Chapter 3
Eliminating Disparities Through Integrated Behavioral and Primary Care: Special Considerations for Working with Puerto Ricans

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According to the latest US census estimate, Hispanics represent the largest minority, with 17.1% of the total estimated population for 2013. Recognizing the diversity within the Hispanic population of the United States in modern times is an important step when integrated behavioral and primary care services are provided. Thus, one important aspect is the recognition of the within-group differences in the Hispanic population and other minority groups. One example is the Puerto Rican population, which has a very particular sociopolitical and biopsychosocial background that should be taken into consideration when quality health services are provided. It is important to recognize these differences because knowledge of the history and worldview of the Puerto Rican population regarding issues of health, disease, health-seeking behaviors, and interaction with health providers among other topics will make it easier for the teams of health professionals to bring better services to the patients being served. This aspect includes the importance of prevention, assessment, and treatment of disease and the development of a professional relationship between the interprofessional/interdisciplinary teams and this population.

General Description of Puerto Ricans

Puerto Ricans are an important group within the growing Hispanic population in the United States because between 2000 and 2010 their number grew by 43 % from 3.4 million to 4.6 million. Although they share some common characteristics with other Latinos, Puerto Ricans are can be distinguished clearly from other Latinos. This diversity could be attributed to differences in cultural and historical backgrounds and how they have assimilated into the mainstream society (Ramos, 2005).

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L.T. Benuto, W. O'Donohue (eds.), *Enhancing Behavioral Health in Latino Populations*, DOI 10.1007/978-3-319-42533-7_3

According to Ramos (2005), Puerto Ricans tend to migrate in circulatory patterns in a back-and-forth movement between the island and the continental United States, as a result of economic factors, including employment conditions in both places. The importance of recognizing, discussing, and teaching the diversity of the Hispanic population results in a better understanding of the four largest Hispanic groups in the United States—Mexican Americans, Puerto Ricans, Cuban Americans, and Dominicans—and their particular characteristics and needs will promote the importance of personalizing health services and reducing the misconceptions and stereotypes that could be factors that hinder the process of seeking health services at all levels.

A 2013 report by the Pew Research Center on the results of the American Community Survey conducted in 2011 by the US Census Bureau with the Puerto Rican community in the United States presents a revealing portrait (Brown & Patten, 2013). An estimated 4.9 million Hispanics (9.5 %) are of Puerto Rican origin and thus are ranked as the second-largest population of Hispanics living in the United States, after the Mexicans, who account for 64.6 %, according to the US Census Bureau's American Community Survey (Brown & Patten, 2013). According to the American Community Survey, their median age is 27 years, well below the average of 37 years for the total population. They are less likely to be married than Hispanics in general, 36 % versus 44 %, among all Hispanics, and they have higher levels of education than the overall Hispanic population, with 16 % older than 25 years having obtained a bachelor's degree. More than 80 % of those aged 5 years or older speak English proficiently. The poverty rate among Puerto Ricans is 27 %, which is higher than both the overall Hispanic rate and the general US rate (25 % and 15 % respectively.) Only 38 % of Puerto Ricans are homeowners, less than the rate for Hispanics overall (47 %) and for the general US population (65 %). Voter turnout among Puerto Ricans was up 3.1 % in 2012 from 2008, with 52.8 % voting, above the 48 % rate for the overall Hispanic population eligible to vote in the United States. Most Puerto Ricans in the United States—3.4 million in all—were born in the 50 states or the District of Columbia. Additionally, about one third (31 %) of the Puerto Rican population in the United States—1.5 million—were born in Puerto Rico. People born in Puerto Rico are also considered native born because they are US citizens by birth (Brown & Patten, 2013).

Moreover, according to the American Community Survey, more than eight in ten Puerto Ricans (82 %) aged 5 years or older speak English proficiently. The other 18 % report speaking English less than very well, compared with 34 % of all Hispanics. Puerto Ricans are concentrated in the Northeast (53 %), mostly in New York (23 %), and in the South (30 %), mostly in Florida (18 %). Puerto Ricans have higher levels of education than the Hispanic population overall but lower levels than the US population overall. Some 16 % of Puerto Ricans aged 25 years or older compared with 13 % of all US Hispanics and 29 % of the US population have obtained at least a bachelor's degree. According to the American Community Survey, Hispanics of Puerto Rican origin aged 16 years or older in the United States had median annual personal earnings of $25,000 in the year before the survey—greater than the median earnings for all US Hispanics

($20,000) but less than the median earnings for the US population ($29,000). The share of Puerto Ricans who live in poverty, 28 %, is higher than the rate both for the general US population (16 %) and for Hispanics overall (26 %). Fifteen percent of Puerto Ricans do not have health insurance, compared with 30 % of all Hispanics and 15 % of the general US population (Brown & Patten, 2013).

A study by Rivera-Batiz and Santiago indicates that Puerto Ricans born on the mainland are improving their economic status, although a significant proportion (30 %) of mainland Puerto Ricans remain in poverty. It is not surprising that the group with the highest rate of psychological distress and disorders is the poorest segment of the population regardless of where they reside as the Puerto Rican mental health profile resembles that of the general US population. Loss of cultural identity is a prominent issue related to Puerto Rican mental health (Flores, 1993). Decades of efforts to Americanize Puerto Rico have taken their toll on the sense of cultural autonomy Puerto Ricans experience relative to other Latino groups, who draw renewal from relatively intact home cultures. The development of a "Nuyorican" culture, although a vibrant force on the mainland, has led to discrimination when migrants return to Puerto Rico to live. The high rates of circular migration have created a subpopulation that is "neither here nor there." Although the implications of these issues are difficult to document in terms of specific mental health outcomes, they provide an important context for understanding the Puerto Rican migrant experience in comparison with that of other Latino immigrants.

Health Service Use and Health Disparities Among Puerto Ricans

Puerto Ricans are relatively high users of health services, particularly the general medical sector (Martinez, Interian, & Guarnaccia, 2013). Access to a widespread public health system in Puerto Rico and eligibility for health benefits and federal health programs on the mainland make financial access issues less of a barrier than for other Latinos. Given the high use of the medical sector both in Puerto Rico and on the mainland, recognition of mental health problems by primary care providers is a significant issue. Recognition of the expressions of *nervios* and *ataque de nervios* as important signs of psychological distress among many Spanish-speaking Puerto Ricans, especially those from working class and poor backgrounds, can contribute to recognition of psychosocial problems in primary care. At the same time, there are not simple translations of these idioms of distress into psychiatric diagnoses; rather they cut across a range of distress and disorders requiring careful assessment of both the symptoms and the contexts of the experience (Martinez et al., 2013). These representations of symptoms have been recognized lately as cultural manifestations in the DSM-5.

Both Espiritismo and Santeria continue to flourish in Latino neighborhoods of New York City. Their presence is more variable in smaller cities in the northeast, where Puerto Ricans have spread. Epidemiological studies with Puerto Ricans (Guarnaccia et al., 2005) report that the use of these alternatives to traditional medi-

cine appears to be more frequent when Puerto ricans seek assistance with their mental health problems. Better educated Puerto Ricans have done well economically and adjusting to the American society mainstream and rely less on folk alternatives while less educated rely more on these alternatives when seeking mental health assistance. Although the role of the Catholic and newer protestant churches, including their clergy and layorganizations, in support of people in psychological distress has been less studied (Guarnaccia et al., 2005), it is equally important as the folk sector.

Puerto Ricans despite being US citizens still experience high levels of discrimination. On arrival many are treated as a foreigner for having a different language and culture. Thus, they have to navigate new and menacing environments, including the health system. Some of their cultural values, such as family values, gender role, and assumption of mental health, have their roots in their Puerto Rican culture and heritage, which often clash with those of mainstream society. Thus, they face the possibility of not achieving full acculturation. At the same time, because of the circulatory nature of the migration of Puerto Ricans mentioned before, some elements of the Puerto Rican culture remain very active as they face the challenges of a very traumatic acculturation experience (Ramos, 2005). From an ecological perspective, acculturation occurs as individuals socialized in one cultural context try to adjust to a different cultural milieu to improve the person–environment fit. This process of adaptation could be conceptualized as very fluid oriented to action and change instead of adjustment to the status quo (Ramos, 2005). For individuals with a separate distinct culture, acculturation can be a source of stress in a society that is strongly influenced by a mainstream culture. Stressors stemming from, for example, language differences and conflicting cultural values disrupt the person–environment fit and, depending on an individual's coping resources, may result in an increased risk of psychological distress. Puerto Ricans who traditionally learn to rely on the family and community and are rewarded for respectful, less assertive behavior may experience conflict and anxiety in a society that discourages passivity and promotes independence and individualism (Martinez et al., 2013). Minority status can inhibit the ability to adjust freely and successfully to the new environment and negotiate mismatches in value systems.

Rates of Behavioral Health Problems Among Latinos and Puerto Ricans

As discussed already, Puerto Ricans have a lower educational and economic status on average. Thus, Puerto Rican children and adults are at a higher risk of mental health problems than other Latino groups, such as Cuban Americans, given their lower educational and economic resources. Puerto Rican Americans reported more sick days due to health disability, more days spent in bed, and more hospitalizations than did Mexican Americans and Cuban Americans, according to Hajat (2000), who conducted interviews in English and Spanish of a nationally representative sample.

Another set of epidemiological studies using diagnostic measures found that Puerto Ricans who reside in Puerto Rico had lower prevalence rates of depression and other mental health disorders than did Mexican Americans who were born in the United States, Mexican immigrants had who lived in the United States for 13 years or more, or Puerto Ricans who lived on the mainland. This consistent pattern of findings across independent investigations, different sites, and Latino subgroups suggests that factors associated with daily living in the United States lead to an increased risk of mental disorders. Some authors have interpreted these findings as suggesting that acculturation may lead to an increased risk of mental disorders. One limitation of this type of research is that the relationship between acculturation and prevalence has never been tested to show that these rates are indeed related. At best, the place of birth and the number of years living in the United States are proxy measures of acculturation. Moreover, acculturation is a complex process; it is not clear what aspect or aspects of acculturation could be related to higher rates of disorders. Is it the changing cultural values and practices, the stressors associated with such changes, or negative encounters with American institutions (e.g., schools or employers) that underlie some of the different prevalence rates.

Lewis-Fernandez et al. examined the clinical risk factors for major depression in US Hispanics in a meta-analysis of previous research on the topic. They noticed that this research has grown significantly during the past two decades. Moreover, Ortega completed an analysis of the National Comorbidity Study and concluded that even after age, income, and education had been controlled for, US-born Hispanics had a significantly higher risk of psychiatric disorder than foreign-born Hispanics. A significant association was observed among separate analyses of Puerto Ricans, Mexican Americans, and other Hispanics. In addition, a comparative study of Puerto Ricans living in poor residential areas in Puerto Rico and New York City revealed similar levels of clinically significant self-reported depressive symptoms in each group. Comparatively, high levels of depressive symptoms were found among Puerto Ricans living in Puerto Rico (29.1 %) and Puerto Ricans living in New York City (28.6 %). These findings suggest that we should not overgeneralize that acculturation increases the risk of depression and suggest a need to examine in greater detail cultural differences between and within Hispanic subgroups and evaluate cultural variation across self-report and structured research interviews of depression.

Although it remains unclear why Puerto Ricans living in the United States have higher rates of mental health problems than other Latinos, researchers have suggested several possible explanations. Research has indicated that the relatively low socioeconomic status of Puerto Ricans could contribute to the risk of worse mental health outcomes (Guarnaccia et al., 2005). According to Sanchez et al., another possible explanation that researchers have postulated for the relatively poor health outcomes for Puerto Ricans is related to the circular migration patterns of Puerto Ricans because of their status as US citizens. In particular, some studies have suggested that many Puerto Ricans come to the United States for treatment of medical problems (Guarnaccia et al., 2005). If that is the case, it might prove useful to examine the

comorbidity between mental health problems and physical health problems, which might help researchers understand this pattern. These factors assist us in making better and informed clinical diagnoses and recommendations when working with the Spanish-speaking Puerto Rican population in primary care settings.

Significant Prejudices Experienced by Puerto Ricans and the Behavioral Health Impact

One important aspect of the prejudices that Puerto Ricans living in the United States experience daily could be categorized as multifactorial and thought provoking. This is because this cultural group is not as homogeneous as many would like to think, as will be explained next. Since 1917 Puerto Ricans have been US citizens through the Jones–Shafroth Act, and the opportunities they have to travel, live, and work freely on the US mainland are derived from the rights of being a United States citizen. However, this citizenship is guaranteed only as long as the US Congress determines it so. The US Congress has the power to change laws and in this respect the Jones–Shafroth Act is not dissimilar from other laws. Despite this, Puerto Ricans have to clarify their legal status and even when it has been clarified still receive different social services, in contrast to their Caucasian counterparts.

The main language spoken in Puerto Rico is Spanish and less than half of the population of Puerto Rico is fluent in English. The language barrier when Puerto Ricans are in the United States as a result of migration and/or living on the mainland but not being acculturated or assimilated impacts the mobility of the group in mainstream society (Guarnaccia et al., 2005). According to the Pew Research Center (Brown & Patten, 2013), in the United States more than 82 % of Puerto Ricans aged 5 years or older speak English proficiently. The other 18 % report speaking English not proficiently, which is lower of the 34 % for the rest of the Hispanics (Brown & Patten, 2013). Language fluency is an important factor that could positively or negatively impact most Puerto Ricans in their mobility through North American society, and at the same time this impacts the process of receiving medical and/or mental health services that help reduce the health disparities experienced by the group. Urciuoli (1996) describes how racism and prejudice operate for Puerto Ricans in “English-only America.” Urla describes how Urciuoli (1996) in her book describes how the mainstream society’s discourse points out that Puerto Ricans speak “bad” or broken English and that if they get rid of their “accent” they will be able to move to mainstream society with all the economic and sociopolitical benefits that represent being part of the “American dream.” However, working class, low-income Puerto Ricans who do not speak the language, face exclusion in many aspects, including access to better social services, increasing as a consequence health disparities. The limited number of health providers both in the medical realm and in the mental health realm that speak Spanish and are culturally competent often impacts the active participation of Puerto Ricans in the dynamic of health-seeking behaviors and adhering to treatment.

Another factor is the lack of health insurance because of the nonexistence of provision of insurance by employers of Latinos (Guarnaccia et al., 2005). There is also discrimination against Latinos in mental health services. According to Guarnaccia et al. (2005), this discrimination results from both racial and cultural bias. Although there is more evidence of discrimination for medical conditions (Institute of Medicine, 2002), it is likely these factors operate in the mental health sector as well. Prejudice can also be exhibited by health providers by their having negative attitudes toward minority populations with mental health issues. This could be noticeable by service providers' communication of negative, hopeless, and stigmatizing messages that define people solely by their illness or illness labels (Nemec, Swarbrick, & Legere, 2015). "Microaggression" is a term used by Sue et al. (2007) in the study of cross-cultural communication. According to Deegan (2004), microaggressions tend to be invisible, yet the cumulative effect creates unmistakable tensions between people. For Reidy (1993), patronizing phrases such as "my client," a condescending tone of voice, and dehumanizing language are frequently cited as examples of prejudice. It is for this reason that the most promising approaches for stigma reduction are education and contact (Corrigan, Mueser, Bond, Drake, & Solomon, 2008). The best recommendation to reduce the stigma and prejudice from service provision to minority patients with mental health issues according to Nemec et al. (2015) is the following: education of care staff to guide and shape the work of direct care staff by teaching monitoring, evaluating, and correcting communication skills that express prejudice and discrimination. Teaching and training settings can be structured according to the Nemec et al. to convey a message of hope and recovery rather than focusing on the person served in negative terms, as belligerent, resistant, unmotivated, or disinterested. It is important to model positive and respectful attitudes by use of person-first and culturally sensitive language by the sharing of examples of multidimensional people with strengths, successes, and multiple roles, not just illustrations of illness, failure, and risk. Contact with the population seems to improve attitudes and behavioral intentions toward people with mental illness(es) (Corrigan, Morris, Michaels, Rafacz, & Rüsch, 2012). The influence of the service system impacts the provision of services and perpetuates the stigma toward minorities with mental health issues. For this reason, it is important to change the culture by instilling a sense of hope and optimism by the sharing of achievements and not only the negative aspects of the different interventions (Nemec et al., 2015). Although the system cannot be changed instantly, it is important to have training programs for students, health professionals, and service staff directed at making them aware of the cultural issues experience by the different minority population. Nemec and associates (2015) also proposed that more opportunities to interact with the patients of minority populations need to be provided to service staffs to make them more sensitive to these populations' needs and problems.

Other Stressors Associated with Acculturation

Although acculturation can be stressful for both sexes, Puerto Rican males and females may need to face different types of stressors, specifically, stressors that are the result of having to adapt to the new gender roles and family structure as defined by the new mainstream society. For example, adherence to traditional gender roles in a mainstream society that does not value such roles as machismo can be conflictive and burdensome. Women may also experience role strain as they try to fulfill expected idealized roles of wife and mother while simultaneously working outside the home and adapting to a society with a different set of values and expected roles for women. For traditional men, stressors may relate to role reversal, especially when they are not able to be the main source of income or cannot bring any income at all, which is not unusual given the limited access to employment of many Puerto Ricans in the United States. Ethnic discrimination is associated with poorer mental and physical health, worse health behaviors, and increased mortality, in addition to overall health disparities (Martinez et al., 2013). More specifically, it has been suggested as a possible determinant of the significant race/ethnic differences in the quantity and quality of medical care received by individuals in the United States.

Given the growing diversity in the United States and the prevalence of discrimination, more research regarding the impact on health care utilization is needed. Only when all the factors influencing patient behaviors are better understood will policies and interventions designed to improve them be successful. These are important steps that will help us achieve our national goal of eliminating race/ethnic disparities in health (Schenker et al., 2010) Health disparities need to be diminished in minorities, and the adherence factor is essential to improve their quality of life. Schenker et al. (2010) studied how limitations in English proficiency and concordance between the patient's language and the physician's language negatively impact the treatment of patients with diabetes. They point out the importance of assessing the association of limited English proficiency and physician language concordance with patient reports of clinical interactions is that the provision of services in the native language requires to be improved. Quality and performance assessments should consider physician–patient language concordance.

Nevertheless, Hispanic Americans are the ethnic group least likely to have health insurance coverage, and one third lack a regular source of primary health care Andrés-Hyman, Ortiz, Añez, Paris, and Davidson (2006). Reversing the tide of health disparities for US Hispanics will entail redressing socioeconomic barriers to treatment and improving access, engagement, and therapeutic strategies that operate within specific cultural contexts (Andrés-Hyman et al. 2006). Baig et al. (2014) designed a study that assessed the relationship between community health center providers' Spanish language skills and cultural awareness. They found that providers that saw a significant number of Latinos had good access to interpreter services but that did not have any formal cultural competency training. It is for this reason that Spanish language skills training and better access to cultural competency training with Latinos are needed to provide more effective linguistically and culturally tailored medical care to Latino patients.

According to Ho et al. (2006), more studies are warranted to examine if the acculturated lifestyle, quality of health services, access to health care, and effectiveness in controlling diabetes and its complications are factors associated with the poor health status of mainland Puerto Ricans. This inquiry could be extended to other medical conditions as well as to the provision of mental health services. It is for this reason that we should be aware of the studies available and their findings to help understand the different factors that impact and could impact the provision of primary care services to Puerto Ricans in the United States. For example, Andrés-Hyman et al. (2006) proposed a model where cultural concepts were analyzed from an ecological perspective. They offer practical recommendations that follow from a model based on the specific cultural beliefs of the patients. Although not comprehensive, these recommendations do offer specific approaches for the provision of health services that are consistent with the understanding of Puerto Ricans in their context and consistent with their heritage. This model considers information related not only to the history, value systems, and psychosocial stressors of each patient, but also to the needs of providers and thus demonstrates an appreciation of the patient's and the provider's whole context (Andrés-Hyman et al., 2006).

The literature suggests that treatment of native Spanish-speaking Latinos by bilingual providers is preferable (Comas-Diaz, 1988), even for bilingual clients. As Schyve has reported, the Joint Commission has stated that there are three threats to effective health communication. The health service providers have called this set of threats the "triple threat" to effective health communication; namely, low health literacy, cultural barriers, and limited English proficiency. However, health literacy has often been seen apart from interventions designed to overcome cultural and linguistic barriers. Thus, researchers such as Hahn et al. and DeWalt et al. are working to understand the relationship between health culture, literacy, and language and health outcomes. Despite mastery of a second language, a bilingual client may find that certain feelings or emotions are difficult or impossible to adequately convey in a language other than his or her native tongue. This incompatibility may ensue because emotions are anchored to the first language learned as a child (Guttfreund, 1990), and many words and concepts do not exist or have the same meaning in different languages. In recognition of these issues, many behavioral health agencies have employed bilingual interpreters to translate information. However, several authors have raised misgivings about confidentiality, client discomfort, and the potentially negative impact of third parties on the therapeutic alliance (Altarriba & Santiago-Rivera, 1994; Rivera et al., 2011; Schwartz, Rodríguez, Santiago-Rivera, Arredondo, & Field, 2010). Clients validated these concerns during focus groups, characterizing the use of interpreters in other programs as "no good" (Altarriba & Santiago-Rivera, 1994; Rivera et al., 2011; Schwartz et al., 2010). Moreover, even with interpreters who are carefully selected and trained, information distortion may occur because of differences in dialect and the challenge of matching a client's words with their intended meaning in another language (Altarriba & Santiago-Rivera, 1994; Rivera et al., 2011). Whereas words with concrete referents are easily translated, words that describe abstract concepts (e.g., emotions) are not as readily interpreted (Rivera et al., 2011). Bilingual providers may also be better able to address issues associated

with code switching, or reverting to speaking a second language when describing an upsetting event, ostensibly to acquire psychological distance from threatening emotions. Code switching has been proposed as a treatment method to recognize forms of avoidance and to approach difficult topics (Altarriba & Santiago-Rivera, 1994; Andrés-Hyman et al., 2006; Rivera et al., 2011). Therefore, it is crucial that health practitioners familiarize themselves with the cultural values of the Puerto Rican population and other Latino groups.

Puerto Rican Cultural Elements (*Marianismo*, *Familismo*, etc.) and Their Relation to Behavioral Health

The importance of recognizing the importance of cultural elements and/or values in the provision of services in behavioral health and/or in the health-seeking behaviors of individuals provides opportunities to approach the Puerto Rican population from a more culturally competent and culturally sensitive perspective. According to Guarnaccia et al. (2005), examples are the recognition of the idioms/culturally bound syndrome of *nervios* and *ataque de nervios*. Importance should also be given to both Espiritismo and Santeria, and to the role of the Catholic and newer Protestants churches, their clergy, and lay organizations in support of people with psychological distress. Another important aspect within the religion/Espiritismo aspects of religion are that many patients prefer to go first to their religious leaders/community rather than the mental health providers because of the stigma that still permeates the Puerto Rican community seeking help for mental health issues. Given the high use of the medical sector both in Puerto Rico and on the mainland, recognition of mental health problems by primary care providers is a significant issue (Guarnaccia et al. 2005).

Regarding the cultural element of machismo and *marianismo* it is important and relevant to bring it into the process of recruiting Puerto Ricans to behavioral health services by working on eliminating the stigma of men receiving mental health services and not wanting to be seen as "weak" or less of a man and, in addition, by allowing them the space and opportunity to recognize the existence of more adaptive options of masculinity. In regard to the element of *marianismo*, the inclusion of this element provides the opportunity to discuss it and help reduce the pressure of being "perfect" and not vulnerable despite the different stressors of their daily lives. Dignity and respect are important elements to include in the provision of services as a way to retain patients. Providing services in Spanish and recognizing the importance of cultural traditions and nuances could make a difference when mental health services are engaging with patients and increase their sense of trust and will impact adherence. One example of these types of inclusion in treatment would be the recognition of cultural expressions, celebrations of cultural holidays, and cultural beliefs when working with the Puerto Rican population (Andrés-Hyman et al., 2006). Another important aspect is to provide information regarding treatment and the condition/s in the preferred language. The same applies to the labels on the

medications. Finally, the inclusion of the element/value of *familismo* is a key factor to engage with, work with, and promote a respectful relationship with patients and their loved ones. Engagement of family members with the patient's authorization in the treatment helps to develop a sense of teamwork that resonates in attendance at appointments, communication with openness to discuss health issues and questions, and adherence to treatment protocols.

By recognizing the importance of the previously mentioned aspects, providers will be able to deliver more culturally sensitive and competent services to the Puerto Rican community taking into consideration the particular characteristics, in addition to not looking at this group as a stereotype but as a group with a lot of diversity from within and as a very important part of the "American collage." The extension of this knowledge to health-related issues for services cannot be the exception.

It is important to not generalize that all Latinos have the same values and in that way perpetuate ethnic stereotypes. Therefore, each value related to Latino values and especially to Puerto Ricans is discussed in the following sections

Dignidad y Respeto (Dignity and Respect)

"Dignity" (honor) and "respect" refer to a cultural value that underscores a reverence for all forms of life, particularly the intrinsic worth of humanity. Accordingly, irrespective of status or wealth, all people merit respect. Respect is also closely associated with a hierarchy of deference in which elders and parents are at the pinnacle (Andrés-Hyman et al., 2006). By convention, youth defers to age, children to parents, women to men, employees to employers, laypeople to experts, and so forth. However, *respeto* promotes "equality, empathy, and connection" in every relationship, even within those perceived as hierarchical (Torres, Solberg, & Carlstrom, 2002, p. 166). The tenets of *respeto* are reinforced through the use of proverbs (*dichos*), which are moral and life lessons recounted in everyday conversation as well as in the instruction of children (Andrés-Hyman et al., 2006).

Beliefs in the intrinsic merit of humanity may be a protective factor and a source of strength. Individuals may avoid discussing problems that compromise dignity. Dissent may be communicated indirectly (e.g., nod as if in tacit agreement). Individuals may seek the provider's advice and recommendations because of her or his professional status. Even if someone does not personally ascribe to the tenets of *respeto*, early learning experiences and enduring cultural expectations may be consonant with these values, and others may anticipate adherence to these mores.

You should attend to the physical environment to communicate respect for the culture (e.g., Hispanic artwork, Spanish reading material, bilingual phone reception), use a formal address before broaching the subject of a person's preferred address, engage in a measured exploration of problems to safeguard dignity, avoid asking personal questions before establishing trust (*confianza*), and explore treatment expectations and offer your view of your role in the helping relationship.

Dignidad y Respeto in Practice

Language barriers were overcome by offering services and forms in Spanish. In addition, the recruitment and retention of bilingual and bicultural staff served to convey esteem and an agency-wide investment in the language and traditions of clients. Bicultural providers also often used *dichos* in their work remind clients of *las condiciones madres* (conditions of the motherland) or of shared cultural experiences and commonly held truths. Admiration of the richness of Hispanic cultural traditions was also communicated through the observance of traditional holidays (e.g., Epiphany) that included the elements of family and community, typical dishes and music, and saying grace before dinner.

Familismo (Family Values and the Value of the Family)

Familismo is an all-centric cultural value related to stressing the centrality of family attachments, reciprocity, and loyalty to family members beyond the boundaries of the nuclear family (Martinez et al., 2013). Allocentrism is a "cultural value by which people understand themselves through others, emphasizing social relationships and highlighting group goals rather than individual ones" (La Roche, 2002, p. 116). Traditionally, the bounds of the family extend far beyond the nuclear family to include extended relatives and close family friends who are assimilated into the family as godparents, conferring an elevated role in the family system somewhat akin to co-parenthood (i.e., *compadrazco*). Families tend to be emotionally close (Comas-Diaz, 1988) and often live together in the same households or neighborhoods and function interdependently. Members of a family may strengthen their bonds by visiting and/or talking with each other daily, celebrating life cycle milestones together (e.g., anniversaries), and proffering financial support and gifts (Falicov, 2005).

Personalismo

Personalismo refers to preferring to relate to others in a personal manner instead of a formal manner. Among the many cultural manifestations of *personalismo* is the permeability of Hispanic households. Relatives and friends commonly drop by one another's homes unannounced for informal conversation. Another implication for social etiquette involves the form of greetings. The most ubiquitous greeting among women is a quick kiss on the cheek and an embrace; among men, a handshake or a pat on the shoulder or back; and among mixed pairs possibly an embrace or kiss. Irrespective of gender, however, physical touch is used more often by Puerto Ricans than Euro-Americans as a sign of warmth and a more personal relationship by the same token, the appropriate physical proximity during a normal conversation for

Puerto Ricans is much closer than for Euro-Americans. Thus, the use of appropriate touch (e.g., handshake) in a greeting or to bid farewell is consistent with the value of personalismo. Thus, it is recommended to introduce clients to new providers when care is being transferred (e.g., from triage).

Moreover, children and parents may continue to have a profound interdependence into adulthood. Immigration and/or family separation may be linked to behavioral health problems, and failure to send money to the family may be a disgrace (Falicov, 2005). Individuals may avoid or feel guilty about disparaging the family in conversation. Professional assistance may be sought as a last resort (after the family or clergy). Parents may leave children with grandparents as they establish financial stability in the United States (Falicov, 2005; La Roche, 2002). If the person is in accord, family members should be integrated into the treatment and the family's troubles (e.g., immigration) should be attended to if these are a priority. Family narratives and photos should be elicited to enhance rapport (La Roche, 2002). The family's treatment expectations, level of adherence to traditional values, and support of recovery goals should be explored. Family problems should be framed constructively to temper guilt about disclosure.

Machismo

Popular lore and the academic literature describe a largely negative and stereotypic conceptualization of Latino machismo, typified by controlling behavior toward women and children, promiscuity, alcohol abuse, stoicism, and aggression (Torres et al., 2002). However, this represents a pathological extension of masculinity observed across ethnicities and cultures, including among Euro-American men, rather than an accurate characterization of a genuine Latino cultural phenomenon (Torres et al., 2002).

Masculinity and gender roles in Puerto Rican culture are alive and well. Despite the stereotype of machismo in Puerto Rican culture both on the island and on the mainland, the cultural value of machismo and gender roles regarding the role of men in society has been evolving. The rapid changes in modern society, women's role in the working world, and gender–role ambiguity among other factors have impacted the "traditional perception" of what machismo is. Traditionally, according to Torres (1998), researchers have focused on the negative connotation of machismo as dominance, aggression, patriarchy, authoritarianism, and oppressive behavior toward women and children, failing to recognize the positive aspects such as emphasis on self-respect and on responsibility for protecting and providing for the family, patience, sensitivity, artistic appreciation, and open verbal communication that exist within the Puerto Rican culture. It is for this reason that Torres (1998) emphasizes the fact that the dominant culture does not permit Latino men to explore adaptive options of masculinity. For example, according to Torres et al., (2002) women's new role as self-sufficient breadwinners impacts their traditional sense of masculinity, but the question for us will be what can they do to change this

schema? The schema could be changed by the emphasizing of the positive aspects of being a *machista* (i.e., self-assertiveness) and by the presenting of emotional aspects of themselves. For Gil and Vasquez (1996) the adjustment to the male role also includes a change in the vision of *marianismo*, another cultural value that emphasizes the moral and spiritual superiority of women. At the same time this includes adjustment to changing gender roles in the Puerto Rican family and to the constructs of machismo and *marianismo* and its impact on the different levels of acculturation. Doyle (1983) described that the mainland's societal criteria for manhood are intensified by the psychological stress and role strains stemming from immigration, acculturation, racism, and poverty. According to Torres (1998), one way to address the changes regarding "the new way of doing things" is the adoption of an ecosystemic orientation that takes into account multiple elements such as cultural, linguistic, educational, economic, gender, political, and environmental context engaging the positive aspects of machismo, and other cultural values such as *respeto* and *dignidad*. Another aspect worth mentioning is empowerment of men by facilitative approaches by the societal systems such as providing psychoeducational groups for men and culturally competent providers that emphasize the importance of change for men without diminishing their sense of self but empower them by facilitating their adaptation to healthier roles in their personal and social lives. As a consequence this will impact different areas of their lives, including health-seeking behaviors.

Marianismo

Marianismo, which is rooted in the Roman Catholic adoration of the Virgin Mary, refers to the traditional cultural prescriptive assigned to women. Accordingly, unmarried women are expected to remain chaste before marriage, and the onus for remaining virginal and for transmitting religious and cultural traditions to succeeding generations rests with women. Moreover, women can achieve a higher status of spiritual achievement with motherhood than men and consequently enjoy a commensurate amount of power (Comas-Diaz, 1988). On the other hand, Madonna mothers are expected to embody the virtues of selflessness and to endure suffering with dignity. This value leads to aspirations of humility and kindness and the transmission of norms (for both sexes) to treat others with kindness and display sympathy for others' feelings (i.e., value of *simpatía*; Andrés-Hyman et al., 2006). The pathological extension of *marianismo* is that a woman may become submissive, or a perception of martyrdom may engender conflict with her US-born children.

Religion and Spirituality

Faith, rooted in Roman Catholicism, is generally the cornerstone of Hispanic life (Andrés-Hyman et al., 2006). The rituals of the indigenous peoples of the Americas and of Africans transported to Hispaniola during the slave trade are also evident in the contemporary practices of spiritism and folk healing. In the Hispanic Caribbean, two main forms of spiritism exist: Espiritismo (Mesa Blanca) and Santeria (the worship of saints). As a whole, spiritists attribute problems to either spiritual or material causes, or stated differently, those requiring spiritual or medical intercession, and turn to indigenous healers (*espiritistas* or *santeros*) for aid with problems with spiritual origins, such as being afflicted with and tormented by bad spirits (Andrés-Hyman et al., 2006; Berthold, 1989). Women may avoid appointments that conflict with spending time with their family. Sex may be an improper or private subject, particularly with male providers. Substance abuse may cause or exacerbate feelings of worthlessness. Women may view acceptance of problems and/or suffering as obligatory and proper and hesitate to complain about problems or loved ones. Goals should be framed in line with personal narratives (e.g., helping a mother to assist her family). One should inquire about a potential preference for a woman provider. The level o adherence to traditional gender norms should be explored. Intimate topics should be explored tentatively. One should inquire about a woman's relationship with her family, particularly her children. Socioeconomic concerns should be considered when operating hours are being devised.

Although spiritism is practiced by only a small subset of Puerto Ricans, the belief that the individuals "destiny is at the mercy of God is prevalent across the Spanish-speaking world and is evident in widespread references to God's Will" (Andrés-Hyman et al., 2006; Falicov, 2005). The importance of spirituality and religion in Puerto Rican culture is demonstrated in the structure of the New Life Program of Connecticut: a faith-based agency, composed of a cooperative of churches, formed one arm of the tripartite project. In addition, community spiritual leaders were invited to join advisory boards and other important decision-making bodies. Through these collaborations, a spiritual component was incorporated into each program event.

Culturally Adapted, Tailored Treatment Versus Standard Treatment of Puerto Rican Patients in Primary Care

Culturally competent practices may have a profound impact on treatment access, adherence, and outcomes. These recommendations are intended to serve as a resource for improving the quality of behavioral health care for Puerto Ricans through the use of approaches that are compatible with commonly held cultural values. Additional research is required to examine the effectiveness of these approaches through the use of clinical trials (Sue, 2003). The importance of incorporating a cross-cultural interview in primary medicine has been related to a patient's perception of the illness and any alternative therapies he or she is

undergoing and facilitates the development of a mutually acceptable treatment plan (Juckett, 2005, 2013). According to Juckett (2005, 2013), patients should understand instructions from their physicians and be able to repeat them in their own words. Potential cultural conflicts between a physician and a patient include differing attitudes toward time, personal space, eye contact, body language, and even what is important in life.

In addition, many patients use home remedies or traditional healers before seeking conventional medical treatment (Juckett, 2005, 2013). Others return to traditional healers instead of completing an ongoing conventional treatment. Juckett (2005, 2013) reports that the healing traditions of Latinos, including Puerto Ricans, are rich and culturally meaningful but can affect management of chronic medical and psychiatric conditions. For this reason it is important to know the different traditional healing practices and their meanings given by patients and their families. Patients may lose confidence in their physicians if they do not receive prompt, culturally comprehensible treatment. Thus, the practitioner needs to know which non-traditional healing techniques the patient is using and if possible use them complementarily. Efforts directed toward instituting more culturally relevant health care enrich the physician–patient relationship and improve patient rapport, adherence, and outcomes. Clinical success often depends on communicating with these healers and prioritizing tests and treatments (Juckett, 2005, 2013).

Puerto Ricans in comparison with other cultural groups have physical health problems with the worst, or nearly the worst, rates for many diseases when compared with other race and ethnic groups. For example, heart disease rates are 20 % higher for Puerto Ricans than for any other Hispanic group. Also, studies that have used these same data have reported higher levels of overweight and comparable hypertension rates among Puerto Ricans (especially women) than Cubans and Mexican Americans. The rates of mental health problems are no different. It is for this reason that the development of culturally adapted tailored treatments plays an important role in the engagement and process of contacting, engaging, and maintaining adherence in the provision of health services independently if they are for physical or mental conditions or both. Culturally adapted treatments are defined as health care interventions that are tailored to patients' norms, beliefs, and values, as well as to their language and literacy skills. This specific type of care may incorporate language or music preferences, or may delve more deeply into cultural considerations such as social, psychological, and economic factors. Examples of culturally adapted care include matching specialists to patients by race or ethnicity; adapting patient materials to reflect patients' culture, language, or literacy skills; offering education via community-based health advocates; incorporating norms about faith, food, family, or self-image into patient care; and implementing patient involvement strategies.

Kohn-Wood and Hooper provide recommendations for mental health care providers working in primary care settings, while keeping in mind racial/ethnic disparities in mental health, and sustainable solutions to provide culturally tailored solutions. According to these authors, the clinical mental health care providers (psychiatrists, mental health counselors, psychologists, psychiatric nurses, family therapists, and

social workers as well as primary care physicians) have a critical need to learn how to improve the treatment they provide to racial and ethnic minorities, given that the current disparities lead to significant rates of untreated mental illness among them.

Finally they emphasized that the most important issues for providers are to (1) recognize factors that underlie disparities in mental health treatment, (2) understand how conceptualizations of cultural competence are evolving, and (3) use and contribute to the literature on cultural tailoring as a way to improve mental health treatment rates for racial/ethnic minority groups in primary care settings.

It is important to mention examples of culturally tailored interventions for Puerto Ricans, such as the brief culturally tailored intervention for Puerto Ricans with type 2 diabetes developed by Osborn et al. Another example with medical conditions is the culturally adapted family asthma management intervention called "CALMA" (an acronym of the Spanish for "take control, empower yourself, and achieve management of asthma") in reducing asthma morbidity in poor Puerto Rican children with asthma developed by Canino et al.

These interventions were conducted with both island and mainland Puerto Rican children. Canino et al. evaluated the effectiveness of the intervention and found it seems promising for the reduction of asthma morbidity. Finally, Duarté-Vélez et al. reported culturally adapted cognitive-behavioral therapy in the case of a Puerto Rican adolescent, who participated in a randomized clinical trial for the treatment of major depression disorder. They maintained fidelity to the treatment protocol, but promoted flexibility addressing cultural values about sexual orientation, spirituality, the family, and identity development as a central part of the treatment. The results evidence that the intervention was successful, being tailored to the particular needs of the patient and taking into consideration the nuances and cultural sensitivity and cultural competence that are required when one is working with the Puerto Rican population, recognizing their similarities and differences under the same scope without losing the importance and respect for the particular characteristics of the individual being treated and that person's ecological surroundings plus a holistic view of the person. These interventions may take more time and effort than the ones with the average population but are worth it considering the increase of the Puerto Rican population in the United States and the importance they play as Hispanics/Latinos in the fabric of that country.

Recommendations on Behavioral Health Screens to Screen for Depression, Anxiety, Pain, and Other Problems Associated with Physical Illnesses in an Integrated Health Care Setting Serving Puerto Ricans

First, to make decisions about implementing systematic depression screening for Spanish-speaking populations, primary care physicians and mental health providers need to know which Spanish language depression-screening instruments are accurate. Reuland et al. reviewed systematically the evidence regarding the diagnostic

accuracy of depression-screening instruments in Spanish with primary care populations. They found that the Spanish language version of the Center for Epidemiologic Studies Depression Scale had sensitivities ranging from 76 to 92 % and specificities ranging from 70 to 74 %. The Spanish language version of the Postpartum Depression Screening Scale was 78 % sensitive and 85 % specific for combined major–minor depression (one US study). For depression screening in Spanish-speaking outpatients, fair evidence supports the diagnostic accuracy of the Center for Epidemiologic Studies Depression Scale and the nine-item PRIME-MD in general primary care and the 15-item Geriatric Depression Scale (Spanish) for geriatric patients, meaning that although they a few in number and in more instruments are needed for the Spanish-speaking population in the United States, clinicians could use these instruments in their primary care interventions. On the other hand, Rodero and his team in Spain validated the Chronic Pain Acceptance Questionnaire (CPAQ) for the assessment of acceptance in fibromyalgia. The value of this is that it could be normalized for Spanish-speaking populations in the United States. Analysis of results showed that the Spanish CPAQ had good test–retest reliability (intraclass correlation coefficient 0.83) and internal consistency reliability (Cronbach's α 0.83). The Spanish CPAQ score significantly correlated with pain intensity, anxiety, depression, pain catastrophizing, health status, and physical and psychosocial disability. The Scree plot and a principal components factor analysis confirmed the same two-factor construct as the original English CPAQ. For this reason teams in the United States should work to validate the questionnaire for Spanish-speaking populations. D'Alonzo describes that as Spanish-speaking immigrants participate in and become the focus of research studies, questions arise about the appropriateness of existing research tools, and explains that very little has been written regarding the testing and evaluation of research tools among less educated Latino immigrants. It is for this reason that more culturally appropriate methods should be evaluated for use with the Spanish-speaking population, such as the Self-Efficacy and Exercise Habits Survey, the Latina Values Scale Revised, and the Hispanic Stress Inventory. The tests could be translated and validated to provide a more complete service but also to expand the scope of information to work with the Spanish-speaking population in the United States and particularly in primary care.

The cross-cultural interview proposed by Juckett (2005, 2013) requires time and patience. First, small talk can establish trust (*confianza* in Spanish) between the patient and the physician. According to Juckett (2005), physicians should use a patient's formal name if they are unsure of the appropriate way to address the patient. According to Juckett, patients will sometimes avoid eye contact with physicians out of respect, especially if they are of a different sex or social status. Consequently, the physician should ask the patient what the illness means to him or her and what treatments the patient is currently undergoing. This will allow the physician to explain the different treatment options and find a mutually acceptable treatment plan. The physician should provide instructions, preferably in writing (if the patient or a family member is literate), and ask the patient if the plan is acceptable. Rather than asking, "Do you understand?" the physician should have patients repeat the instructions in their own words.

Time perception and management differ among cultures. For example, many Latinos and especially Puerto Ricans have a relaxed sense of time, and personal relationships are considered more important than schedules. Thus, practitioners should, if a patient is late, tactfully explain the importance of being on time in the US medical setting (Juckett, 2005, 2013; Sue, 2013).

Tseng and Streltzer (2008) mentioned the following as important factors in adherence to prescriptions that need to be taken into consideration to increase adherence to prescriptions recognizing the specific cultural aspects of Puerto Ricans:

1. Patient's concept of the illness, as well as the symbolic meaning of the illness in the patient's culture
2. Medication characteristics, which may be important to the patient
3. The symbolic power and value of the medication in the patient's culture
4. Dietary habits and nutritional interactions with alternative treatments used by the patient
5. The physician–patient relationship, including expectations and symbolic meaning of giving and receiving medication, as well as other transferential aspects of the relationship

According to Levensky and O'Donohue (2006), several variables are extremely important for adherence to treatment:

1. Having a multicultural and multilingual staff
2. Using trained interpreters and receiving training on how to integrate interpreters into clinical practice
3. Providing written instructions in the language spoken by the particular patient/client
4. Training professionals in multicultural awareness
5. Including relevant cultural components in the treatment
6. Consulting, collaborating with, and involving folk healers in the treatment
7. Respecting the client's/patient's culturally based explanations/interpretations
8. Increasing participation by extended family members.

Conclusions and Final Recommendations for Best Practices with Puerto Ricans

An adequate assessment that is culturally sensitive is the basis for promotion of use to health services and adherence to treatment in ethnic minorities, including Puerto Ricans. Ones should always evaluate adherence by taking into account the behavioral, cultural, and environmental factors that affect it. People bring into the consultation their own beliefs and perceptions about the illness, and this may have consequences in the promotion or failure of adherence to treatment that may affect their quality of life (Rodriguez-Gomez, 2006). According to Rodriguez-Gomez, it will be necessary to study the positive short, medium-, and long-term effects that culture-sensitive adherence strategies may have for the survival of minorities so as to diminish physical and mental health disparities (Rodriguez-Gomez, 2006).

One of the most influencing factors on adherence is communication. Patients who do not speak the same language as their clinicians rate their visit with physicians as less participatory as whites (Rodriguez-Gomez, 2006). It is imperative to take into consideration culturally sensitive elements such as the use of folk or home remedies that may have an effect on treatment adherence. Finally, the importance of becoming aware and knowledgeable as providers and teams about how race, culture, and gender affect communication styles is important to provide high-quality services (Sue, 2013). It is important for training programs in primary care and related professions to use an approach that call for openness and flexibility both in conceptualization and in actual skill building (Sue, 2013).

According to Ho et al. (2006), more studies are warranted to examine if the acculturated lifestyle, quality of health services, access to health care, and effectiveness in controlling a chronic illness such as diabetes and its complications are factors associated with the poor health status of mainland Puerto Ricans. This inquiry could be extended to other medical conditions as well to the provision of mental health services. It is for this reason that we should be aware of the studies available and their findings to help understand the different factors that impact and could impact the provision of primary care services to Puerto Ricans in the United States. Primary-care-based interventions that have been effective in non-Latinos could incorporate culturally appropriate elements, and lessons from community-based research and could be applied to Latinos so that their effectiveness can be assessed in this group (O'Malley, Gonzalez, Sheppard, Huerta, & Mandelblatt, 2003). If we recognize these variables and expand the opportunities for teaching, training, supervision, research, and practice with Latinos, in particular with the mainland Puerto Rican population, and exchange information with the treatment and research teams on the island, it should be possible to improve and increase the cultural competence knowledge and skills in the setting of the Puerto Rican population in primary care.

References

Altarriba, J., & Santiago-Rivera, A. L. (1994). Current perspectives on using linguistic and cultural factors in counseling the Hispanic client. *Professional Psychology, Research and Practice, 4*, 388.

Andrés-Hyman, R. C., Ortiz, J., Añez, L. M., Paris, M., & Davidson, L. (2006). Culture and clinical practice: recommendations for working with Puerto Ricans and other Latinas(os) in the United States. *Professional Psychology, Research and Practice, 37*(6), 694–701.

Baig, A. A., Benitez, A., Locklin, C. A., Campbell, A., Schaefer, C. T., Heuer, L. J., … Chin, M. H. (2014). Community health center provider and staff's Spanish language ability and cultural awareness. *Journal of Health Care for the Poor & Underserved*, *25*(2), 527–545.

Berthold, M. S. (1989). Spiritism as a form of psychotherapy: implications for social work practice. *Social Casework, 90*, 89–91.

Brown, A., & Patten, E. (2013). *Hispanics of Puerto Rican origin in the United States, 2011*. Pew Research Center Report. Retrieved from http://www.pewhispanic.org/2013/06/19/hispanics-of-puerto-rican-origin-in-the-united-states-2011/.

Comas-Diaz, L. (1988). Mainland Puerto Rican women: a sociocultural approach. *Journal of Community Psychology, 16*(1), 21–31.

Corrigan, P. W., Morris, S. B., Michaels, P. J., Rafacz, J. D., & Rüsch, N. (2012). Challenging the public stigma of mental illness: a meta-analysis of outcome studies. *Psychiatric Services, 63*, 963–973. http://dx.doi.org/10.1176/appi.ps.201100529.

Corrigan, P. W., Mueser, K. T., Bond, G. R., Drake, R. E., & Solomon, P. (2008). *Principles and practice of psychiatric rehabilitation*. New York, NY: Guilford Press.

De La Cancela, V. (1986). A critical analysis of Puerto Rican machismo: implications for clinical practice. *Psychotherapy: Theory, Research, Practice, Training, 23*, 291–296.

Deegan, P. (2004). Mentalism, micro-aggression and the peer practitioner. Retrieved from https://www.patdeegan.com/blog/posts/mentalism-micro-aggression-and-peer-practitioner.

Deyoung, Y., & Zigler, E. F. (1994). Machismo in two cultures: relation to punitive child-rearing practices. *American Journal of Orthopsychiatry, 64*, 386–395.

Doyle, J. A. (1983). *The male experience*. Dubuque, IA: William C. Brown.

Falicov, C. (2005). Emotional transnationalism and family identities. *Family Process, 44*(4), 399–406.

Gil, R. M., & Vasquez, C. A. (1996). *The Maria paradox: how Latina women can merge Old World traditions with New World self-esteem*. New York, NY: Putnam.

Guarnaccia, P. J., Martinez, I., & Acosta, H. (2005). Mental health in the Hispanic immigrant community. An overview. *Journal of Immigrant & Refugee Services, 3*(1/2), 21.

Guttfreund, D. G. (1990). Effects of language usage on the emotional experience of Spanish-English and English-Spanish bilinguals. *Journal of Consulting and Clinical Psychology, 5*, 604.

Ho, G., Qian, H., Kim, M., Melnik, T., Tucker, K., Jimenez-Velazquez, I., … Rohan, T. (2006). Health disparities between island and mainland Puerto Ricans. *Revista Panamericana De Salud Publica*, *19*(*5*), 331–339.

Institute of Medicine. (2002). *Unequal treatment: confronting racial and ethnic disparities*. Washington, DC: The National Academies Press.

Juckett, G. (2005). Cross-cultural medicine. *American Family Physician, 72*(11), 2267.

Juckett, G. (2013). Caring for Latino patients. *American Family Physician, 87*(1), 48–54.

La Roche, M. J. (2002). Psychotherapeutic considerations in treating Latinos. *Harvard Review of Psychiatry, 10*(2), 115.

Levensky, E. R., & O'Donohue, W. T. (2006). *Promoting treatment adherence: a practical handbook for health care providers*. Thousand Oaks, CA: SAGE Publications.

Martinez, I., Interian, A., & Guarnaccia, P. (2013). Antidepressant adherence among Latinos: the role of the family. *Qualitative Research in Psychology, 10*(1), 63–85. doi:10.1080/14780887.2011.586102.

Nemec, P. B., Swarbrick, M., & Legere, L. (2015). Prejudice and discrimination from mental health service providers. *Psychiatric Rehabilitation Journal, 38*(2), 203–206.

O'Malley, A. S., Gonzalez, R. M., Sheppard, V. B., Huerta, E., & Mandelblatt, J. (2003). Review and special article: primary care cancer control interventions including Latinos. A review. *American Journal of Preventive Medicine, 25*, 264–271.

Ramos, B. M. (2005). Acculturation and depression among Puerto Ricans in the mainland. *Social Work Research, 29*(2), 95.

Reidy, D. E. (1993). *"Stigma is social death": mental health consumers/survivors talk about stigma in their lives*. Holyoke, MA: Education for Community Initiatives.

Rivera, F., López, I., Guarnaccia, P., Ramirez, R., Canino, G., & Bird, H. (2011). Perceived discrimination and antisocial behaviors in Puerto Rican children. *Journal of Immigrant & Minority Health, 13*(3), 453–461.

Rodriguez-Gomez, J. (2006). Adherence in ethnic minorities. In W. T. O'Donohoue & E. Levensky (Eds.), *Promoting treatment adherence: a practical handbook for health care* (pp. 415–420). Thousand Oaks, CA: SAGE Publications.

Schenker, Y., Karter, A. J., Schillinger, D., Margaret Warton, E., Adler, N. E., Moffet, H. H., … Fernandez, A. (2010). The impact of limited English proficiency and physician language concordance on reports of clinical interactions among patients with diabetes: the DISTANCE study. *Patient Education and Counseling 81*(*2*): 222–228.

Schwartz, A., Rodríguez, M. D., Santiago-Rivera, A. L., Arredondo, P., & Field, L. D. (2010). Cultural and linguistic competence: welcome challenges from successful diversification. *Professional Psychology, Research and Practice, 41*(3), 210–220.
Sue, S. (2003). In defense of cultural competency in psychotherapy and treatment. *The American Psychologist, 58*(11), 964–970.
Sue, D. W. (2013). *Counseling the culturally diverse: Theory and practice*. [serial online]. Retrieved May 20, 2015, from Bibliotheksverbund Bayern, Ipswich, MA.
Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M. B., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: implications for clinical practice. *American Psychologist*, *62*, 271–286.
Torres, J. B. (1998). Masculinity and gender roles among Puerto Rican men: a dilemma for Puerto Rican men's personal identity. *American Journal of Orthopsychiatry, 68*, 16–26.
Torres, J. B., Solberg, V. H., & Carlstrom, A. H. (2002). The myth of sameness among Latino men and their machismo. *American Journal of Orthopsychiatry, 72*(2), 163–181.
Tseng, W., & Streltzer, J. (2008). *Cultural competence in health care*. New York, NY: Springer.
Urciuoli, B. (1996). *Exposing prejudice: Puerto Rican experiences of language, race, and class*. Long Grove, IL: Waveland Press.