THE EFFECTS OF EARLY GOAL-SETTING IN A GOAL-ORIENTED RECORD SYSTEM ON PERSONAL COMMITMENT OF MEXICAN AMERICAN MENTAL HEALTH CLIENTS TO THERAPY

by

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DEDICATION

Dedicated to my children for their understanding and patience while I was a full-time student and full-time mother.

Also to Richard, whose love, support and faith made this achievement a reality.

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ABSTRACT

This study was designed to compare the commitment to psychiatric therapy of two groups of Mexican American mental health clients who were treated under two different mandatory recording systems in two different time periods, the problem-oriented record system, June-August 1979, or the goal-oriented record system, June-August 1980. More specifically, this study sought to answer the following question: Will the incidence of broken and canceled appointments among Mexican American clients be significantly greater in a goal-oriented system than in a problem-oriented system?

The collection of data for this study included demographic characteristics of the Mexican American mental health client such as age, sex, family size, and annual income. In addition, each client's record of broken and canceled appointments was analyzed. Several analyses were conducted to provide information concerning the effectiveness of the two types of record keeping systems and to determine what demographic variables might be related to the incidence of broken and canceled appointments.

In summary, the results show that there was no significant difference in the incidence of broken and canceled appointments among Mexican American mental health clients under the early goal-setting recording system and the problem-oriented recording system.

CHAPTER 1

INTRODUCTION

The successful delivery of quality care by a community mental health center depends upon many factors. One important factor is the use of a recording system which can clearly communicate the service provided. To be helpful the recording system should document the treatment provided, the rationale for treatment selection, a description of the course of therapy, and observations of treatment outcome. A recording system can also be a means of evaluating the effectiveness or ineffectiveness of treatment by reporting the therapist's judgment and observations of client outcome.

The documentation of the treatment outcome through a recording system becomes a matter of paramount importance in agencies that are publicly funded. It is not sufficient for a community mental health center to claim that it is helping people in order to receive funding or accreditation. The agency must provide written evidence of its interventions. In addition, documentation serves as legal protection for the staff and the agency should a client complain of violation of rights during provision of services.

The specifics of what is included in community mental health center records are usually dictated by the purpose and needs of the agency, and the demands of regulatory bodies such as state and federal agencies and the Joint Commission of Accreditation of Hospitals. For

example, data requirements might include the client's name, age, address, marital status, sex, race or ethnicity, date of birth, name and address of the client's next of kin, and the name of the counselor or therapist. An additional element often recorded is the therapist's assessment of the client. In this assessment, a determination must be made of the client's needs, strengths and resources, and the services needed. This includes an evaluation of the presenting problem(s); the diagnostic formulation, including clinical evidence and social history supporting the diagnostic formulation; a list of medication used by the client; a summary of the evaluator's observations of the client; progress notes, which should include a summary of the contact and the type of contact (i.e., individual, group, telephone, emergency); and a discharge summary which includes a summary of treatment, prognosis, reasons for termination, and a description of client status at the time of termination.

The use of an effective recording system in a community mental health center is essential for several other reasons. While recording provides evidence of what transpires in treatment and documents the treatment being provided, this information is kept available to the staff, the client, funding sources, and regulatory bodies. Thus, recording is a means of communication for all those involved in the care of the client. In multi-disciplinary settings the record becomes the most essential means of communicating client information between the disciplines involved in the client's care in the event of the therapist's absence, so that treatment can be provided based on

information in the record. Likewise, when a client needs to be transferred to a new program component, the record can be transferred as well. The record is a tool for monitoring the care of the client which substantiates the intervention method. At the same time, the record documents the progress or lack of progress the client is making in treatment, which may indicate the need to reevaluate the treatment plan.

A plan may be problem-oriented, goal-oriented, or both. Since its inception in 1969, a mental health center in Tucson, Arizona, which is the setting for this study, has operated under the problem-oriented record system (POR). POR is a systematic method of organizing patient records. The POR system is "problem-oriented" in that each of its components focuses on the client's problem(s). This method of recording was developed by Dr. Lawrence Weed (1968) in order to apply the scientific method to the medical-recording system. It is intended to bring order and cohesion, and serve as an efficient form of communication. Ultimately, he hoped that a systematic recording system would result in improved quality of care.

The problem-oriented recording system is a means by which to record collected data. The data base includes information about the problems presented by the client, and progress notes reflect the progress of the client in treatment which is addressed to the problems listed. With the POR, information is retrieved quickly, facilitating the review of records for chart audits. This charting method is designed to provide an accurate reflection of the client's current status.

Although the POR brings order and cohesion to the record-keeping through its systematic approach, regulatory bodies often demand a more explicit kind of recording system that includes reports of patients' participation in their treatment, and specification of the steps taken to alleviate the present problems.

To comply with regulatory bodies such as the Joint Commission of Accreditation of Hospitals and the National Institute of Mental Health, the community mental health center under study added a goal-oriented record system to the problem-oriented record system in June 1980. The new combined system is designed to add clarity to the record through the addition of clear treatment goals. According to the guidelines, each goal must be measurable, address the problem in the problem list, and be targeted for achievement within a specified time frame.

The goal-oriented record system, in conjunction with the problem-oriented record system, appears to satisfy both internal program needs and external regulatory needs by providing documentation of actions and reported outcomes of client treatment. The intent is that the system will also provide some measure of the quality of services offered.

The goal-oriented system used by the center has the following requirements not found in the problem-oriented record system: (1) the client is initially confronted with his/her problems and the goals of therapy which must be established within fourteen days of initiation of therapy; (2) all goals are stated in measurable terms and have a specified time limitation for completion; (3) clients and/or their

families are parties to the goal-setting process; this is documented in the record by signatures of the therapist and client.

Although a goal-oriented record system is not a method of therapy, it may force the therapist to be very directive early in therapy. Therefore, to be able to record all the pertinent information that both systems require, the therapist must pressure the client to identify and verbalize his/her individual problem(s) within fourteen days of the beginning of therapy. The pressure upon the client to set goals early in therapy may create a negative effect in the first stage of therapy. According to Wolberg (1977, p. 488), "The cultivation of the proper working relationship between patient and therapist is indeed the primary objective of the first treatment phase."

In a setting with a client population that is 45 percent Mexican American, there is a special need to assess the impact of early goal-setting on this cultural group. Chavez (1979, p. xii) states that "Many Mexican Americans continue to attach verguenza (shame) to receiving treatment for mental illness. They are too proud and sensitive to expose their personal problems to outsiders." Nevertheless, she states, "Mental health practitioners continue to utilize their familiar diagnostic tools with an unwarranted confidence that people from different socioeconomic or cultural orientation will respond similarly when disturbed. The assumption is that both the Mexican American client and the therapist will view problems from the same frame of reference; all will have similar expectations for problem resolution."

Ramirez (1979) points out that when dealing with Mexican American mental health clients, the initial sessions of therapy are most crucial if the therapist's aims are toward the client staying in therapy. He suggests that during the initial sessions the client's positive cultural attributes be acknowledged, and that once a good working relationship has been established, based on trust, respect and equality, the therapist can begin dealing with problematic areas. When the client's cultural and individual needs are considered, the client is more likely to return for future therapy sessions.

Burruel and Chavez (1974), in addressing the needs of the Mexican American mental health clients who may be experiencing family problems, suggest that time is an important factor in therapy. They point out that in Mexican American families, discussion of feelings and open communication is not commonplace and that it may therefore take a longer time for these clients to become accustomed to this type of communication. In the Mexican American culture, it is not proper to talk about family problems to individuals outside of the family. To do so means to compromise loyalty to the family, and it may take a long time to arrive at this point. Because of this view, diagnosis and goal-setting will often require twice as much time as with Anglo clients (Boulette 1975).

Since early goal-setting requires identification and verbalization of problems by the client early in therapy, this method may be inappropriate for the Mexican American mental health clients. The investigator will study the commitment to therapy of Mexican American clients by comparing the incidence of broken and canceled appointment

rate in two time periods in the same clinic, one period before and one period after the initiation of a system of early goal-setting. For the purpose of this study, the frequency of broken and canceled appointments will be a measure of clients' commitment to therapy.

Statement of the Problem

Client commitment to therapy sessions is an important factor in effective treatment outcome. However, the effect upon Mexican American clients of early goal-setting in therapy when a goal-oriented recording system is utilized has not been noted by the investigator in the published literature. In a community mental health center with a 45 percent Mexican American population, early goal-setting may be incongruent with client expectations of what are appropriate, acceptable demands in therapy.

The Mexican American culture may view early goal-setting as confusing and insensitive. If this is true, Mexican Americans may resist further treatment and demonstrate their resistance by failing to return for further counseling sessions. If a recording system is imposing demands upon both therapists and clients and thereby driving clients away from treatment, a serious problem may result because clients will not get the help they need.

Statement of the Purpose

Minimal information is available in the literature related to the effect of early goal-setting on continuity in therapy for mental health clients in a community mental health center. No information was found regarding Mexican American clients.

The purpose of this study is to answer the question: "Does early goal-setting in psychiatric therapy increase the incidence of broken and canceled appointments among Mexican American clients?"

The study was conducted in a community mental health center with a sample of Mexican American clients. The effect of early goal-setting on this sample's commitment to therapy was measured by tabulating the broken and canceled appointments by means of a retrospective chart audit.

Definition of Terms

For the purpose of clarity and consistency within this study, the following definitions are provided:

1. Commitment: The degree of cooperation in therapy as measured by the rate of broken and canceled appointments.
2. Goal: The aim, the outcome, or end product to be accomplished as a result of treatment; i.e., what the therapist and client are trying to achieve.
3. Broken Appointment: The non-compliance of the client when the client and the therapist agree to a specific time and date to resume therapy and the client does not appear and makes no effort to contact the therapist to reschedule the appointment.
4. Canceled Appointment: On the agreed date and time for the therapy the client does not appear, but does notify the therapist or the client and reschedules another appointment.
5. Client: A person who receives treatment in a community mental health center.

6. Problem-Oriented Record System: A medical record keeping system that provides client demographic characteristics, client problem list, progress in therapy, and outcome of therapy.

7. Mexican American: Clients who identify themselves as Mexican American when completing the intake form at the clinic which is the setting for the study.

8. Goal-Oriented Record System: A medical record keeping system that provides clear treatment goals. These goals are stated in measurable terms and have a time limitation for completion. In addition, the clients and/or their families are parties to the goal-setting process and this is documented in the record by a signature of the therapist and the client.

Conceptual Framework

According to Wolberg (1977, p. 488), "The cultivation of the proper working relationship between patient and therapist is indeed the primary objective of the first treatment phase. Without a working relationship, the patient will not resolve basic resistance to the meaningful resolution of his/her problems."

When investigating the cause of treatment failure, Wolberg (1977, p. 488) states, "We often find that the patient has been unable to take advantage of the benefits of therapy because of his anxiety or because of the refusal to make any effort on his own behalf on the basis of an infantile magical expectancy. . . . What is basically lacking in the therapeutic situation, and what probably has been missing from the inception of therapy, is the proper kind of working

relationship between the patient and the therapist. This relationship ideally is a unique interpersonal experience in which the patient feels a quality of warmth, trust, acceptance, and understanding such as he has never before encountered with any human being."

The length of time required to establish a working relationship ". . . will depend upon the skill of the therapist and also on the intensity of resistance exhibited by the client" (Wolberg 1977). Respect for the client's resistance is a way of expressing tolerance. Therefore, Wolberg (1977, p. 498) states, "The therapist must be content at the start of therapy to move at as slow or as rapid a pace as the patient may dictate."

Goal-setting within fourteen days of initiation of therapy, as defined by the goal-oriented record system, may not allow the client and therapist to develop a working relationship at a pace the client needs. According to Freedman, Kaplan and Sadock (1976), forcing the client to recognize problems before a trustful relationship has been established can increase resistance. This resistance can be clinically manifested by avoiding therapy or canceling future appointments.

Figure 1 shows the three phases of therapy and the difference in the development of the client-therapist relationship between a p-o (problem-oriented) and a g-o (goal-oriented) system. The first phase of therapy consists of the development of a working relationship. In Phase I, warmth, trust, acceptance, and understanding are developed between the client and therapist. Once the client experiences these emotions, the therapist may move to Phase II.

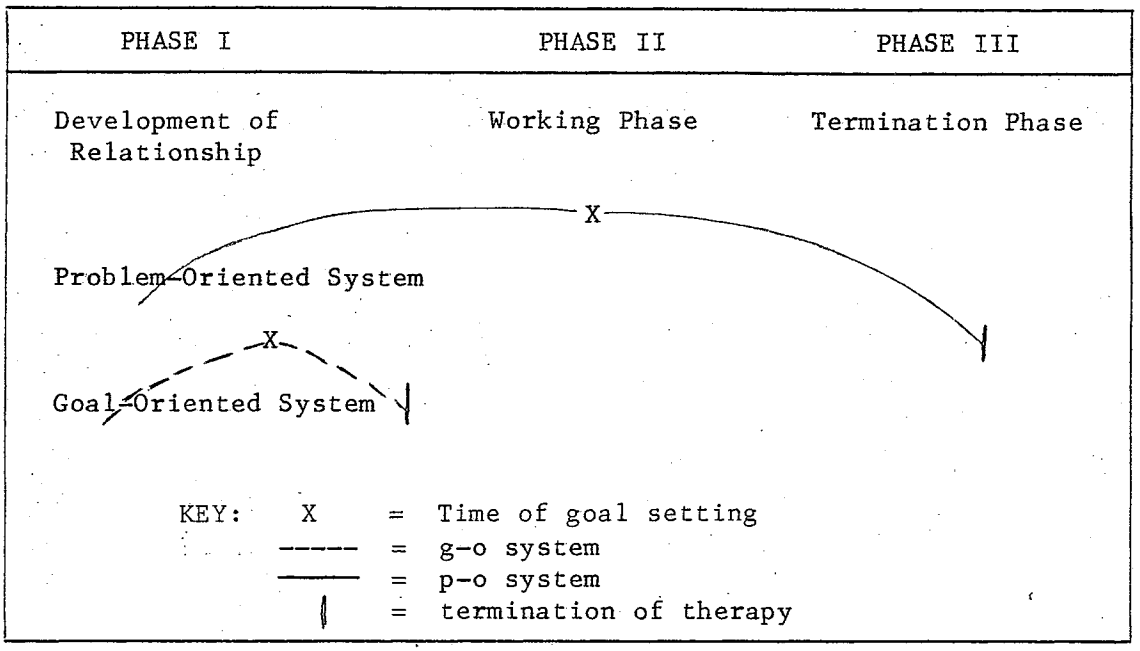

Fig. 1. Three Phases of Therapy in Problem-Oriented Versus Goal-Oriented Systems (Based on Wolberg 1977).

In Phase II the therapist encourages the client to identify and verbalize his/her problems and to find solutions to alleviate them (i.e., goal-setting).

In Phase III, alleviation of problems is achieved, resulting in termination of therapy.

The goal-oriented system, as illustrated in Phase I, requires the least amount of time to develop a working relationship between the client and the therapist since the goals must be set in the first phase. The setting of goals in such an early stage results in premature termination of therapy in the first stage as illustrated by a | on the figure.

Assumptions

The investigator made four assumptions concerning this study:

1. The client cannot progress unless there is commitment to therapy.
2. The therapist is not discouraging the client from keeping scheduled appointments.
3. Broken and canceled appointments are a measure of client resistance and/or commitment to therapy.
4. The therapist is consistent in recording broken and canceled appointments in the client's record.

Limitations

The following limitations are acknowledged in this study:

1. Little generalization can be done since data collection was done in only one community mental health center.
2. In a retrospective study, the researcher lacks control over the definition and measurement of the variables being studied, as well as the setting and the subjects.
3. Data were collected during one time period before the implementation of the goal-oriented record system, and one time period after the implementation of the system. This method does not allow for identification of change of patterns over time and may result in spurious conclusions based upon one-time sampling.

CHAPTER II

REVIEW OF THE LITERATURE

A recording system that can provide clear communication between staff and reflect the services provided is of paramount importance in a community mental health center. This recording system needs to yield information about client data, reasons for treatment, and specific steps in administering client treatment, in order to account for the services provided.

Presently, the mental health system is incurring great controversy and debate about the kind of recording system that should be in operation. While in the past mental health professionals were concerned predominantly with clinical issues related to the delivery of services, they now find themselves preoccupied with the law and politics of meeting the demands of external regulatory bodies as they relate to recording systems that specify quality care.

Standards for the purpose of delivering quality care in community mental health facilities have been established by the Joint Commission on Accreditation of Hospitals (JCAH) and the Arizona State Standards for Behavioral Health Centers. The standards are aimed at providing a uniform basis for professional treatment so that the treatment may meet the needs of the clients in the most appropriate setting, and for the proper length of time.

The JCAH is not the only regulatory body suggesting standards for quality care. Legislators, who appropriate money for the mental health system, are also demanding standards of treatment. Kopolow (1976) and Riedel, et al. (1974) suggest the relative inability of mental health professionals to demonstrate the effectiveness of treatment through a recording system. They note that to demonstrate the relationship between a hypothesized etiology of care of mental illness and the client's response to treatment through a recording system is not an easy matter.

Standards that can measure the quality of care in community mental health centers through a recording system have not been developed appropriately. According to Menninger (1977), there is a great need to revise the criteria that define the treatment and the outcome of treatment for psychiatric patients. He believes that this set of criteria should be developed not in accordance with the medical model, but by members of the psychiatric discipline and other mental health professionals who are dealing with mental health clients, to better define quality care as related to psychiatric treatment. Therefore, recording systems concerning mental illness need further study in order that people engaged in mental health services gain more understanding of what constitutes effective treatment and outcome since in psychiatry the individual differences are very important, compared to the practice of general medicine.

Publicly funded mental health centers require the utilization of a recording system which can reflect the treatment and the treatment outcome for the client in a positive manner. This is the only means

to assure funding continuation. While the reflection of treatment using a medical model may be easily recorded, the outcome criteria for quality in the psychiatric context require a systematic and comprehensive look at the outcome consequences of a variety of interventions. As Menninger (1977, p. 480) states: "A person's age, physical health, level of intelligence, socioeconomic value system, genetic predispositions, and set of total life experiences all interact to form a unique individual." Thus, a more complete picture of the client is needed to judge the outcome of treatment. Because outcome criteria for quality care for psychiatric clients do not include this total picture, the guidelines provided by funding sources often place restraints on psychiatric treatment.

Problem-Oriented Record System

The Problem-Oriented Record (POR) System is used by many hospitals and other health care facilities. This system, developed by Dr. Lawrence Weed in 1968, permits the recording of patient data in a systematic way.

Mead (1971), in his writings, suggested that it is easier to test memory than to evaluate performance. He criticized the teaching of students in the medical field, stating that if students were taught to make use of problem-oriented recording, it would put them in a real situation where they may search for real solutions to the problems. This method, which would help the students to observe, could at the same time help them to develop confidence in finding solutions to problems. He also points out that the POR system teaches

the coupling of basic science to real clinical situations when the need for information arises. Also, it would yield opportunities to find answers to basic questions of research from clinical activities.

When Antoniou, et al. (1979), in a study of forty-two student hospital doctors, asked them about their experience with the POR system, a majority (76 percent) favored this method of recording. The reasons cited were the de-emphasis of disease entitites and the emphasis on the conventional and customary note taking, thus providing a more holistic approach to the patient. The authors were convinced that the POR leads to a better understanding of the patient's medical, social and personal difficulties. The students who criticized the POR system referred to the tedious amount of time needed to write all the follow-up notes under the problem headings of subjective, objective, analysis and plan. While Antoniou, et al. support this system as a proper method of recording, they also acknowledge that the method is time-consuming. They note that the extra efforts are rewarded by an increase in efficiency of persons engaged in the treatment of mental illness.

Hofind, et al. (1979) endorse the POR as a method of documenting patient care as to the patient's problem because POR provides the opportunity to document aspects of care which other systems do not provide. They point out that the POR also includes mechanisms for documenting teaching plans and results, as well as the evaluation of the care provided. They cite another very important factor, that POR helps identify discharge planning. They believe that the POR

provides a logical way of reviewing a chart to analyze the treatment given. However, they also believe that identifying problems is not sufficient, and that modification of the system is needed to incorporate problem-solving techniques.

Because compliance with the rules of keeping records is an aspect of assurance of quality, community mental health centers across the country have adopted the POR system to document care given to the population served as measured by chart audits. Stephen, et al. (1973) and McIntyre, et al. (1972) state that the POR is supported by many physicians, not only in hospitals but also in general practice, as the kind of recording that provides a satisfactory and comprehensible framework for case notes. This system is viewed as a practical method to deal with the demands of recording important data in regard to clients.

In assessing the POR system as a basic tool for patient care, Weed (1969) suggested that to work effectively at the community level, the system must be implemented through a comprehensible system of communication. Standards for such a system must be fixed so that problems and progress of patients can be defined. He believes that the medical record should serve the patient as well as medical personnel. The recording, then, must represent the events and the decisions made, so that errors can be detected and corrected, and continuity of care may be provided. Weed (1969) also points out that through the operations system of the POR, the clients' pertinent data can be reviewed in sequence, thus providing a better assessment of medical standards which can be properly applied. He

cites numerous advantages of the POR, from the general management aspects of health care systems to the area of fiscal planning, organization by resources, and measurement of efficiency, in addition to the effective, on-going education of the medical student. However, he brings to the readers' attention that the POR, with its up-to-date and precise data as a means of communication, will not by itself lead to the best medical practice. Without precision and form, good care is difficult to give. Gahan (1976) suggests that, when interacting with clients receiving psychiatric care in mental health centers, if the levels of functioning of the clients are low due to the inability to cope with the environment, a list of problems cannot be sufficient to manage a case. Gahan (1976) notes that when clients in such settings finally decide to receive some sort of help or assistance, they often feel like helpless victims. The suggestion in this instance is to make use of the problem-solving approach in order for the client to have some control and responsibility for himself and his problems.

While the POR may help the clinician in a mental health center to channel his efforts toward helping the client identify his problems and record them in a problem list, the record system does not provide the client's participation in goal setting or problem solving, nor does it provide the specific steps to meet these goals with a time frame that may yield effective treatment such as is demanded by federal and state funding agencies as well as the JCAH.

Goal-Oriented Recording System

For the purpose of reflecting a more accurate record system of client treatment and its positive outcome, the Goal-Oriented Recording (GOR) System was suggested as a measure of quality assurance which could be reviewed through a chart audit. While the POR yields a list of problems, the GOR provides a list of goals to alleviate the listed problems. These goals need to be operational as well as resolvable within a specific time frame.

In the center studied, guidelines provided to the clinician state that the goals must be stated (recorded) by the fourteenth day. This suggests a very active participation by the client early in therapy. Sydney (1977) suggests that forcing the client to set goals related to the problems under discussion early in therapy may be too much to ask. The possibility exists that early goal-setting may mobilize defense mechanisms, such as denial, projection and externalization of inner conflict; this may be reflected through avoidance behavior manifested by broken appointments.

There is minimal information available in the literature regarding the GOR system. Some studies (Garwick 1974; Miller, et al. 1974; and Jones, et al. 1973) have indicated that in some instances where the client is constructing his treatment plan and treatment is goal-oriented, the client generally progresses faster than if he takes a passive role. Dyer and Unried (1977) suggest that effective goal-setting is a vital part of the counseling activity once the relationship between the client and the counselor has been established. The client's achievement, or lack of it, based on the goals set,

becomes a standard for assessing counseling effectiveness in every stage of the process.

Swaringen, et al. (1977) suggest that for psychiatric practitioners, goal-setting is generally accepted as an important component of therapeutic strategy. They also point out that a goal-oriented treatment approach to therapy may be more appropriate, not only for the psychiatric client but also the subacute and chronic physical disease population. This would suggest that when goal-oriented recording is used, it allows the opportunity to add the client's strengths and environmental resources. In addition, when the goals are specific and understood by both the client and staff, client involvement in the treatment is increased. They add that if the goals are realistic and reasonable, the staff may be more willing to use all possible resources for their achievement. They continue that by stating specific reasonable goals in the treatment plan, clinic practice can be better evaluated, thus affording the opportunity to change or improve the treatment plan based on needs.

Gagliano, et al. (1975), in a study involving a geriatric population and the importance of record keeping, observed various methods of recording. When reviewing problem and goal-oriented systems, they suggest that extensive record keeping would be required if the patient's observable problems were recorded, in order to generate treatment goals in a treatment plan. Therefore, in practice, either problem-oriented or goal-oriented recording could be used, the authors said, since problem-oriented records tend to drift toward a goal concept anyway, and because problems are usually stated in only

sufficient detail to serve as a guide to treatment. The authors' experience with both kinds of recording systems, when studying 143 state hospital patients whose mean age was seventy-four years, led them to prefer the problem-oriented system in the treatment of geriatric patients, because these patients seem to have numerous physical problems. The authors discourage the use of both systems simultaneously, due to the extreme amount of recording that would be required, but suggest that the system be selected which clinicians felt would be suitable to the particular care.

In order to provide for the future as well as current needs, Spano (1976) presented a paper about an operational model to help achieve accountability for social workers in health care. This paper dealt with recording systems that could reflect services provided, feedback reports to the staff, and summary reports to hospital administrators. The structure of Spano's operational model had a framework derived from management by objectives, and was composed of the following elements: (1) a transaction-based management information system; (2) service definitions developed by the Southern Regional Educational Board; (3) problem identification and record-keeping with problem-oriented medical records; and (4) outcome evaluation through Goal-Attainment scaling. The author believes, when using all its components in a recording system, this operational framework will reflect the involvement and accountability of the staff in the treatment of the client by social workers in health care.

Swaringen, et al. (1977), Gagliano, et al. (1975), and Spano (1976) agree in some areas. They agree that the problem-oriented system helps organize pertinent data which can help the staff to obtain a total picture of the client. From these data, a care plan can be developed. The authors seem to agree that the goal-oriented recording system helps the staff set goals for a positive outcome, including active participation by the client in his treatment.

However, no information was found in the literature to substantiate a positive outcome if the POR and GOR systems are used simultaneously, mostly because the goal-oriented recording system demands that the therapist help verbalize the client's problems and set goals to alleviate them early in treatment. In the instance of the Study Center, these goals must be stated by the fourteenth day of therapy.

In addition, the literature studied does not yield any information about the utilization of these two systems in a variety of ethnic populations and the potential resistance to therapy, as measured by keeping appointments or not keeping them, and the feelings by clients that their problems or conditions were insoluble, etc., or that the goals set were too difficult. These problems, which might result from the use of both systems or either of them, are questions to be addressed in this study.

Broken and Canceled Appointments and Mexican American Mental Health Clients

In this study, the investigator was unable to cite the effects of early goal-setting in the goal-oriented record system, specifically in the area of broken and canceled appointments with the Mexican American mental health clients. This section contains relevant areas such as the Mexican American and psychotherapy, low utilization of mental health services by the Mexican American, client dropout, and factors in broken and canceled appointments by various ethnic groups.

The goal-oriented record system, as mentioned in Chapter I, is not a method of psychiatric therapy. However, this system demands that the client verbalize his/her problems, set goals to alleviate the presenting problems in measurable terms, and ensure that this is recorded in the client's chart by the fourteenth day of initial therapy session. The Mexican American culture may view early goal-setting as insensitive. If this is true, Mexican Americans may resist further treatment and demonstrate this resistance by failing to return for further counseling sessions.

According to Wolberg (1977), psychiatric therapy consists of three stages. The first stage consists of the development of a working relationship between the client and the therapist. In Stage II, the therapist encourages the client to identify and verbalize his/her problems and to find solutions to alleviate the

problems. Stage III, alleviation of problems, is achieved, resulting in termination of therapy. While Wolberg (1977) did not specify how long these three stages should last, setting goals by the fourteenth day of initiation of therapy, as defined by the goal-oriented record system, may not allow the client and therapist to develop a working relationship at a pace the client may need. Forcing the client to recognize problems before a trustful relationship has been established can create resistance. This resistance can be clinically manifested by avoiding therapy or canceling future appointments (Freedman 1976). Stage I in therapy is also stressed by Castro (1977), who points out that getting to know the client through probing into the nature of the client's problems as he/she sees them and probing into the client's background requires maximum sensitivity by the clinician. Castro (1977) further speculates that the Spanish speaking client may drop out of therapy if time is not allowed to establish a trusting relationship in order to set the stage for mobilizing the client's favorable expectations.

Burruel and Chavez (1974) also stressed the need to allow time in the first stage of therapy with the Mexican American population. Boulette (1975) suggests that when working with the Mexican American mental health client, the client may need twice as much time to develop a relationship than an Anglo client, due to cultural loyalty and different value system.

Cultural loyalty and a different value system could be a factor in the expectancy of services by the Mexican American mental health client and the rate of broken and canceled appointments. Chavez (1975) suggests that the Mexican American bears the basic norms and expectations from two sources; the first source she believes comes directly from the environment, such as the immediate family and the extended family. As socialization progresses, the Mexican American is exposed to the broader societal expectations, norms and value system of the majority culture, thus yielding the possibility of a dual culture, which may have contradictory expectations of mental health services in some areas. Chavez (1975, p. 25) states, "If he abides by one set of expectations, he may be sanctioned by one group but ostracized by the other. This dual socialization may have some effects on his expectations when requesting mental health services." Miranda (1976) points out that while mental health specialists have become increasingly aware of the psychological adjustment problems of the Spanish speaking population in society, it is recognized that mental health services are still inadequate for this population. This is demonstrated by the low success outcome and the high dropout rate.

Karno (1966, p. 519) asserted that "The Mexican American's relative passivity, deference, and polite inhibited silence are poor equipment for successful engagement in psychotherapy." However, these speculations were not based on extensive research findings. Chavez (1975) and Lorion (1974) suggest that the low

utilization of mental health services by the Mexican American may not be an indicator of poor verbal skills, but rather an incongruency between what this group needs and expects, and what is offered. Thus, increasing awareness of practitioners about the Mexican American culture and adequate time to develop a working relationship would yield a more favorable treatment outcome or utilization rate. Padilla et al. (1975), in addressing the low utilization rate and the high rates of premature termination by Mexican American mental health clients, suggests that culture-bound values such as behavior as observed by mental health practitioners and the lack of understanding toward this culture could be a contributing factor to the low utilization of services and premature termination. However, another reason for low utilization of services could be that the Mexican American often uses more traditional sources to deal with psychological problems. Other sources that might be of more familiarity are: physicians, a relative or compadre, or a priest/minister (Carlos and Keefe [1976]).

To briefly summarize, there are variations in knowledge of the Mexican American in mental health. In reality, therefore, not much is known about the Mexican American mental health client commitment to therapy when early goal setting is used.

CHAPTER III

METHODOLOGY

This chapter includes a description of the design, setting, study sample, and methodology used in this study.

Design

This was an ex post facto study comparing the incidence of broken and canceled appointments by Mexican American mental health clients, in two time periods as an indication of client's personal commitment to therapy.

The investigator wishes to ascertain whether Mexican American mental health clients have less commitment to therapy under a goal-oriented record system than under a problem-oriented record system by comparing the number of appointments broken and canceled by the clients.

In this study, the dependent variable was the client's personal commitment to therapy, which was operationalized as the recorded incidence of broken and canceled appointments. The independent variable was early goal-setting in the goal-oriented record system.

Setting

A community mental health center in Tucson, Arizona was the setting for this study. The center serves a catchment area of approximately 154,000 individuals. The ethnic breakdown of the

population is as follows: 45 percent Mexican American, 42.1 percent Anglo, 4.7 percent Native American, 4.2 percent Black, and 3.1 percent others.

Study Sample

Criteria for the selection of the subjects in this study were:

1. Mexican American.
2. Males and females, ages 18-60 years.
3. Clients must be receiving services during the periods of June to August 1979 (25), and June to August 1980 (25), forming the sample for this study. The population pool consisted of thirty clients in the 1979 period and thirty-eight clients in the 1980 period. From this population pool, twenty-five clients were selected for each of the two time periods.
4. Mental health clients without substance abuse.
5. No missing data in client record.

The collection of data for this study was done through computer-run retrospective chart audit. A computer program was used not only as a form to generate the clients' pertinent information but also as a form to insure maximum confidentiality. Originally, there was to be a systematic sample using every second element, chosen from a sampling frame comprised of Mexican American adult intakes into the mental health center studied. However, since the population pool as so small, a random sample was used instead, numbering each element using a table of random numbers.

Data Collection

The data consisted of dependent measures of the number of broken and canceled appointments. The demographic variables included: (1) age; (2) sex; (3) annual family income; and (4) family size (the number of individuals comprising the family unit). The continuous variables of income, family size and age were post-coded into categorical variables. Age was broken down into the categories of: (1) 18-25 years; (2) 26-35 years; (3) 36-55 years; and (4) 55-60 years. Income was categorized as: (1) $0-$999; (2) $1000-$3999; (3) $4000-$7999; and (4) $8000 or more. Similarly, family size was broken down into: (1) one individual; (2) two individuals; (3) three individuals; (4) four individuals; and (5) five or more individuals.

The incidence of broken and canceled appointments in relation to the demographic characteristics of age, sex, income, and family size was displayed in crosstab matrices. Statistical analysis test of significance was used to determine the significance between the two time periods.

Protection of Human Subjects

The study was submitted to and approved by the University of Arizona Human Subjects Committee. It was determined that human subjects were not at risk (see Appendix A for letter of approval). Permission to conduct the study at the community mental health center was obtained in writing (see Appendix B) from the Director of Program Evaluation and the Executive Director.

Data Analysis

Percentage and frequency analysis of broken and canceled appointments was performed as well as analysis of the demographic characteristics of the sample population and the total population. The demographic characteristics of the sample and the population pool were compared in order to determine if the sample selected was representative.

A chi-square test of significant was performed to ascertain whether there was a statistically significant difference in the incidence of broken and canceled appointments of Mexican American clients under the two types of recording systems (problem-oriented record system, 1979, vs. goal-oriented record system, 1980).

To determine the relationship between the incidence of broken and canceled appointments and the demographic variables of age, sex, family size, and annual income, several chi-square tests of significance were conducted.

CHAPTER IV

ANALYSIS OF DATA

Agencies that receive public funding must document the treatment outcome and the treatment that is used with their patients. The use of recording systems provides the means for such documentation. One such recording system is the goal-oriented recording system, which was designed to meet the standards of the Joint Commission on Accreditation of Hospitals and the Arizona State Approval Standards for Behavioral Health Centers. Goal-oriented record keeping systems document goal-setting in therapy by requiring that the client's problems and goals of therapy be written in the record within fourteen days of initiation of therapy. The goals are to be stated in measurable terms and completed within a specified period of time. In order to insure that the client and/or the family participate in the goal-setting process, the signatures of both the therapist and the client(s) are required in the record.

There has been little investigative attention given to the question of the impact of rapid and early goal-setting in compliance with accountability of record keeping demands upon the therapist's relationship with Mexican American clients. However, as noted in Chapter II, in the literature review, the goal-oriented recording system may be inappropriate for Mexican American mental health

clients. Given that there are many community mental health centers which serve large Mexican American populations, it is important to evaluate the effects of a goal-oriented record keeping system, which includes mandatory early goal-setting, upon the retention of Mexican American clients in therapy.

The purpose of this study was to compare the commitment to therapy of two groups of Mexican American clients who were treated under two different mandatory recording systems in two consecutive time periods (the problem-oriented or the goal-oriented recording systems). More specifically, this study sought to answer the following question: Will the incidence of broken and canceled appointments among Mexican American clients be significantly greater in a goal-oriented system than in a problem-oriented system?

The present study was an ex post facto study comparing the incidence of broken and canceled appointments in two time periods as an indication of the personal commitment of Mexican American clients to therapy in a goal-oriented system. The study was conducted in a mental health center in Tucson, Arizona, which had utilized a problem-oriented recording system for eleven years and in June 1980 changed to the early goal-setting recording system. The purpose of this study was to ascertain whether Mexican American clients had less commitment to therapy under a goal-oriented recording system than under a problem-oriented recording system. This objective was met by comparing the incidence of broken and canceled appointments under the two types of recording systems.

In the present study, the dependent variable was the client's personal commitment to therapy, operationalized as the recorded incidence of broken and canceled appointments. The independent variables were early goal-setting in the goal-oriented recording system and problem solving in the problem-oriented recording system.

The subjects were selected in accordance with the following criteria: (1) The subjects must be Mexican American; (2) They must be between the ages of eighteen and sixty years; (3) They must be clients who were receiving services, either during the period of June to August 1979 (problem-oriented record keeping system clients) or during the period of June to August 1980 (goal-oriented record keeping system clients). The population pool consisted of thirty clients in the 1979 period and thirty-eight clients in the 1980 period. From this population pool, twenty-five clients were selected for each of the two time periods. Originally, there was to be a systematic sample using every second element, chosen from a sampling frame comprised of Mexican American adult intakes into the clinic. However, since the population pool was so small, a random sample was used instead, numbering each element using a table of random numbers.

The demographic characteristics included in this study were: (1) age; (2) sex; (3) annual family income; and (4) family size, defined as the number of individuals comprising the family unit. The continuous variables of income, family size, and age were post-coded into categorical variables. Age was broken down into the

categories of: (1) 18-25 years; (2) 26-35 years; (3) 36-55 years; and (4) 56-60 years. Income was categorized as: (a) $0-$999; (2) $1000-$3999; (3) $4000-$7999; and (4) $8000 or more. Similarly, family size was broken down into: (1) one individual; (2) two individuals; (3) three individuals; (4) four individuals; and (5) five or more individuals.

The demographic characteristics of the sample and the population pool were compared in order to determine if the samples selected were representative. For each following table, the populations represent all Mexican American intakes into the adult program at the mental health center studied for the periods of June to August 1979 and June to August 1980. The samples were chosen randomly from the two population pools.

Demographic Characteristics

Table 1 provides the comparison of the sample and population under the two recording systems (1979 and 1980) for the variable age. The percentages for the 1979 sample and the population are similar for all four age groups. However, for the 1980 data, the modal distribution of age categories differs between the sample and the population in one category only. When compared to the figures for the client population, the 1980 sample shows half the number of subjects in the 18-25 years category. Thus, the 1979 sample age distribution appears more representative of the client population than does the 1980 sample.

Table 1. Comparison of Age Distribution Between Sample and Population in Two Time Periods (1979 and 1980).

Age Category	Problem-Oriented Recording System 1979				Problem- and Goal-Oriented Recording Systems 1980			
	Number		Percent		Number		Percent	
	S	P	S	P	S	P	S	P
18 - 25	8	9	32.0	30.0	3	10	12.0	26.3
26 - 35	8	10	32.0	33.3	10	13	40.0	34.2
36 - 55	6	7	24.0	23.3	9	12	36.0	31.5
56 - 60	3	4	12.0	13.3	3	3	12.0	8.0
Total	25	30	100.0	99.9	25	38	100.0	100.0

KEY: S = Sample
P = Population

Table 2 on the following page shows that the 1980 sample is representative of the sex distribution in the population pool. This is less true for the 1979 sample where the sample contains fewer males and more females than does the 1979 population.

Table 2. Comparison of the Sex Distribution Between Sample and Population in Two Time Periods (1979 and 1980).

Sex Category	Problem-Oriented Recording System 1979				Problem- and Goal-Oriented Recording Systems 1980			
	Number		Percent		Number		Percent	
	S	P	S	P	S	P	S	P
Male	9	13	36.0	43.3	4	6	16.0	15.8
Female	16	17	64.0	56.7	21	32	84.0	84.2
Total	25	30	100.0	100.0	25	38	100.0	100.0

KEY: S = Sample
P = Population

Table 3 presents a comparison of the sample and population for the variable annual income. The 1979 sample and population percentages are similar. The 1980 data also provide evidence that the sample is representative of the population since the percentages for the sample and population are similar.

Table 3. Comparison of Annual Income Distribution Between Sample and Population in Two Time Periods (1979 and 1980).

Income Category	Problem-Oriented Recording System 1979				Problem- and Goal-Oriented Recording Systems 1980			
	Number		Percent		Number		Percent	
	S	P	S	P	S	P	S	P
$ 0 - $999	3	3	12.0	10.0	5	8	20.0	21.0
$1000-$3999	9	10	36.0	33.3	8	10	32.0	26.3
$4000-$7999	6	8	24.0	26.7	8	13	32.0	34.2
$8000 or more	7	9	28.0	30.0	4	7	16.0	18.5
Total	25	30	100.0	100.0	25	38	100.0	100.0

KEY: S = Sample
P = Population

In summary, comparison of the demographic variables of age, sex, and income between the sample and the population for each time period studied (1979 and 1980) indicated that the Mexican American sample was representative of the population pool of Mexican Americans in the mental health center.

Uncontrolled Interacting Variables

When the two samples are compared with each other (1979 vs. 1980), some differences were noted which may interact with the treatment and may influence commitment to therapy. The most notable discrepancies were as follows: In the age category of

18-25 years, the 1979 sample had almost three times more subjects than the 1980 sample, and was therefore a more youthful sample. Also, the ratio of males to females was slightly higher in the 1979 sample (1:1.7), compared with the 1980 sample (1:5.2). In terms of income, there were no large discrepancies (over 15 percent) between the two groups. In summary, the 1979 sample was proportionately younger and had a higher ratio of males to females.

Broken and Cancelled Appointments in 1979 and 1980

The frequency of broken and cancelled appointments under the two different recording systems (problem-oriented recording system, 1979, vs. goal-oriented recording system, 1980) appeared to be similar. This was confirmed by a chi-square test of statistical difference which was not significant ($X^2 = .306$, df = 1, p = .58).

Table 4. Frequency of Broken and Canceled Appointments in 1979 and 1980.

Appointments	FREQUENCY	
	Problem-Oriented Recording System 1979	Problem- and Goal-Oriented Recording Systems, 1980
Broken Appointments	16	16
Canceled Appointments	12	16
Total Appointments	190	174
	$X^2 = .306$, df = 1, p = .58	

Broken and Canceled Appointments According to Demographic Variables

Broken and canceled appointments (BA/CA) in each sample were summated to provide an overall index of commitment to therapy. Since there was some question regarding the potential interaction of the demographic variables of age, sex, family size, and annual income upon commitment to therapy, these independent variables were separately analyzed in relation to the dependent variable (BA/CA).

Table 5 presents the summary statistics for these analyses of the relationship between the dependent variable (BA/CA) and each of the demographic variables. In Table 5, the raw data describing the proportion of BA/CA's to total appointments is given as well as its calculated percentages. Thus, for the age group of 18–25 years under the 1979 problem-oriented recording system, 14 percent of the 84 total appointments were canceled or broken (n = 12). Correspondingly, of these 84 appointments, 86 percent of the appointments were kept (n = 7). Since the total number of scheduled appointments was not equal for each group, all of the analyses were based on the percentage reflecting the proportion of BA/CA to total scheduled appointments, thereby decreasing any bias that might be introduced into the data as a result of unequal number of scheduled appointments among the groups.

Table 5. Proportion and Percentage of BA/CA Under Problem-Oriented Recording System (1979) and Problem- and Goal-Oriented Recording Systems (1980) for Age, Sex, Family Size and Annual Income.

Demographic Characteristics	Problem-Oriented Recording System 1979		Problem- and Goal-Oriented Recording Systems 1980	
	Percentage of BA/CA	Proportion of BA/CA to Total Number of Appointments	Percentage	Proportion of BA/CA to Total Number of Appointments
Age: 18-25	14	12/84[1]	32	7/22
26-35	13	4/38	17	13/79
36-55	19	9/47	13	7/55
56/60	10	2/21	28	5/18
$X^2 = 9.84$, df = 3, $p < .02$				
Sex: Male	10	6/61	4	1/25
Female	21	24/115	21	13/149
$X^2 = 1.95$, df = 1, $p = .16$				
Family Size: 1	26	8/31	24	17/70
2	7	2/29	30	11/37
3	27	14/51	0	0/0
4	13	2/16	20	1/5
5 or more	7	4/57	6	3/53
$X^2 = 42.94$, df = 4, $p < .0001$				
Annual Income:				
$0-$999	30	7/23	19	5/27
$1000-$3999	26	15/57	18	10/56
$4000-$7999	15	5/30	30	14/47
$8000 or more	5	3/63	4	1/25
$X^2 = 8.88$, df = 3, $p < .05$				

[1] The numerator corresponds to the raw frequency of total broken and canceled appointments, and the denominator is the total number of appointments that were scheduled.

Table 5 shows that the percentage of BA/CA's was higher under the 1980 recording system for the age ranges of 18-25, 26-35, and 56-60 than under the 1979 recording system, and lower in the 1980 system as compared to the 1979 recording system. This difference was significant (X^2 = 9.84, df = 3, pf .02), indicating that there was a significant relationship between the client's age and the incidence of BA/CA. Table 5 shows that females had a higher incidence of BA/CA for both recording systems than did males. However, these differences were not significant (X^2 = 1.95, df = 1, p = .16). Family size showed a significant relationship with the type of recording system used (X^2 = 42.94, df = 4, p < .0001). In families that consisted of only one individual (the client) and in families of five or more, there was no significant difference between the type of recording system and BA/CA's. However, in families with two and four individuals there was a higher incidence of BA/CA's in 1980 but a lower incidence for families with three individuals. On the variable annual income, for those clients with no income or those earning between $1000 and $3999, there was a lower incidence of BA/CA's under problem- and goal-oriented recording systems than under problem-oriented recording system. However, for individuals earning between $4000 and $7999, the incidence of BA/CA's was higher under the problem- and goal-oriented recording system, while it was the same for earnings of $8000 or more. The degree of significance in BA/CA's between 1979

and 1980 according to income was significant ($X^2 = 8.88$, df = 3, $p < .05$). The implication of the above data and the data shown in previous tables is discussed in Chapter V.

CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

Recording systems that can reflect the kind of service provided in a community mental health center are of great importance for accreditation of the center as well as funding purposes. Recording systems are also a form of quality assurance. This study was designed to obtain information related to the effects of early goal-setting as dictated by the goal-oriented record keeping system.

Although the goal-oriented recording system is not a method of therapy, it forces the therapist to be directive and time limited from the beginning of therapy. With the goal-oriented record system, the client is initially confronted with his/her problems and the goals of therapy, which must be stated within fourteen days of initiation of therapy. The goals of therapy must be recorded in measurable terms and have a specified time for completion. When the measurable objectives are jointly established, they are written in the client's record and co-signed by both parties, the therapist and client. The goal-oriented record system requires a person who is verbal and willing to work on his/her problems as well as place a high degree of trust on the therapist early in therapy.

Early goal-setting as required by the goal-oriented recording system is in need of investigative attention. There is

very little information on whether early goal-setting is an effective type of recording system. This is especially true with Mexican American clients. What little research that has been done with early goal-setting and Mexican Americans has shown that this type of system is not effective because Mexican Americans are considered to need more time to adjust to the clinical setting (Chavez 1979; Burruel, et al. 1974; Boulette 1975; and Ramirez 1979). The significance of this study is that it provides a determination of whether the goal-oriented recording system is as effective as the problem-oriented recording system in a community mental health center with a 45 percent Mexican American clientele.

The purpose of this study was to compare the commitment to therapy of two groups of Mexican American clients who were treated under two different mandatory recording systems in two consecutive time periods (the problem-oriented recording system and the goal-oriented recording system). More specifically, this study sought to answer the following question: Will the incidence of broken and canceled appointments among Mexican American clients be significantly greater in a goal-oriented system than in a problem-oriented system?

In this study, the dependent variable was the client's personal commitment to therapy, which was operationalized as the recorded incidence of broken and canceled appointments. The independent variables were early goal-setting in the goal-oriented

record keeping system and the problem solving in the problem-oriented recording system.

The assumptions underlying this study were as follows: (1) the client could not progress unless there was commitment to therapy; (2) the therapist was not discouraging the client from keeping scheduled appointments; (3) broken and canceled appointments were a measure of client resistance or commitment to therapy; and (4) the therapist was consistent in recording broken and canceled appointments in the client's record.

The collection of data for this study included demographic characteristics of the Mexican American mental health client such as age, sex, family size, and annual income. In addition, each client's record of canceled and broken appointments was analyzed.

Several analyses were conducted to provide information concerning the effectiveness of the two types of record keeping systems and to determine what demographic variables might be related to the incidence of broken and canceled appointments for Mexican American mental health clients. The first analysis that was conducted was a chi-square test of significance to ascertain whether there is a statistically significant difference in the incidence of broken and canceled appointments of Mexican American clients under the two types of recording systems. Results from the chi-square test demonstrated that there was no significant difference in the incidence of broken and canceled appointments under the goal-oriented and problem-oriented recording systems ($X^2 = .306$, $df = 1$, $p = .58$). These results can be interpreted as indicating

that the Mexican American mental health client has the same amount of commitment to therapy under the goal-oriented recording system as under the problem-oriented recording system.

The lack of significance between the two types of recording systems is inconsistent with the results recorded in other studies. For example, Karno (1966) and Boulette (1975) indicate that Mexican American clients do not function successfully in psychiatric therapy. Further, Burruel and Chavez (1974) suggest that Mexican American mental health clients need more time in therapy than Anglos. Since there was no significant difference under the two recording systems, it appears that the Mexican American mental health client is successfully staying in therapy under both record keeping systems. This result also suggests that Mexican American mental health clients may not need more time in psychiatric therapy to establish a working relationship with the therapist.

To determine the differences between the two time periods according to the demographic variables of age, sex, and annual income, several chi-square tests of significance were conducted. For the variable of age, results showed significant differences between the two recording systems, where the frequency of broken and canceled appointments was higher under the goal-oriented recording system for the age ranges of 18-25, 26-35, and 56-60 years, and the frequency of broken and canceled appointments was lower for the age range of 45-55 years ($p < .02$). The variable of sex, however, was not significantly related to the type of recording system ($p = .16$).

In general, females had a higher incidence of broken and canceled appointments under both recording systems. The variable of family size was significantly related to broken and canceled appointment frequency ($p < .0001$). In families with only one individual or more than five individuals, there was no difference under the two types of recording systems. Families with two or four individuals had a higher incidence, and families with three individuals had a lower incidence of broken and canceled appointments under the goal-oriented record keeping system. Annual income was also significantly related to the incidence of broken and canceled appointments ($p < .05$). Surprisingly, there was a lower incidence of broken and canceled appointments in the $0-$999 and $1000-$3999 groups than in the higher income groups. This result of annual income is inconsistent with Peterson (1976), who points out that lower-class individuals are less likely to keep their appointments.

In summary, the results showed that there was no significant difference in the incidence of broken and canceled appointments among Mexican American mental health clients under the goal-oriented recording system and the problem-oriented recording system. This finding suggested that Mexican American mental health clients were as committed to therapy regardless of which type of recording system was used. Further, the findings from the analyses of the relationship between the incidence of broken and canceled appointments and the demographic variables indicated that age, income, and family size all influenced the patient's commitment to therapy, depending

on the type of recording system that was used. A Mexican American mental health client's commitment to therapy under the goal-oriented recording system was therefore probably influenced by a combination of variables including socioeconomic factors, family size, and age.

Several limitations must be kept in mind in interpreting and generalizing the study's findings. First, this was a retrospective study and the data were collected during a short period of time under each recording system, one time period before the implementation of the goal-oriented recording system and one time period after the implementation of the system. This method does not allow for the identification of change in patterns over time and the possible result of spurious conclusions based upon one-time sampling. Another limitation of this study was the collection of data in only one community mental health center. Also acknowledged in this study was the lack of control over the definitions and measurement of the variables being studied, the setting, and the subjects because of the retrospective nature. Finally, the small number of subjects that were available for study precluded the use of more complex analyses of the data.

Recommendations and Nursing Implications

The results of this study showed that the variables of age, sex, family size, and annual income can affect how often a Mexican American mental health client breaks or cancels appointments. Thus, these variables should be considered in establishing treatment programs for Mexican American mental health clients. Considerably

more research must be conducted to determine: (1) whether Anglos and Mexican American mental health clients differ in their commitment to therapy in a program with early goal-setting, and (2) what other variables (e.g., time of appointment, transportation problems, language barriers) may influence a mental health client's commitment to therapy.

Nursing, as well as other disciplines which work with different ethnic groups, must be cautious when interpreting the available literature, especially as it relates to the Mexican American mental health client. Often the literature may give an impression that may not necessarily represent a group in its best interests. For example, the literature reviewed for this study reflecting the Mexican American mental health client (e.g., Karno 1966) suggests that Mexican Americans may be poor candidates for psychiatric therapy because of their relative "passivity" and "polite inhibited silence." Boulette (1975) points out the need to be less rushed with Mexican American mental health clients during psychiatric therapy. Similarly, Burruel and Chavez (1974) stress the need to keep a slow pace with this ethnic group if the goal is to keep the client in therapy.

The point to be stressed here is that a client's individual expectancies and needs must be considered when dealing with the Mexican American mental health client, rather than by evaluating their needs from the generalizations made about Mexican Americans.

Much more systematic research about the Mexican American mental health client is needed before serious conclusions about treatment can be drawn and recommendations for treatment can be made.

APPENDIX A

HUMAN SUBJECTS COMMITTEE LETTER OF APPROVAL

THE UNIVERSITY OF ARIZONA
TUCSON, ARIZONA 85724
HUMAN SUBJECTS COMMITTEE
ARIZONA HEALTH SCIENCES CENTER 2305

18 December 1980

Isabel Moore, B.S.N.
822 South Langley
Tucson, Arizona 85710

Dear Ms. Moore:

We are in receipt of your project, "The Effects of Early Goal Setting in a Goal Oriented Record System on Personal Commitment of Mexican American Mental Health Clients to Therapy", which was submitted to the Human Subjects Committee for review. We concur with the opinion of your Departmental Review Committee that this is a minimal risk project. Therefore, approval is granted effective 18 December 1980.

Approval is granted with the understanding that no changes will be made to the procedures followed (as outlined in your request for approval) without the knowledge and approval of the Human Subjects Committee and the Departmental Review Committee.

Sincerely yours,

Milan Novak

Milan Novak, M.D., Ph.D.
Chairman

MN/jm

cc: Ada Sue Hinshaw, R.N., Ph.D.
Departmental Review Committee

APPENDIX B

DIRECTOR OF PROGRAM EVALUATION AND THE EXECUTIVE DIRECTOR LETTER OF APPROVAL

LA FRONTERA CENTER, INC.

PROVIDING MENTAL HEALTH, ALCOHOL AND DRUG ABUSE SERVICES

Maribel Moore
La Frontera Clinic
1933 So. Sixth Ave.
Tucson, Arizona 85713

Dear Maribel:

This letter is to inform you that your thesis project, entitled "Effects of Early Goal-Setting in a Goal-Oriented Record System on Personal Commitment of Mexican American Mental Health Clients to Therapy," has been approved by me and by the Director of Program Evaluation.

You therefore have permission to collect your data, under the following conditions:

The data will be obtained from a computer run, which will provide information to be used in aggregate form only.

Data collection will be supervised by Dr. Elizabeth Katz, the Director of Program Evaluation.

A copy of the thesis will be reviewed by the Executive Director before it is sent to the thesis committee for approval.

A final copy of the thesis will be given to La Frontera Center.

Yours sincerely,

Nelba Chavez, Ph.D.
Executive Director

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