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ABSTRACT

The literature on stereotyping from a social-cognitive perspective has important implications for the mental health treatment of minority-group members since it suggests that the unavoidable cognitive process of categorization is implicated in intergroup biases and discriminatory behaviors. This study tested for ethnic bias against Hispanic females among licensed mental health professionals. It examined how ingroup-outgroup status of the practitioner affected this bias. A 2 (ethnicity of client) x 2 (ethnicity of subject) x 2 (gender of subject) design was used. Dade County, Florida licensed psychologists, mental health counselors, marriage and family therapists, and clinical social workers were recruited to serve as subjects (N=99). An ethnic bias against the Hispanic client (limited to non-Hispanic therapists) was found in the prognosis rating. No ethnic bias was found in the ratings of the appropriateness of gender-stereotyped goals, although significant effects were found for sex of subject and ethnicity of subject. Overall, no systematic bias was found against the Hispanic client. The bias was limited to non-Hispanics but they made up 83% of the professionals. Future studies on ethnic bias should examine how culture is related to symptomatology and therapy issues. (Author/ABL)

Ethnic Bias in Judgments about Prognosis and Appropriateness of Goals

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ABSTRACT

This study tested for ethnic bias against Hispanic females among licensed mental health professionals and looked at how the ingroup - outgroup status of the practitioner affected this bias. A 2 (ethnicity of client) x 2 (ethnicity of subject) x 2 (gender of subject) design was used. Subjects were recruited by means of a mail survey. A sample representative of the sampling frame (licensed practitioners in Dade County, Florida) and with no detectable response bias was obtained with an overall response rate of 61.9%. An ethnic bias against the Hispanic client (limited to non-Hispanic therapists) was found in the prognosis rating. No ethnic bias was found in the ratings of the appropriateness of gender-stereotyped goals, although significant effects were found for sex of subject and ethnicity of subject. Overall, no systematic bias was found against the Hispanic client. The bias was limited to non-Hispanics but they made up 83% of the licensed professionals.

Ethnic Bias in Judgments about Prognosis and Appropriateness of Goals

The literature on stereotyping from a social-cognitive perspective has important implications for the mental health treatment of minority-group members since it suggests that the unavoidable cognitive process of categorization is implicated in intergroup biases and discriminatory behaviors.

Social-cognitive research has shown that we selectively attend to, interpret, elaborate on, and recall information according to preexisting theories (Linville, 1982). The general categories or superordinate category prototypes that we form about groups are impervious to change (Brewer, Dull, & Lui, 1981) even when confronted with inconsistent information (Cohen, 1981; Park & Rothbart, 1982). It has been shown that we do not remember, have difficulty learning (Cohen, 1981; Park & Rothbart, 1982), or simply relegate to peripheral basic categories (Brewer, Dull, & Lui, 1981) any information that is inconsistent with our prototype of a group.

These cognitive mechanisms not only affect the information that we learn or remember, but also affect

intergroup evaluations (Linville, 1982) and are implicated in intergroup discrimination (Allen & Wilder, 1975; Boski, 1988; Howard & Pike, 1986; Locksley, Ortiz & Hepburn, 1980). Ingroup favoritism and outgroup discrimination had been elicited by even random assignment of individuals to groups (Locksley, Ortiz, & Hepburn, 1980; Sachdev & Bourhis, 1984) and this effect can be accentuated by negative affect between real life social groups (Stephan, 1977).

The fact that the ingroup - outgroup effects of perceiving outgroup members as more homogeneous and undifferentiated than ingroup members has been shown to exist even among men and women (Park & Rothbart, 1982), groups that have continual contact with each other, suggests that ethnic, racial, and sex biases are likely to be prevalent.

Research on clinical inferences has shown that experienced therapists are also likely to make cognitive errors and be influenced by characteristics of their clients (Arnoult & Anderson, 1988; Arkes, 1981; Faust, 1986; Leary & Miller, 1986). Together with the research on categorization, this suggests that ethnic biases are highly probable even among trained psychotherapists.

Hispanics are the fastest growing minority group in

the United States (Rogler, Malgady, Costantino, & Blumenthal, 1987) and although there are no empirical studies of ethnic bias in psychotherapy with this group, there are some indications of possible bias in their mental health treatment related to common stereotypes about this group.

Mexican Americans are less likely to be accepted into therapy and more likely to be offered medication and/or brief supportive or directive counseling (Karno, 1966). Insight-based and non-directive therapies have been considered inappropriate for Hispanics (Philippus, 1971; Valdes, 1983) since the stereotypical Hispanic client is assumed not to be interested in therapy (Acosta, 1979). The stereotype of Hispanics as having negative attitudes towards mental health services was not supported in a review of the available research by Keefe and Casas (1980). This ethnic group does have, however, environmental constraints in accessing services (Acosta, 1980; Leaf, Bruce, Tischler, & Holzer, 1987) related to their socioeconomic status.

A common assumption that has been made is that therapy with the Hispanic client has to be different from that offered to the non-Hispanic client and isomorphic to the Hispanic culture in order to be

effective (Philippus, 1971; Queralt, 1984; Szapocznik, Scopetta, Aranalde, & Kurtines, 1978; Szapocznik, Scopetta, & King, 1978). The problems with this assumption are that Hispanics are heterogeneous in linguistic and sociocultural background (Malgady, Rogler, & Costantino, 1987) and that the Hispanic culture that is discussed is more stereotype than reality for Hispanics living in the United States.

The stereotypical Hispanic family, which is treated as the norm despite lack of supporting evidence, consists of an unceasingly self-sacrificing woman with no aspirations for self and the authoritarian and dominating man to whom she is married (Andrade, 1982). Sex roles in this "typical" Hispanic family are rigid and traditional.

Some Hispanic therapists have accepted the above stereotype as the prototype of healthy family functioning for their ethnic group. Citing the importance of cultural sensitivity, they have recommended that hierarchical structures be validated in client's life context (Szapocznik, Scopetta, Aranalde, & Kurtines, 1978; Szapocznik, Scopetta, & King, 1978). This position demonstrates an insensitivity and/or devaluation of the needs of the women in those families.

Traditional sex roles have been implicated in the higher incidence of depression in women as compared to men (Canino, Rubio-Stiper, Shrout, Bravo, Stolberg, & Bird, 1987; Carmen, Russo, & Miller, 1981; Golding & Karno, 1988; Roberts & Roberts, 1982). The isomorphic reinforcement of the culture of origin advocated by these therapists has negative implications for the mental health of Hispanic women whether or not the stereotype is accepted as the norm. It is also interesting to note that therapists who foster traditional sex roles in non-ethnic clients are considered sex biased (American Psychological Association, 1975) and not culturally sensitive. The Hispanic woman seeking psychotherapy may not be offered the most appropriate treatment to relieve her distress and improve her functioning. A combination of ethnic and sex bias is likely to result in treatment that reinforces powerlessness and devaluation and is destructive to her mental health (Carmen, Russo, & Miller, 1981).

No attempts have been made to test empirically whether an ethnic bias exists among psychotherapists and whether psychotherapists have a different standard of mental health for Hispanic women, one which involves

adherence to traditional sex roles. This study used an analogue design in a mail survey of licensed mental health professionals to attempt to answer these questions by testing whether psychotherapists differentially judged the likelihood of benefiting from psychotherapy and the appropriateness of masculine and feminine goals for a Hispanic and a White woman whose case descriptions only differed in ethnicity. This study also looked at how the ingroup - outgroup status of therapists, in relation to client's gender and ethnicity, affected their judgments of the client.

The following hypotheses were postulated:

1. Mental health professionals will adhere to the stereotype of Hispanics as not appropriate for psychotherapy and will rate the Hispanic client as less likely to benefit from psychotherapy than the non-Hispanic.
2. Ingroup - outgroup effects will be found in the rating of likelihood of benefiting from psychotherapy according to the mental health professionals' ethnic and gender subgroups. Hispanic therapists will show less bias than non-Hispanics. Hispanic females will show the least bias. Non-Hispanic males will show the greatest bias.

3. Ratings of the appropriateness of male-valued versus female-valued goals and of the ratings of male-valued and female-valued goals separately will differ according to client ethnicity. These results would indicate that, given identical information about the client, the ethnic label elicits different assumptions about her sex-role behavior and these assumptions result in different goals.
4. Similarly to hypothesis 2, the ethnicity and gender of the mental health professional will determine how differently the goals for the Hispanic and the non-Hispanic client are rated.

METHOD

Subjects

The sampling frame for this study was licensed psychologists, mental health counselors, marriage and family therapists, and clinical social workers in Dade County, Florida. The Florida Department of Professional Regulation provided a listing of all these licensed professionals.

Only mental health professionals practicing in Dade County were included to increase the likelihood of previous exposure to the Hispanic culture. Dade County

has a large Hispanic population and it was assumed that therapists working and/or living in the area have had some contact with Hispanics.

A total of 99 (61.9%) of the sampled professionals completed and returned the research packets. Twenty-three of the respondents were non-Hispanic males, 23 were non-Hispanic females, 28 were Hispanic males, and 25 were Hispanic females. Most respondents were licensed psychologists followed closely by social workers. The number of years licensed was less than 10 for 75.8% of the respondents.

Materials

Client Presentation

For this analogue study, two case descriptions were used which were identical except for the first name of the client and her ethnicity. The client described was a female client suffering from symptoms of depression. An attempt was made to make the presentation typical of female working class clients since Hispanic women are overrepresented among the lower socioeconomic classes (Amaro & Russo, 1987). Information about client's education, employment, sex-role status, relationships and support systems was purposely kept vague. We wanted to allow therapists to make assumptions about these

areas according to whatever cognitive categorization systems they had available since these systems determined how information is processed (Brewer, Dull, Lui, 1981; Cohen, 1981) and what information is sought in actual clinical interviews.

Measure of Likelihood of Benefiting from Psychotherapy

The subjects were asked to rate how much they thought the client described in the analogue would benefit from psychotherapy on a 7-point Likert scale ranging from not much (1) to very much (7).

Male-Valued and Female-Valued Goals

The appropriateness of masculine and feminine goals was measured by using the 18 goals used in the Billingsley (1977) study of sex bias in psychotherapy. These goals were taken from Broverman et al.'s (1970) male- and female-valued items of the Stereotype Questionnaire. Unlike Billingsley's (1977) study in which therapists were asked to choose 6 initial goals from a checklist of the 18 goals, therapists were asked to rate the appropriateness of each goal (presented randomly in the questionnaire) on a 7-point Likert scale from not appropriate (1) to very appropriate (7). Three dependent measures were computed using these goals.

Appropriateness of Male-Valued Goals

The mean rating for the nine male-valued goals was computed to measure how appropriate the masculine goals were judged to be for the client.

Appropriateness of Female-Valued Goals

The mean rating for the nine female-valued goals was computed to measure how appropriate the feminine goals were judged to be for the client.

Appropriateness of Male-Valued Versus Female-Valued Goals

The ratio of the mean of the male-valued goals over the mean of the female-valued goals was computed. A score of 1.00 on this measure indicates that male-valued and female-valued goals were judged to be equally appropriate for client. A score greater than 1.00 indicates that male-valued goals were judged to be more appropriate than female-valued goals while a score less than 1.00 indicates that female-valued goals were judged to be more appropriate than male-valued goals.

Additional Data Collected

Appropriateness of Therapy Modalities

Subjects were asked to rate the appropriateness of seven different therapy modalities for the described client on a Likert scale ranging from not appropriate

(1) to very appropriate (7). The therapy modalities were: insight-oriented therapy, group therapy, supportive therapy, chemotherapy/medication, social-skills training, cognitive-behavior therapy, and assertiveness training.

Demographic Information

Mental health professionals were asked to indicate their sex, ethnicity, and highest degree completed. They were also asked to check all the professional licenses that they held and the number of years they had been licensed.

Procedure

A stratified systematic sample was done on the sampling frame. Potential subjects were then randomly assigned to one of the two client conditions.

Subjects were mailed one of two research packets in a 6.5 in. by 9.5 in. envelope according to which client condition they had been randomly assigned. The packets included a cover letter, the client description, the questionnaire, a stamped postcard, and a self-stamped envelope to be used to return the questionnaire.

Two followup mailings were done after the initial mailing. The first consisted of a followup letter and was mailed five days after the initial mailing. The

second included another packet and was mailed two weeks after the initial mailing.

RESULTS

Preliminary Analyses

An overall response rate of 61.9% was achieved for this study. The sample was representative of the population and response bias was not detected in the dependent measures.

The respondent groups differed in that non-Hispanic respondents had been licensed for more years than Hispanic respondents [χ^2 (2, N = 96) = 5.98, $p < .05$] and in that most female respondents were social workers while most male respondents were psychologists [χ^2 (2, N = 99) = 7.27, $p < .05$.

Both the mean male-valued goals measure and the mean female-valued goals measure were found to have acceptable internal reliability. The internal reliability, using Cronbach's alpha, was .7233 for the male-valued goals and .7935 for the female-valued goals.

Primary Analyses

Likelihood of Benefiting from Psychotherapy

A three-way analysis of variance was performed on the rating of likelihood of benefiting from therapy by

client ethnicity, therapist ethnicity, and therapist sex. This analysis addressed hypotheses 1 and 2. Table 1 shows the means and standard deviations obtained. A significant main effect was found for therapist ethnicity, F (1, 88) = 14.07, $p < .001$, and a significant interaction effect was found for client ethnicity by therapist ethnicity, F (1, 88) = 4.72, $p < .05$. No other main or interaction effects were found significant.

Table 1

Means and Standard Deviations for Rating of Likelihood of Client Benefiting from Psychotherapy

Mental Health Professionals	Purported Client					
	Hispanic			White		
	n	M	SD	n	M	SD
Hispanic						
Male	15	6.133	0.990	13	6.385	0.506
Female	11	6.364	0.924	13	5.923	1.256
Non-Hispanic						
Male	10	5.000	1.155	11	6.000	0.632
Female	11	5.091	1.136	12	5.667	1.073

Hispanic therapists did not rate the Hispanic client (M = 6.2308, SD = .951) significantly different from the White client (M = 6.1538, SD = .967), t (50) = .29, p > .05. Non-Hispanic therapists rated the White client (M = 5.8261, SD = .887) as significantly more likely to benefit than the Hispanic client (M = 5.0476, SD = 1.117), t (42) = -2.57, p < .05. Mental health professionals' ethnic groups did not differ in their ratings of the White client, t (47) = .225, p > .05, but differed significantly in their ratings of the Hispanic client, t (45) = 3.92, p < .001, with non-Hispanic therapists rating her as less likely to benefit from psychotherapy. (See Figure 1).

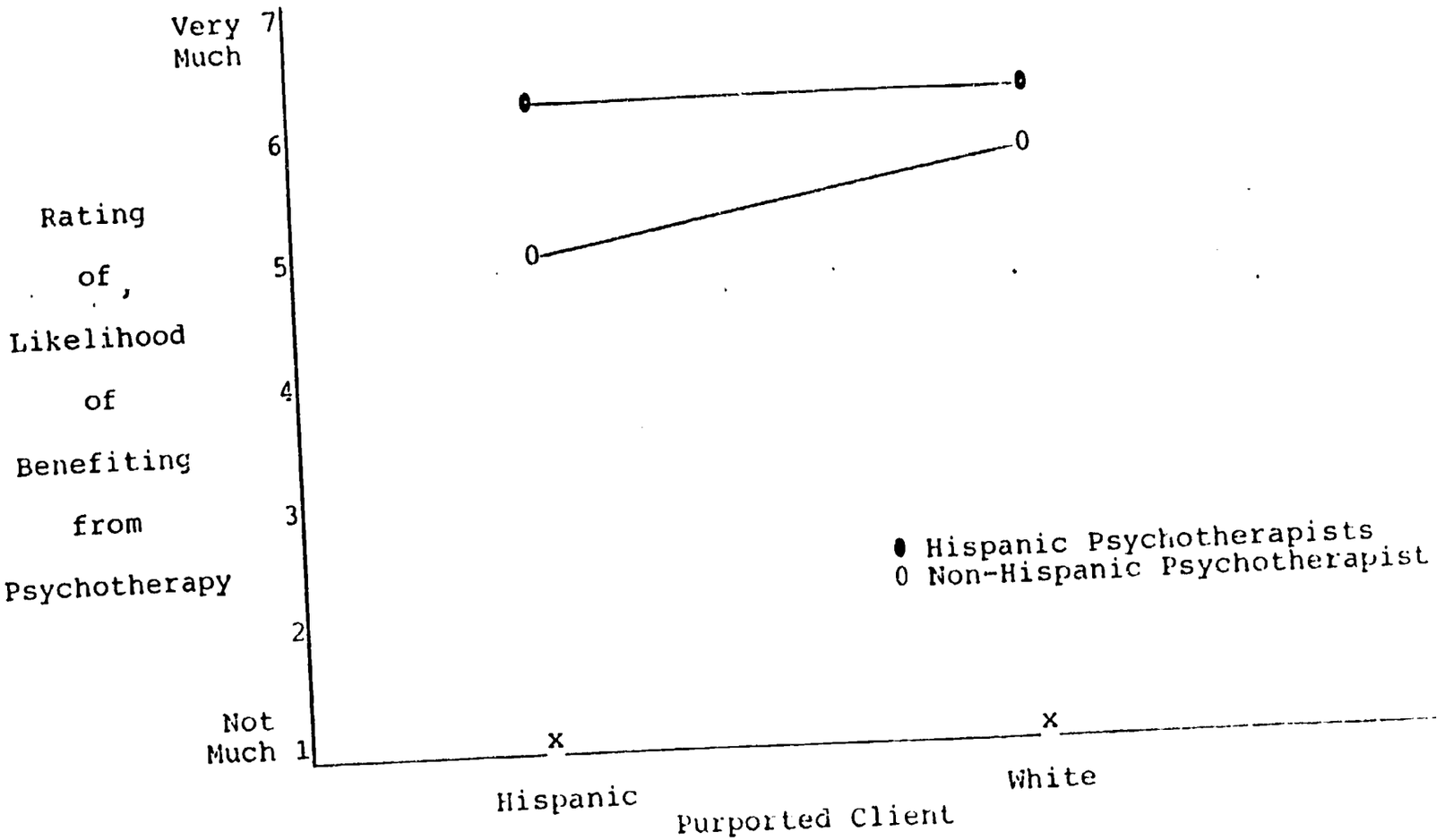

Figure 1. Mean rating of likelihood of benefiting from psychotherapy given for each purported client by each ethnic group of mental health professionals.

Since Hispanic therapists differ significantly from non-Hispanic therapists in the number of years they have been licensed, a one-way analysis of variance was done on the rating of likelihood of benefiting by years licensed (three groups : less than five years, six to ten years, and more than ten years). No significant difference in ratings was found, F (2, 90) = .3766, $p > .05$ suggesting that experience cannot explain the significant effects related to therapist's ethnicity.

The results of the analyses only partially supported hypothesis 1. The bias against the Hispanic client appears to be limited to non-Hispanic therapists. Hypothesis 2 was supported for the effect of ethnic ingroup - outgroup. Hispanics did not show bias against the purported client of their ethnic group. A significant three-way interaction was not found so there was no support for the second part of hypothesis 2 about the combined effects of therapists' gender and ethnicity on their evaluation of the client.

Appropriateness of Goals

The following analyses addressed hypothesis 3 and hypothesis 4.

Ratio of Male-Valued Versus Female-Valued Goals

A three-analysis of variance was performed on the

ratio of male-valued to female-valued goals by client ethnicity, therapist ethnicity, and therapist sex. (See Table 2 for the means and standard deviations). The only effect that reached significance was therapist sex, F (1, 87) = 4.17, $p < .05$. Male therapists obtained a mean overall ratio of 1.2312 (SD = 3.30) while female therapists obtained a mean overall ratio of 1.1216 (SD = .212). All therapists judged male-valued goals as more appropriate than female-valued goals. Male therapists differentiated more between male-valued and female-valued goals than did female therapists. No support was found for hypothesis 3 with this measure. Partial support was found for hypothesis 4 for a gender ingroup - outgroup effect.

Table 2

Means and Standard Deviations for the Ratio of Male-Valued to Female-Valued Goals by Subject Group

Mental Health Professionals	Purported Client					
	Hispanic			White		
	n	M	SD	n	M	SD
Hispanic						
Male	14	1.196	0.278	12	1.217	0.303
Female	12	1.139	0.144	13	1.211	0.256
Non-Hispanic						
Male	11	1.161	0.258	11	1.362	0.465
Female	11	1.071	0.194	11	1.047	0.221

Appropriateness of Male-Valued Goals

A three-way analysis of variance was performed on the mean rating of the male-valued goals by client ethnicity, therapist ethnicity, and therapist sex. Table 3 shows the means obtained by the different groups. The only effect that reached significance was therapist ethnicity, F (1, 87) = 4.95, $p < .05$. Hispanic mental health professionals rated male-valued

goals as significantly more appropriate for the client (*M* = 5.3875, *SD* = .894) than did non-Hispanic mental health professionals (*M* = 4.9737, *SD* = .921). A one-way analysis of variance of the mean for male-valued goals by years licensed was not significant [*F* (2, 89) = .215, *p* > .05] indicating that experience could not account for the effect of therapists' ethnicity.

Table 3

Means and Standard Deviations for the Mean Rating of Appropriateness of Goals by Subject Group

Mental Health Professionals	Purported Client					
	Hispanic			White		
	n	*M*	*SD*	*n*	*M*	*SD*
			Male-Valued Goals			
Hispanic						
Male	14	5.324	0.958	12	5.077	0.713
Female	12	5.667	1.109	13	5.485	0.742
Non-Hispanic						
Male	11	4.677	0.797	11	5.343	0.625
Female	11	5.083	1.009	11	4.792	1.142
			Female-Valued Goals			
Hispanic						
Male	15	4.489	1.105	13	4.522	1.238
Female	12	5.111	1.449	13	4.729	1.162
Non-Hispanic						
Male	11	4.101	0.485	11	4.184	1.030
Female	11	4.784	0.809	11	4.648	1.077

Appropriateness of Female-Valued Goals

A three-way analysis of variance was performed on the mean rating of the female-valued goals. Table 3 shows the means obtained by the different subject groups. The only effect that reached significance was therapist sex, F (1, 89) = 4.91, $p < .05$. Female therapists rated female-valued goals (M = 4.8204, SD = 1.132) as more appropriate than male therapists rated them (M = 4.3453, SD = 1.011). Neither professional license [F (2, 94) = .6618, $p > .05$] nor highest degree obtained [F (2, 90) = .2294, $p > .05$] could account for the significant effect of therapist sex on the rating of female-valued goals.

Summary of Appropriateness of Goals Results

No support was found for hypothesis 3 and only partial support was found for hypothesis 4 in the measures of appropriateness of goals. Client ethnicity did not result in different ratings of appropriateness for the goals. Ethnicity of therapist was found to have a significant effect on the ratings given to the male-valued goals and sex of therapist was found to have a significant effect on the ratings given to the female-valued goals. Hispanics rate male-valued goals higher than non-Hispanics and females rate female-valued goals

higher than males.

Secondary Analyses

In the appropriateness ratings of the therapy modalities, an ethnic bias was found for assertiveness training and social-skills training. This bias, which was limited to non-Hispanic males in assertiveness training and to males in social-skills training, resulted in higher ratings for the White client by these two therapist groups.

An ingroup - outgroup effect for gender was found in the rating of appropriateness of supportive therapy. This effect seemed to be related to therapist's professional license and education.

Therapist ethnicity had an effect on the ratings of the appropriateness of cognitive-behavior therapy. Hispanic mental health professionals rated this modality higher in appropriateness than did non-Hispanic professionals.

No significant effects were found in the following therapy modalities: (a) chemotherapy, (b) group therapy, and (c) insight-oriented therapy.

Post-Hoc Analyses

Univariate analyses of the individual goals found an ethnic bias which was limited to the non-Hispanic

male therapist in the male-valued goals of increase in ability to make decisions and increase in assertiveness.

An ingroup - outgroup effect for gender was found in the male-valued goal of increase in self-confidence and in the female-valued goals of increase in ability to express emotions, increase in awareness of own feelings, and increase in ability to communicate easily.

Hispanic mental health professionals rated the male-valued goal of increase in independence and the female-valued goal of increase in interest in own appearance higher in appropriateness than did non-Hispanic mental health professionals.

The male-valued goals that had no significant effects were: (a) increase in ability to take risks, (b) increase in directness in dealing with others, (c) increase in ability to take charge over others, (d) increase in objectivity, and (e) increase in ability to think logically. The female-valued goals with no significant effects were: (a) increase in expression of tender feelings, (b) increase in gentleness, (c) increase in ability to accept the influence of others, (d) increase in awareness of feelings of others, and (e) increase in tactfulness.

Results of correlational analyses suggest that

female-valued goals are not associated with psychotherapy (as defined by seven therapy modalities) and male-valued goals are only weakly associated.

DISCUSSION

The purpose of this study was to test for an ethnic bias against Hispanic female clients among mental health practitioners. It also studied how the ingroup - outgroup status of the practitioner in relation to client's ethnicity and gender affected the bias.

The first hypothesis was that the Hispanic client would be rated as less likely to benefit from psychotherapy compared to the White client. This hypothesis was based on the literature on psychotherapy with Hispanics which suggests that Hispanics are not interested in psychotherapy and do not benefit from it.

This hypothesis was partially supported. Non-Hispanic mental health professionals rated the purported Hispanic client lower in likelihood of benefiting from psychotherapy than the purported White client. Given that the two client descriptions were identical except for the ethnic label, it can be concluded that categorizing the client as Hispanic reduced the expectancies of successful psychotherapy. The Hispanic therapists, as members of the ingroup, have more complex

categorizations of Hispanics and were not as influenced as non-Hispanics by the stereotype.

Hypothesis 2 discussed the ingroup - outgroup effect on ratings. The first part of this hypothesis was supported, Hispanics showed less bias than non-Hispanics.

The second part of hypothesis 2 dealt with the three-way interaction which was not found significant. Ingroup - outgroup effects were only found for ethnicity and they were of the pattern expected for majority and minority groups. The minority group (Hispanic), because of its familiarity with the majority culture, did not show any bias against its outgroup.

Hypothesis 3 was not supported by the data. Client's ethnicity was not found to have any significant effects either alone or in interaction with therapist's ethnicity or gender.

In the ratio of male-valued to female-valued goals, the only significant effect was therapist's gender. Although all subjects rated male-valued goals higher than female-valued goals, female therapists differentiated less between the gender-stereotypic goals. Therapist's gender was also the only effect that reached significance for the mean rating of female-

valued goals with female therapists rating these goals higher in appropriateness than male therapists.

Above results can be interpreted as partial support for hypothesis 4 since they show an ingroup - outgroup effect based on gender. Females showed less polarization in their ratings of gender-stereotypic goals for a female client.

The above results are also consistent with some of the literature on sex bias. Male and female therapists have been shown to use different cognitive dimensions when making clinical judgments (Zygmond & Denton, 1988) and female therapists have been found to judge relationship problems more severely than male therapists (Oyster-Nelson & Cohen, 1981). Ability to express emotions and ability to communicate easily as well as awareness of own feelings are all important for successful relationships and these were the female-valued goals that female therapists rated significantly more appropriate than male therapists.

The female-valued goals that were not rated significantly different such as expression of tender feelings, gentleness, awareness of the feelings of others, and tactfulness may have been assumed to already be part of the client's repertoire. Increase in ability

to accept the influence of others is not a goal that is likely to be endorsed by a mental health professional for a client suffering from depressive symptomatology.

Billingsley (1977) demonstrated that therapists respond to psychopathology when choosing male-valued and female-valued goals. The psychopathology presented in the case description (depression) is typical of female clients and has been associated with traditional sex-roles (Canino et al., Carmen, Russo, & Miller, 1981; Golding & Karno, 1988; Roberts and Roberts, 1982). It is not surprising therefore, that therapists found male-valued goals more appropriate for the client.

The unexpected effect of Hispanic therapists rating male-valued goals significantly more appropriate for both client conditions than non-Hispanic therapists may be explained by looking at the correlations of goals with therapy modalities. Male-valued goals are more associated with therapy than female-valued goals. Hispanic therapists are more optimistic about the outcome of therapy and more likely to use cognitive-behavior therapy. Assertiveness training (which can be considered a type of cognitive-behavior therapy) and cognitive-behavior therapy were significantly correlated with male valued goals at the .001 level and at the .01

level respectively. It is not surprising, therefore, to find the more optimistic and cognitive-behavioral clinicians endorsing male-valued goals.

Overall, no systematic bias was found against the Hispanic client. A main effect for client ethnicity was not found in primary, secondary, or post-hoc analyses. The bias that was found appeared limited to non-Hispanic mental health professionals. Non-Hispanics made up 83% of the sampling frame for this study so there is cause for concern about any clinical decisions that are based on first impressions and limited information. Situations in which mental health professionals are asked to make decisions about the most appropriate services for a client after a brief interview are typical in community mental health centers and other centers that serve the needs of lower socioeconomic class clients. Psychotherapy tends to be limited in this type of situations and being perceived as not likely to benefit from it can result in a referral to less appropriate services.

It is also of concern that bias against the Hispanic client was found in assertiveness training and the appropriateness of the assertiveness goal since lower assertiveness was associated with more pathology

in a study of Hispanic women (Soto & Shaver, 1982).

Some of the limitations of this study have to do with the research design. Mail surveys that do not achieve 100% response rates leave unanswered the question of whether the respondents were systematically different from the non-respondents. Although this study achieved an acceptable response rate and found no indication of response bias, there is the possibility that if the timing of the mailings had not been right after the Thanksgiving holiday and prior to the Christmas holiday, it would have yielded even higher response. Considering that the population was homogeneous and that late respondent bias was not detected, there is little reason to suspect that the results would have been different given a higher response rate.

Analogue designs have also been criticized as being too artificial to be generalizable to actual clinical situations (Stricker, 1977). Lopez (1989) concluded in his review of the literature on bias in clinical judgments that analogue research and clinical research do not differ in their ability to uncover bias and that analogue studies are capable of identifying patient variable biases. The patient variable manipulation in

analogues using a between subjects design has not been found to be transparent to most clinician subjects (Lopez, 1989). This concern about whether subjects respond in an unbiased manner because they are aware of the purpose of the study can be simply addressed in future studies by asking subjects what they believe is the nature of the study (Austad & Aronson, 1987).

Future studies on ethnic bias need to address several issues. Given that a majority of therapists consider culture in their clinical evaluations (Lopez & Hernandez, 1986) and that this study has shown that this can result in bias, there is a need for good epidemiological research on how culture is related to symptomatology and therapy issues. This research needs to take into consideration the heterogeneity of the Hispanic population in the United States. There is a need for the literature on Hispanics in professional journals to move from the anecdotal to the empirical.

In addition to collecting empirical data on the characteristics of Hispanics as they relate to mental health, research should also continue to use experimental methodology to study biases in current clinical practices. If nothing else, research of the type presented in this study can result in an increase

awareness of the existence of ethnic bias. Making professionals more aware of their own biases can result in a decrease in those biases as has been demonstrated by the research on sex bias (Brodsky, 1980; Whitley, 1979).

As has been recommended by Lopez (1989), the stimuli in these studies should more closely approximate the actual clinical stimuli. Studies approximating the interactive nature of clinical judgments are ideal but not realistic at this stage of the ethnic bias research. There is not enough of a data base on which variables may be relevant to be able to use it in designing such complex and expensive studies. The next step needs to be more simple - test other patient and therapist variables as they relate to clinical judgments of Hispanic clients. A systematic program of research should be developed based on what is known about social-cognitive processes. Researchers should avoid "shotgun" approaches (testing as many variables as they can think of at once) and attempt to base their research in theory.

Research on ethnic bias should also avoid getting stuck at the level of first impressions. Once it has been established that a client characteristic results in

differential clinical judgments or decisions that are not empirically related to that characteristic, the next step is to test whether the initial judgments persist with more individualized information and under what conditions.

Given the current status of research on Hispanics, how can clinicians be trained not to be biased? The literature on stereotyping and intergroup relations as well as the literature on errors in clinical judgments suggests that bias and error are unavoidable parts of our cognitive processes. The best way to diminish all biases is to be aware that they exist.

Classes on minority issues and exposure to minority group members might increase the amount of information one has about a group but is not likely to eliminate bias. There is no need for clinicians to become experts on all possible groups that they may encounter in therapy (including all the variability within those groups) in order to offer competent and unbiased psychological services. Even if a clinician could acquire all that knowledge, there is no guarantee he/she will use it correctly.

It is more effective to have future clinicians educated about the role of cognitive processes in bias

and clinical errors. This education should not only involve book knowledge of theory but assignments that expose students to their own personal biases and their proclivities towards certain types of errors. Students can learn how to become aware of the assumptions they make based on client characteristics and how to test those assumptions by looking for information that disproves them as well as information that supports them. Clinicians trained in this way would be less likely to become defensive when the topic of biases in clinical practice comes up and more likely to observe their own behavior to see if their practices are affected by those biases.

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