results of the statistical analyses conducted for this study in three sections. The first section reports the psychometric properties of the measures used, examines sex differences, and correlations among independent, moderator, and dependent variables. The second section focuses on the tests of the study hypotheses. The third section examines and summarizes data regarding participants' self-reported coping strategies.

## Psychometric Properties of Instruments, Sex Differences, and Correlations among Independent, Moderator, and Dependent Variables

### Psychometric Properties of Instruments

In addition to a demographic questionnaire, participants responded to seven instruments. Sources of strain or stressors were measured by the Mental Health Professionals Stress Scale. Depressive affect, a psychological response to stressors, was measured by the Center for Epidemiologic Studies Depression Scale short form. Family and significant other support were assessed with the Multidimensional Scale of Perceived Social Support. Job social support was measured by the Job Content Questionnaire. The Brief COPE and the Brief RCOPE were used to assess coping strategies and religious coping, respectively, and the Abbreviated Multidimensional Acculturation Scale for Latinos short form was used to assess biculturalism. Table 3 presents possible score ranges, means, and standard deviations of the scores obtained from these instruments for males, females, and the total sample. The table also displays Cronbach's alpha

coefficients for the instruments used. As shown in Table 3, instruments were responded by more than ninety percent of the participants in this study, suggesting a small proportion of missing data. Analyses were conducted with complete and valid questionnaires.

**Mental Health Professionals Stress Scale**. The MHPSS total job stress index for each respondent was computed by multiplying the severity rating for each item by its frequency rating, summing these products, and dividing by 42. The maximum possible total job stress score was 49. The mean score for total job stress suggest a low level of occupational stress in this sample (see Table 3). Previous studies using the original version of the MHPSS have used a four-point scale, scored from 0 to 3 (Cushway et al., 1996; Rao & Mehrotra, 1998). Cushway et al. (1996) reported a total stress mean of 1.17 with a standard deviation of .36 for their sample of clinical psychologists in United Kingdom and Rao and Mehrotra (1998) reported a total stress mean of 34.09 with a standard deviation of 16.04 for their sample of clinical psychologists in India. In both studies the level of stress reported by psychologists was low and below the mid-point of the scale.

Following the procedures proposed by Vagg and Spielberger (1998), the MHPSS total job stress raw scores were transformed into *T* scores, with a mean of 50 and a standard deviation of 10. A *T* score of 60 was used as a "cutoff score," indicating a high degree of occupational stress. In this study, 15% ($n$ = 85) of the participants scored at or above a *T* score of 60. Item-total correlations for the total job stress ranged from .31 to

.65. Cronbach alpha reliability coefficients for the total job stress index indicated a high level of internal consistency. Only the total job stress index was used for the analyses.

**Center for Epidemiologic Studies Depression Scale**. The CESD was scored by adding the ratings for all the items after reversing the positive affect items (5 & 8). The mean score for the CESD indicates minimal symptom presence in this sample (see Table 3). According to Andresen et al. (1994), scores at or above 10 mean probable depression. Item-total correlations for the scale ranged from .25 to .60. Cronbach alpha coefficient for the scale indicated a satisfactory internal consistency.

**Multidimensional Scale of Perceived Social Support.** The MSPSS total support score for each respondent was computed by summing the ratings for each item of family and significant other support scales and dividing by 8. High scores indicate a heightened perception of available social support. Studies using the complete version of the MSPSS with university undergraduates reported total mean scores ranging from 5.58 to 5.81 with standard deviations from 1.07 to .79 respectively (e.g., Dahlem et al.,1991; Kazarian & McCabe, 1991). The mean score for total support suggests an overall optimal level of social support in this sample (see Table 3). Item-total correlations for the scale ranged from .68 to .79. Cronbach alpha reliability coefficients for the total support index of the MSPSS indicated a high level of internal consistency. Only the total support index was used for the analyses.

**Job Content Questionnaire**. The JCQ coworker support score and supervisor support score were computed by summing the ratings for each item of the subscales and dividing by the number of items in each subscale. Two hundred and thirty-nine

participants reported having no supervisor. Because most participants did not have a supervisor, the supervisor support score was not used in the analyses. Analyses were conducted using the coworker support score representing work support. Vermeulen and Mustard (2000) reported mean scores of support at work for male and female Canadian employees by levels of job strain. Means (with standard errors in parentheses) for men and women in high strain jobs were 2.51 (.08) and 2.96 (.09) and in low strain jobs 3.20 (.08) and 3.77 (.09), respectively. On the average, results suggested fairly high levels of helpful social interaction available on the job from coworkers (see Table 3). Item-total correlations for the questionnaire's nine items ranged from .20 to .83. Cronbach alpha reliability coefficient for the coworker support scale indicated a high level of internal consistency.

**Brief COPE**. For the purposes of the present study items of the Brief COPE subscales were combined to use as indicators of problem-focused and emotional-focused coping responses. Problem-focused coping included items from active coping, planning, and use of instrumental support subscales. Problem-focused coping scores were computed by summing the ratings for each item of the subscales and dividing by 6. Emotional-focused coping included items from humor, positive reframing, and substance use subscales. Emotion-focused coping scores were computed by summing the ratings for each item of the subscales and dividing by 6. High scores on the scale indicate relatively greater use of a particular coping strategy. On the average, participants employed more problem-focused coping strategies than emotional-focused coping strategies. Item-total correlations for the problem-focused scale ranged from .43 to .49.

Item-total correlations for the emotional-focused scale ranged from .14 to .56. Results suggest that the problem-focused coping dimension possess satisfactory reliability, though the Cronbach estimate for emotional-focused coping dimension is not optimal (see Table 3).

**Brief RCOPE**. Responses to the scale items were summed and averaged to produce a positive religious coping score. High scores on the scale indicate relatively greater use of the coping strategy. Pargament et al. (1998) reported data of positive religious coping for two samples, church members in Oklahoma City and college students. Mean scores (with standard deviations in parentheses) for church members were 1.55 (.67) and 1.30 (.81) for college students, respectively. The mean score for the Brief RCOPE indicates a moderate tendency to use positive religious coping strategies to deal with stressful situations (see Table 3). Item-total correlations for the scale items ranged from .62 to .87. Cronbach alpha coefficient for the religious coping scale indicated a high level of internal consistency.

**Abbreviated Multidimensional Acculturation Scale**. The AMAS was designed to measure a Latino individual's orientation toward the U.S. American culture (Americanism), orientation toward the participant's own culture (Hispanicism), and the simultaneous acculturation to both U.S. American and Hispanic cultures (biculturalism). Biculturalism was computed by multiplying the U.S. Americanism and Hispanicism averaged scores together. Zero-order correlations between Americanism and Biculturalism ($r$ = .39, $p$ = .01, two-tailed) and Hispanicism and Biculturalism ($r$ = .81, $p$ = .01, two-tailed) suggested that the degree of biculturalism is strongly associated with

participants' orientation to Hispanic culture. Rivera (2003) reported a biculturalism mean score of 11.82 with a standard deviation of 1.94 for her sample of Hispanic higher education administrators. According to the biculturalism mean score, participants of this study may be considered as moderately bicultural (see Table 3). Cronbach alpha reliability coefficients for the Americanism (.80) and Hispanicism (.88) scales of the AMAS indicated an adequate level of internal consistency.

**Sex Differences among Independent, Moderator, and Dependent Variables**

Independent samples *t* test were computed to explore possible sex differences in the obtained scores for independent, moderator, and dependent variables. Because of the large number of statistical tests conducted and to control for the probability of a Type I error for the set of comparisons, the experimentwise alpha level was computed (.05/8 = .006). Statistically significant differences were found between males ($M$ = 1.82, $SD$ = .86) and females ($M$ = 2.07, $SD$ = .92) on use of positive religious coping, $t(571) = 3.22$, $p$ = .001 (two tailed). Hispanic female psychologists tend to use religious coping somewhat more frequently than do male psychologists. The effect size index for the *t* test result was obtained using the following procedure (Rosnow & Rosenthal, 1993, p.262).

Effect size $r = \sqrt{\frac{t^2}{t^2 + df}} = \sqrt{\frac{3.22^2}{3.22^2 + 571}} = .13$

The effect size correlation coefficient is .13. No additional statistically significant differences were found.

Table 3

Psychometric Characteristics of Instruments for Males, Females, and Total Sample

| | | | Sex | | | | | | Alpha Coefficient | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Males | | Females | | Total | | Sex | | |
| Scales | *N* | Range | *M* | *SD* | *M* | *SD* | *M* | *SD* | Males | Females | Total |
| MHPSS | | | | | | | | | | | |
| Total Job Stress | 568 | .12 - 34 | 10.39 | 6.93 | 10.72 | 6.64 | 10.63 | 6.80 | .94 | .93 | .93 |
| CESD | | | | | | | | | | | |
| Depressive Affect | 575 | 0 - 21 | 5.13 | 4.10 | 4.99 | 3.92 | 5.06 | 4.00 | .77 | .74 | .75 |
| MSPSS | | | | | | | | | | | |
| Total Support | 574 | 1 - 6 | 5.04 | .93 | 5.09 | 1.00 | 5.07 | .98 | .91 | .93 | .93 |
| JCQ | | | | | | | | | | | |
| Coworker Support | 523 | 1 - 4 | 3.27 | .55 | 3.33 | .55 | 3.31 | .55 | .87 | .86 | .86 |
| Brief COPE | | | | | | | | | | | |
| Problem-focused | 575 | 10 - 24 | 19.33 | 2.57 | 19.77 | 2.77 | 19.60 | 2.70 | .71 | .73 | .73 |
| Emotion-focused | 575 | 6 - 24 | 12.32 | 2.80 | 12.09 | 2.83 | 12.18 | 2.81 | .70 | .67 | .68 |
| Brief RCOPE | | | | | | | | | | | |
| Positive Religious Coping | 574 | 1 - 4 | 1.82 | .86 | 2.07 | .92 | 1.98 | .90 | .94 | .94 | .94 |
| AMAS | | | | | | | | | | | |
| Biculturalism | 573 | 4 - 16 | 10.96 | 2.10 | 10.70 | 2.10 | 10.80 | 2.10 | | | |

**Correlations among Independent, Moderator, and Dependent Variables**

Pearson product-moment correlations were computed to examine possible significant correlations among independent, moderator, and dependent variables. To control for the probability of a Type I error for the set of comparisons, the experiment wise alpha level was computed (.05/55 = .001). Only findings showing an effect size of .10 or above are discussed. As shown in Table 4, occupational stress was positively correlated with depression and emotion-focused coping, and negatively correlated with biculturalism, non-work sources of social support, coworker support, years of experience, and degree of bicultural work setting. Results suggest that as occupational stress increases depression also tends to increase. Occupational stress also increases with the use of emotion-focused coping strategies. However, occupational stress tends to decrease as the degree of biculturalism, support from significant others and family, coworkers, years of experience, and degree of biculturalism in the work setting increases.

Depression was inversely correlated with biculturalism, support from non-work sources, and coworker support. Problem-focused, emotion-focused, and positive religious coping were all minimally intercorrelated, suggesting that these coping strategies are probably complementary with each other. Problem-focused coping was positively correlated with total support. Total support was correlated with positive religious coping. Results suggest that as support from family and significant others increase, reliance on religious or spiritual strategies for coping also tends to increase. Coworker support was correlated with problem-focused coping and total support. Results

suggest that coworker support may complement the supportive function of family and significant others.

The degree of importance of religion or spirituality was positively correlated with biculturalism, positive religious coping, emotion-focused coping, total support, and coworker support. As the importance of religion or spirituality increases for the individual, so does his or her bicultural identity, involvement with family or significant others, and the use of emotional management and religious strategies to reduce emotional distress. The degree to which a work setting is considered bicultural was positively correlated with biculturalism and coworker support, and negatively to total job stress. Results suggest that bicultural work setting may be associated with supportive interactions and less stress.

Table 4

Intercorrelations for Scores on Demographic, Independent, Moderator, and Dependent Variables

| Variables | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| 1. Total job stress | ---- | | | | | | | | | |
| 2. Biculturalism | -.12** | ---- | | | | | | | | |
| 3. Positive religious coping | .09* | .10* | ---- | | | | | | | |
| 4. Problem-focused | .03 | -.01 | .03 | ---- | | | | | | |
| 5. Emotion-focused | .14** | -.04 | .12** | .28** | ---- | | | | | |
| 6. Total Support | -.10* | .09* | .11** | .17** | .07 | ---- | | | | |
| 7. Coworker support | -.26** | .06 | .05 | .12** | .05 | .18** | ---- | | | |
| 8. Years of experience | -.14** | .11** | -.09* | -.08 | -.02 | -.06 | -.03 | ---- | | |
| 9. Importance of religion or spirituality | .03 | .12** | .63** | .06 | .14** | .12** | .10* | .00 | ---- | |
| 10. Degree of bicultural work setting | -.13** | .29** | .05 | -.05 | -.03 | .03 | .14** | .08 | .00 | ---- |
| 11. Depressive affect | .36** | -.14** | .05 | -.10* | -.07 | -.23** | -.26** | -.07 | -.07 | -.05 |

*$p$ <.05. **$p$ <.01, two-tailed.

## Hypothesis Tests

A primary purpose of this study was to test the theoretical assumptions postulated by the Multicultural Model of Stress Process (Slavin et al., 1991). More specifically, the study was designed to investigate the degree to which coping behaviors, social support, biculturalism, and positive religious coping moderate the relationship between occupational stress and depressive affect. Hierarchical multiple regression analyses (HMR) (e.g., Cohen, Cohen, West, & Aiken, 2003; Pedhazur, 1997) were performed to test the research hypotheses.

For all analyses, examination of the residual scatterplots and histograms indicated no severe departure from the assumptions of normality, linearity, and homoscedasticity between scores of depression and the errors of prediction. Since there were few outliers no particular corrective action was taken. Results of the Durbin-Watson test indicated no autocorrelation patterns in the data. Tolerance values for predictor variables in the regression equations did not indicate multicollinearity. To reduce potential problems with multicollinearity between the main effect and interaction terms, the independent and moderator variables were centered prior to testing the significance of the product terms.

All ordered summary tables provide enough information to reproduce the F ratios to test the multiple $R^2$ at each step. Only nonadjusted $R^2$ scores are reported for regression analyses. Since no statistically significant differences were revealed between males and females scores in total job stress and depressive affect, HMR analyses were performed for the whole sample. Following are the results of the hypotheses tested in this study.

**Hypothesis One**

Hypothesis one stated that depressive affect would be significantly predicted by occupational stress. Results of a zero-order correlation supported this hypothesis. As shown in Table 4, occupational stress accounted for 13% of the variance in depressive affect ($r$ = .36).

A supplemental multiple regression analysis was performed to examine the amount of variance in depressive affect that could be accounted for by the seven stressors measured by the MHPSS (viz., (a) workload, (b) client-related difficulties, (c) organizational structure and processes, (d) relationships and conflicts with other professionals, (e) lack of resources, (f) professional self-doubt, and (g) home-work conflict). Predictors were entered simultaneously into the equation.

The analysis revealed statistically significant results, $F(7,555) = 15.65$, $p = .001$. The set of seven predictors explained 17% of the variance in depressive affect scores ($R$ = .41). Of the seven predictors, professional self-doubt ($\beta = .12$), $t(555) = 2.36$, $p < .05$, and home-work conflict ($\beta = .30$), $t(555) = 4.75$, $p = .001$, made a statistically significant contribution to the variance in depressive affect scores.

**Hypothesis Two**

Hypothesis two stated that coping strategies, social support, biculturalism, and positive religious coping would, individually and collectively, explain significant variance in depressive affect. The individual contribution of moderator variables to the variance in depressive affect was tested with Pearson product-moment correlation coefficient. Table 4 displays the matrix of zero-order correlations between moderator

variables and depressive affect. Results indicated that four of the six correlations were statistically significant, but small in effect size, indicating that factors other than those tested account for a large proportion of the variance in depressive affect. The individual variables accounted for between 0 and 7% of the variance in depressive affect.

A multiple regression analysis was performed to explore the collective contribution of moderator variables to the variance in depressive affect (see Table 5). Predictors were entered simultaneously into the equation. Regression analysis results supported this hypothesis, $F(6,507) = 12.91$, $p = .001$. The set of variables accounted for 13% of the variance in depressive affect ($R = .36$). In general, these variables combined were associated with lower depressive affect scores. Specifically, biculturalism, coworker support, total non-work support, and positive religious coping made a statistically significant contribution to the variance in depressive affect scores.

Table 5

Regression Analysis relating Moderator Variables with Depressive Affect ($N = 514$)

| Variable | β | *SE* | *t* |
|---|---|---|---|
| Biculturalism | -.12 | .08 | 2.93** |
| Problem-focused coping | -.04 | .06 | .80 |
| Emotion-focused coping | -.04 | .06 | .93 |
| Positive religious coping | .10 | .18 | 2.38* |
| Total support | -.20 | .18 | 4.70*** |
| Coworker support | -.21 | .30 | 4.98*** |

Note. Residual degrees of freedom = 507.
*$p$<.05. **$p$ <.01. ***$p$ <.001.

**Hypothesis Three**

Hypothesis three indicated that coping strategies would moderate the relationship between occupational stress and depressive affect, such that the relation of stress to depressive affect will be weaker under conditions of high versus low use of coping strategies. Moderated regression analyses for problem-focused coping (PFC) and emotion-focused coping (EFC) were performed to explore the incremental variance of product terms beyond that of main effects (see Table 6).

The data do not support this hypothesis. The interaction terms with coping strategies did not add significant incremental variance to the equation. The $R^2$ change values revealed no significant increments in variance attributed to the product term above and beyond the statistically significant main effects. Coping strategies contributed minimally to the prediction of depressive affect. Although occupational stress and coping strategies contributed uniquely to the prediction of depressive affect, the non-significant interaction indicates that use of problem or emotion-focused coping strategies do not affect the relation of job stress to depressive affect.

Table 6

Hierarchical Regression Analysis Predicting Depressive Affect from the Job Stress X Coping Strategies Interactions ($N$ = 558)

| Predictors | $R$ | $\Delta R^2$ | $df$ | $\Delta F$ | β |
|---|---|---|---|---|---|
| Step 1 | .37 | .14*** | 554 | 29.99*** | |
| Job Stress | | | | | .37*** |
| Problem Focused Coping | | | | | -.08* |
| Emotion Focused Coping | | | | | -.10* |
| Step 2 | .38 | .00 | 552 | 1.63 | |
| Job Stress x PFC | | | | | .03 |
| Job Stress x EFC | | | | | -.08 |

Note. PFC = problem-focused coping. EFC = emotion-focused coping.
*$p$<.05. ***$p$ <.001.

**Hypothesis Four**

Hypothesis four suggested that social support would moderate the relationship between occupational stress and depressive affect, such that the relation of stress to depressive affect will be weaker under conditions of high versus low social support. The total support score represent the combination of family and significant other support. The Coworker support score represent a source of support at work. Moderated regression analyses for total support and coworker support were performed to explore the incremental variance of product terms beyond that of previously entered predictors (see Table 7).

The data do not support this hypothesis. Specifically, the interaction terms with each of the social support variables did not add significant incremental variance to the equation. The $R^2$ change values revealed no significant increments in variance attributed to the product term above and beyond the statistically significant main effects. Although

occupational stress and social support variables contributed uniquely to the prediction of depressive affect, the non-significant interaction indicates that social support does not affect the relation of job stress to depressive affect.

Table 7

Hierarchical Regression Analysis Predicting Depressive Affect from the Job Stress X Work and Non-Work Support Interactions ($N$ = 509)

| Predictors | $R$ | $\Delta R^2$ | $df$ | $\Delta F$ | β |
|---|---|---|---|---|---|
| Step 1 | .43 | .18*** | 505 | 37.79*** | |
| Job Stress | | | | | .33*** |
| Total support | | | | | -.21*** |
| Coworker support | | | | | -.11** |
| Step 2 | .43 | .00 | 503 | .19 | |
| Job Stress x Total support | | | | | -.02 |
| Job Stress x Coworker support | | | | | .00 |

**$p$ <.01. ***p <.001.

**Hypothesis Five**

Hypothesis five suggested that biculturalism would moderate the relationship between occupational stress and depressive affect, such that the relation of stress to depressive affect will be weaker under conditions of high versus low biculturalism. A moderated regression analysis for biculturalism was performed to explore the incremental variance of the product term beyond that of main effects (see Table 8).

The data do not support this hypothesis. The interaction term with biculturalism did not add significant incremental variance to the equation. The $R^2$ change values revealed no significant increments in variance attributed to the product term above and beyond the statistically significant main effects. Although occupational stress and

biculturalism contributed uniquely to the prediction of depressive affect, the non-significant interaction indicates that the degree of biculturalism does not affect the relation of job stress to depressive affect.

Table 8

Hierarchical Regression Analysis Predicting Depressive Affect from the Total Job Stress X Biculturalism Interaction ($N$ = 560)

| Predictors | | $R$ | $\Delta R^2$ | $df$ | $\Delta F$ | β |
|---|---|---|---|---|---|---|
| Step 1 | | .37 | .13*** | 557 | 42.79*** | |
| | Job Stress | | | | | .34*** |
| | Biculturalism | | | | | -.09* |
| Step 2 | | .37 | .00 | 556 | .06 | |
| | Job Stress x Biculturalism | | | | | .01 |

*$p$ <.05. ***$p$ <.001.

**Hypothesis Six**

Hypothesis six stated that positive religious coping would moderate the relationship between occupational stress and depressive affect, such that the relation of stress to depressive affect will be weaker under conditions of high versus low positive religious coping. A moderated regression analysis for positive religious coping was performed to explore the incremental variance of the product term beyond that of main effects (see Table 9).

The data do not support this hypothesis. The interaction term with positive religious coping did not add significant incremental variance to the equation. The $R^2$ change values revealed no significant increments in variance attributed to the product term above and beyond the statistically significant main effects. Occupational stress

made a unique statistically significant contribution to the prediction of depressive affect. Positive religious coping and its product term with job stress did not make a significant contribution to the prediction of depressive affect. Positive religious coping does not affect the relation of job stress to depressive affect.

Table 9

Hierarchical Regression Analysis Predicting Depressive Affect from the Job Stress X Positive Religious Coping Interaction ($N$ = 562)

| Predictors | $R$ | $\Delta R^2$ | $df$ | $\Delta F$ | β |
|---|---|---|---|---|---|
| Step 1 | .36 | .13*** | 559 | 40.63*** | |
| Job Stress | | | | | .36*** |
| Positive Religious Coping | | | | | .03 |
| Step 2 | .36 | .00 | 558 | .05 | |
| Job Stress x Positive Religious Coping | | | | | .00 |

***$p$ <.001.

**Hypothesis Seven**

Hypothesis seven suggested that social support would moderate the relationship between occupational stress and depressive affect above and beyond coping strategies. Moderated regression analyses were performed to explore the incremental variance of product terms including social support variables beyond product terms including coping strategies entered first into the equation. Table 10 displays hierarchical regression results testing the effects of social support beyond coping strategies.

The data do not support this hypothesis. The interaction terms with social support variables did not add significant incremental variance to the equation. The $R^2$ change

values revealed no significant increments in variance attributed to the product terms above and beyond the statistically significant main effects. Coping strategies did not contribute to the prediction of depressive affect. Although occupational stress and social support contributed uniquely to the prediction of depressive affect, the non-significant interactions indicate that social support does not affect the relation of job stress to depressive affect above and beyond coping strategies.

Table 10

Hierarchical Regression Analysis Predicting Depressive Affect from the Job Stress X Coping Strategies, and Job Stress X Social Support Interactions ($N$ = 509)

| Predictors | $R$ | $\Delta R^2$ | $df$ | $\Delta F$ | β |
|---|---|---|---|---|---|
| Step 1 | .44 | .20*** | 503 | 24.64*** | |
| Job Stress | | | | | .31*** |
| Problem Focused Coping | | | | | -.05 |
| Emotion Focused Coping | | | | | -.06 |
| Total support | | | | | -.19*** |
| Coworker support | | | | | -.13** |
| Step 2 | .45 | .00 | 501 | .91 | |
| Job Stress x PFC | | | | | .03 |
| Job Stress x EFC | | | | | -.06 |
| Step 3 | .45 | .00 | 499 | .25 | |
| Job Stress x Total support | | | | | -.03 |
| Job Stress x Coworker support | | | | | .00 |

Note. PFC = problem-focused coping. EFC = emotion-focused coping.
**$p$ <.01. ***$p$ <.001.

**Hypothesis Eight**

Hypothesis eight stated that biculturalism would moderate the relationship between occupational stress and depressive affect, above and beyond coping strategies and social support. Moderated regression analyses were performed to explore the incremental variance of a product term including biculturalism beyond product terms including coping strategies (viz., problem-focused coping & emotion-focused coping) and social support variables (viz., total support and coworker support) entered first into the equation. Table 11 display hierarchical regression results testing the effects of biculturalism beyond problem and emotion focused coping and social support variables.

The data do not support this hypothesis. The interaction term with biculturalism did not add significant incremental variance to the equation. The $R^2$ change values revealed no significant increments in variance attributed to the product terms above and beyond the statistically significant main effects. Coping strategies did not contribute to the prediction of depressive affect. Although occupational stress, social support, and biculturalism contributed uniquely to the prediction of depressive affect, the non-significant interaction indicate that biculturalism does not affect the relation of job stress to depressive affect above and beyond coping strategies and social support.

Table 11

Hierarchical Regression Analysis Predicting Depressive Affect from the Job Stress X Coping Strategies, Job Stress X Social Support, and Job Stress X Biculturalism Interactions ($N$ = 509)

| Predictors | $R$ | $\Delta R^2$ | $df$ | $\Delta F$ | β |
|---|---|---|---|---|---|
| Step 1 | .45 | .20*** | 502 | 21.40*** | |
| Job Stress | | | | | .30*** |
| Problem Focused Coping | | | | | -.05 |
| Emotion Focused Coping | | | | | -.06 |
| Total support | | | | | -.18*** |
| Coworker support | | | | | -.13** |
| Biculturalism | | | | | -.08* |
| Step 2 | .46 | .00 | 498 | .52 | |
| Job Stress x PFC | | | | | .03 |
| Job Stress x EFC | | | | | -.05 |
| Job Stress x Total support | | | | | -.04 |
| Job Stress x Coworker support | | | | | .00 |
| Step 3 | .46 | .00 | 497 | .09 | |
| Job Stress x Biculturalism | | | | | .01 |

Note. PFC = problem-focused coping. EFC = emotion-focused coping.
*$p$<.05. **$p$ <.01. ***$p$ <.001.

**Hypothesis Nine**

Hypothesis nine stated that positive religious coping would moderate the relationship between occupational stress and depressive affect above and beyond coping strategies, social support, and biculturalism. Moderated regression analyses were performed to explore the incremental variance of a product term including positive religious coping beyond product terms including problem-focused coping, emotion-focused coping, total support, coworker support, and biculturalism entered first into the

equation. Table12 display hierarchical regression results testing the effects of positive religious coping beyond coping strategies, social support, and biculturalism.

The data do not support this hypothesis. The interaction term with positive religious coping did not add significant incremental variance to the equation. The $R^2$ change values revealed no significant increments in variance attributed to the product terms above and beyond the statistically significant main effects. Coping strategies did not contribute to the prediction of depressive affect. Although occupational stress, social support, and biculturalism contributed uniquely to the prediction of depressive affect, positive religious coping and its product term with job stress did not contribute to the prediction of depressive affect. Positive religious coping does not affect the relation of job stress to depressive affect above and beyond coping strategies, social support, and biculturalism.

Table 12

Hierarchical Regression Analysis Predicting Depressive Affect from the Job Stress X Coping Strategies, Job Stress X Social Support, Job Stress X Biculturalism, and Job Stress X Positive Religious Coping Interactions ($N$ = 508)

| Predictors | $R$ | $\Delta R^2$ | $df$ | $\Delta F$ | β |
|---|---|---|---|---|---|
| Step 1 | .46 | .21*** | 500 | 19.07*** | |
| Job Stress | | | | | .28*** |
| Problem Focused Coping | | | | | -.05 |
| Emotion Focused Coping | | | | | -.07 |
| Total support | | | | | -.19*** |
| Coworker support | | | | | -.14** |
| Biculturalism | | | | | -.09* |
| Positive Religious Coping | | | | | .08 |
| Step 2 | .46 | .00 | 495 | .43 | |
| Job Stress x PFC | | | | | .03 |
| Job Stress x EFC | | | | | -.06 |
| Job Stress x Total support | | | | | -.04 |
| Job Stress x Coworker support | | | | | .00 |
| Job Stress x Biculturalism | | | | | .00 |
| Step 3 | .46 | .00 | 494 | .38 | |
| Job Stress x Positive Religious Coping | | | | | .03 |

Note. PFC = problem-focused coping. EFC = emotion-focused coping.
*$p$<.05. **$p$ <.01. ***$p$ <.001.

## Self-Reported Coping Strategies

Coping strategies of participants were explored through their responses to the survey question "What do you do to cope with difficult or stressful events at work?" The purpose of the question was to explore the nature of their coping repertoire and examine how cultural and social resources may influence the behaviors and cognitions in which Latino/a professionals engage when contending with complex situations at work. Using frequency counts, participants' self-reported coping strategies were grouped into categories for men, women, and group in general (see Table 13).

Of the 580 Latino psychologists who participated in this study, 85% ($n$ = 494) answered the question regarding their coping strategies. Sixty-four percent ($n$ = 315) were female and 36% ($n$ = 179) male. Participants indicated using a wide variety of coping strategies, yielding 1,720 total responses that were classified by the researcher into 14 coping categories originally developed by Arellano (2000), Carver (1997), and Carver et al. (1989). Categories were assigned a code number which was used to classify participants' responses. The list of coping categories is presented in Appendix H.

These responses point to the richness and variety of actions and resources available in their repertoires. The five most frequently endorsed or mentioned coping strategies were (a) social support, (b) planning and active problem solving, (c) work support, (d) recreational or disengagement activities, and (e) sports and exercise. Among the least endorsed or mentioned coping strategies were (a) acceptance, (b) humor, and (c) personal psychotherapy or counseling.

Table 13

Responses to Survey Question "What do you do to cope with difficult or stressful events at work?"

| | Sex | | | | | |
|---|---|---|---|---|---|---|
| | Males | | Females | | Total | |
| Self-reported coping strategies | *n* | % | *n* | % | *n* | % |
| Social Support[a] | 98 | 16.25 | 241 | 21.58 | 339 | 19.71 |
| Planning & Active Problem Solving | 95 | 15.75 | 157 | 14.06 | 252 | 14.65 |
| Work Support[b] | 66 | 10.95 | 159 | 14.23 | 225 | 13.08 |
| Recreational Activities | 78 | 12.94 | 131 | 11.73 | 209 | 12.15 |
| Sports & Exercise | 70 | 11.61 | 92 | 8.24 | 162 | 9.42 |
| Spirituality & Religion | 34 | 5.64 | 56 | 5.01 | 90 | 5.23 |
| Artistic & Literary Activities | 34 | 5.64 | 54 | 4.83 | 88 | 5.12 |
| Positive Reframing | 27 | 4.48 | 58 | 5.19 | 85 | 4.94 |
| Alternative Therapies | 24 | 3.98 | 38 | 3.40 | 62 | 3.60 |
| Relaxation or Rest | 26 | 4.31 | 34 | 3.04 | 60 | 3.49 |
| Acceptance | 7 | 1.16 | 17 | 1.52 | 24 | 1.40 |
| Humor | 8 | 1.33 | 16 | 1.43 | 24 | 1.40 |
| Psychotherapy or Counseling | 4 | 0.66 | 13 | 1.16 | 17 | 1.00 |
| Other | 32 | 5.31 | 51 | 4.57 | 83 | 4.83 |
| Total | 603 | 100 | 1,117 | 100 | 1,720 | 100 |

Note. a = family, significant others, and friends. b = coworkers and/or supervisors. Values represent amount and percentage of endorsement provided to a coping strategy.

These results suggested that seeking social support from family, significant others, friends, mentors, coworkers and/or supervisors for both emotional and instrumental reasons seems to be one of the most meaningful ways of dealing with stressful events. Coping strategies were used in combination or simultaneously with others. For example, planning or coming up with a strategy and taking action to solve the problem or deal with the stressful event involved a process of self-reflection, exchange of ideas, and/or receiving advice from trusted others.

Recreational or disengagement activities involved outdoor events, going to the beach, gardening, traveling, watching TV, movies, going to the theater, taking a vacation, hobbies, or other activities to take one's mind off of work. Recreational activities provided opportunities for either sharing with family and friends or personal replenishment. Many participants also coped by using sports and physical exercise including swimming, running, weight training, and walking.

Other coping responses included seeking comfort and strength in prayer and engaging in religious and spiritual practices. Participants reported the use of artistic and literary activities such as music, dancing, reading, journal writing, and other forms of creative expression. Positive reframing or looking for something good in the event, seeing it from a different perspective, or learning from it, was mentioned by participants. The use of yoga, tai-chi, folk healers, meditation, massage, and herbal teas as forms of alternative therapies and relaxation/breathing exercises, though part of the repertoire, were mentioned less frequently.

## Summary

The above analyses indicated that 13% of the variance in depressive affect is predicted by occupational stress. Furthermore, coping strategies, positive religious coping, social support, and biculturalism collectively explained 13% of the variance in depressive affect. Specifically, coworker support ($\beta = -.21$, $p < .001$), total non-work support ($\beta = -.20$, $p < .001$), biculturalism ($\beta = -.12$, $p < .01$), and positive religious coping ($\beta = .10$, $p < .05$) made a statistically significant contribution to the variance in depressive affect scores.

Analyses showed that interactions terms between occupational stress and coping strategies, work and non-work social support, biculturalism, and positive religious coping did not moderate the relationship between occupational stress and depressive affect. No increments in variance attributed to the product terms above and beyond main effects were found. Results revealed significant main effects for the predictor variables, except for positive religious coping, beyond occupational stress. Coping behaviors, work and non-work social support, and biculturalism, were negatively associated with depressive affect regardless of the level of occupational stress.

Analysis of participants' self-reported coping strategies indicated a wide variety of coping responses. The most frequently mentioned coping strategies were (a) social support, (b) planning and active problem solving, (c) work support, (d) recreational or disengagement activities, and (e) sports and exercise. Among the least endorsed or mentioned coping strategies were (a) acceptance, (b) humor, and (c) personal psychotherapy or counseling.

# CHAPTER V

# DISCUSSION

The purpose of this study was to expand understanding of the sources of occupational stress, coping behaviors, and strengths of Latino/a professionals. More specifically, the study was designed to investigate the degree to which coping behaviors, various sources of social support, biculturalism, and positive religious coping moderate the relationship between occupational stress and depressive affect. This study was guided by Slavin et al.'s (1991) Multicultural Model of the Stress Process (MMSP), an expanded formulation of Lazarus and Folkman's (1984) cognitive phenomenological stress model. The MMSP represents an effort to incorporate specific culturally relevant dimensions into Lazarus and Folkman's model. This chapter presents an interpretative summary of the research findings in relation to the hypotheses tested and integrates these results with those of previous research. This is followed by a discussion of implications for practice, methodological limitations, and suggestions for future research.

## Preliminary Analyses: Occupational Stress and Depressive Affect

### Occupational Stress

In this study, Latino psychologists reported moderate levels of occupational stress. Similar findings were reported in studies with British psychologists (e.g., Cushway & Tyler, 1994), psychologists in India (e.g., Rao & Mehrotra, 1998), and non-Hispanic U.S. psychologists (e.g., Boice & Myers, 1987; Hellman et al., 1986; Nash et al., 1984). One interpretation of this finding is that, as a group, psychologists are fairly healthy, knowledgeable, and aware of strategies to deal with stressors (e.g., Case, 2001;

Coster & Schwebel, 1997; Cushway & Tyler, 1994; Guy & Norcross, 1998; Kramen-Kahn & Hansen, 1998; Mahoney, 1997; Medeiros & Prochaska, 1988; Shoyer, 1998; Thoreson et al., 1989). An alternative interpretation could be that psychologists experiencing a high degree of occupational stress may be less inclined to participate in the study.

Some authors suggest that psychologists may be less inclined to report or admit serious stresses (e.g., Cushway & Tyler, 1994; Guy, 1987; Nash et al., 1984). These authors also suggested that variables such as years of experience, job environments, professional role satisfaction, skill utilization, decision autonomy, personal coping behaviors, and feelings of acceptance or recognition by ones colleagues may help explain reports of moderate levels of occupational stress among psychologists (e.g., Boice & Myers, 1987; Cushway & Tyler, 1994; Hellman et al., 1986; Nash et al., 1984; Rao & Mehrotra, 1998). In addition, Ott (1986) found that psychotherapists who diversify their clinical duties to include teaching, administration, writing, research, consultation, and supervision report a greater degree of overall career satisfaction. Working in more than one setting also brings interaction with other colleagues, variety of work, educational opportunities, and financial rewards (Tryon, 1983). Relatedly, Thoits (1983) found that experiencing up to seven roles is positively related with better mental health in men and women. Results of this study identified a variety of job positions and combinations of employment settings, and revealed that various sources of social support and biculturalism were associated with low scores in occupational stress.

Consistent with findings of other studies with psychologists (e.g., Cushway & Tyler, 1994; Rao & Mehrotra, 1998), this study found no gender-related differences in occupational stress. This finding suggests that male and female psychologists may appraise or experience the severity and frequency of work-related stressors in a similar way. Comprehensive reviews and studies of stress in organizations have found no evidence of sex differences in workplace stress (e.g., Beehr & Schuler, 1980; Di salvo, Lubbers, Rossi, & Lewis, 1995; Guppy & Rick, 1996; Martocchio & O'Leary, 1989; Spielberger & Reheiser, 1995).

**Depressive affect**

This sample's average score in the CESD indicates minimal symptom presence or a low level of depressive affect. This finding appears consistent with results from Cushway and Tyler (1994), Cushway et al. (1996), and Rao and Mehrotra, (1998) with psychologists in the United Kingdom and India, respectively. In these studies, psychologists scored below the established cutoff score to indicate depression or severe distress. No gender-related differences were found in depressive affect. This finding may suggest that male and female psychologists may appraise or experience depressive symptoms in a similar way. On the other hand, psychologists may be less willing to admit to psychological symptoms (Cushway & Tyler, 1994; Deutsch, 1985).

In contrast with these findings, other research suggests that depression is one of the most prevalent symptoms of professional distress reported by psychologists responding to open questions, checklists, or questionnaires (e.g., Deutsch, 1985; Gilroy et al., 2001, 2002; Guy et al., 1989; Mahoney, 1997; Pope & Tabachnick, 1994; Wood et

al., 1985). However, methodological considerations preclude comparisons of results. For example, in these studies, no instrument was used to formally assess depression; participants simply self-identified as depressed or nondepressed. In addition, most of these studies did not report the ethnic composition of their samples.

## Hypothesis Tests

### Prediction of Depressive Affect by Occupational Stress

Results showed that depressive affect was significantly predicted by occupational stress, with occupational stress accounting for 13% ($r = .36$, $p < .01$) of the variance of depressive affect. This finding is consistent with results from previous studies in occupational stress research suggesting that confronting a variety of occupational stressors that exceed one's adaptive skills and resources is associated with symptoms of depressive affect or depression (e.g., Beehr, 1995; Cooper et al., 2001; Arnold, Cooper & Robertson, 1998; Cushway et al., 1996; Israel et al., 1989; Kahn & Byosiere, 1992; LaRocco et al., 1980; Motowidlo, Packard, & Manning, 1986; Rao & Mehrotra, 1998; Revicki & May, 1985; Tennant, 2001).

### Moderator Tests

The study's findings did not support the hypothesized role of social support, biculturalism, positive religious coping, or non-religious coping strategies as moderators of stress-depressive affect relationships. However, several of these variables did show direct or "main effects" relations to depressive affect. Present findings seemed consistent with previous studies supporting the additive effect model of coping (e.g., Beehr, 1995;

Folkman & Lazarus, 1985; Kahn & Byosiere, 1992; Kobasa, 1982; Shinn et al., 1984). These relations will be discussed, below.

**Social support.** In this study, Latino/a psychologists with perceived adequate support from family, significant others, and coworkers appeared less likely to report depressive symptoms and occupational stress. This finding is consistent with previous research supporting the main effect model of social support relative to psychological strain (for reviews, see Beehr, 1985, 1995; Blau, 1981; Buunk et al., 1998; Caplan et al., 1975; Cohen & Wills, 1985; Cooper et al., 2001; House, 1981; Kahn & Boysiere, 1992; LaRocco & Jones, 1978; LaRocco et al., 1980; Payne & Jones, 1987; Pinneau, 1975, 1976). It is also consistent with findings that therapists find support from family, supervisors, and colleagues essential to cope with the effects of stress (e.g., Casas et al., 1980; Coster & Schwebel, 1997; Culbertson et al., 1992; Cushway & Tyler, 1994; Cushway et al., 1996; Deutsch, 1985; Farber & Heifetz, 1981, 1982; Gilroy et al., 2001, 2002; Kahill, 1986; Kramen-Kahn & Hansen, 1998; Ross et al., 1989; Sherman & Thelen, 1998; Shinn et al., 1984; Shoyer, 1998; Turnipseed & Turnipseed, 1991). The present findings also lend support to research highlighting the importance and function of family and coworker support for the well-being of Latino/a individuals (e.g., Amaro et al., 1987; Arellano, 2000; Gandara, 1982; Gant & Gutierrez, 1996; Gomez, 1996; Llerena-Quinn, 1987; Rojas & Metoyer, 1995; Valtierra, 1989).

**Biculturalism.** Biculturalism was negatively related to depressive affect. Consistent with the present findings, prior research suggests that bicultural individuals tend to experience minimal psychological distress (e.g., Amaro et al., 1987), low stress

levels (e.g., Arellano, 2000; Cervantes & Castro, 1985; Rodriguez-Charbonier & Burnette, 1994; Valtierra,1989), and healthy psychological adjustment (e.g., Birman, 1991; Fernandez-Barillas & Morrison, 1984; Kurilla, 1998; Lang et al., 1982; Rivera-Sinclair, 1997). Taken together these studies support the view that competence in the dominant (Anglo-European) culture and one's own culture (Latino/a subgroup) may be important for the psychological well-being and psychological adaptation of Latinos/as (and other individuals from visible race and ethnic groups as well) (e.g., Gomez & Fassinger, 1994; LaFromboise et al., 1993; Padilla, 1994; Ramirez, 1984; Szapocznik & Kurtines, 1980).

**Coping strategies.** Consistent with prior research (e.g., Billings & Moos, 1981; Felton & Revenson, 1984; Felton, Revenson, & Hinrichsen, 1984; Folkman & Lazarus, 1985; Kobasa, 1982; Latack, 1986; Pearlin & Schooler, 1978; Richard & Krieshok, 1989; Shinn et al., 1984), this study found significant main effects for coping strategies in relation to depressive affect. However, these modest relations disappeared when social support from family, significant others, and coworkers was entered into the equation. As in previous studies, quantitative analysis (e.g., Menaghan & Merves, 1984; Osipow & Davis, 1988; Osipow, Doty, & Spokane, 1985 Shinn et al., 1984), showed no gender differences in the use of coping strategies. This may suggest that male and female psychologists use a variety of coping strategies to the same extent or frequency.

Qualitative data seemed to indicate possible differences in coping strategies suggesting that women tend to employ more relational and more active strategies. Similar results were reported by Thoits (1991) who found that women were more likely

than men to express their feelings freely, reinterpret the situation, seek social support, and write about the situation suggesting an expressive coping style. One interpretation of the possibly contrasting quantitative and qualitative findings in this study is that women can overtly express their feelings and emotions more readily than men (e.g., Greenglass, 1982). As in Thoits (1991), gender differences in expressivity (or motivation or verbal skills) may have influenced the number of coping strategies that were spontaneously reported by participants. An alternative interpretation could be that primary researcher's biases may have influenced the coding process of respondents' coping strategies and qualitative results.

**Positive religious coping.** Results indicated that almost 50% of the participants in this study identified themselves as Catholic. More than half of the sample regarded religion or spirituality as highly important for them. In addition, Hispanic female psychologists tend to use religious coping somewhat more frequently than do male psychologists. These results are consistent with findings suggesting that psychologists and Latino/a professionals tend to address spiritual and religious issues in their personal lives, view religious beliefs in a positive light, and regard religion and spirituality among the several self-care behaviors used to cope with stress (e.g., Arellano, 2000; Coster & Schwebel, 1997; Gomez, 1996; Guy & Norcross, 1998; Llerena-Quinn, 1987; Mahoney, 1997; Norcross & Prochaska, 1986; Persing, 1999; Shafranske, 1996; Shoyer, 1998; Valtierra, 1989). Gender differences in the use of religious coping may suggest organized religion (e.g., Catholicism's hierarchical and patriarchal organization) influence on the delineation of Latino/a gender roles (Comas-Diaz, 1987; Peña & Frehill,

1998). However, positive religious coping did not relate significantly to depressive affect. Similar to these findings, Stark (1990) found that an intrinsic religious orientation does not explain significant variance in burnout, and Pargament et al. (1998) found that positive religious coping was not related to depression, emotional distress, or callousness.

## Implications for Practice

The following implications are offered tentatively pending replication and extension of these findings, and further research within the Multicultural Model of the Stress Process (Slavin et al., 1991) framework. These and previous results demonstrate the relationship of occupational stress to psychological strain, as posited by the transactional model of psychological stress (Lazarus & Folkman, 1984; Slavin et al., 1991). This study provides Latino/a professionals in psychology with descriptive information regarding multiple and particular stressors that may contribute to depressive affect. Thus, professionals are encouraged to identify personal and contextual factors that may increase their vulnerability to job stressors which may compromise their well-being. Latinos/as would do well in identifying, developing, and maintaining sources of personal and collective strength which may contribute to their optimal well-being. In particular, Hispanic professionals are encouraged to continue nurturing their relationships with family, significant others, and peers, and to explore ways to reconcile competing job and family issues. Present findings encourage practitioners to further explore the complex role of biculturalism, religion, and spirituality in helping them cope with various stressful situations and in their personal and professional development.

Moreover, counselors are therefore encouraged to consider Latinos/as' phenomenological perspectives in the identification of job-related events as potential sources of stress and evaluation of the degree of stressfulness. For example, stress related to home-work conflict may involve exploration of potential discrepancies between traditional cultural sex-role stereotypes or expectations and personal values, beliefs, and behaviors. Further insight into the issues faced by dual-career couples would also help in addressing concerns in this area. Counselors need to be aware of the differences and similarities among Latino subgroups and be sensitive to variations within individuals from the same subgroup.

Present findings substantiate the importance of assessing the level of biculturalism as a measure of a Latino/a's capacity to interact in both cultures and develop a bicultural identity. Counselors may want to consider the extent to which biculturation may influence occupational behavior, appraisal of stressors, availability and usefulness of coping strategies or resources, expression of psychological distress, and educational and career development. Counselors should also consider the possible effects of bicultural stress (i.e., management of cognitive, emotional, and behavioral demands from the Anglo culture and Latino subgroup culture in the work environment) on occupational well-being (Bell, 1986, 1990).

Family members, significant others, and coworkers were identified as reliable sources of support. Counselors may wish to consider the potential value of each of these sources in exploring clients' coping resources and strategies for the implementation of culturally competent interventions. In addition, counselors may encourage the utilization

or development of support groups for Latino/a professionals. Many participants placed a high value on spiritual-religious issues. Although positive religious coping was not a reliable predictor of depressive affect, culturally sensitive counseling requires counselors to recognize and respect clients' religious and/or spiritual beliefs and values (APA, 1993).

The present findings may be relevant to training programs and professional associations. For example, graduate students in counseling and clinical psychology training programs may benefit from learning about stressors related to the practice of psychology, strains, and adaptive stress management techniques. Faculty may consider the benefits of promoting students' awareness of personal strengths and vulnerabilities, encouraging the adoption of self-care behaviors, and promoting the development of supportive relationships early in the training process. Collegial, supportive relationships developed with faculty and fellow students during the training years may play an important role in future personal and professional development.

Courses in professional development and discussions with practicum, externship, and internship supervisors may provide a forum to learn about the relevant contemporary literature and to process personal experiences regarding the challenges, stresses, and satisfactions of practicing psychology. Students may also appreciate learning about faculty members' challenging experiences in their own professional development and how they applied self and psychological knowledge to manage the situation. Faculty members' modeling of supportive interactions and self-care behaviors could play an important role in students' development.

Psychology professional associations can also aid practitioners to adopt a proactive position in regard to occupational stress and strain. Professional associations may, for example, sponsor workshops addressing the issue or encourage members to engage in peer consultation or professional support groups. Such initiatives may provide the opportunity for sharing information, case consultation, personal support, and problem solving regarding occupational stressors and stress management.

## Methodological Limitations

Caution should be exercised when interpreting or generalizing these findings due to methodological limitations. For example, this study did not consider possible differences among Latino/a subgroups. Also, this study used a non-experimental or passive observational design, which did not permit direct manipulation or control over the independent variables. Therefore, no inferences of causality can be made and alternative interpretations of the phenomena cannot be ruled out (Heppner, Kivlighan, & Wampold, 1992; Kerlinger, 1986; Rosenthal & Rosnow, 1984; Stone-Romero, 2002; Wampold, 1996). Participants' scores in many of the variables suggested an overall healthy level of functioning. The restriction in range of scores and possible insensitivity of measurement may have reduced the magnitude of the zero-order correlation coefficients and possibly decreased the probability of showing the presence of moderating effects in this study. Also, other variables not explored in this study such as, positive affect, hardiness, sense of coherence, cognitive style, and perceived self-efficacy at work (e.g., Cooper & Payne, 1991; Nelson & Simmons, 2003) may be contributing to the psychological health of participants in this study.

The return rate and missing data also affect the generalizability of the results. It is possible that respondents' lack of interest in the topic and the length of the questionnaire may have affected the return rate. In addition, the mail survey method is susceptible to self-selection bias (convenience sample) (Dillman, 1978, 1983; Hackett, 1981; Vaux, 1996; Weathers et al., 1993). Self-report measures are vulnerable to response distortions. Despite the steps taken to ensure confidentiality and anonymity, it is possible that some individuals were cautious in their responses and did not report the full extent of their feelings. Also, the limited or unavailable normative data for Latinos/as on most measures used in this study call for further caution in interpreting the results (Heppner et al., 1992; Kerlinger, 1986).

Other measurement considerations should be noted. First, the emotion-focused coping scale used in this study produced a marginal internal reliability estimate. Second, for the purposes of this study, modifications were made in the wording of items and the response format of the Mental Health Professional Scale (MHPSS). Third, this study used the product term of Americanism and Hispanicism to index biculturalism. Evans (1991) expressed serious concerns about the use of multiplicative composites in simple regression or bivariate analyses. Lastly, self-reported coping strategies were independently sorted by the primary researcher and his personal biases may have guided the coding process of participants' responses. Another researcher or research team may have used other categories or sorted the responses differently.

## Suggestions for Future Research

The findings of this study provided partial support for the theoretical assertions of the Multicultural Model of the Stress Process (Slavin et al., 1991) in regard to social support and biculturalism as relevant dimensions in the stress-coping process. However, the role of problem-focused coping, emotion-focused coping, and religious coping in the stress-coping process deserve further attention. It may also be valuable for future research on stress and coping to replicate and extend the findings of this study by applying the theoretical model to other segments of the Latino population in different occupations.

Results of a supplemental regression analysis indicated that two of the seven occupational stressors, professional self-doubt and home-work conflict, accounted for statistically significant variation in depressive affect scores. These stressors have been consistently reported in previous research with psychotherapists. Consistent with findings of previous studies conducted with non-Hispanic psychotherapists, the work experience of Latino/a counseling and clinical psychologists seems characterized by having limited time for recreation with family, taking work home, harboring feelings of responsibility for client's progress, uncertainty about therapeutic efficacy, and fear of making clinical errors (Book, 1989; Culbertson et al., 1992; Cushway & Tyler, 1994; Deutsch, 1984, 1985; Farber & Heifetz, 1981, 1982; Hellman et al., 1986, 1987a; Hellman & Morrison, 1987; Nash et al., 1984; Rao & Mehrotra, 1998; Rodolfa et al., 1988; Shinn et al., 1984).

These occupational stressors (home-work conflict and professional self-doubt) deserve further attention in future research with Latino/a professionals. Balancing family and professional roles has been identified as a relevant source of stress for Latino/a professionals (e.g., Amaro et al., 1987; Arellano, 2000; Cervantes, 1992; Gomez, 1996). Studies also reveal that family and significant others are important sources of support for Hispanic professionals (e.g., Amaro et al., 1987; Arellano, 2000; Gandara, 1982; Gomez, 1996; Llerena-Quinn, 1987; Valtierra, 1989). According to Romero-Ramos (1990, cited in Comas-Diaz, 1997), many Latinos pay a high emotional cost in the form of personal sacrifices and strained interpersonal relationships with families and significant others because of their academic and professional success. Future research would help to discern whether home-work conflict develops from situations where (a) the time spent on activities in one role affects the fulfillment of responsibilities of another role, (b) the pressure from one role interferes with fulfilling the requirements of another, or (c) the behavior in one role cannot be adjusted to be compatible with behavior in another role (Arellano, 2000; T. D. Allen, personal communication, March 31, 2005).

Empirical findings suggest that professional self-doubt (e.g., harboring feelings of responsibility for client's progress, uncertainty about one's therapeutic efficacy) are stressors shared by psychotherapists in general (Book, 1989; Casas et al., 1980; Cushway & Tyler, 1994; Cushway, Tyler, & Nolan, 1996; Deutsch, 1984, 1985; Farber & Heifetz, 1981, 1982; Hellman et al., 1986; Hellman & Morrison, 1987; Nash et al., 1984; Rodolfa et al., 1988; Shinn et al., 1984). However, the literature suggests that Latinos/as often need to contend as well with ethnocultural value conflicts, institutional barriers, and

dysfunctional organizational dynamics in their professional lives (Comas-Díaz, 1997; Comas-Díaz & Greene, 1994; Fernandez, 1981).

Lassiter (1990) suggested that practitioners from visible racial or ethnic groups difficulties often begin their training years with the stigma of having been admitted to a training program in part because of affirmative action. Social stereotypes of Latinos/as may also interfere with their ability to function at full capacity (Tafolla, 1985). Comas-Díaz (1997) asserted that Latino/a professionals typically confront dysfunctional organizational dynamics including: (a) questions about their qualifications, (b) exclusionary practices, (c) unclear evaluation criteria and feedback about performance, (d) mixed messages about success, (e) unrealistic demands, and (f) overt or covert discriminatory actions. According to these authors, these situations may compromise Latinos/as' physical and mental health, as well as their adjustment, performance, and advancement in the workplace. Further research would help to explore how such organizational characteristics (e.g., perceived discrimination) affect Latino/a's sense of professional competence or efficacy.

This study assessed the perceived adequacy of social support from family and significant others, and the overall level of instrumental and emotional support from coworkers. House (1981) distinguished different forms or kinds of social support including (a) emotional concern, (b) instrumental aid, (c) informational, and (d) appraisal. Pargament (1997; Pargament et al., 1998; 2000) also identified spiritual support. It is possible that certain forms of support are more influential than others in contributing to the well-being of Latino/a individuals depending on the frequency and intensity of

different types of stressors. Further research is necessary to examine the predictive utility of these forms of support in the stress-coping process of Hispanics.

The role of religious coping also deserves further attention in studies with Latinos/as. In this study the degree of occupational stress and depressive affect were not at particularly harmful levels for most participants. Pargament (1997) suggests that religion may become a compelling coping solution when facing overwhelming situations and when non-religious coping methods do not provide solutions. Hence, it would be valuable to examine the main and interactive effects of religious coping in dealing with situations, like occupation-related injuries, illnesses, or rehabilitation processes that pose higher levels of stress or strain.

Finally, further attention should be devoted to the measurement of biculturalism, its role in stress-coping research, and the procedures used to analyze the effects of multiplicative composite scores on other variables. This study found that biculturalism is negatively related to occupational stress and depressive affect, and positively related to positive religious coping, importance of religion or spirituality, and degree of bicultural work environment. However, all of these relationships were small in magnitude. Further research could aid understanding of biculturalism as a predictor of psychological well-being in the work setting.

APPENDIX A

List of Categories of Ethnic Heritage

| Latino/Hispanic Identity | *n* | *%* |
|---|---|---|
| Mexican American-Chicano/a | 115 | 19.8 |
| Mexican | 52 | 9.0 |
| Puerto Rican | 106 | 18.3 |
| Central or South American | 103 | 17.8 |
| Cuban | 102 | 17.6 |
| Hispanic | 38 | 6.6 |
| Latino/a | 31 | 5.3 |
| Spanish | 5 | .9 |
| Spanish-Mexican | 4 | .7 |
| Dominican | 3 | .5 |
| Cuban-Venezuelan | 1 | .2 |
| Argentinian-European | 1 | .2 |
| Colombian | 1 | .2 |
| Other | 17 | 2.9 |

Note. $N = 579$. One participant did not report Hispanic/Latino/a heritage.

APPENDIX B

U.S. Geographic Regions*
(Therrien, M. & Ramirez, R. 2000)

| | |
|---|---|
| Northeast | Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, & Vermont |
| Midwest | Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, & Wisconsin |
| South | Alabama, Arkansas, Delaware, Washington, DC, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, & West Virginia |
| West | Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, & Wyoming |

*Puerto Rico is not included.

Latinos by Region of Residence

| Region of Residence | Census 2000 % | Participants in this study % |
|---|---|---|
| Northeast | 14.1 | 22.1 |
| Midwest | 7.9 | 11.0 |
| South | 33.2 | 32.2 |
| West | 44.7 | 34.7 |

APPENDIX C

List of Categories of Religious-Spiritual Preferences

| Religious-Spiritual Preference | *n* | % |
|---|---|---|
| Catholic | 277 | 47.8 |
| Protestant | 59 | 10.2 |
| Jewish | 37 | 6.4 |
| Agnostic | 32 | 5.5 |
| Eastern | 25 | 4.3 |
| Spiritually Eclectic | 16 | 2.8 |
| Christian | 10 | 1.7 |
| Catholic & Eastern | 6 | 1.0 |
| Unitarian Universalist | 6 | 1.0 |
| Spiritism | 4 | .7 |
| Indigenous spiritual beliefs | 3 | .5 |
| Quaker | 3 | .5 |
| Budism & Spiritual | 2 | .3 |
| God Centered | 2 | .3 |
| Catholic, Indigenous, & Eastern | 2 | .3 |
| Catholic, Afro-Caribbean, & Spiritism | 2 | .3 |
| Afro-Caribbean religion | 1 | .2 |
| Catholic & Afro-Caribbean | 1 | .2 |
| Humanistic | 1 | .2 |
| Indigenous, Afro-Caribbean, & Spiritism | 1 | .2 |
| Bahái | 1 | .2 |
| Metaphysic | 1 | .2 |
| Deist | 1 | .2 |
| LDS Mormon | 1 | .2 |
| Vedantic | 1 | .2 |
| None | 69 | 11.9 |
| Other | 15 | 2.6 |
| Total | 579 | 100 |

Note. One participant did not report religious-spiritual preferences.

APPENDIX D

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**COLLEGE OF EDUCATION**
***Department of Counseling and Personnel Services***

July 2004

Dear Colleague / Estimado(a) Colega:

I would like to invite you to participate in a study for my doctoral dissertation that investigates Latino(a) psychologists' experiences in the workplace and self-care behaviors. Your participation is very important in helping understand how various factors contribute to Latino/a professional's general well-being at work. Your participation in this study is greatly needed, very much appreciated, and completely voluntary. Participation in this study will require you to answer the enclosed anonymous survey, which will take you about 20 minutes to complete. Participation in this study is deemed to pose minimal risk. You are free to withdraw from participation at any time without penalty and prejudice by simply returning the blank enclosed survey.

Your responses will remain confidential to the extent permitted by law and your identity will remain anonymous throughout the data collection, analyses, and reporting. Each booklet has been assigned an identification number printed on the top right corner that will permit tracking of unreturned questionnaires and calculation of a response rate. Only I will have access to the list of identification numbers and names. Once the completed surveys are received, I will write down the identification number and cut off the right corner of the questionnaire. The list of names and corresponding numbers will be locked in my file cabinet and destroyed at the completion of the study. Only those who do not return the completed or blank survey will receive reminder post cards.

Your completion and return of your completed survey will serve as your consent to participate in this study. A stamped, self-addressed envelope for returning the survey has been enclosed for your convenience. As you know from your own research, each response is very important to ensure the high overall response rate required for accurate interpretation of survey results. Please return your completed survey at your earliest convenience. This research was approved by the University of Maryland Human Subjects Institutional Review Board. If you have questions about your rights as a research participant or wish to report a research-related injury, please contact: Institutional Review Board Office, University of Maryland, College Park, MD, 20742; irb@deans.umd.edu ; Tel. 301-405-4212.

If you are interested in receiving a summary of the results of this study when they become available, please complete and return the enclosed post card indicating your interest. My advisor and I will be glad to answer any questions you might have concerning this study or your participation in it. Please feel free to contact either of us at the numbers or addresses listed below.

Thank you for your interest, collaboration, and timely response.

Sincerely,

Mr. Leslie E. Maldonado, MA
Doctoral Candidate
lemf@wam.umd.edu

Robert W. Lent, Ph.D.
301-405-2878
Boblent@wam.umd.edu

APPENDIX E

FA _____

# Hispanic/Latino(a) Psychologist Survey

## A nationwide survey of Latino(a) psychologists experiences at work

Dear Latino/a Psychologist:

Very little is known about the psychological strengths of Latinos/as with professional status and how cultural factors influence our coping behaviors. Occupational stress research literature needs information about Latino/a professionals' stressors and coping strategies influencing our well-being at the workplace. The information you provide in this study will contribute to increase our knowledge on how Latino/a professionals in the United States cope with occupational stress. You also will be helping me in completing the requirements for my doctoral degree in counseling psychology for which I am deeply thankful.

Thank you for completing this survey in its entirety and
returning the questionnaire booklet at your earliest convenience.

Sincerely
Mr. Leslie E. Maldonado, MA
Doctoral Candidate

**These items ask what you do to cope with stressful situations, including events at work. Please circle the answer that best indicates to what extent you do what the item says. Don't answer on the basis of what works or not–just whether or not you do it. Make your answers as true FOR YOU as you can**

| | Not at all | Somewhat | Quite a bit | A great deal |
|---|---|---|---|---|
| 1. Concentrate my efforts on doing something about the situation I'm in. | 1 | 2 | 3 | 4 |
| 2. Use alcohol or other drugs to make myself feel better. | 1 | 2 | 3 | 4 |
| 3. Take action to try to make the situation better. | 1 | 2 | 3 | 4 |
| 4. Get help and advice from other people. | 1 | 2 | 3 | 4 |
| 5. Use alcohol or other drugs to help me get through it. | 1 | 2 | 3 | 4 |
| 6. Try to see it in a different light, to make it seem more positive. | 1 | 2 | 3 | 4 |
| 7. Try to come up with a strategy about what to do. | 1 | 2 | 3 | 4 |
| 8. Look for something good in what was happening. | 1 | 2 | 3 | 4 |
| 9. Make jokes about it. | 1 | 2 | 3 | 4 |
| 10. Try to get advice or help from other people about what to do. | 1 | 2 | 3 | 4 |
| 11. Think hard about what steps to take. | 1 | 2 | 3 | 4 |
| 12. Make fun of the situation | 1 | 2 | 3 | 4 |

**Please circle the one response that best describes the extent to which you agree with each of the statements. Please base your ratings with reference to your family of origin (i.e., parents & siblings) and spouse or partner respectively**.

| | Very Strongly Disagree | Strongly Disagree | Mildly Disagree | Mildly Agree | Strongly Agree | Very Strongly Agree |
|---|---|---|---|---|---|---|
| 1. There is a special person who is around when I am in need. | 1 | 2 | 3 | 4 | 5 | 6 |
| 2. My family really tries to help me. | 1 | 2 | 3 | 4 | 5 | 6 |
| 3. There is a special person with whom I can share my joys and sorrows. | 1 | 2 | 3 | 4 | 5 | 6 |
| 4. I get the emotional help and support I need from my family. | 1 | 2 | 3 | 4 | 5 | 6 |
| 5. I have a special person who is a real source of comfort to me. | 1 | 2 | 3 | 4 | 5 | 6 |
| 6. I can talk about my problems with my family. | 1 | 2 | 3 | 4 | 5 | 6 |
| 7. There is a special person in my life who cares about my feelings. | 1 | 2 | 3 | 4 | 5 | 6 |
| 8. My family is willing to help me make decisions. | 1 | 2 | 3 | 4 | 5 | 6 |

**Please circle the one response that best describes the extent to which you agree with each of the statements.**

| | Strongly Disagree | Disagree Somewhat | Agree Somewhat | Strongly Agree |
|---|---|---|---|---|
| 1. I think of myself as being U.S. American. | 1 | 2 | 3 | 4 |
| 2. I feel good about being U.S. American. | 1 | 2 | 3 | 4 |
| 3. I feel that I am part of U.S. American culture. | 1 | 2 | 3 | 4 |
| 4. I am proud of being U.S. American. | 1 | 2 | 3 | 4 |
| 5. I think of myself as being Latino/Hispanic. | 1 | 2 | 3 | 4 |
| 6. I feel good about being Latino/Hispanic. | 1 | 2 | 3 | 4 |
| 7. I feel that I am part of the Latino/Hispanic culture. | 1 | 2 | 3 | 4 |
| 8. I am proud of being Latino/Hispanic. | 1 | 2 | 3 | 4 |
| **How well do you** ... | **Not at all** | **A little** | **Pretty well** | **Extremely well** |
| 9. SPEAK English in general? | 1 | 2 | 3 | 4 |
| 10. UNDERSTAND English in general? | 1 | 2 | 3 | 4 |
| 11. SPEAK Spanish in general? | 1 | 2 | 3 | 4 |
| 12. UNDERSTAND Spanish in general? | 1 | 2 | 3 | 4 |
| **How well do you know ...** | | | | |
| 13. popular U.S. American newspapers and magazines? | 1 | 2 | 3 | 4 |
| 14. popular U.S. American actor and actresses? | 1 | 2 | 3 | 4 |
| 15. U.S. American History? | 1 | 2 | 3 | 4 |
| 16. U.S. American political leaders? | 1 | 2 | 3 | 4 |
| 17. popular Latino/Hispanic newspapers and magazines? | 1 | 2 | 3 | 4 |
| 18. popular Latino/Hispanic actor and actresses? | 1 | 2 | 3 | 4 |
| 19. Latino/Hispanic history? | 1 | 2 | 3 | 4 |
| 20. Latino/Hispanic political leaders? | 1 | 2 | 3 | 4 |

**Please Continue**

**Based on your personal experience, on the LEFT column please rate the average amount of pressure you perceive to be associated with each event. If you have not experienced a particular situation, base your rating on an estimation of the amount of pressure you would experience if the situation is encountered.**

**On the RIGHT column please indicate the approximate number of days during the preceding six months on which you have experienced each of the events. A rating of 0 indicates that you did not experience the event, the event did not occur. A rating of 7+ indicates that you experienced the event on 7 or more days during the past six months. Please consider each of the items individually from the others and circle the number that best corresponds to your answer.**

| Amount of Pressure | | | | | | | Work-Related Events | Number of Days on Which the Event Occurred During the Past 6 Months | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Low | | | Moderate | | | High | | | | | | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | Too much work to do | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7+ |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | Ending treatment with clients/patients | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7+ |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | Lack of support from management | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7+ |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | Conflict with other professionals e.g., physician, psychiatrist. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7+ |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | Lack of adequate staffing | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7+ |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | Feeling inadequately skilled for dealing with emotional needs of clients/patients | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7+ |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | Not enough time with family | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7+ |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | Too many different things to do | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7+ |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | Dealing with death or suffering | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7+ |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | Relationship with immediate supervisor | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7+ |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | Conflicting roles with other professionals | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7+ |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | Lack of financial resources for training courses/workshops | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7+ |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | Uncertainty about own capabilities | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7+ |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | Inability to separate personal from professional role | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7+ |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | Not enough time to complete all tasks satisfactorily | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7+ |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | No change or slowness of change in clients/patients | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7+ |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | Communications and flow of information at work | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7+ |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | Working in a multidisciplinary team | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7+ |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | Shortage of adequate equipment/supplies | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7+ |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | Feeling inadequately skilled for working with difficult clients/patients | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7+ |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | Taking work home | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7+ |

| Amount of Pressure | | | | | | | Work-Related Events | Number of Days on Which the Event Occurred During the Past 6 Months | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Low | | | Moderate | | | High | | | | | | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | Too many clients/patients | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7+ |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | Difficult and/or demanding clients/patients | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7+ |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | Poor management and supervision | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7+ |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | Criticism by other professional e.g., physician, psychiatrist... | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7+ |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | Lack of adequate cover in potentially dangerous environment | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7+ |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | Doubt about the efficacy of therapeutic endeavors | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7+ |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | Relationship with spouse/partner affects work | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7+ |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | Working too long hours | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7+ |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | Physically threatening clients/patients | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7+ |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | The way conflicts are resolved in the organization | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7+ |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | Lack of emotional support from colleagues | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7+ |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | Inadequate clerical/technical back up | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7+ |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | Keeping professional/clinical skills up to date | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7+ |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | Work emphasizes feelings of emptiness and/or isolation | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7+ |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | Not enough time for recreation | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7+ |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | Managing therapeutic relationships | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7+ |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | Organizational structure and policies | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7+ |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | Difficulty of working with certain colleagues | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7+ |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | Poor physical working conditions | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7+ |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | Fear of making a mistake over a client/patient's treatment | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7+ |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | Inadequate time for friendships/social relationships | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7+ |

**Please Continue**

**These items ask what you do to cope with stressful situations, including events at work. Please circle the answer that best indicates how much or how frequently you do what the item says. Don't answer on the basis of what works or not–just whether or not you do it. Make your answers as true FOR YOU as you can.**

| | Not at all | Somewhat | Quite a bit | A great deal |
|---|---|---|---|---|
| 1. Look for a stronger connection with God. | 1 | 2 | 3 | 4 |
| 2. Seek God's love and care. | 1 | 2 | 3 | 4 |
| 3. Seek help from God in letting go of my anger. | 1 | 2 | 3 | 4 |
| 4. Try to put my plans into action together with God. | 1 | 2 | 3 | 4 |
| 5. Try to see how God might be trying to strengthen me in this situation. | 1 | 2 | 3 | 4 |
| 6. Ask forgiveness for my sins. | 1 | 2 | 3 | 4 |
| 7. Focus on religion to stop worrying about my problems. | 1 | 2 | 3 | 4 |

**Please indicate how often you have been feeling this way during the past week, including today, by marking the appropriate space.**

| | LAST WEEK | | | |
|---|---|---|---|---|
| | Not at all or Less than one day | Some of the time 1 – 2 days | Occasionally 3 – 4 days | NEARLY EVERY DAY 5 – 7 days |
| 1. I was bothered by things that usually don't bother me | ❍ | ❍ | ❍ | ❍ |
| 2. I had trouble keeping my mind on what I was doing | ❍ | ❍ | ❍ | ❍ |
| 3. I felt depressed | ❍ | ❍ | ❍ | ❍ |
| 4. I felt that everything I did was an effort | ❍ | ❍ | ❍ | ❍ |
| 5. I felt hopeful about the future | ❍ | ❍ | ❍ | ❍ |
| 6. I felt fearful | ❍ | ❍ | ❍ | ❍ |
| 7. My sleep was restless | ❍ | ❍ | ❍ | ❍ |
| 8. I was happy | ❍ | ❍ | ❍ | ❍ |
| 9. I felt lonely | ❍ | ❍ | ❍ | ❍ |
| 10. I could not "get going" | ❍ | ❍ | ❍ | ❍ |

**Please circle the one response that best describes the extent to which you agree with each of the statements.**

**Job Content Questionnaire - Job Social Support Scales**


Dr. Robert A. Karasek
One University Ave., Kitson 200
Lowell, MA 01854-2867
http://www.uml.edu/Dept/WE
or the JCQ Center at JCQCenter@uml.edu
Tel. (978)934-3348

**DEMOGRAPHIC INFORMATION**

What is your age?_____ What is your sex?_____ Male _____Female

How do you identify yourself in terms of your Hispanic heritage? (choose the one that fits best)

_____ Puerto Rican (e.g., Boricua) _____ Cuban
_____ Mexican _____ Mexican American-Chicano/a
_____ Latino(a) _____ Hispanic
_____ Central or South American (specify) _____
_____ Other (specify) _____

What is your Marital Status? ____ Never married ____ Married _____ Separated/Divorced
____ Widowed ____ Partnered/committed relationship

Were you born in the United States? _____ Yes _____ No
If NO, How long have you been living in the United States? _____ years

What is your current religious - spiritual preference?

_____ Catholic _____ Spiritism (e.g., espiritismo)
_____ Protestant _____ Eastern (e.g., Buddhist)
_____ Jewish _____ Agnostic
_____ Indigenous spiritual beliefs (e.g., curanderismo) _____ None
_____ Afro-Caribbean religion (e.g., santería) _____ Other (specify)
_____

Please rate on the following scale how important is religion or spirituality to you?

0 1 2 3 4 5 6 7 8 9 10
**Not at All** **Very Important**

**PROFESSIONAL INFORMATION**

Type of doctoral degree (Select only one option.) _____ Ph.D. _____ Psy.D. _____ Ed.D.

What is your current Major Field? (Select only one option)
_____ Counseling Psychology _____ Clinical Psychology_____ Other (specify)_____

How many years have you been practicing psychology? _____

**EMPLOYMENT INFORMATION**

What is your current primary job position?
_____ Faculty _____ Administrator _____ Consultant _____ Researcher
_____ Direct Human Services-practitioner _____Other (specify) _____

Select the one response that best describes your current employment status.
_____ Employed full-time (30 or more hours per week) _____ Unemployed
_____ Employed part-time (fewer than 30 hours per week) _____ Retired

Indicate the employment setting for your primary position
_____ University or college (e.g., Psych. Dept.)
_____ Human service setting (e.g., counseling center, hospital)
_____ Consulting and independent practice
_____ Private sector organization
_____ Public sector organization (e.g., federal, state, or local government)
_____ Other (specify)_____

Number of years of work experience in primary job position _____

A bicultural environment is characterized by allowing plentiful access to Latino and Anglo-American cultures, with a similar number of persons speaking Spanish and English languages, and with equal availability/accessibility to telecommunications, publications, services, and other key elements of both cultures.

To what extent do you consider your **work setting** a bicultural environment?

| 0 | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| **Not at all** | | | | | **Very** |

What do you do to cope with difficult or stressful events at work?

_____

_____

Thank you for your participation ~ Gracias por su participación

APPENDIX F

Post Card Request of Results

Front

Thank you so much for helping me collect data for my dissertation.

By completing this card you will help me to monitor the return rate and determine who will receive reminder post cards. This card also informs me of your interest in receiving a summary of the study's results when they become available. This card will be immediately separated from the questionnaire to protect your anonymity.

Instructions:

1.Complete the reverse side of this card if you would like to receive a summary of the results.
2.Enclose the card in the self-addressed return envelope along with the completed questionnaire.

Mr. Leslie E. Maldonado, MA
lemf@wam.umd.edu SEE REVERSE

Back

I have completed and returned the survey questionnaire.

I would like to receive a summary of the study's results sent to the following postal or e-mail address.

Name:_____

Postal Address:_____

_____

_____

E-mail:

_____

APPENDIX G

Follow-up post card

Back

Dear participant

Approximately two weeks ago you should have received a survey about the Latino psychologist experiences at work as part of my effort to conduct my dissertation. If you already have returned the survey, thank you very much for your prompt cooperation. If you have **not** yet returned the survey, please take a few moments to complete it and send it back to me at your earliest convenience. Each response is very important to ensure the high overall response rate required for accurate interpretation of survey results. If you need an additional survey, please contact me at the e-mail below.

Thank you so much for helping me collect data for my dissertation.

Mr. Leslie E. Maldonado, MA
Doctoral Candidate
lemf@wam.umd.edu

Front

Leslie E. Maldonado, MA
Return Address

# APPENDIX H

## Coping Categories for Survey Question "What do you do to cope with difficult or stressful events at work?"

Social Support - instrumental or emotional support from family, significant others, and friends

Planning and Active Problem Solving - come up with a strategy, make a plan, think about steps to take; take action to solve the problem or circumvent stressors

Work Support - instrumental or emotional support from coworker, supervisors, and colleagues

Recreational or Disengagement Activities - outdoor activities, go to the beach, gardening, traveling, watch TV or movies, take vacations, hobbies, play with kids or pets, turn to work or other activity to take mind off, daydream

Sports & Exercise - swimming, running, weight training, walking, gym, hiking

Spirituality & Religion - religious practices, pray, seek comfort in religion

Artistic & Literary Activities - music listening, dancing, reading, writing

Positive Reframing - look for something good, see it in different light, learn from it, maintain perspective

Alternative Therapies - massage, yoga, tai-chi, folk healers, herbal teas, meditation

Relaxation, Rest, or Breathing Exercises

Acceptance - learn to live with it, accept reality; general expectancy for positive outcomes

Humor - don't take things (or oneself) too seriously, look for something amusing in the situation

Psychotherapy or Counseling - traditional

Other - e.g., moderate use of alcohol or cigarettes

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