

Attributions and Emotions Regarding Health Care Mistreatment Impact Continuity of Care Among Latino and Anglo American Women

Patricia M. Flynn
Loma Linda University

Hector Betancourt
Loma Linda University and Universidad de La Frontera

Carlos Garberoglio
Loma Linda University Medical Center

Gregory J. Regts, Kayla M. Kinworthy, and
Daniel J. Northington
Loma Linda University

Ethnic minority and lower socioeconomic status (SES) populations report less positive health care encounters and lower continuity of health care compared with higher SES and non-Latino White (Anglo) Americans. This study examined similarities and differences concerning the influence of patients' causal attributions for health care mistreatment and related emotions on continuity of health care among 335 Latin American (Latinas) and Anglo American women in Southern California. A mixed methods research approach was implemented to identify and assess perceptions of health care mistreatment, causal attributions for mistreatment, negative emotions, and continuity of cancer screening care. Multigroup structural equation modeling revealed that causal attributions for health care mistreatment and related emotions explained continuity of care above and beyond what was explained by patients' exposure to health care mistreatment alone, for both ethnic groups. Still, the improvement in variance accounted for by including attributions and emotions was considerably more for Latinas (194%) than Anglo women (109%). Compared with attributions having to do with the health care environment (e.g., time constraints), attributions to the health care professional (e.g., uncompassionate) were related to higher levels of negative emotions for both Latinas and Anglo women and lower continuity of care, particularly for Anglo women. Results also suggest that for Latinas continuity of care was more a function of the attribution–emotion process, particularly the negative emotions associated with attributions concerning mistreatment, whereas for Anglo women it was more a function of mistreatment and the attribution itself. Interventions designed to improve professionals' communication and interpersonal skills may help enhance continuity of health care and reduce health disparities.

Keywords: attribution–emotion processes, continuity of care, health care mistreatment, health disparities, patient–professional relations

Continuity of health care, defined as an ongoing patient–professional relationship based on trust and responsibility, significantly increases the use of preventive medical services (Saultz & Lochner, 2005). In fact, having a regular source of care was the single most important factor in the receipt of breast and cervical cancer screening when compared alongside factors such as income and health insurance (Bindman, Grumbach, Osmond, Vranizan, & Stewart, 1996). Although the relationship between continuity of

health care and cancer screening exams is well documented (Gonzalez et al., 2012), evidence suggests that Latin American (Latino) women in the United States report poorer adherence to cancer screening recommendations (American Cancer Society, 2009) and less continuity of care than non-Latino White (Anglo) Americans, even when controlling for health insurance (Zuvekas & Taliaferro, 2003). At the same time, Latino women (Latinas) and lower socioeconomic status (SES) patients value continuity of health care more than Anglo and higher SES patients (Becker & Tsui, 2008; Nutting, Goodwin, Flocke, Zyzanski, & Stange, 2003).

The previous findings concerning lower continuity of care among Latinas raise questions concerning the factors that may explain such health disparities. Research in this area has revealed that Latino Americans are more likely than Anglo Americans to perceive medical staff as being disrespectful (Blanchard & Lurie, 2004), less likely to report that their health professional listened to them carefully (Blendon et al., 2008), and more likely to report feeling discriminated based on “look[ing] Mexican” (Barr & Watanat, 2005). Recent research has also revealed that perceptions of health care mistreatment such as a lack of respect, poor communication, and unprofessional conduct on the part of health care professionals negatively impacts continuity of cancer screening

Patricia M. Flynn, Department of Psychology, Loma Linda University; Hector Betancourt, Department of Psychology, Loma Linda University and Department of Psychology, Universidad de La Frontera; Carlos Garberoglio, School of Medicine, Loma Linda University Medical Center; Gregory J. Regts, Kayla M. Kinworthy, and Daniel J. Northington, Department of Psychology, Loma Linda University.

This research was supported by a grant from the American Cancer Society, PFT-08-014-01-CPPB to Patricia M. Flynn, PI.

Correspondence concerning this article should be addressed to Patricia M. Flynn, Loma Linda University, Department of Psychology, 11130 Anderson Street, Loma Linda, CA 92354. E-mail: pflynn@llu.edu

care among Latinas (Betancourt, Flynn, & Ormseth, 2011). This is particularly important for low SES and ethnic minority populations such as Latinas in the United States because differences in cancer screening rates and delayed follow-up for abnormal screening results are some of the potential factors that may contribute to higher mortality rates among this population (ACS, 2009; Press, Carrasquillo, Sciacca, & Giardina, 2008). For example, Latinas are 20% more likely to die from breast cancer and nearly 50% more likely to die from cervical cancer as compared with Anglo women (ACS, 2012; Jemal, Clegg, Ward, et al., 2004; Reynolds, 2004).

These studies suggest that the shared negative experience of ethnic minority and low SES groups with health care professionals may influence the likelihood that individuals from those groups will discontinue cancer screening care (Betancourt et al., 2011). From a psychological perspective, understanding the cognition–emotion processes of patients who perceive health care mistreatment (e.g., thoughts concerning why it happened and how they feel about it) may help health care professionals to improve clinical encounters, patient–professional relations, continuity of care, and health outcomes for culturally diverse populations.

According to Weiner's attribution theory of motivation and emotion (for reviews see Weiner, 1986, 2006), the perceived controllability and intentionality of the attributions we make for the behavior of others in interpersonal settings can differentially influence the emotions we experience and, in turn, how we respond to such actions. For instance, the more we attribute a person's harmful behavior to causes perceived as controllable (under the control of the perpetrator), the more likely we are to judge that individual as being responsible for the negative action. Consistent with appraisal theories of emotion (e.g., Lazarus, 1991), attribution theory predicts that judgments of responsibility for such actions will result in anger, which in turn gives rise to responses such as aggression or avoidance. On the other hand, if the causes of the action are perceived as uncontrollable, it is less likely that we will experience anger and respond in a negative manner. A meta-analysis of research in this area (Rudolph, Roesch, Greitemeyer, & Weiner, 2004) has confirmed this cognition–emotion–behavior motivational sequence and the implications for behavioral phenomena such as avoidance or violence in interpersonal and group interactions.

Given the increasing diversity of the United States population, research that attempts to unravel the complexity of cognition–emotion processes in the clinical encounter and how they may affect the health behaviors and outcomes of culturally diverse patients is necessary for a better understanding of health disparities. In fact, the study of emotion has received significant attention in cultural psychology (e.g., Matsumoto & Hwang, 2012), and recent evidence suggests differences between Latinas and Anglo women on how emotions may affect their responses to health care encounters. For instance, anxiety associated with breast cancer screening exerted a stronger influence on screening compliance for Latinas as compared with Anglo women (Flynn, Betancourt, & Ormseth, 2011). Another study revealed that although Latinas and Anglo women reported similar levels of negative interpersonal emotions (e.g., anger) associated with health care mistreatment, these emotions exerted a greater impact on continuity of cancer screening for Latinas (Betancourt et al., 2011). The more influential role of emotions on behavior for Latinas as compared with Anglos is consistent with other cultural research examining the

impact of interpersonal emotions on performance motivation (Savani, Alvarez, Mesquita, & Markus, 2013).

Because emotions are an important component of social interactions and relations, the role of emotions is likely to be influenced by differences in cultural values and practices concerning interpersonal relationships (De Leersnyder, Boiger, & Mesquita, 2013). For instance, the Latino cultural script of *simpatía* reflects a pattern of social interactions in which individuals strive for social harmony in their interpersonal relations (Triandis, Marín, Lisansky, & Betancourt, 1984). An individual who is high in *simpatía* tends to avoid interpersonal conflict and is likely to emphasize positive behaviors in positive situations while deemphasizing negative behaviors in negative situations. Consistent with this cultural script, research revealed that Latinas are more likely to report experiencing interpersonally engaging emotions (e.g., affection) in social interactions and less likely to report experiencing interpersonally disengaging emotions (e.g., anger) as compared to Anglo Americans (Savani et al., 2013). These findings suggest that the experience of negative interpersonal emotions in the context of health care may be particularly deleterious for Latinas as such emotions may motivate them to avoid future potentially negative health care encounters with a health professional involved in a mistreatment incident and thus discontinue care.

The aim of this study was twofold: (a) to test the potential influence of attribution–emotion processes relevant to perceived health care mistreatment on continuity of cancer screening care among Latinas and Anglo women in Southern California, and (b) to examine the similarities and differences in these attribution–emotion processes across ethnicity. First, it was expected that patients' causal attributions for health care mistreatment and related emotions would explain continuity of cancer screening care above and beyond the negative impact of health care mistreatment alone, for both Latinas and Anglo women. Second, it was expected that for both Latinas and Anglo women attributing health care mistreatment to characteristics of the health care professional (e.g., uncompassionate) would be associated with higher levels of negative emotions (e.g., anger) and less continuity of cancer screening care as compared with causal attributions having to do with the health care environment (e.g., time constraints). Third, it was hypothesized that ethnicity would moderate the relations among attribution–emotion variables related to continuity of cancer screening care. Specifically, negative emotions related to attributions for health care mistreatment were expected to be associated with continuity of cancer screening care for Latinas more than for Anglo women.

Method

Participants and Procedures

Multistage, stratified sampling was conducted to obtain nearly equal proportions of self-identified Mexican-origin Latinas and Anglo women of varying demographic backgrounds. Based on U.S. Census tract data from the Federal Financial Institutions Examination Council, demographic projections for ethnicity, education, income, and age were anticipated for a number of recruitment settings including churches, markets, universities, mobile home parks, and community settings in Southern California. Once permission was obtained from the selected sites, a Spanish and/or

English language recruitment flyer was posted describing the study, eligibility criteria, and the time and on-site location where interested women could go to participate in the study.

Approval for the study was obtained from the Institutional Review Board before data collection. Bilingual Spanish-English research assistants greeted the interested women at each research location, described the purpose of the study, and restated the eligibility criteria (self-identified Mexican-origin Latinas or Anglo women, ≥20 years old, able to read English or Spanish). After participants provided informed consent, they were administered an English or Spanish version of the instrument, which took approximately 30 to 45 minutes to complete. Participants were compensated \$15 for their participation.

After data was collected from each site, the distribution of participants across demographic criteria was examined. Based on the updated demographic distributions, additional recruitment settings were identified and flyers were posted to recruit participants that would meet the corresponding demographic criteria. As a result of multistage stratified sampling, the sample was well balanced between Latinas (*n* = 164) and Anglo women (*n* = 171) for a combined sample of 335 women from diverse socioeconomic backgrounds (see Table 1).

Research Approach and Measures

The study used a bottom-up mixed methods cultural research approach to instrument development (Betancourt, Flynn, Riggs, & Garberoglio, 2010). The approach begins with specific observations relevant to an area of research (e.g., patient–professional relations), which are derived through interviews with the popula-

tion of interest (e.g., Latinas and Anglo women), and evolves from these observations to the development of quantitative instruments. There are several advantages of this research approach. First, the population of interest provides the content necessary for the development of the quantitative instruments, which prevents the potential for researchers to develop instruments that may be based on stereotypical views of culturally diverse populations (Betancourt et al., 2010; Ponterotto, 2010). Second, the inclusion of a comparison group (e.g., Anglos) produces instruments that can be used with minority and mainstream populations to examine ethnic-based disparities. Finally, the resulting instruments are more likely to achieve measurement equivalence because of the procedures implemented during item development (e.g., decentering, back translation, etc.). As a result, researchers can be more confident that any ethnic-based differences are attributable to differences in the elements being assessed, rather than to measurement artifacts (Chen, 2008).

In the first phase of research, 20 interviews were conducted with Latinas (*n* = 10) and Anglo (*n* = 10) women to identify specific instances of interpersonal health care mistreatment, attributions for health care mistreatment, and related emotions. First, women were asked a general question about their experience with health care professionals who perform breast or cervical cancer screening exams. Participants who responded with a positive experience were then asked whether they ever had a negative experience and if so to describe the experience. Participants that responded to the general question with a negative experience were also asked to describe a positive experience. For the purpose of this study, only perceptions of health care mistreatment were examined. To iden-

Table 1
Sample Demographics Based on Ethnicity

Demographic	Perceived health care mistreatment		No perceived health care mistreatment	
	Latinas (<i>n</i> = 101)	Anglos (<i>n</i> = 116)	Latinas (<i>n</i> = 51)	Anglos (<i>n</i> = 47)
Age <i>M</i> (<i>SD</i>) ^{a,d}	46.58 (13.80)	48.32 (16.59)	43.67 (15.56)	56.40 (19.90)
Education <i>M</i> (<i>SD</i>) ^{c,d}	11.56 (3.83)	14.09 (2.60)	10.88 (4.50)	13.26 (2.28)
Income (%)				
≤\$14,999	24.8	25.9	29.4	44.7
\$15–24,999	18.8	19.0	25.5	23.4
\$25–39,999	15.8	13.8	13.7	4.3
\$40–59,999	13.9	13.8	15.7	10.6
\$60–79,999	6.9	12.1	2.0	6.4
\$80–100,000	7.9	2.6	3.9	2.1
>\$100,000	5.9	8.6	5.9	4.3
Not specified	5.9	4.3	3.9	4.3
Place of birth (%) ^{c,d}				
Mexico	43.6	0.0	54.9	0.0
Europe	0.0	0.9	0.0	0.0
Africa	0.0	0.9	0.0	0.0
United States	56.4	97.4	45.1	100.0
Not specified	0.0	0.9	0.0	0.0
Spanish survey (%) ^{b,c,d}	42.6	0.0	64.7	0.0
Health insurance ^d	73.0	82.8	62.5	91.3
Usual source of care ^d	83.7	88.8	72.9	91.1

^a Significant differences between Anglos who perceived versus did not perceive health care mistreatment. ^b Significant differences between Latinas who perceived versus did not perceive health care mistreatment. ^c Significant differences between Latinas and Anglos who perceived health care mistreatment. ^d Significant differences between Latinas and Anglos who did not perceive health care mistreatment.

tify causal attributions for health care mistreatment, participants were asked “why” they thought the health professional acted this way. Finally, participants were asked about the emotions they experienced with regard to the health care professional’s behavior.

The qualitative interviews were transcribed and coded in their original language, by a group of monolingual English and bilingual Spanish-English judges using standard content analysis procedures. Based on the resulting content codes, frequency distributions were calculated for Latinas and Anglo women separately. In the second, quantitative phase of research, close-ended items were developed based on the most frequently reported content codes. To ensure scale equivalence, the items were constructed in the language of the interview from which they emerged. All items were then translated using the double-back, decentering, and final back translation procedures (Brislin, 1980; Leong, Leung, & Cheung, 2010). The resulting instruments are reported below.

Perceptions of interpersonal health care mistreatment. Findings from the qualitative interviews resulted in 24 dichotomous items representing specific instances of interpersonal health care mistreatment (see Appendix A for items). Participants were presented with the 24 items and asked to check a box if they had ever experienced the mistreatment incident with a health care professional during routine breast or cervical cancer screening. Exploratory factor analysis of this scale revealed a one-factor solution. The reliability for this scale was strong for both Latinas ($\alpha = .93$) and Anglo ($\alpha = .94$) samples. A “cumulative exposure to perceived health care mistreatment” score was derived by summing the total instances endorsed by participants.

Causal attributions for health care mistreatment. Responses from the interviews resulted in seven causal attribution items. Five items represented attributions having to do with characteristics of the health professionals (i.e., prejudiced, uncompassionate, unfriendly, not knowledgeable, and not good communicator). Two items represented attributions having to do with the health care environment (i.e., insurance restrictions and limited time with patients). Participants were asked to think about the mistreatment incident that bothered them the most and answer questions concerning why they thought the health professional had acted this way. All items were placed on a 7-point Likert scale anchored at the extremes from *strongly disagree* to *strongly agree*.

Exploratory factor analysis of the seven items revealed two separate factors, attributions to the health care professional and attributions to the health care environment. For Latinas, the item “not knowledgeable” had a markedly lower item loading (.31) compared with the other items. As a result this item was eliminated from subsequent analyses. The attributions to the health care professional factor included four items and demonstrated good reliability for both ethnic groups (Latinas: $\alpha = .79$; Anglos: $\alpha = .86$). The attributions to the health care environment factor included two items and demonstrated adequate reliability (Latinas: $\alpha = .74$; Anglos: $\alpha = .71$). Measurement equivalence for the two ethnic groups was also demonstrated.

Negative emotions. To assess the degree to which participants experienced negative emotions as a result of the mistreatment incident, they were first presented with the question *How much did you feel the following emotions toward the health care professional, as a result of the incident?* Then they were asked to rate the degree to which they experienced three emotions (i.e., anger, rage, and irritation) on a 7-point Likert scale anchored at the extremes

from *not at all* to *very much*. Exploratory factor analysis revealed a one-factor solution and the scale demonstrated good reliability for Latinas ($\alpha = .80$) and Anglo ($\alpha = .82$) women. Measurement equivalence was also achieved.

Continuity of cancer screening care. Participants indicated whether as a result of the incident they returned to (a) the same health professional, and (b) the same clinic for future cancer screenings. The reliability was excellent (Latinas $\alpha = .86$; Anglo $\alpha = .89$), and measurement equivalence was also achieved.

Covariates. Because health disparities are considered to be a function of patient, professional, and health care system factors (Smedley, Stith, & Nelson, 2003), a number of covariates were examined based on previous research (Betancourt et al., 2011). Patient factors included age, income, education, country of birth, instrument language, and social desirability, as assessed by the 13-item Marlow Crowne Social Desirability Scale (Crowne & Marlowe, 1960). Professional factors included ethnicity and gender. Health care system factors included ability to choose one’s health professional, health care setting (i.e., public vs. private), and insurance status.

Results

Preliminary Analyses

Of the total 335 participants, 237 reported at least one health care mistreatment incident (see Table 1). As compared with Anglo women, Latinas were less likely to have a usual source of care (80.1% vs. 89.4%; $\chi^2(1) = 5.17, p = .02, \phi = .13$). Anglo women who perceived health care mistreatment were younger ($M = 48.32, SD = 16.59$) than those that did not ($M = 56.40, SD = 19.90$), $t(159) = 2.65, p = .009$. Latinas who perceived health care mistreatment were more likely to have completed the instrument in English compared with Latinas who did not perceive mistreatment (42.60% vs. 64.70%; $\chi^2(1) = 6.64, p = .01$). After eliminating 20 (12 Latinas, 8 Anglos) cases because of missing data on more than half of the items from one of the noted multi-item scales and imputing values for 16 Latino and 13 Anglo cases using the expectation-maximization algorithm, the final sample included 217 women (101 Latinas, 116 Anglos).

An examination of the demographic variables revealed equal distributions across ethnicity for age, income, and health insurance status, which indicates the effectiveness of the employed multi-stage stratified sampling procedure. Still, Anglo participants reported more years of education compared with Latinas, $t(170.63) = 5.57, p < .001$. However, the effect size for this difference was small ($d = .09$). As expected, Latinas were more likely to be born outside of the United States, $\chi^2(4) = 64.72, p < .001$, and to have completed the instrument in Spanish, $\chi^2(1) = 61.59, p < .001$.

Before testing the study hypotheses using structural equation modeling, an examination of potential covariates was conducted. The variance from all relevant covariates was partitioned from the study variables to maintain a simplified structural equation model without using up model degrees of freedom (Kammeyer-Mueller & Wanberg, 2003). Results revealed that age, education, income, insurance, gender of the health care professional, ethnic-concordance, health care setting, and social desirability were associated with the study

variables (see Appendix B). In addition, Latinas who completed the survey in Spanish as compared with English reported less cumulative exposure to health care mistreatment. They were also less likely to report that mistreatment was attributable to the health care professional being prejudiced and more likely to report irritation toward the health care professional. Also, foreign-born Latinas were less likely than U.S.-born Latinas to report that mistreatment was attributable to the health care professional being prejudiced.

Table 2 includes the frequencies, means, standard deviations, and correlations for the study variables after accounting for the noted covariates. Concerning ethnic group differences, Latinas were less likely than Anglo women to report that the health care professional was uncompassionate. Latinas also scored lower on negative emotions associated with health care mistreatment. Fischer *r*-to-*z* test of differences also revealed some significantly different bivariate correlations based on ethnicity. The relations between cumulative exposure to health care mistreatment and continuity of care as well as the relations between attributions for health care mistreatment and continuity of care were stronger for Anglo than for Latino women. These findings confirmed the need for a test of invariance (i.e., moderation).

Structural Equation Modeling

All hypotheses were tested using Bentler's structural equation modeling program (EQS 6.1; Bentler, 2005) with the maximum likelihood method of estimation, for the Latina and Anglo samples independently. The data were screened revealing no outliers and no violation of multivariate normality for either ethnic group. Adequacy of fit for each ethnic group was assessed using the nonsignificant χ^2 goodness-of-fit statistic, a ratio of less than 2.0 for the χ^2/df (Tabachnick, Fidell, & Osterlind, 2001), a Comparative Fit Index (CFI) of .95 or greater (Bentler, 2005), a Standardized Root Mean Square Residual (SRMR) of less than .08 (Hu & Bentler, 1999), and a Root Mean Square Error of Approximation (RMSEA) of less than .08 (MacCallum, Browne, & Sugawara, 1996) with the 90% confidence interval (Kline, 2005).

The first hypothesis, which predicted that including causal attributions and emotions relevant to perceived health care mistreatment would account for more variance in continuity of cancer screening care than cumulative exposure to perceived mistreatment alone, was tested with two structural equation models. A

simplified model, which only examined the direct effect of cumulative exposure to perceived mistreatment on continuity of cancer screening care accounted for 8.5% of the variance for Latinas [CFI = 1.00, $\chi^2(1, n = 101) = .13, p = .72, \chi^2/df = .13, SRMR = .009, RMSEA = .000, 90\% CI (.000, .189)$] and 24.4% of the variance for Anglo women [CFI = .97, $\chi^2(1, n = 116) = 4.56, p = .03, \chi^2/df = 4.56, SRMR = .045, RMSEA = .18, 90\% CI (.041, .351)$]. A second, more comprehensive model included the hypothesized and theory-based relations among cumulative exposure to perceived health care mistreatment, causal attributions for perceived mistreatment, negative emotions, and continuity of cancer screening care (see Figure 1).

The first hypothesis was confirmed in that the inclusion of causal attributions and emotions as determinants of continuity of cancer screening care accounted for an additional 16.5% (Latinas) and 26.6% (Anglos) of the variance above and beyond what was accounted for by participants' cumulative exposure to perceived mistreatment alone. In regards to the amount of variance accounted for, the improvement from Model 1 to Model 2 was 194% for Latinas and 109% for Anglo women.

To examine the second hypothesis, concerning the differential impact of causal attributions for perceived mistreatment (health care professional vs. health care environment) on emotions and continuity of cancer screening care, equality constraints were imposed on these paths for the Latina and Anglo models to examine potential differences in these structural paths. A baseline model for each ethnic group, which allowed the structural paths of interest to be freely estimated, was compared against a constrained model in which the structural paths were set to be equal (Bollen, 1989). The LM test of equality constraints was reviewed, and constraints were released if doing so improved the model fit (LM $\chi^2 \geq 5.0$ per *df*; Scott-Lennox & Lennox, 1995).

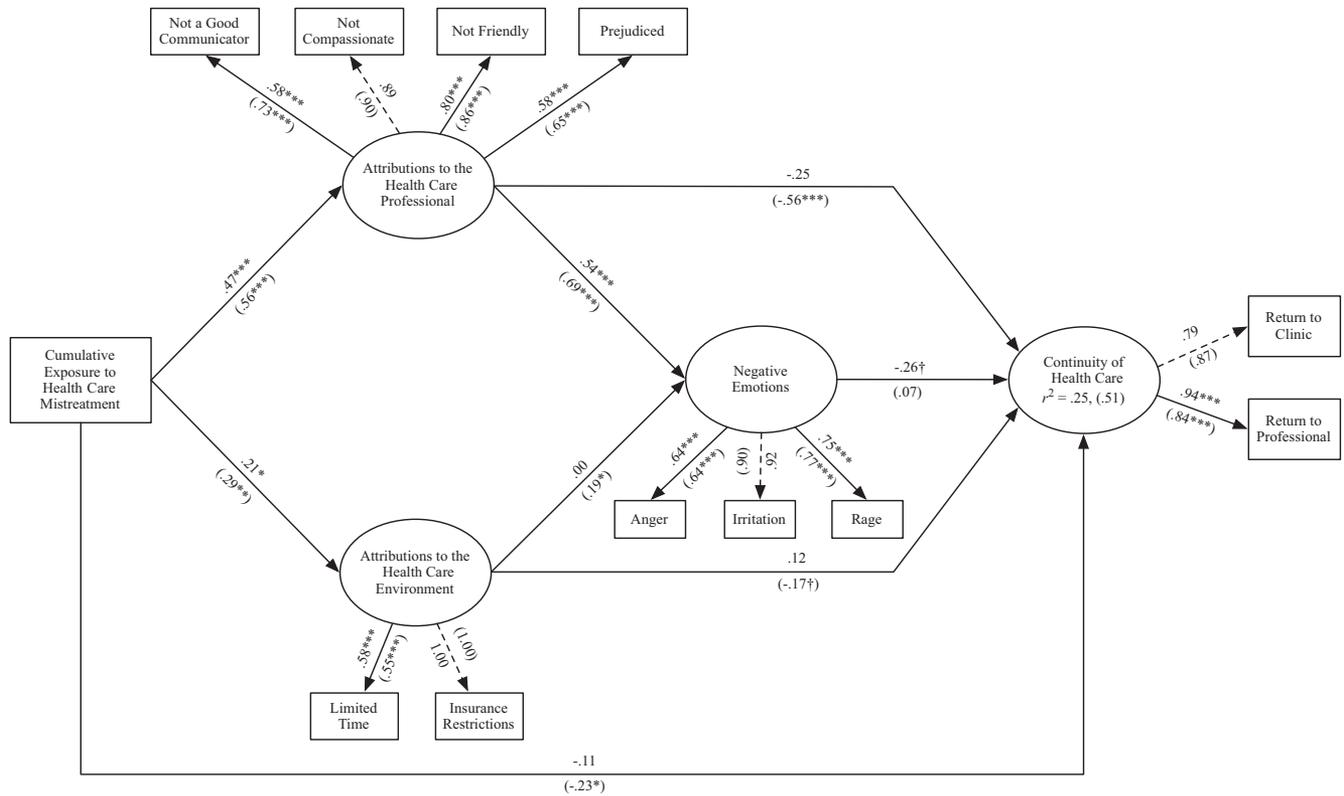
The LM test for the Latina (LM $\chi^2(1) = 7.36, p = .01$) and Anglo model (LM $\chi^2(1) = 19.09, p = .00$) indicated that the constraint from causal attributions to emotions should be released for both ethnic groups, thereby confirming the hypothesis. Causal attributions to the health professional elicited higher levels of negative emotions for both Latinas ($\beta = .54, p < .001$) and Anglo women ($\beta = .69, p < .001$) than attributions to the health care environment (Latinas $\beta = .00, p = NS$; Anglo $\beta = .19, p < .05$). There was a trend suggesting that negative emotions were in turn associated with lower levels of continuity of cancer screening care

Table 2
Correlations, Means, and Standard Deviations as a Function of Ethnicity

Variable	1	2	3	4	5
1. Cumulative exposure to health care mistreatment	—				
2. Attribution to the health professional	.429** (.536**)	—			
3. Attribution to the health care environment	.179 (.253**)	.074 (.137)	—		
4. Negative emotions	.150 (.402**)	.457** (.611**)	.050 (.194*)	—	
5. Continuity of health care	-.277** (-.511**)	-.366** (-.545**)	.096 (-.200*)	-.318** (-.434**)	—
<i>M</i>	8.43 (9.30)	2.73 (3.11)	3.96 (4.13)	3.35 (3.88)	.47 (.48)
<i>SD</i>	5.93 (6.70)	1.51 (1.78)	1.97 (2.10)	1.76 (1.68)	.42 (.43)

Note. Intercorrelations, *M*, and *SD* for Latinas ($n = 101$) are outside the parentheses and values in parentheses are Anglo participants ($n = 116$). Boldface indicates groups differ significantly at $p < .05$.

* $p < .05$. ** $p < .01$.



Latino Fit Indices: CFI = 1.00, χ^2 (48, n=101) = 54.31, $p = .25$, $\chi^2/df = 1.13$, SRMR = .056, RMSEA = .036, 90% CI (.000, .077)

Anglo Fit Indices: CFI = 1.00, χ^2 (48, n=116) = 70.78, $p = .02$, $\chi^2/df = 1.47$, SRMR = .052, RMSEA = .064, 90% CI (.027, .094)

Figure 1. Attributions for health care mistreatment, negative emotions, and continuity of health care for Latinas and Anglo women. Paths for Anglo participants are represented in parentheses, † $p < .06$, * $p < .05$, *** $p < .01$, **** $p < .001$. Dashed lines represents paths fixed to 1.0.

for Latinas ($\beta = -.26$, $p < .06$), but not Anglo women ($\beta = .07$, $p = \text{NS}$). Also consistent with the second hypothesis, the LM test for the Anglo model (LM $\chi^2(1) = 6.31$, $p = .01$) revealed that attributions to the health professional were associated with lower continuity of cancer screening care ($\beta = -.56$, $p < .001$), as compared with causal attributions to the health care environment ($\beta = -.17$, $p < .06$). For Latinas, a similar trend was evident (LM $\chi^2(1) = 3.43$, $p = .06$).

To test the third hypothesis, which predicted ethnicity-based differences in the relations among the study variables, multigroup structural equation modeling for Latinas and Anglo women was conducted. The LM test (LM $\chi^2(1) = 4.78$, $p = .029$) revealed a between-ethnic group difference in the path from causal attributions to the health care environment and continuity of cancer screening care. For Anglo women, the path from causal attributions to the health care environment and continuity of cancer screening care was negative ($\beta = -.17$, $p < .06$), whereas for Latinas this path was positive ($\beta = .12$, $p = \text{NS}$).

Discussion

This research points to the importance of considering patients' cognition (attribution)–emotion processes in relation to health care

mistreatment and implications for Latino and Anglo women's health. The causal model representing the attribution–emotion–behavior relations fit the data well for both ethnic groups. Still, to some extent the strength of relations among some of the cognition–emotion variables as determinants of continuity of care differed for Latinas and Anglo women.

Consistent with predictions based on Weiner's attribution theory of motivation and emotion (Weiner, 1986, 2006), findings revealed that for both Latinas and Anglo women, causal attributions for mistreatment and related emotions explained continuity of health care, above and beyond what is learned from the consequences of perceived mistreatment alone. A comparative examination of the simple structural equation model (exposure to mistreatment) to the more comprehensive model (addition of attributions and emotions) revealed that although the inclusion of attributions and emotions provided a more comprehensive understanding of continuity of care for both ethnic groups, the degree of improvement was considerably greater for Latinas (~200%) as compared with Anglo patients (~100%). Specifically, results from the comprehensive model (see Figure 1) suggest that for Latinas the effect of health care mistreatment on continuity of care was more a function of the negative emotions associated with attributing mistreatment to the health

care professional. On the other hand, for Anglo women, the decision to discontinue care seems to be more a consequence of the attribution itself, in addition to the direct effect of mistreatment.

Findings regarding the differential influence of causal attributions are particularly important to consider within the health care context. Compared with causal attributions having to do with the health care environment, causal attributions having to do with the health care professional (e.g., not compassionate, not friendly) played a more critical role by increasing the levels of negative emotions for both Latinas and Anglo women and decreasing continuity of health care, particularly in the case of Anglo women. These findings point to the need for education and training efforts designed to cultivate the interpersonal and empathy skills of professionals. Research suggests that when patients perceive professionals to be empathic, they are more likely to continue seeing that professional (Amador, 2012) and experience positive health outcomes (Kim, Kaplowitz, & Johnston, 2004). In fact, research shows that when individuals are encouraged to empathize with others, they tend to make attributions more consistent with the individuals they interact with, they experience more positive emotions, and are more likely to engage in helping behaviors (Betancourt, 1990, 2004).

There were also interesting ethnic differences regarding the relations between attributing mistreatment to the health care environment and continuity of care. For Anglo women, there was a trend for attributions to the health care environment to negatively influence continuity of care, which was not the case for Latinas. From a cultural perspective, research indicates that individuals from collectivistic cultures are more likely to take into consideration situational factors when thinking about the causes for interpersonal behaviors (Markus & Kitayama, 1991; Zaw, 2006). It may be that when Latinas attribute mistreatment to the health care environment, they perceive these causes as less controllable and intentional on the part of the professional whereas Anglo women may perceive them to be more controllable. As a consequence, Latinas may be more forgiving of their behavior than Anglo women. In the present study it was implied that environmental causes are likely to be perceived as less controllable and intentional than causes pertaining to the professional. Future research examining ethnic differences and similarities in patients' actual perceptions of intentionality and controllability of the causes for mistreatment could provide a more comprehensive picture of the role of attribution–emotion processes relevant to health care mistreatment.

Consistent with previous research on the role of emotions (Betancourt et al., 2011; Flynn et al., 2011; Savani et al., 2013) and *simpatía* (Triandis et al., 1984), this study revealed that the experience of emotions differed for Latinas as compared with Anglo women. Although Latinas reported lower mean scores on negative emotions relevant to health care mistreatment even after controlling for social desirability (see Table 2), negative emotions exerted a stronger influence on continuity of care for Latinas than for Anglo women (see Figure 1). It may be culturally inconsistent for patients high in *simpatía* to bring up negative aspects of the health care encounter, which may cause them to report less anger than they may actually experience. Rather than potentially face another negative health care encounter, the experience of anger may motivate Latinas to avoid the health care professional.

The differential role of emotions on continuity of care may also have to do with research (e.g., Rasinski & Czopp, 2010) that suggests that individuals from stigmatized groups such as low SES, ethnic, or racial minorities may experience important personal costs involved in dealing with or confronting discrimination or biased remarks. On the other hand, there is research (e.g., Major, Quinton, & Schmader, 2003) suggesting that when facing negative encounters such as those investigated here, attributing them to discrimination may serve a protective function by shifting self-blame for negative interpersonal interactions to more external reasons. It is possible that the anger experienced by Latinas in this study had more to do with perceptions of discrimination and therefore exerted a stronger influence on continuity of care as compared with Anglo women. Future research incorporating phenomena such as attributions of mistreatment to discrimination and how culturally diverse individuals experience and respond to them may shed light on the complexities of the attribution–emotion process in health care interactions.

Overall, findings from this research may have important implications for the development of interventions designed to enhance continuity of care among culturally diverse patients. Interventions directed at improving communication and interactions between professionals and patients could enhance continuity of care and reduce disparities in health outcomes. However, it is apparent that for such programs to be effective with culturally diverse populations, attention needs to be given to distinct aspects of the attribution–emotion process associated with the corresponding cultural background of patients. For instance, health professionals may be particularly effective at improving relations with their Anglo patients by inquiring about their attributions or causal explanations for negative health care interactions. When health professionals work with Latinas, in addition to demonstrating concern regarding their patients' attributions, they may also want to pay attention to their emotional reactions associated with these attributions. In this case, it would be important for health care professionals to be aware of Latino cultural values such as *respeto* (respect) and *cortesía* (courtesy), which could be important for patient–professional relations (Abraido-Lanza, Céspedes, Daya, Florez, & White, 2011). Moreover, future research could also examine the influence of these and other cultural factors on attribution–emotion processes relevant to the health care encounter.

Despite the significance of the study findings, some limitations should be considered. For instance, the Latina sample of this study reflected the demographic reality of Southern California, which is predominantly of Mexican cultural background. Therefore, it is unclear whether the results would be the same with Latinas from other regions of the United States that represent different Latin American origins. Future research could include Latinas from different national origins or levels of acculturation. At the same time, the generalizability of the study findings to Anglo women from other regions of the United States should also be viewed with caution. In addition, although the test of structural invariance revealed one noninvariant structural path, the relatively small sample size used for the separate analysis of each ethnic group may have resulted in the inability to detect additional significant paths, particularly considering that a number of bivariate correlations between the study vari-

ables were significantly moderated by ethnicity. Finally, although the tested propositions are solidly grounded in theory, the cross-sectional design of this study limits the test of temporal relations. Future work could use longitudinal data to examine such relations in a more definitive manner. Because health disparities are common among ethnic, racial, and SES groups in the United States, future research could also benefit from examining the role of cognition–emotion processes relevant to health care encounters among other minority populations such as African Americans, Asian Americans, and Native Americans.

References

- Abraído-Lanza, A. F., Céspedes, A., Daya, S., Flórez, K. R., & White, K. (2011). Satisfaction with health care among Latinas. *Journal of Health Care for the Poor and Underserved*, *22*, 491–505. <http://dx.doi.org/10.1353/hpu.2011.0042>
- Amador, J. (2012). *Perceptions of health care professionals' empathy and cancer screening continuity of care among Latina and Anglo women* (Unpublished master's thesis). Loma Linda University, Loma Linda, CA.
- American Cancer Society. (2009). *Cancer prevention and early detection facts and figures 2009*. Atlanta, GA: American Cancer Society.
- American Cancer Society. (2012). *Cancer facts & figures for Hispanics/Latinos, 2009–2011*. Retrieved from <http://www.cancer.org/acs/groups/content/@nho/documents/document/ffhispanicslatinos20092011.pdf>
- Barr, D. A., & Wanat, S. F. (2005). Listening to patients: Cultural and linguistic barriers to health care access. *Family Medicine*, *37*, 199–204.
- Becker, D., & Tsui, A. O. (2008). Reproductive health service preferences and perceptions of quality among low-income women: Racial, ethnic and language group differences. *Perspectives on Sexual and Reproductive Health*, *40*, 202–211. <http://dx.doi.org/10.1363/4020208>
- Bentler, P. M. (2005). *EQS 6 structural equations program manual*. Encino, CA: Multivariate Software.
- Betancourt, H. (1990). An attribution-empathy model of helping behavior: Behavioral intentions and judgments of help-giving. *Personality and Social Psychology Bulletin*, *16*, 573–591. <http://dx.doi.org/10.1177/0146167290163015>
- Betancourt, H. (2004). An attribution-empathy approach to conflict and negotiation in multicultural settings. In M. Martinko (Ed.), *Attribution theory in the organizational sciences: Theoretical and empirical contributions* (pp. 243–256). Charlotte, NC: Information Age Publishing.
- Betancourt, H., Flynn, P. M., & Ormseth, S. R. (2011). Health care mistreatment and continuity of cancer screening among Latino and Anglo American women in southern California. *Women & Health*, *51*, 1–24. <http://dx.doi.org/10.1080/03630242.2011.541853>
- Betancourt, H., Flynn, P. M., Riggs, M., & Garberoglio, C. (2010). A cultural research approach to instrument development: The case of breast and cervical cancer screening among Latino and Anglo women. *Health Education Research*, *25*, 991–1007. <http://dx.doi.org/10.1093/her/cyq052>
- Bindman, A. B., Grumbach, K., Osmond, D., Vranizan, K., & Stewart, A. L. (1996). Primary care and receipt of preventive services. *Journal of General Internal Medicine*, *11*, 269–276. <http://dx.doi.org/10.1007/BF02598266>
- Blanchard, J., & Lurie, N. (2004). R-E-S-P-E-C-T: Patient reports of disrespect in the health care setting and its impact on care. *The Journal of Family Practice*, *53*, 721–730.
- Blendon, R. J., Buhr, T., Cassidy, E. F., Pérez, D. J., Sussman, T., Benson, J. M., & Herrmann, M. J. (2008). Disparities in physician care: Experiences and perceptions of a multi-ethnic America. *Health Affairs*, *27*, 507–517. <http://dx.doi.org/10.1377/hlthaff.27.2.507>
- Bollen, K. A. (1989). *Structural equations with latent variables* (8th ed.). Encino, CA: Wiley.
- Brislin, R. W. (1980). Translation and content analysis of oral and written materials. In H. C. Triandis & J. W. Berry (Eds.), *Handbook of cross-cultural psychology*. Boston, MA: Allyn & Bacon.
- Chen, F. F. (2008). What happens if we compare chopsticks with forks? The impact of making inappropriate comparisons in cross-cultural research. *Journal of Personality and Social Psychology*, *95*, 1005–1018. <http://dx.doi.org/10.1037/a0013193>
- Crowne, D. P., & Marlowe, D. (1960). A new scale of social desirability independent of psychopathology. *Journal of Consulting Psychology*, *24*, 349–354. <http://dx.doi.org/10.1037/h0047358>
- De Leersnyder, J., Boiger, M., & Mesquita, B. (2013). Cultural regulation of emotion: Individual, relational, and structural sources. *Frontiers in Psychology*, *4*, 55. <http://dx.doi.org/10.3389/fpsyg.2013.00055>
- Flynn, P. M., Betancourt, H., & Ormseth, S. R. (2011). Culture, emotion, and cancer screening: An integrative framework for investigating health behavior. *Annals of Behavioral Medicine*, *42*, 79–90. <http://dx.doi.org/10.1007/s12160-011-9267-z>
- Gonzalez, P., Castaneda, S. F., Mills, P. J., Talavera, G. A., Elder, J. P., & Gallo, L. C. (2012). Determinants of breast, cervical and colorectal cancer screening adherence in Mexican-American women. *Journal of Community Health*, *37*, 421–433. <http://dx.doi.org/10.1007/s10900-011-9459-2>
- Hu, L., & Bentler, P. M. (1999). Cutoff criteria for fit indexes in covariance structure analysis: Conventional criteria versus new alternatives. *Structural Equation Modeling*, *6*, 1–55. <http://dx.doi.org/10.1080/1070519909540118>
- Jemal, A., Clegg, L. X., Ward, E., Ries, L. A., Wu, X., Jamison, P. M., . . . Edwards, B. K. (2004). Annual report to the nation on the status of cancer, 1975–2001, with a special feature regarding survival. *Cancer*, *101*, 3–27. <http://dx.doi.org/10.1002/cncr.20288>
- Kammeyer-Mueller, J. D., & Wanberg, C. R. (2003). Unwrapping the organizational entry process: Disentangling multiple antecedents and their pathways to adjustment. *Journal of Applied Psychology*, *88*, 779–794. <http://dx.doi.org/10.1037/0021-9010.88.5.779>
- Kim, S. S., Kaplowitz, S., & Johnston, M. V. (2004). The effects of physician empathy on patient satisfaction and compliance. *Evaluation & the Health Professions*, *27*, 237–251. <http://dx.doi.org/10.1177/0163278704267037>
- Kline, R. B. (2005). *Principles and practice of structural equation modeling* (2nd ed.). New York, NY: Guilford Press.
- Lazarus, R. S. (1991). *Emotion and adaptation*. New York, NY: Oxford University Press.
- Leong, F. T., Leung, K., & Cheung, F. M. (2010). Integrating cross-cultural psychology research methods into ethnic minority psychology. *Cultural Diversity and Ethnic Minority Psychology*, *16*, 590–597. <http://dx.doi.org/10.1037/a0020127>
- MacCallum, R., Browne, M. W., & Sugawara, H. M. (1996). Power analysis and determination of sample size for covariance structure modeling. *Psychological Methods*, *1*, 130–149. <http://dx.doi.org/10.1037/1082-989X.1.2.130>
- Major, B., Quinton, W. J., & Schmader, T. (2003). Attributions to discrimination and self esteem: Impact of group identification and situational ambiguity. *Journal of Experimental Social Psychology*, *39*, 220–231. [http://dx.doi.org/10.1016/S0022-1031\(02\)00547-4](http://dx.doi.org/10.1016/S0022-1031(02)00547-4)
- Markus, H. R., & Kitayama, S. (1991). Culture and the self: Implications for cognition, emotion, and motivation. *Psychological Review*, *98*, 224–253. <http://dx.doi.org/10.1037/0033-295X.98.2.224>
- Matsumoto, D., & Hwang, H. S. (2012). Culture and emotion: The integration of biological and cultural contributions. *Journal of Cross-Cultural Psychology*, *43*, 91–118. <http://dx.doi.org/10.1177/0022022111420147>
- Nutting, P. A., Goodwin, M. A., Flocke, S. A., Zyzanski, S. J., & Stange, K. C. (2003). Continuity of primary care: To whom does it matter and

- when? *Annals of Family Medicine*, 1, 149–155. <http://dx.doi.org/10.1370/afm.63>
- Ponterotto, J. G. (2010). Qualitative research in multicultural psychology: Philosophical underpinnings, popular approaches, and ethical considerations. *Cultural Diversity and Ethnic Minority Psychology*, 16, 581–589. <http://dx.doi.org/10.1037/a0012051>
- Press, R., Carrasquillo, O., Sciacca, R. R., & Giardina, E. G. (2008). Racial/ethnic disparities in time to follow-up after an abnormal mammogram. *Journal of Women's Health*, 17, 923–930. <http://dx.doi.org/10.1089/jwh.2007.0402>
- Rasinski, H. M., & Czopp, A. M. (2010). The effect of target status on witnesses' reactions to confrontations of bias. *Basic and Applied Social Psychology*, 32, 8–16. <http://dx.doi.org/10.1080/01973530903539754>
- Reynolds, D. (2004). Cervical cancer in Hispanic/Latino women. *Clinical Journal of Oncology Nursing*, 8, 146–150. <http://dx.doi.org/10.1188/04.CJON.146-150>
- Rudolph, U., Roesch, S. C., Greitemeyer, T., & Weiner, B. (2004). A meta-analytic review of help giving and aggression from an attributional perspective: Contributions to a general theory of motivation. *Cognition and Emotion*, 18, 815–848. <http://dx.doi.org/10.1080/02699930341000248>
- Saultz, J. W., & Lochner, J. (2005). Interpersonal continuity of care and care outcomes: A critical review. *Annals of Family Medicine*, 3, 159–166. <http://dx.doi.org/10.1370/afm.285>
- Savani, K., Alvarez, A., Mesquita, B., & Markus, H. R. (2013). Feeling close and doing well: The prevalence and motivational effects of interpersonally engaging emotions in Mexican and European American cultural contexts. *International Journal of Psychology*, 48, 682–694. <http://dx.doi.org/10.1080/00207594.2012.688131>
- Scott-Lennox, J. A., & Lennox, R. D. (1995). Social support and depression among disabled rural adults. In R. Hoyle (Ed.), *Structural equation modeling: Issues and applications* (pp. 199–216). Beverly Hills, CA: Sage.
- Smedley, B., Stith, A., & Nelson, A. (Eds.). (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, DC: National Academies Press.
- Tabachnick, B. G., Fidell, L. S., & Osterlind, S. J. (2001). *Using multivariate statistics* (5th ed.). New York, NY: Allyn & Bacon Publishing.
- Triandis, H. C., Marín, G., Lisansky, J., & Betancourt, H. (1984). Simpatía as a cultural script of Hispanics. *Journal of Personality and Social Psychology*, 47, 1363–1375. <http://dx.doi.org/10.1037/0022-3514.47.6.1363>
- Weiner, B. (1986). *An attributional theory of motivation and emotion*. Mahwah, NJ: Erlbaum. <http://dx.doi.org/10.1007/978-1-4612-4948-1>
- Weiner, B. (2006). *Social motivation, justice, and the moral emotions*. Mahwah, NJ: Erlbaum.
- Zaw, G. (2006). *The attribution of intentionality in relation to culture and self* (Unpublished doctoral thesis). Loma Linda University, Loma Linda, CA.
- Zuvekas, S. H., & Taliaferro, G. S. (2003). Pathways to access: Health insurance, the health care delivery system, and racial/ethnic disparities, 1996–1999. *Health Affairs*, 22, 139–153. <http://dx.doi.org/10.1377/hlthaff.22.2.139>

(Appendices follow)

Appendix A

Exposure to Perceived Health Care Mistreatment Incidents by Ethnicity

Incident	n (%)	
	Latinas	Anglos
1. Did not treat me with respect*	25 (24.80)	44 (38.30)
2. Was not very thorough and careful	32 (32.70)	38 (33.00)
3. Did not answer my questions	39 (39.00)	49 (43.40)
4. Did not explain what they were doing	27 (27.80)	37 (31.90)
5. Was not totally honest with me	29 (28.70)	32 (27.80)
6. Started the exam without any introduction	24 (24.00)	33 (28.70)
7. Did not perform the exam correctly	23 (23.50)	22 (19.30)
8. Did not give me a chance to say all the things I wanted*	46 (46.50)	70 (60.30)
9. Did not provide me with enough information	50 (50.50)	66 (56.90)
10. Did not ask me any questions	41 (41.40)	50 (43.50)
11. Did not respect my need for privacy	20 (19.80)	25 (21.60)
12. Was not clear when explaining my test results	41 (40.60)	48 (41.70)
13. Treated me like an object	26 (25.70)	37 (32.20)
14. Did not pay attention to me	33 (34.00)	44 (37.90)
15. Rushed or hurried when they treated me**	45(44.60)	79 (68.10)
16. Jumped to conclusions about my health without details	35 (35.40)	41 (36.00)
17. Did not warn me that the exam may be painful	36 (36.00)	33 (28.40)
18. Touched me inappropriately	15 (14.90)	13 (11.30)
19. Did not listen to me	46 (45.50)	54 (47.40)
20. Was rough while performing the exam	33 (32.70)	52 (45.20)
21. Made offensive comments	16 (16.20)	19 (16.70)
22. Did not return my calls	32 (32.00)	48 (41.40)
23. Used words I did not understand	60 (60.60)	58 (50.90)
24. Kept me waiting too long	77 (77.00)	87 (75.00)

* $p < .05$. ** $p < .01$.

(Appendices continue)

Appendix B
Covariate Means, Standard Deviations, and Correlations With Study Variables as a Function of Ethnicity

Variable	Age	Education	Income	Insurance	Male (0) female (1) provider	Choice in health provider	Ethnic concordance	Public (0) private (1) health care setting	Social desirability	Foreign born	Spanish survey
1. Cumulative exposure to health care mistreatment	.14 (.11)	-.18 (-.15)	-.13 (-.13)	-.17 (-.17)	-.03 (-.20*)	-.26** (-.24*)	.28** (.06)	-.06 (-.17)	-.10 (-.05)	-.16 (-)	-.20* (-)
2. Attribution to the health care professional	.08 (.03)	-.07 (-.13)	-.13 (-.10)	-.21* (-.16)	-.06 (-.09)	-.06 (-.16)	.20* (.05)	-.12 (-.14)	.08 (-.08)	-.16 (-)	-.17 (-)
3. Not communicative	.12 (.03)	.01 (-.07)	-.05 (-.02)	-.16 (-.10)	-.08 (-.12)	-.01 (-.07)	.09 (.09)	-.02 (-.13)	.07 (-.08)	-.16 (-)	-.10 (-)
4. Not compassionate	.07 (-.03)	.01 (-.13)	-.07 (-.05)	-.25* (-.09)	.03 (-.10)	-.08 (-.18)	.08 (.06)	-.13 (-.11)	.09 (-.09)	.03 (-)	-.05 (-)
5. Not friendly	.04 (.08)	-.09 (-.16)	-.09 (-.19*)	-.12 (-.17)	-.01 (-.12)	-.02 (-.21*)	.22* (.01)	-.13 (-.12)	.001 (-.04)	-.16 (-)	-.09 (-)
6. Prejudiced	.01 (.01)	-.174 (-.09)	-.21* (-.08)	-.12 (-.18)	-.13 (.06)	-.10 (-.08)	.27** (.03)	-.12 (-.12)	.09 (-.04)	-.22* (-)	-.33** (-)
7. Attribution to the health care environment	-.05 (.19*)	.08 (-.09)	.05 (-.06)	.03 (.01)	-.07 (-.02)	-.23* (-.10)	.13 (.15)	-.004 (-.05)	-.17 (.10)	-.08 (-)	-.01 (-)
8. Limited time	-.06 (.19*)	.12 (-.02)	.12 (.06)	-.02 (.06)	-.05 (.03)	-.13 (-.02)	.14 (.12)	-.05 (.04)	-.14 (.14)	-.02 (-)	.05 (-)
9. Insurance restrictions	-.02 (.14)	.02 (-.14)	-.04 (-.14)	.08 (-.04)	-.07 (-.06)	-.28** (-.14)	.09 (.15)	.04 (-.12)	-.16 (.04)	-.12 (-)	-.06 (-)
10. Negative emotions	.08 (-.04)	.05 (-.10)	.06 (-.07)	-.10 (-.17)	-.02 (-.31****)	-.02 (-.19*)	.24 (.10)	.02 (-.25**)	-.16 (-.03)	.00 (-)	.06 (-)
11. Anger	.07 (.06)	.01 (-.10)	.03 (-.04)	-.17 (-.07)	-.06 (-.23*)	.02 (-.08)	.12 (.15)	-.02 (-.16)	-.07 (.01)	-.04 (-)	-.02 (-)
12. Rage	.06 (-.06)	-.06 (-.22*)	-.10 (-.16)	-.05 (-.18)	-.07 (-.25**)	-.16 (-.18*)	.35**** (.12)	-.07 (-.32****)	-.08 (.03)	-.11 (-)	-.08 (-)
13. Irritation	.11 (-.11)	.17 (.05)	.19 (.03)	-.04 (-.19*)	.03 (-.23*)	.17 (-.25*)	.14 (-.19*)	.07 (-.19*)	-.26** (-.10)	.14 (-)	.24* (-)
14. Continuity of health care	.01 (-.10)	.05 (.20*)	.06 (.13)	.36**** (.20*)	.20* (.18)	.13 (.32**)	.04 (.03)	.22* (.15)	-.16 (.02)	.06 (-)	.10 (-)
15. Clinic	.01 (-.11)	.04 (.16)	.06 (.10)	.38**** (.18*)	.20 (.16)	.12 (.30**)	.02 (-.02)	.22* (.18)	-.17 (.04)	.05 (-)	.08 (-)
16. Professional	.01 (-.08)	.05 (.21*)	.05 (.14)	.30** (.20*)	.18 (.18)	.13 (.30**)	.05 (.07)	.19 (.10)	-.13 (.01)	.06 (-)	.10 (-)
M	46.58 (48.32)	11.56 (14.09)	3.02 (3.10)	.72 (.83)	.49 (.39)	2.27 (2.28)	.18 (.59)	.63 (.81)	8.95 (7.03)	.43 (-)	.43 (-)
SD	13.80 (16.59)	3.83 (2.60)	1.83 (1.87)	.45 (.38)	.50 (.49)	1.18 (1.26)	.38 (.49)	.48 (.39)	2.71 (2.82)	.50 (-)	.50 (-)

Note. Intercorrelations, *M*, and *SD* for Latinas (*n* = 101) are outside parentheses and values in parentheses are Anglo participants (*n* = 116).

* *p* < .05. ** *p* < .01. **** *p* < .001.