PUERTO RICAN AND ANGLO CONCEPTIONS OF APPROPRIATE MENTAL HEALTH SERVICES

Walter J. Torres

ABSTRACT

Many cultural differences between Puerto Ricans and Anglo-Americans reflect basic differences between folk or "natural" societies and industrial/technological societies. In light of this and related considerations, it is probable that certain helping practices that instantiate the industrial/technological traditions of Anglos will not be appropriate to Puerto Ricans of folk society traditions. Four hypotheses were drawn concerning differences in Puerto Ricans' and Anglos' concepts of client and therapist role appropriateness. A questionnaire was administered (in Spanish) to 37 low-income Puerto Rican residents of Chelsea, Massachusetts, and (in English) to a matched sample of 37 Anglos. Hypothetical situations were presented concerning appropriate treatment duration, compliance with medical

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advice, self-disclosure to a therapist, and sources of help for nine mental health problems. Participants responded by selecting from among pre-set responses. All hypotheses were supported. Less acculturated Puerto Ricans equated lack of prompt improvement with failure of treatment; Puerto Ricans were more inclined to disregard expert advice after symptom relief. Puerto Ricans saw the disclosure of intimate information by a female client to a male therapist as unacceptable and peculiar. They saw psychiatrists as appropriate for individual psychopathology problems, but marginally appropriate at best for social-interaction problems. Puerto Ricans valued religious help for all nine mental health problems more than did Anglos. The findings offer strong support for this study's conceptualization of Puerto Rican and Anglo differences in relation to mental health secular experts. The findings help explain Puerto Rican underutilization of, and attrition from, traditional mental health treatment.

This study deals with the question of why Puerto Ricans are less likely to use psychotherapy and other mental health services than Anglo-Americans by examining the fit between the presuppositions of standard psychotherapeutic practices and the characteristics of Puerto Rican traditional culture. A major thesis of the study is that the provision of mental health services is a set of practices within a particular culture and hence embodies the presuppositions of that way of life. To the extent that ways of life differ in practices and presuppositions, what will be seen as appropriate and effective treatment for personal problems will also differ. The identification of such specific differences serves as an important step toward the development and provision of mental health services more adequately tailored to the needs of different cultural groups. This study makes this sort of contribution by identifying differences between Anglo-Americans' and Puerto Ricans' conceptions of appropriate responses to mental health problems and to current modes of mental health service.

REVIEW OF PRIOR RESEARCH

There are relatively few empirical studies that contribute to our understanding of Hispanic Americans' attitudes toward mental health problems and their treatment. Few compare these attitudes with those of Anglos, and most of the relevant studies have focused exclusively on Hispanic Americans of Mexican American descent. The findings of several studies have established that Mexican Americans underutilize mental health services (Jaco, 1959; Karno, 1966; Karno & Edgerton, 1969; Keefe, Padilla & Carlos, 1978; Torrey, 1972) and often drop out of treatment after only a brief number of sessions (Acosta, 1979; Sue, 1977). Keefe (1979) compared those Mexican Americans who have utilized mental health services with those who have not. Using factors that have traditionally been cited as critical to Mexican American underutilization of mental health services such as socioeconomic status, presence of extended family, reliance on alternate sources of support (relatives, "compadres," "curanderos"), commit-

ment to folk medicine systems, and attitudes toward mental health services, she found that none of these factors bore any significant relationship to contact with mental health clinics by the Mexican Americans surveyed. Keefe goes on to suggest that the main reason for the Mexican American's underutilization revolves around his perception of mental illness and its required treatment and recommends that research be conducted to determine if, in fact, Anglo- and Mexican American models of mental illness differ in ways that might explain ethnic differences in clinic use. Indeed, to study "underutilization," cross-cultural studies are especially in order since underutilization is a relative notion that relies on Anglo patterns of utilization as a normative baseline.

Cortese (1979) reviewed studies on Hispanic Americans' responsiveness to psychotherapy. She points out that the few studies in this area (Acosta & Sheehan, 1976; Bergland & Lundquist, 1975; Boulette, 1976; La Calle, 1973; Naun, 1971) when taken together "suggest that intervention methodologies that de-emphasize self-disclosure or client interaction are more effective with Hispanics" (Cortese, 1979, p. 15). However, since only the Acosta and Sheehan study makes inter-ethnic comparison (and these on college students), one cannot reliably conclude from these studies that amount of self disclosure and/or degree of client interaction has differential effects on Anglos' and Hispanics' responsiveness to treatment.

While it is recognized that the Puerto Rican, like the Mexican American, underutilizes mental health services (Mizio, 1978), no studies have systematically addressed the reasons for this underutilization. There have been no studies that compare Anglo and Puerto Rican needs, expectations, and treatment preferences in relation to therapy.

CONCEPTUAL FRAMEWORK

This paper will present a conceptual framework for understanding several aspects of Anglo and Puerto Rican relationships with mental health practitioners. From this framework, certain hypotheses will be derived concerning differences in Puerto Rican and Anglo concepts of client and therapist role appropriateness. The hypotheses have implications for ethnic group differences in rates of utilization, length of stay in treatment, willingness to self-disclose in treatment, and, ultimately, for treatment and service delivery strategies.

Culture usually serves as the orienting matrix within which our relationships are embedded, as a set of givens that connect us to another who shares these givens. When an interaction is cross-cultural, the participants in that interaction are prone not to know what perspective the other has, what allowances to make for one another, or what appropriate choices they have with respect to one another. If the participants in that interaction are therapist and client, the former must understand the givens in the client's culture *enough,* so that he or she is in a position to successfully apply universal principles of behavior change to the

client's problem. Yet to approach the problem by taking culture into account does not replace dealing with individuals. It does, however, give a route of approximation to a new set of individuals.

Current frameworks of therapy indicate what is doable and effective given the antecedent conditions, the givens, of their own home culture. Since there is a general failure to recognize the *inherent* cultural relativity of the effectiveness of *any* one therapeutic procedural framework, a number of problems have resulted:

1. Forms of therapy that are devised for "nontraditional" groups and which do not conform to "standard" therapeutic theory and practice have been seen as exceptions, deviations from appropriate and "real" therapeutic theory and practice; as such, they are relegated to a bastardized status, lacking the respectability and validity provided by a theoretical conceptual framework. This problem is aptly exemplified in the title of Gould's (1967) excellent article: "Dr. Strangeclass: or how I *stopped worrying about theory and began treating* the blue collar worker" (emphasis added). The treatment of these clients is a "theoryless," misfit sort of treatment.

2. Given the lack of a validating conceptual framework for these maverick treatment procedures, the therapist who must implement them in order to treat a low socioeconomic status clientele is prone to view his activity as one that does not really qualify as therapy—but rather more as caretaking, baby-sitting, advice giving, or in any case, something short of "the real thing." It is no surprise, then, that psychiatric residents have tended to view the treatment of these clients with such distaste as boring and as lacking in any value for their training as therapists (Carlson, 1965).

3. The lack of awareness of the cultural relativity of effective procedures raises the likelihood that what the therapist of one culture will count as therapy, the client of another culture will not (i.e., what the therapist proposes to the client may lack face validity and motivational compellingness as something that will help with his problem). In effect, then, the therapist has not provided the client with treatment, and it would not be surprising if the client dropped out after the first visit. The anecdote of the older Mexican American woman who, upon leaving the therapist's office, exclaims, "We had a very nice talk, but he didn't give me any treatment" is all too telling in this respect. Conversely, what may in fact constitute treatment for the client may be anathema to the therapist, in light of his precepts, training, experience, and cultural background.

4. Since cultural factors have not been adequately accounted for in psychotherapeutic theoretical and procedural frameworks, the therapist may tend to attribute his client's failure to participate in the usual practices to pathology or other form of personal inadequacy.

With the adoption of a culturally relative framework for the application of therapeutic procedures, we do not come to view treatments of different groups as "variations from the norm," "deviations," "sources of bias," or "primitive psychiatry." Rather, the relativity that is built in tends to assure a rightful, conceptually valid place of its own for any particular form of therapy that is appropriate for any one particular group.

ANGLO VS. TRADITIONAL PUERTO RICAN CULTURE

A contrast of Anglo-American and folk Puerto Rican world views is called for in order to shed light on the problems in applying traditional psychotherapy to Puerto Ricans. One difference between folk Puerto Rican and Anglo-American cultures that is of potential significance to the effectiveness of psychotherapy is that between a traditional or folk orientation and a technological/industrial orientation. In industrial societies such as that of Anglos, technology and secular expertise occupy central positions as means of problem solving. This problem-solving approach places a high value on *efficiency,* that is, on conditions being optimal for the solution of a target problem. Because of the central importance of efficiency, much room is made in technological/industrial societies for formal, nonpersonal relations between people engaged in joint efforts at problem solving. A team of people operating conjointly like a smooth-running machine is only possible when people are operating in nonpersonal ways. Though this extreme is not always possible or desirable, problem-solvers of Anglo culture clearly tend to lean in this direction. It is not only the Anglo professional secular expert who is prepared to give a place to efficiency-serving, nonpersonal relations. The Anglo worker, as a problem-solver in many diverse roles, understands how to act according to the constraints essential to an efficient mode of problem solving.

The Anglo is ready to apply the nonpersonal problem-solving methods of technology and secular expertise not only to work problems, but to a vast array of concerns—including personal and intimate concerns. Thus, one finds the lay person making use of experts' advice and help with the raising of children, personal development, health maintenance, personal appearance, sexual relations, and so on. Psychotherapy for the solution of personal problems, as a concept and as a practice, arises from this tradition in the use of technology and secular expertise.

The Anglo orientation has been described as emphasizing "mastery over nature" (Kluckhohn & Strodtbeck, 1961). In contrast, Puerto Rican folk culture tends to regard the favorable and unfavorable states of affairs brought by nature as something to be accepted and to be lived with. In this context, religion and the supernatural realm take on special importance. They help provide the mean-

ingfulness needed to withstand unhappy circumstances that are to be lived with. Furthermore, what may not be changed through our own natural powers may be subject to change by appeal to the supernatural. In short, we may say that whereas the Anglo does *about,* the Puerto Rican does *with*. Because of the presence of Anglo technology and secular expertise in Puerto Rico, Puerto Rican folk have become more disposed to utilize certain experts, particularly physicians, as means for solving problems. However, as I shall discuss later, the overall place of technology and secular expertise in folk Puerto Rican life is a peripheral one, and a far cry from the central and practically uncontested position it holds in Anglo life.

Some of the contrast between the cultures has also been articulated as the difference between an emphasis on *doing* and an emphasis on *being* (Spiegel & Papajohn, 1975). The latter emphasis is exemplified in the Puerto Rican's willingness to make ample room in his world for spontaneity and free expression of feelings.

> Tempers fly, laughter rings out, tears flow. One knows where one stands in the feelings of others. Children are freely scolded and punished; they are also freely and effusively loved. No one is expected to control his feelings except before strangers (Papajohn & Spiegel, 1975, p. 47).

The Puerto Ricans' tendency to (1) accept naturally arising states of affairs as something to be lived with and (2) to give high priority to personal expressiveness leaves little reason or opportunity for efficiency-oriented, nonpersonal relationships.

In summary, the Anglo orientation is seen as embodying a technological/industrial orientation, which involves an emphasis on mastery over nature, a high valuation of efficiency, heavy reliance on secular experts, reliance on nonpersonal means of problem solving, and a conception of personal problems as amenable to solution through nonpersonal, professional means. In contrast, the Puerto Rican folk orientation is seen as embodying a naturalistic orientation, which involves an emphasis on accepting what is brought by nature as something to be lived with; low emphasis on efficiency; high emphasis on personal spontaneity and expressiveness and the personal relationships that allow for these; and little reason to believe that personal matters could belong in anything other than a personal relationship.

Like any cultural orientation, the Anglo and Puerto Rican orientations each carry points of vulnerability, that is, they lend themselves readily to particular and characteristic ways of going wrong. The Anglo emphasis on efficiency and on problem-solving instrumental activity, on "doing about," has as a liability the prospect of self-alienation. For to objectify what is personally natural, to the extent that it involves taking an observer's or critic's standpoint, tends to reduce ordinary participation in what is natural from an actor's standpoint. One thinks in

this connection of the person living according to "how to" books, of the person taking a concerted problem-solving instrumental posture at the expense of awareness and solidarity with the inner life, and of the "organization man." It is not surprising, given this problem, that helpers in Anglo culture have strived to generate more recognition, acceptance, and participation in natural processes, to encourage clients to "let things happen" and to not try to be in control of it all.

The Puerto Rican emphasis on personal expressiveness and on "doing with," has as liabilities the prospect of losing control over personal feelings and impulses, and of failing to strive for solutions to problems out of a sense of self-defeating hopelessness. Given this context, it is not surprising that the indigenous Puerto Rican helper has strived to generate in their clients more action toward problem solving and more hopefulness (as that which comes from having the supernatural forces of God and spirits on your side). One may detect a rough reversal between the Anglo and Puerto Rican strengths and points of vulnerability. That is, what one culture tends to lack, the other tends to have an excess of, and vice versa.

ANGLO VS. PUERTO RICAN RELATIONSHIP WITH MENTAL HEALTH SERVICES

Because the concept and practice of current psychotherapy arises out of the cultural traditions of Anglo life, one could expect problems in applying it to Puerto Ricans. First, it should be noted that the practice of psychotherapy requires that two individuals, a particular sort of secular expert and his client, engage in a professional relationship with the objective of solving the personal problems of the client. In spite of the fact that they are dealing with personal, subjective, or even intimate matters of the client, and that both may experience personal feelings toward one another, the relationship ultimately operates with the constraints of a nonpersonal, professional one. The fact that the relationship is nonpersonal increases the efficiency of the problem-solving endeavor, as at least one of the participants is committed to maintaining an objective stance, while offering perspectives and/or recommendations on the personal, subjective affairs of the client.

It has been noted here that the Puerto Rican makes far less place for efficiency-serving, nonpersonal relations than does the Anglo as a way of dealing with problems at large. Given this tendency, one could only expect that the Puerto Rican would be especially reluctant to deal with his personal, subjective, intimate problematic affairs by way of the interpersonal context of a nonpersonal relationship. That he be so inclined need not be seen as peculiar or as calling for an explanation. By tautology, personal matters belong in a personal relationship. It is placing such matters in a nonpersonal relationship that calls for an explanation.

Secondly, the Puerto Rican has less acquaintance with secular expertise in general than does the Anglo. He has less faith in the promise of secular experts and less reason to expect rewards out of the instrumental activities recommended or required by secular experts. His stance vis-à-vis secular experts may be like that of the man from Missouri—"Show me."

A number of specific issues arise from these and other important basic differences between Puerto Ricans and Anglos, regarding their orientation toward secular experts and toward nonpersonal, efficiency-oriented relationships. Because the Puerto Rican has less a priori faith in secular experts than the Anglo, one could expect that for the psychotherapist to gain the faith and participation of the Puerto Rican, the therapist would be more heavily required to demonstrate his efficacy when dealing with a Puerto Rican than when dealing with an Anglo. The latter, with his a priori faith in secular expertise and technology, does not require early demonstrations or proofs and is more willing to give the benefit of the doubt to the expert. The following hypothesis is in line with this expectation.

HYPOTHESIS 1. *Puerto Rican subjects are more likely than Anglo subjects to believe that one should quit treatment if relief is not achieved early in treatment.*

Given the traditional Anglo way-of-life reliance on secular experts, one can expect the Anglo to monitor basic health through secular expertise, to seek expert advice on health even though he may be unsymptomatic (e.g., yearly check-ups, reading on health maintenance practices, etc.). The Puerto Rican, on the other hand, would be more likely to accept his basic health as a natural state of affairs and to seek expert advice only if distressingly symptomatic. Because the Puerto Rican is not as oriented toward living by secular expert advice as the Anglo, the following hypothesis is made.

HYPOTHESIS 2. *Puerto Rican subjects will be less likely than Anglo subjects to see a need to continue receiving treatment and heeding expert advice after symptom relief has been achieved, even though a secular expert may have directed them to do so.*

Because the Anglo is more apt to accept that the domain of secular expertise extends over personal, human matters than is the Puerto Rican, one may expect the Anglo more easily to reveal intimate aspects of his life to a secular expert than the Puerto Rican.

HYPOTHESIS 3. *Puerto Rican subjects are more likely than Anglo subjects to regard personal revelation to a secular expert as ill-fitting, strange, alien and inappropriate—in effect, to re-*

gard a relationship which blends nonpersonal and personal elements as a peculiarly faulty personal *relationship.*

It may follow, incidentally, that the Puerto Rican who does share intimate matters with a secular expert is more likely to take it that he has established a personal relationship than is the Anglo who has shared such matters with an expert.

Some Hispanic minorities have been reported to have a priori faith in psychiatrists (Edgerton & Karno, 1969). This seems to be the case with Puerto Ricans as well. However, there is reason to believe that such faith in psychiatrists stems from the belief that psychiatrists are primarily *medical* specialists administering treatment through primarily organic, medicinal means. One should note in this connection that the physician is one secular expert who has gained the faith of the Puerto Rican, because the physician has ample opportunity to demonstrate his beneficiality quickly and effectively, as with analgesics and tranquilizers. Furthermore, the physician puts somatic, not personal, matters under the realm of technology and secular expertise, hence his authority is more acceptable to the Puerto Rican. Since Puerto Ricans may tend to view the phenomenological discomfort of "nerves" and "mental problems" as originating from physical, organic bases, the following hypothesis is made:

Hypothesis 4. *Puerto Rican subjects will tend to conceive of the psychiatrist's role as appropriate only for problems that are formulated in terms of individual psychopathology and not for problems formulated in social-interactional terms; in contrast, Anglo subjects will tend to see the psychiatrist as appropriate for both sorts of problems.*

METHOD

Sample

Forty Puerto Ricans and forty Anglo-Americans living within six square blocks of an ethnically mixed poverty area in Chelsea, Massachusetts, were interviewed in their residences. The participation of subjects was solicited from households which were selected on a random basis within the designated area. The Puerto Rican sample was obtained first so that an Anglo sample matching in age, sex, and income level could then be sought.

The Interview

An interview questionnaire was administered in either Spanish or English (depending on the group to which the subject belonged), by interviewers of the

same culture group as the subject. Each question was presented simultaneously in oral and written form. Two persons other than the experimenter who are proficient in both languages reviewed and revised both versions of the questionnaire to ensure the accuracy of the translation.

The interviewer recorded each subject's gender, age, level of education, religious practices, and the income of the head of the household. The interviewer asked the Puerto Rican subjects to rate their proficiency in speaking, reading, and writing the English language. The interview was divided into five sections. (See Torres [Note 2] for complete information.)

Section I. To assess the tendency to terminate therapy if improvement did not develop quickly, the following vignette was presented and participants selected one of two alternatives:

> A woman has been quite nervous and depressed and went to see the psychiatrist. She has been seeing him weekly. She has seen him now five times (that is, for five weeks), and she continues to feel poorly.

With which of these two opinions are you in more agreement?

a. She hasn't seen him enough times yet to realistically expect to be cured already.

b. Looks like he doesn't really know how to help her. Maybe she should stop seeing him or begin looking for another one.

Section II. To assess the tendency to continue to comply with a secular expert's advice[1] after his treatment has generated symptom relief, subjects were questioned about the following vignette:

> Suppose that you feel poorly and that you go see the doctor. The doctor examines you and seems to understand what your complaint is all about. He gives you some medicine and tells you to take it for fifteen days. You start taking the medicine and find that after four or five days of taking it, you feel well again.

Subjects answered the following questions, "What would you do?" "What do you think most other people around here would do?" and "What should one do?" by choosing between (1) "take the medication only for the five days that it took to cure," and (2) "take the medication for the whole fifteen days."

Section III. The interviewer presented a description of a relationship between a therapist and a female client. For half of the subjects of each group the therapist was designated to be a counselor, referred to on a first name basis; for the other half a psychiatrist, referred to as "Doctor." The description of the interaction follows:

A woman has been feeling quite nervous and depressed and has had many problems in her love life. Because of these problems she has been seeing a counselor [or psychiatrist] whose name is Paul Ryan [José Rivera in Spanish version; psychiatrist referred to as Doctor Ryan in English version, unnamed in Spanish and referred to merely as 'el siquiatra']. The more she speaks with him, the more trust she gains in him. Accordingly, she has begun to speak to him quite openly about her life's problems. She speaks to him frequently about problems that she is having in the intimate and private areas of her life. She has wept several times in front of him and has begun to feel free to show him many of her personal feelings. Sometimes she even becomes angry with him and lets him know of it. But later they speak of what angered her, she gets over it and things go on. Paul [or José, Dr. Ryan, or el Doctor] listens to her attentively and understandingly and speaks to her about the problems that she brings up. It's been several months now that they meet weekly in order to talk about her life, her intimate problems, her needs, and her feelings.

The interviewer then obtained the subject's opinion of what had been described by presenting the following questions:

From what you see here, do you think that

a. what is happening is to be expected when a person goes to see a counselor [or psychiatrist]?
b. what is happening is good for her?
c. it's good that she speaks with Paul [or José, or Dr. Ryan or el Doctor] about problems in the initimate area of her life?
d. she is making correct use of her visits with the counselor [or psychiatrist]?
e. what is happening is strange?

To each of these questions, the subjects responded according to the following rating scale:

Yes, I am sure of it.	I am not sure but I think so.	I am not sure but I don't think so.	___ No, surely not.

Section IV. The interviewer presented ten different personal problems, five formulated in individual psychopathology terms, three in social-interactional terms, and two miscellaneous problems, a sexual dysfunction and a somatic problem. The titles of the ten problems are, in order of their presentation to the subjects, Ineffective Disciplinarian, Psychogenic Ills, Violent Temper, Anxiety Attack, Abused Woman, Depression, Cognitive Confusion, Family in Strife, Sexual Dysfunction, and Somatic Symptoms. Examples of individual psychopathology and social-interactional problems, respectively, are the following:

Anxiety Attack. A person has been suffering from certain panic attacks which the person doesn't understand. Suddenly this person feels much nervousness and fear and begins to shake. The person doesn't know why this is happening.

Abused Woman. A woman has been married three times. All of the men she has married have been drinkers and have been very jealous and very violent. Presently, she's married to a man who beats her frequently and who has a mistress on the side.

The titles that are assigned here to each problem were not made available to the subjects.

After presenting each problem, the interviewer presented a constant set of various sorts of responses to problems. The set of response alternatives consisted of (a) keep it a secret, (b) put up with it, (c) see a doctor, (d) see a psychiatrist, (e) see a counselor, (f) take care of the problem by yourself without seeking help from anyone else, (g) appeal to God/Religion, (h) see a psychic or a medium (''espiritista'' for Puerto Rican subjects), and (i) go to a family relative for help. The subject was asked to rate how appropriate each response alternative was as a way of contending with the problem presented. These appropriateness ratings were made by asking the subject to indicate whether a given response alternative was ''ideally appropriate,'' ''very appropriate,'' ''somewhat appropriate,'' or ''not appropriate'' as a way of contending with the mentioned problem. Any time that the subject indicated that a response alternative was ''not appropriate'' for a particular problem, the interviewer asked the subject whether or not the inappropriate response would have harmful effects if it were used to contend with that problem.

RESULTS

Sample

When three participants from each group were dropped, the gender and age distributions of the groups were well matched. The mean age of each group was 32.5 for Anglos and 34.2 for Puerto Ricans; ages ranged from 20 to 59 and the spread of the age distributions was similar; the proportion of men was 43.3% for Anglos, and 48.7% for Puerto Ricans. Both groups were heavily weighted, though not closely matched, in the low-income category—38% of Anglos and 66.6% of Puerto Ricans had incomes under $8,000 a year per head of household; 38.3% of Anglos had incomes between $15,000 and $23,000 a year, but no Puerto Ricans reported incomes within this range.

To test for possible confounding effects resulting from the lack of a close match in income levels, (a) correlations were run between the independent variable of Anglo income level and all Anglo dependent variables, (b) chi-squares were run comparing the responses of those Anglos who matched and those who did not match the Puerto Ricans on income level, and (c) multiple regressions that included the independent variable of income were run on Anglo dependent variables. None of these analyses yielded any significant relationship between Anglo income levels and pattern of response. It should also be noted that Anglo income did not correlate with any other independent variables, such as education, sex, age, religion, and so on. These results provide sufficient assurance that any differences in the groups' responses are not confounded by the apparent mismatch of income levels.

Two and seven-tenths percent of Anglos and 56.7% of Puerto Ricans had dropped out of school by the seventh grade; 32.4% of Anglos and 86.4% of Puerto Ricans had not completed high school. These sample differences in educational level reflect the educational level differences of low socioeconomic status Puerto Ricans and Anglos at large (Mizio, 1978).

Given that (1) the Puerto Rican sample is predominantly poor, (2) the responses of the Anglo sample are consistent with those of poor Anglos, (3) the two samples live in the same six-square block, economically depressed urban area, (4) the two groups match closely in age and sex distributions, and (5) the educational level differences of the samples reflect the educational differences of the Anglo and Puerto Rican populations, the samples seem to provide an adequate basis for comparing the attitudes of low-income Anglos and Puerto Ricans.

Other relevant descriptors of the groups pertain to religion and English language proficiency. Whereas 94.6 of Puerto Ricans claimed to practice religion, 59.5 of Anglos did so. The English-speaking proficiency of the Puerto Rican group, as derived from each subject's rating of his own proficiency, was "good" 16.2%, "considerable" 16.2%, "little" 37.9% and "none", 29.7%.

Predictions

It was predicted that Puerto Ricans would be more likely to terminate therapy than Anglos if no improvements were made after five visits. Only 32% of the Anglos would terminate in this case, but 48.6% of the Puerto Ricans, X^2 (1) = 1.40, $p < .12$, would do so. When the more Anglo-acculturated Puerto Ricans were deleted (by dropping the 12 Puerto Ricans who had "considerable" or "good" English-speaking proficiency), then the pattern predicted was found. Sixty percent of the Puerto Ricans would terminate vs. 32% of the Anglos, (X^2 (1) = 3.56, $p < .05$). A multiple regression performed on the Puerto Rican sample (before deleting for Anglo-acculturation) found that the factors of Puerto Rican income and English language proficiency reached a multiple r of .69 (r square = .48), F (3, 19) = 5.85, $p < .01$, with the tendency to quit treatment if early improvement was not achieved.

The prediction that Puerto Ricans would be more likely than Anglos to not comply with medical advice after symptom relief had been achieved, was met. Whereas 17.6% of Anglos would choose noncompliance with the advice in this circumstance, 64.7% of Puerto Ricans would choose noncompliance, X^2 (1) = 12.8, $p < .001$. Interestingly, when Puerto Ricans were asked what course of action they *should* choose, only 33.3% said that they should choose noncompliance. Indeed, the discrepancy between the option that Puerto Ricans said they *would* choose versus the option they felt they *should* choose was significant, X^2 (1) = 10.9, $p < .001$. No such discrepancy was found within the Anglo group.

It was predicted that the Puerto Ricans would be less likely than Anglos to

agree with the notions (a) that the depicted therapist-client interaction represents what is to be expected in such a situation, and (b) that the interaction is good for the client; (c) that it is good that she speaks with the therapist about problems in the intimate areas of her life, and (d) that the client is making correct use of her sessions with the therapist. It was also predicted that the Puerto Ricans would be more likely than Anglos to agree with the notion (e) that the depicted interaction is strange. Three of the predictions were met in the full Puerto Rican sample. All of these predictions were met after deleting the more Anglo-acculturated Puerto Ricans. Ninety percent of Anglos vs. 60% of unacculturated Puerto Ricans, X^2 (1) = 5.7, $p < .01$, saw the interaction as "what is to be expected." This prediction was also met without deleting for Anglo-acculturation, X^2 (1) = 3.9, $p < .05$. Ninety percent of Anglos vs. 64% of unacculturated Puerto Ricans, X^2 (1) = 4.29, $p < .05$, saw the interaction as being "good for the client." Ninety-two percent of Anglos vs. 52% of unacculturated Puerto Ricans, X^2 (1) = 10.9, $p < .001$, saw it as "good that the client talk about intimacies with the therapist." This prediction was also met without deleting for Anglo-acculturation, X^2 (1) = 7.64%, $p < .01$. Eighty-three and eight-tenths percent vs. 56% of unacculturated Puerto Ricans, X^2 (1) = 4.5, $p < .05$, saw the client as making "correct" use of her sessions. Only 5.4% of Anglos vs. 56.7% of unacculturated Puerto Ricans, X^2 (1) = 11.18, $p < .001$, saw the interaction as "strange." This prediction was also met without deleting for Anglo-acculturation, X^2 (1) = 8.36, $p < .01$.

Several findings suggest factors that may be predictive of Puerto Rican and Anglo clients' willingness to put personal matters within the reach of the secular expert therapist through personal self-disclosure. In the Puerto Rican group, approval of talking to a therapist about personal matters correlated positively with prior use of mental health services ($r = .42$, $p < .01$) and with English-speaking proficiency ($r = .48$, $p = < .01$), for a multiple of r of .59 (r square = .35), F (2,20) = 5.27, $p < .05$). In the Anglo group, older age and male sex correlated negatively ($r = -.52$, $p < .001$, $r = .34$, $p < .05$, respectively) with agreeing with the above proposition, for a multiple r of .60 (r square = .36), F (2, 17) = 4.82, $p < .05$.

Other relevant findings were that, for the full Puerto Rican sample, agreement with the proposition that the relationship was "good for" the client correlated negatively with frequency of church attendance ($r = -.31$, $p < .05$) and positively with educational level ($r = .31$, $p < .05$). Agreement with the proposition that the relationship represented a "correct" use of the therapist had a .40 correlation ($p < .01$) with education. Agreeing that the relationship was "strange" correlated negatively with education ($r = -.40$, $p < .01$) and with English-speaking proficiency ($r = -.35$, $p < .01$). It is noteworthy that no significant correlations were found between the Anglo sample's agreement with these propositions and any of the independent variables, suggesting uniformity of attitudes within the Anglo group.

To test for several of the following predictions, the appropriateness ratings of Section 4 of the interview were assigned the following numerical values: Ideal = 1, Very Appropriate = 2, Slightly Appropriate = 3, Inappropriate but not Harmful = 4 and Inappropriate and Harmful = 5. A subject was counted as having rated a response to a problem as "generally appropriate" for a given category of problems if the mean appropriateness rating he gave that alternative as a response to those problems was 2.5 or lower; "generally inappropriate" if the mean rating was higher than 2.5.

It was predicted that Puerto Ricans would tend to rate the psychiatrist as appropriate for individual psychopathology problems more than they would for social-interactional problems, that Anglos would tend to rate the psychiatrist as not differentially appropriate for social-interactional and individual psychopathology problems, and that Anglos would see the psychiatrist as "generally appropriate" for both sorts of problems. All three predictions were met. Whereas 72.9% of Puerto Ricans rated the psychiatrist as an appropriate helper for individual psychopathology problems, only 37.8% of the Puerto Ricans rated the psychiatrist as appropriate for social-interactional problems, X^2 (1) = 3.04, $p < .05$. As predicted, no significant difference was found between Anglos' ratings of the appropriateness of the psychiatrist for individual psychopathology vs. social-interactional problems, with 97.3% rating the psychiatrist as appropriate for individual psychopathology problems and 73% rating the psychiatrist as appropriate for social-interactional problems, X^2 (1) = 0.28, $p < .60$. And, as predicted, Anglos' mean appropriateness ratings of the psychiatrist as a helper for individual psychopathology problems (M = 1.68) and social-interactional problems (M = 2.17) both fell well within the "generally appropriate" range.

It was predicted that for each of the three social-interactional problems Anglos would give higher appropriateness ratings to the psychiatrist than would the Puerto Ricans. The prediction was met with respect to the social-interactional problem "Ineffective Disciplinarian." Anglos' mean rating of the psychiatrist's appropriateness as a helper for this problem approximated "Very Appropriate" (2.3), whereas Puerto Ricans' mean rating approximated "Slightly Appropriate" (2.8), t (72) = 2.25, $p < .05$. For the problem of the "Abused Woman," the prediction was met, with Anglos rating the psychiatrist as better than "Very Appropriate" (1.9), Puerto Ricans rating him as worse than "Slightly Appropriate" (3.2), t (72) = 5.9, $p < .001$. The prediction was also met with respect to "Family in Strife," with the Anglo rating approximating "Very Appropriate" (2.3), the Puerto Rican approximating "Slightly Appropriate" (2.8), t (72) = 1.67, $p < .05$.

One may note from Table 1 that Anglos give significantly higher appropriateness ratings to the psychiatrist than do the Puerto Ricans, not only with respect to the three social-interactional problems noted above, but also in relation to the problems "Psychogenic Ills," "Violent Temper," "Depression," and "Sexual Dysfunction."

Table 1

Comparison of Anglo and Puerto Rican Appropriateness Ratings for Each Alternative Response to Each Problem

		Problems									
		Ineff. Disc.	*Psychogenic Ills*	*Violent Temper*	*Anx. Attack*	*Abused Woman*	*Depression*	*Cogn. Confusion*	*Family in Strife*	*Sexual Dysf.*	*Somatic Symptoms*
Alternatives	*Groups*	*M*	*M*	*M*	*M*	*M*	*M*	*M*	*M*	*M*	*M*
Put Up	P.R.	3.9**	4.2**	4.3***	4.4**	3.4***	4.3***	4.4**	4.4**	4.3*	4.8
	Anglo	4.7	4.9	4.9	4.9	4.9	4.9	4.9	4.9	4.8	4.9
Secret	P.R.	4.2***	4.4**	4.3***	4.6*	3.8***	4.3***	4.5	4.5	4.4	4.9
	Anglo	4.9	4.9	4.9	4.9	4.8	4.9	4.7	4.6	4.4	4.9
Alone	P.R.	3.2***	3.6***	2.7***	4.1	2.5***	3.2***	4.1*	2.8***	4.1	4.4
	Anglo	4.1	4.5	4.4	4.4	4.4	4.7	4.6	4.3	4.1	4.7
Family	P.R.	2.8	2.5*	2.6*	2.8	3.1	2.4	2.6	2.8	3.0	3.1
	Anglo	2.8	2.9	3.1	3.1	2.6*	2.7	3.0	3.0	3.1	3.5
God/Religion	P.R.	2.0***	2.2**	2.2***	2.3***	2.2**	2.1*	2.3***	2.2**	2.9*	2.7***
	Anglo	3.2	3.0	3.1	3.3	2.9	2.6	3.3	2.9	3.5	3.9
Counselor	P.R.	2.0	2.1	1.9	2.5	2.2	2.0	2.3	1.8	2.4	2.7***
	Anglo	2.0	2.4	2.1	2.7	1.8	2.2	2.4	1.5	2.3	3.8
Psychiatrist	P.R.	2.8	2.2	2.4	2.4	3.2	2.4	1.9	2.8	2.7	3.5
	Anglo	2.3*	1.3***	1.5***	1.9	1.9***	1.4***	2.3	2.3*	2.1*	3.2
Physician	P.R.	2.9	2.3	2.5	1.5	3.5	2.7	1.6	3.3	1.1***	1.1
	Anglo	2.9	2.5	2.5	1.5	2.8***	2.4	1.9	3.2	1.6	1.1
Psychic	P.R.	4.8	4.8	4.8	4.8	4.8	4.9	4.8	4.6	4.6	4.8
	Anglo	4.4*	4.6	4.3**	4.4*	4.4*	4.4*	4.4*	4.5	4.4	4.7

Note: The lower the numerical value, the higher the appropriateness rating: 1 = Ideal; 2 = Very Appropriate; 3 = Slightly Appropriate; 4 = Inappropriate but Not Harmful; 5 = Inappropriate and Harmful.

*$p < .05$; **$p < .01$; ***$p < .001$.

It was predicted that for the social-interactional problems, Puerto Ricans would give higher appropriateness ratings to the counselor than to the psychiatrist. The prediction was met with respect to "Ineffective Disciplinarian," t (36) = 5.82, $p < .001$, "Family in Strife," t (36) = 4.46, $p < .001$, and "Abused Woman," t (36) = 5.82, $p < .001$. In addition, Puerto Ricans gave the counselor significantly higher appropriateness ratings than the psychiatrist with respect to "Violent Temper" and "Somatic Symptoms." (One may find on Table 1 the mean appropriateness ratings for each response alternative in relation to each problem). In contrast, Anglos rated the counselor as more appropriate than the psychiatrist for only one of the problems presented, "Family in Strife," t (36) = 3.6, $p < .001$.

Table 2 compares the ratings given to the psychiatrist and the counselor, per problem, per group. One may easily note the greater tendency of the Puerto Rican group to rate the counselor as equally or more appropriate than the psychiatrist as a helper for the problems.

As predicted, Puerto Ricans gave higher appropriateness ratings than did Anglos to Religion/God as a response alternative for each social-interactional problem. "Ineffective Disciplinarian," t (72) = 4.4., $p < .001$, "Abused Woman," t (72) = 2.88, $p < .01$, and "Family in Strife," t (72) = 2.88, p

Table 2
Within-Group Ratings:
Counselors vs. Psychiatrists as Appropriate Caretakers for Different Problems

	Problems for which . . .		
Groups	*Counselor was rated significantly more appropriate than Psychiatrist*	*Counselor was rated as appropriate as the Psychiatrist*	*Psychiatrist was rated significantly more appropriate than Counselor*
Puerto Ricans	Ineff. Disc.*** Abused Woman*** Family in Strife*** Violent Temper* Somatic Symptoms***	Psychogenic Ills Anxiety Attack Depression Cogn. Confusion Sexual Dysfunction	
Anglos	Family in Strife***	Ineff. Disc. Abused Woman Cogn. Confusion Sexual Dysfunction	Psychogenic Ills*** Violent Temper*** Anxiety Attack*** Depression*** Somatic Symptoms***

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

$< .01$. However, as one may see on Table 1, Puerto Ricans gave higher appropriateness ratings than Anglos to Religion/God for every other problem as well.

Table 3 compares the ratings given to the psychiatrist and Religion/God, per problem, per ethnic group. One may note that whereas Anglos rated the psychiatrist as more appropriate than Religion/God for contending with each and every one of the problems, the Puerto Ricans rated Religion/God as more appropriate than the psychiatrist for the three social-interactional problems and for Somatic Symptoms, and equally appropriate as the psychiatrist for the remaining problems.

It was predicted that Puerto Ricans would give higher appropriateness ratings than would Anglos to the alternative of putting up with and resigning oneself to the problem (Put Up With It) as a response to each social-interactional problem. This prediction was met for all three problems, "Ineffective Disciplinarian," t (72) = 3.04, $p < .01$, "Abused Woman," t (72) = 5.88, $p < .001$, and "Family in Strife," t (72) = 2.74, $p < .01$. See Table 1 for the mean appropri-

Table 3
Within-Group Ratings:
Religion/God vs. Psychiatrist as Appropriate Responses to Different Problems

	Problems for which . .		
Groups	*Religion/God was rated significantly more appropriate than Psychiatrist*	*Religion/God was rated as appropriate as the Psychiatrist*	*Psychiatrist was rated significantly more appropriate than Religion/God*
Puerto Ricans	Ineff. Disc.** Abused Woman*** Family in Strife* Somatic Symptoms***	Psychogenic Ills Violent Temper Anxiety Attack Depression Cogn. Confusion Sexual Dysfunction	
Anglos			Ineff. Disc.*** Psychogenic Ills*** Violent Temper*** Anxiety Attack*** Abused Woman*** Depression*** Cogn. Confusion*** Family in Strife* Sexual Dysfunction*** Somatic Symptoms***

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

ateness ratings obtained from each group, and note the especially large disparity between the means of each group on Put Up With It as a response to the predicament in "Abused Woman."

No predictions were made as to how Puerto Ricans and Anglos would compare in appropriateness ratings to the response alternatives of Keep It a Secret, Do It Alone, Psychic, and Seek Help of Family Relatives as helping responses to each of the problems. From Table 1, one may see what differences were found between Puerto Ricans and Anglos in their ratings of these response alternatives as ways of coping with each of the problems.

DISCUSSION

To test for the possibility that some Puerto Rican subjects' acculturation to Anglo way of life was obscuring the differences between Puerto Rican and Anglo response tendencies on given comparisons, those Puerto Ricans judged to be more acculturated were eliminated from those comparisons. Degree of English language proficiency was used as the indicator for acculturation. The rationale for this procedure was based on findings from a previous study by the author (Torres, Note 1). In that study, English-speaking proficiency was the only factor among several (including length of mainland residency, age, education, gender) that correlated with a tendency on the part of Puerto Rican subjects to veer away from the dominant Puerto Rican pattern of response to illness and misfortune, and to express a preference for the dominant Anglo pattern of response to such circumstances. It should be noted that the elimination of the presumably more acculturated Puerto Ricans reduced that sample by nearly one-third and that the remaining acculturation-corrected sample was not matched with the Anglo sample. The correction for acculturation consistently yielded response patterns that were more heavily weighted in the expected Puerto Rican direction than those obtained from the uncorrected Puerto Rican sample. Since only a small portion of the between-group comparisons called for the acculturation correction, the results discussed in this section will be based on the full, uncorrected sample comparisons unless specified otherwise.

The findings of this study yield strong evidence for culturally bound differences between Anglos' and Puerto Ricans' relationships with secular mental health experts. The findings summarized below help explain Puerto Ricans' lower utilization of and higher attrition from traditional mental health services compared to Anglos.

1. Puerto Ricans are more inclined than Anglos to discontinue treatment and disregard expert health advice as soon as symptom relief has been achieved.

2. The less acculturated Puerto Ricans are more likely than Anglos to judge that treatment has been ineffective and should be abandoned if improvement has not been achieved within the first five weekly sessions.

3. Puerto Ricans are more inclined than Anglos to view a female client's emotionally involved relationship with a male therapist as an unexpected, unhealthy, and strange use of a therapist.

4. Puerto Ricans do not see psychiatric services as appropriate sources of help for the social-interactional problems or the male sexual dysfunction problem presented here, whereas Anglos do.

5. Puerto Ricans see the psychiatrist as a less appropriate source of help for all nine mental health problems presented than do Anglos.

6. Puerto Ricans see five of the nine problems as more appropriately helped by a counselor than by a psychiatrist; in contrast, Anglos see but one problem as more appropriately helped in this way.

7. Puerto Ricans see all nine problems as either more appropriately helped, or just as appropriately helped, by Religion/God than by a psychiatrist, whereas Anglos see all nine problems as more appropriately helped by a psychiatrist than by Religion/God.

8. Puerto Ricans see putting up with all of the problems, being secretive with six of the problems, and contending alone without anyone's help with seven of the problems, as less inappropriate and less harmful than do Anglos.

Each of these findings has heuristic value for developing more effective treatment and service delivery practices for Puerto Ricans. The finding that the unacculturated Puerto Rican is more prepared than the Anglo to view five sessions of nonameliorative treatment as evidence of therapist failure and ineffectiveness suggests that the Puerto Rican has less a priori faith in the psychiatrist than does the Anglo. This lesser faith is also suggested by the finding that Puerto Ricans see the psychiatrist as less appropriate a helper for mental health problems than do Anglos. Indeed, the Puerto Rican stance toward a secular expert such as a psychiatrist may be in effect like that of the man from Missouri: "Show me." These findings suggest that to gain the faith and participation of the Puerto Rican, the therapist is more heavily required, than he is with Anglos, to demonstrate his powers to make a beneficial difference soon after initiating treatment. The multiple regression on Puerto Ricans' responses to the five nonameliorative sessions vignette suggests that the therapist should be especially alert to the need for quickly making a beneficial difference when the Puerto Rican patient is in the lowest income categories and speaks little or no English.

The findings indicate that Puerto Ricans may tend to discontinue treatment when improvement is not quickly achieved, but also, just as soon as improvement is achieved. Thus, even if the therapist succeeds in gaining the faith and participation of the Puerto Rican client by establishing his ability quickly to bring about improvement, the duration of therapy is likely to be brief, and it behooves the therapist to orient his therapeutic interventions accordingly.

It is interesting to note that those same Puerto Ricans who explicitly acknowledge that they would discontinue compliance with expert health advice after that advice has led to symptom relief, also tend to express the belief that they *should* continue to comply with that advice. The apparent conflict may rest on the dilemma that, whereas on the one hand the Puerto Rican may hold secular experts as authorities to be respected (and complied with), the Puerto Rican may also see such experts' advice as irrelevant and uncalled for when things are well enough. Thus, if things appear to be well enough and the secular expert is out of sight, the Puerto Rican will give the expert, and his advice, the wave of the hand. An understanding of such cultural factors could ease the bewilderment of clinicians who regularly encounter Puerto Rican clients who, while in the presence of the expert voice no argument against and seemingly accept a directive of the clinician (such as an appointment for a subsequent meeting beyond the point of symptom relief), yet simply do not comply with the presumed agreement.

With respect to the content and tenor of discussion between therapist and client, the findings give strong support to the notion that Puerto Ricans are far less ready than Anglos to see personal, intimate matters as a fitting and appropriate subject for extensive discussion between a female client and a male therapist. Indeed, the difference in Anglos' and Puerto Ricans' ratings of the depicted client-therapist relationship were sharpest when it came to judging whether it was good for the client to be speaking about personal intimacies to the therapist.

Because the Puerto Rican is less likely than the Anglo to have personal matters put under the nonpersonal domain of secular expertise, a Puerto Rican who develops personal feelings toward a therapist (as may happen after personal self-disclosure), would be more likely to take it that a personal relationship has been established. The traditional therapist's expectation that the client reveal and explore personal, even intimate matters *without* the context of a personal relationship would, as the findings suggest, be strange and inappropriate, even unhealthy, to the Puerto Rican client. Indeed, given that the Puerto Rican does not see personal matters as belonging in a nonpersonal framework, the kind of relationship which the traditional therapist proposes would stand out to the Puerto Rican as a peculiarly faulty, indian-giving invitation to a personal relationship: "Talk to me about your personal situations, show me your personal feelings, but let's not *be* personal." It should not be surprising if an ordinarily gregarious and expressive Puerto Rican lapses into silence once in the room with a therapist.

The correlations between independent variables and each group's ratings of the depicted client-therapist relationship suggest that personal self-disclosure and display of personal feelings to a therapist would tend to be most unacceptable to Puerto Ricans of lower education, lower English-speaking poficiency, and high frequency of church attendance; and to Anglos in the older age groups and of male gender.

The findings with respect to Puerto Ricans' and Anglos' assessments of appropriate sources of help for various sorts of problems suggest particular health service delivery strategies for Puerto Ricans.

As may be seen from Table 2, Puerto Ricans and Anglos differ markedly in the relative ratings of appropriateness which they ascribe to counselor and psychiatrist as helpers for various problems. Whereas Anglos tend to prefer the psychiatrist over the counselor, the reverse appears to be the case with Puerto Ricans. It appears to this writer that those problems which Puerto Ricans see as being more appropriately cared for by a counselor than by a psychiatrist—Ineffective Disciplinarian, Abused Woman, Family in Strife, Violent Temper and Somatic Symptoms—may be problems that Puerto Ricans do not regard as being of a "psychiatric," "mental," or "nervous" sort. If this is in fact the case, they are likely to regard "psychiatric" help for these problems as unwarranted and possibly stigmatizing as well. For social-interactional problems, Puerto Ricans would seem to prefer helpers with whom a more informal and personal relationship can *appropriately* be established. A same-sex counselor who can make home visits, help a mother develop more effective discipline strategies through counsel and demonstration, and establish a relatively informal, relaxed alliance that allows for discussion of other problems may instantiate this sort of helper.

The findings indicate that for Puerto Ricans, religious avenues of help compete with and often win out over the psychiatric ones in relevance and appropriateness for contending with all of the problems presented; in contrast, for Anglos, religion and God consistently lose to the psychiatrist in their appropriateness as help for the problems. Thus, it seems that secular mental health services should explore the value and viability of establishing cooperative relationships with nonsecular, religious helping sources, as a way of providing improved, culturally accessible mental health services to the Puerto Rican population.

Compared to other alternative responses to the problems, "Put Up," "Secret," and "Alone" generally received, from both groups, appropriateness ratings that were at the lower range of appropriateness values. However, in between-group comparisons, Puerto Ricans show greater readiness than Anglos to respond with resignation to, and tolerance for, the particular unhappy states of affairs found in all of the mental health problems presented; a greater readiness than Anglos to contend with most of the problems secretly and alone, without seeking anyone's help. These particular Puerto Rican tendencies underscore the need for mental health delivery systems to take the initiative to actively reach out to Puerto Rican communities with services that are in a culturally accessible format.

The especially sharp differences between the groups on their ratings of "Put Up" as a response to the problem "Abused Woman" warrant discussion. The Puerto Ricans' appropriateness ratings for "Put Up" as a response to the problem "Abused Woman" had a mean of 3.4, which falls between "Somewhat Appropriate" and "Inappropriate but not Harmful." In contrast, the Anglo mean was 4.9, which is as close as any mean appropriateness rating gets to "Inappropriate and Harmful." These findings suggest that Puerto Ricans (irre-

spective of sex), are considerably more ambivalent than Anglos about the appropriateness of a woman tolerating or not tolerating abusive behavior from a husband.

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NOTE

1. A medical secular expert was chosen because this is one expert who is familiar to Puerto Ricans and recognized as valid.

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