Rethinking Philosophical Training Needs for Mental Health Therapists
Working with Latinas with Postpartum Depression

A Thesis
submitted to the Faculty of
The School of Continuing Studies
and of
The Graduate School of Arts and Sciences
in partial fulfillment of the requirements for the
degree of
Master of Arts in Liberal Studies

By

Kate Miller, M.A.

Georgetown University
Washington, D.C.
February 14, 2012
ABSTRACT

Postpartum depression (PPD) is a form of mental health impairment. There are reports stating that overall Latinas suffer from more mental health disorders than Latinos and more than women of other ethnic origins. The immigrant Latina community in the U.S. historically has been reluctant to seek treatment for any mental health condition, but especially postpartum depression. Since the Latino/a population is the fastest growing ethnic group in the U.S., it is important to address current mental health practices addressing Latina mother’s with postpartum depression. This literature review has revealed that Master’s-level counselors are limited in their understanding of multicultural clients and ethical principles that may be applied to their clinical practice when working with the Latina mother with postpartum depression. Furthermore, Latina mothers do not have adequate access to mental health care and there has been research that demonstrates that this care can lack quality. Moreover, the results of this review suggest that current-licensed counselors recognize this lack and seek additional training above and beyond their graduate programs. This review suggests strengthening the ethical component of the education and training of Master’s-level graduate programs to better prepare counselors to ethically address the needs of multicultural populations.
ACKNOWLEDGEMENTS

I wish to extend my greatest and deepest appreciation to my advisor, Irene Jillson, for her patience, availability, and guidance on this project.

I would especially like to thank Anne Ridder for her guidance, calm and patient cheerleading, and encouragement over the years. Her ever present reminder and accommodation have been invaluable.

I would also like to thank Bart Leahy, fellow Disney veteran. A nearly 20-year old friendship resurrected on Linkedin resurfacing in time for the role of editor.

A very special thank you and gratitude to my parents Nell & Larry Miller who taught me to believe in myself at all times, in all times, and forever.
DEDICATIONS

To my family -- Chip, Lily, “Tweety”, and Mo
# TABLE OF CONTENTS

ABSTRACT...........................................................................................................ii

ACKNOWLEDGEMENTS ......................................................................................iii

DEDICATIONS.....................................................................................................iv

CHAPTER I: INTRODUCTION...............................................................................1

CHAPTER II: THE LATINA COMMUNITY..............................................................8

CHAPTER III: THE MENTAL HEALTH SERVICES FOR LATINAS: ETHICAL AND CULTURAL COMPETENCY OF THERAPIST.................................32

CHAPTER IV: ETHICAL FRAMEWORKS...............................................................55

CHAPTER V: CONCLUSION..................................................................................77

APPENDIX: Case Study........................................................................................79

BIBLIOGRAPHY...................................................................................................82
CHAPTER I
INTRODUCTION

I.1 Ethical Dilemma

This thesis will explore a graduate-level counselor’s ability to discern ethical dilemmas with the Latino mother suffering with postpartum depression.

Mental health practitioners have the power to change people’s lives. Their competency in diagnosing, confidence in treatment, and ethical sensitivity to cultures and gender is paramount to serving clients.

Notwithstanding the importance of cultural competence to quality care, it is often given a low priority in graduate education of mental health counselors, not necessarily because of a lack of good intentions, but often because consideration of diagnoses and interventions is given more attention. This is true in delivery of counseling services as well.\(^1\) This competence is important even more than other areas of health and medicine because the mental health field is plagued by disparities in the availability of, and access to, its services. These disparities are readily viewed through the lenses of racial and cultural diversity, age and gender.\(^2\)


1.2 Overview

A 2007 study showed there were 353,398 clinically active providers in six mental health professions practicing in the United States: advanced practice psychiatric nurses, licensed professional counselors, marriage and family therapists, psychiatrists, psychologists, and social workers. Provider-to-population ratios varied greatly across the nation, both within aforementioned six mental health professions and overall. Furthermore, the importance of the mental health professionals/population is reflected in the fact that, on average, the higher the number of psychiatrists, psychologists, and social workers per capita in a state, the lower the suicide rate – often a consequence of untreated depression.

Mental health disorders are common in the United States, affecting some 44 million adults and 13.7 million children each year.

---


The unmet need for treatment is greatest in traditionally underserved groups, including elderly persons, racial and ethnic minorities, those with low incomes, those without insurance, and residents of rural areas.\textsuperscript{7}

Furthermore, at certain periods in one’s lifespan, it is estimated that one in five women in the U.S. will develop depression at some point in her life, with that risk peaking during childbearing years.\textsuperscript{8} In fact, women in their childbearing years account for the largest group of Americans with depression.\textsuperscript{9} These include adolescents, pregnant women, and new mothers.\textsuperscript{10}

Notwithstanding this need, the immigrant Latina mother has less access to mental health services than other ethnic groups; indeed, less than one in twenty Latino/a immigrants use services from mental health specialists.\textsuperscript{11} Latinas in the U.S. in general are twice as likely to be diagnosed with a mood or anxiety disorder as Latinos, but are less likely than women of other ethnic groups to use mental health services, even when

\textsuperscript{7} Ibid.


\textsuperscript{9} Ibid.


given the same access. Thus, there are issues of both access to and use of mental health services in this population.

I.3 Specific Aims

This paper, based on an extensive review of published literature and available data, is designed to explore the new counselor’s competency level and demonstrated use of cultural sensitivities when working with the Latina mother.

The definition of a new counselor is a graduated-student, who works under supervision, has practiced less than three years, and has not yet, taken a state licensing board exam.

This paper will use the Center for Disease Control’s definition of ‘Latina’, which is a female of “Cuban, Mexican, Puerto Rican or South or Central-American, or other Spanish culture of origin, regardless of race.”

The three aims of this paper are to:

1) Describe the Latina mother and community and identify the barriers to their seeking mental health care.

2) Explore the strengths and weaknesses of the newly-graduated counselor with respect to providing services for Latinas who have recently given birth.

---


13 Most all graduate students finish with this status and in order to work must be supervised and continue to take courses based on their interest and job requirements.

3) Analyze the use of Utilitarian, Virtue, and Care ethics for cultural flexibility and ease of use for the new counselor.

For purposes of this paper, I use the definition for Postpartum Depression (PPD) by the American Psychological Association (APA): “serious mental health problem characterized by a prolonged period of emotional disturbance, occurring at a time of major life change and increased responsibilities in the care of a newborn infant. PPD can have significant consequences for both the new mother and family.”\textsuperscript{15}

\textbf{1.4 Ethical Frameworks}

In this paper, the applicability of utilitarian, virtue, and care ethics frameworks to mental health services for recent Latina mothers will be explored. This will be done using a recent TV news story about Latina postpartum case. This approach is being used to demonstrate the need for mental health graduate school programs to re-consider the number and content of ethics courses included in their educational requirements.

In order to discern the current requirements for ethics courses, a review of three Washington, D.C.-area mental health graduate program requirements was carried out. Only one ethics course and one cultural diversity course is required for graduation in each of the programs. The course content could not reviewed because none of the syllabi for the courses was available.

In the title for the online ethics course for one of the graduate programs was “Professional and Ethical Issues,” and in this class two ethical ideas were presented – one being mandatory and the second aspirational ethics. The readings and lectures suggested

that practitioners who comply at the first level, mandatory ethics, are generally safe from legal action or professional censure. At the higher level of ethical functioning, aspirational ethics, practitioners go further and reflect on the effects their interventions might have on the welfare of their clients.\textsuperscript{16}

Perhaps because of the relative lack of attention to ethics in the formal educational program, master’s level mental health counseling students often believe that any pursuit of ethical training will be at their discretion. Supporting this fact from a professional ethics handbook cites, we encourage you to challenge your own thinking and apply guidelines to your behavior by asking yourself, “Is what I am doing in the best interests of my clients?”\textsuperscript{17} However, in the article by Wilczenski and Cook it is suggested that raising awareness about the moral dimensions of professional practice should start at the time of admission to graduate school.\textsuperscript{18} They suggest that during the pre-admission interview, presenting an ethical dilemma for discussion among prospective students could help to ascertain the moral reasoning of a prospective student.\textsuperscript{19}

\textbf{1.5 Methods}

This paper is a literature review of mental health counseling techniques and the field’s ability to take into account in graduate education and in services delivery both

\begin{flushright}

\textsuperscript{17} Corey, Corey, and Callanan, \textit{Issues & Ethics in the Helping Professions}, 13.


\textsuperscript{19} Ibid.
\end{flushright}
multicultural variances and ethical considerations, specifically of the Latino mother who has recently given birth and exhibits signs of postpartum depression (PPD).

In examining the Latino culture this paper will highlight the myriad of sociocultural issues these women face when coming to the United States. The paper also will evaluate current mental health academic training and student’s readiness, upon graduation, to immediately provide services to Latinas generally and new Latina mothers specifically

Lastly this paper will recommend that mental health graduate schools offer comprehensive and foundational philosophical ethical training as a way to prepare students for more complete ethical thinking and for applying ethical codes to any given case.

To demonstrate the use of three ethical foundations, utilitarianism, virtue, and care ethics, a recent case of a Latina mother with a severe form of postpartum depression that reached the psychosis stage. The mother, who lived in San Diego, California, committed infantile homicide in August 2011.
CHAPTER II
THE LATINA COMMUNITY

II.1 Latina Overview

Scant published, research-based literature was available related to Latina health generally and Latina’s mental health prior to 1990.\(^1\) However, in the last 15 years, a number of national organizations representing Latino interest in health and mental health have been formed, including the National Resource Center for Hispanic Mental Health (est. 2000),\(^2\) the National Latino Behavior Health Association (est. 2002),\(^3\) and the Latino Behavioral Health Institute (est. 1995)\(^4\). Other state level organizations such as La Clinica del Pueblo, Washington, DC (est. 1983)\(^5\), University of California, San Francisco (est. 1993)\(^6\), and Beth Israel Deaconess, Boston, MA (est. 1997)\(^7\) have issued reports on Latino mental health based on their experience with this population.

---

\(^1\) Many of the resources I have found do not pre-date 1990. Further review on references of other papers yielded the same information.


\(^7\) Beth Israel Deaconess Medical Center, Latino Mental Health, [http://www.bidmc.org/CentersandDepartments/Departments/Psychiatry/LatinoMentalHealth.aspx](http://www.bidmc.org/CentersandDepartments/Departments/Psychiatry/LatinoMentalHealth.aspx) (accessed 5 April 2012).
The first U.S. Surgeon General’s Report on overall mental health, which included some information related to Latinos/as, was published in 1999. The subsequent U.S. Surgeon General’s supplemental report, “Mental Health: Culture, Race Ethnicity, published in 2001, including additional data and findings regarding Latina access to mental health services.

The Latino population in the U.S. includes persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. According to the 2010 U.S. Census Bureau population estimate, there are roughly 50.5 million Hispanics living in the United States. This group represents 16 percent of the U.S. total population. In 2010, among Hispanic subgroups, Mexicans ranked as the largest at 63 percent. Following Mexicans are: Central and South Americans (13 percent), Puerto Ricans (9.2 percent), Cubans (3.5 percent). In 2010, States with the largest Hispanic populations are California (14 million), Texas (9.5 million), New York (3.4 million), Florida (4.2 million), and Illinois (1.2 million).


9 Ibid.


The Hispanic population in the U.S. is much younger than that of non-Hispanic Whites: in 2010, 34.9 percent of Hispanics were under the age 18, compared to 20.9 percent of non-Hispanic Whites.\textsuperscript{12} Hispanics also represent a majority of the foreign-born population. In 2004, the nation's foreign-born population reached 34.2 million, which accounted for twelve percent of the total U.S. population.\textsuperscript{13}

In twenty states, Hispanic populations between 1990 and 2000 grew by more than one hundred percent. Five of these states—again, in the South and West—saw increases of more than two hundred percent: Georgia: 299.6 percent, Tennessee: 278.2 percent, Nevada: 216.6 percent, South Carolina: 211.2 percent, and Alabama: 207.9 percent.\textsuperscript{14}

Most journal articles, book chapters, and interviews begin by noting how expansive the influx of the Latino/a community is in the United States. Today, Hispanics are the largest and fastest growing population in the United States.\textsuperscript{15} In 2009, 12.5 million people became legal residents of the U.S. and the largest numbers of those new residents were of Hispanic background. A quarter (26 percent) of legal residents in 2010 were born in Mexico, far outpacing other Latin American countries, including the Dominican

\begin{footnotes}
\item[12] Ibid.
\item[14] Ibid.
\end{footnotes}
Republic (3.5 percent), Cuba (2.9 percent), El Salvador (2.5 percent), Colombia (1.9 percent) and 1.4 percent from Guatemala.\textsuperscript{16}

Furthermore, Hispanics accounted for 50 percent of the nation’s growth, and more than 18 million Hispanic women of childbearing age were living in the United States.\textsuperscript{17} This estimate of Hispanic immigrants does not include those who are part of the unauthorized immigrant population living in the U.S. This number was estimated to be 11.5 million in January 2011 and 11.6 in January 2010.\textsuperscript{18}

\section*{II.2 Latina Mental Health Overview}

\subsection*{II.2.1 Prevalence of Mental Health Disorders in Latina mothers}

Postpartum depression (PPD) is a form of mental health impairment. There are reports stating that overall Latinas suffer from more mental health disorders than other ethnic counterparts. The immigrant Latina community historically has been reluctant to seek treatment for any mental health condition, but especially postpartum depression.

A 2001 report by the Department of Health and Human Services Mental Health suggested that in the United States, racial and ethnic minorities have less access to mental


health services than do whites. They are less likely to receive needed care. When they receive care, it is more likely to be poor in quality.  

This same report also notes that Latino/a immigrants have less access to mental health services than other ethnic groups, and less than one in twenty Latino/a immigrants use services from mental health specialists.  

Additional reports indicate that Latinas in the U.S. in general are twice as likely to be diagnosed with a mood or anxiety disorder as Latinos, but are less likely than women of other ethnic groups to use mental health services, even when given the same access.  

II.2.2 Prevalence of Postpartum Depression in Latina Mothers  

In one 2009 study that investigated the prevalence of depressive symptoms and their associated risk factors during pregnancy in Latinas in the United States and Mexico, prevalence of depressive symptoms was 32.4% for pregnant Latinas and 36.8% for Mexicans.  

---


20 Ibid.  


Another study done in 2005 found that Hispanic women have higher rates of depression than non-Hispanic women but are less likely to be identified as depressed. It states that the lifetime prevalence for depression in Hispanics is 37%, 12% higher than found in the general population.\(^{23}\)

In many societies, it is difficult to admit to having negative feelings about motherhood or your baby. This may be felt even more strongly in Latino cultures, which have deep-rooted family values and high expectations of new mothers.\(^ {24}\) In reality, PPD can strike any woman, either immediately after the birth of her baby or many months later. Unfortunately, the medical community has a long history of misunderstanding and misdiagnosing PPD.\(^ {25}\) Sometimes healthcare providers don't take a new mother's concerns seriously, brushing them off as hormonal shifts and part of adjusting to motherhood.\(^ {26}\) This misunderstanding is further exacerbating by race and culture. Among Latinas in the U.S., risk factors for depression in pregnancy have seldom been the focus of research.\(^ {27}\)

In a study conducted by Pincay and Guarnaccia, a list of barriers to seeking treatment for depression was collected and one of those suggestions was the “coldness”

\(^{23}\) Ibid.


\(^{25}\) Ibid.

\(^{26}\) Ibid.

of health care providers.\textsuperscript{28} If the immigrant Hispanic mother has the highest fertility rate of all ethnic/racial groups, accounting for 24\% of births in the United States,\textsuperscript{29} perhaps training our medical and mental health practitioners on cultural awareness should be more prevalent.

“The statistics for Latinas suffering from mental illness related to childbirth and untreated depression continue to climb, and depression continues to be the No. 1 complication of pregnancy,” said Lucy Puryear, MD, president of PSI. “We know many of these new mothers are not asked about feeling depressed or anxious during their pregnancy by a health care provider.”\textsuperscript{30}

According to Callister, Beckstrand and Corbett, the biggest issues for Latina mothers in seeking treatment are largely financial, and time constraints and child care.\textsuperscript{31} Additionally, some mothers report they are shuttled from one service to another service. “They send you to another person who is not aware of how to take care of the Hispanic culture. Then they say that this woman is getting crazy over nothing, and then we do not


receive the care that we really need. The appointments are set many months after. They do not help when it is needed, which may lead to more serious problems.”

II.2.2.a Definition of Postpartum Depression

The American Psychological Association offers definitions for children and fathers with mothers and wives diagnosed with PPD and are as follows:

The definition of postpartum depression according to the American Psychological Association website is as follows:

“For mothers, PPD can:

- affect ability to function in everyday life and increase risk for anxiety, cognitive impairment, guilt, self blame, and fear;
- lead to difficulty in providing developmentally appropriate care to infants;
- lead to a loss of pleasure or interest in life, sleep disturbance, feelings of irritability or anxiety, withdrawal from family and friends, crying, and thoughts of hurting oneself or one’s child;
- be particularly problematic because of the social role adjustments expected of new mothers, which include immediate and constant infant care, redefining spousal and familial relationships, and work role.

Children of mothers with PPD can:

- become withdrawn, irritable, or inconsolable;
- display insecure attachment and behavioral problems;
- experience problems in cognitive, social, and emotional development;

---

• have a higher risk of anxiety disorders and major depression in childhood and adolescence.

Fathers can also be depressed in the postpartum period, especially if:

• the mother is depressed or if the father is not satisfied with the marital relationship or with life after the birth of the child.\(^{33}\)

**II.2.2.b Gradations of Postpartum Depression**

The U.S. Department of Health and Human Services defines and separates postpartum depression into three categories (noted below), each with varying time periods and levels of increased need for outside assistance. It is important to note that these terms are used for all ethnic cultures to define postpartum in all women. There are no further suggestions or notations for different cultures or immigrant cultures. After giving birth, about 85 percent of women have some kind of upset mood.\(^{34}\)

A report on womenshealth.gov, a Project of the U.S. Department of Health and Human Services Office on Women’s Health, list postpartum mental health conditions into three categories:

1. Postpartum blues
2. Postpartum depression
3. Postpartum psychosis\(^{35}\)

---


Postpartum blues could last up to two weeks and feelings should go away on their own. Postpartum depression can start at any time post birth up to three months post-delivery. This report did not indicate how long these symptoms would last other than to state symptoms should not last long. Postpartum psychosis is the most severe form of postpartum depression happening in 1 or 2 women for every 1000 births. Symptoms start immediately post birth and continue to show symptoms up to two weeks. Similar to postpartum depression or blues there is no real indicator of how long these symptoms will linger.36

I.4 Factors affecting Latina mothers seeking postpartum depression treatment

II.4.1 Definition of Latina

While the Latino/a community is the fastest growing population across the country one of the biggest problems in collecting information (data), research, and working with this population is the number of ethnicities within the Latina community. At present, our tendency in the United States is to title all with Hispanic backgrounds as “Latino/a” when there are differences in each culture’s ability to assimilate into the U.S. As was described in section II.1, Latinos/as are from varying countries with varying immigrant experiences.

With the exception of references to published data that uses the term Hispanic, this paper uses the term “Latina” throughout. This is currently the most commonly used terminology for this population. There are 21 main countries in Latin America, if you go

36 Ibid.
by the definition that it is the region of the Americas where Latin languages are spoken. These languages are Spanish, Portuguese and French - part of the legacy of the colonizations of the continent by European powers starting in the 16th century, and each brings a different experience, history and culture to the U.S.

These differences are important for mental health service delivery: origin can be considered as the heritage, nationality group, lineage or country of the person or the person’s parents or ancestors before their arrival in the United States. People who identify their origin as Hispanic or Latino may be of any race.”

While researchers and the U.S. Government have taken strides to clarify the term Hispanic in reporting, prevalent social thinking still views this community as one culture and one “problem.” When news stories or written articles report statements such as the following, “It also shows that out of all Latino nationalities, Mexican women are most susceptible to postpartum” it fails to recognize the variety of cultures and in using the term “Mexican” one might hear this report and assume it includes them event if they are Cuban, or Latin American

---


Research, reports, and websites are slowly beginning to note that Latinas are not a homogenous group.\textsuperscript{40} As previously noted, data is not keeping pace with the growth of the Latina community.

\textit{II.4.2 Factors affecting Latina's seeking Postpartum Depression Treatment}

There is an increasing body of published literature on Latino medical and mental health seeking pattern and this is encouraging; however, the research is scattered across the United States and finding resources on specific mental health disorders such as postpartum depression yields few articles or little information.

This section of the literature review will look at the influence of socioeconomic status, ethnic backgrounds, immigration status, acculturation, gender and family on the Latina mother.

\textit{II.4.2.a Socioeconomic Status}

From 2008 to 2009, both the poverty rate as well as the number of Latinos/as living in poverty increased; in 2009, 25.3 percent or 12.4 million Latinos/as lived in poverty, up from 23.2 percent or 11 million Latinos/as in 2008. Further, in 2009, Latinos/as were approximately two times more likely than their white counterparts to be living in poverty than their white counterparts.\textsuperscript{41}


Additionally, the economic status of three of the main subgroups parallels their educational status. Cuban Americans are more affluent in standing than Puerto Ricans and Mexican Americans, as reflected in median family incomes (Cubans, $39,530; Puerto Ricans, $28,953; Mexicans, $27,883), the percentage of persons below the poverty line (Puerto Ricans, 31 percent; Mexicans, 27 percent; Cubans, 14 percent) and the unemployment rates of persons 16 years and older (Puerto Ricans, 7 percent; Mexicans, 7 percent; Cubans, 5 percent).42

Also contributing to this factor is that Hispanics in these poverty levels do not have health insurance. A nationwide study released by the UW-Madison School of Medicine and Public Health and in the fall of 2009 found that 2,130 women who were black, Hispanic and other minority mothers were among the least likely to be helped.43 Women with health insurance were more than three times as likely to receive adequate care compared to uninsured mothers, the study found.44

Access to mental health services for Latinas in the U.S. is, for the most part, predicated on health insurance coverage. “Expanding health insurance coverage to mothers with depression is a critical step in helping them get the care that they need,”


said lead author Whitney Witt, assistant professor of population health sciences at UW-Madison.  

The implementation of the health care reform law, now known by its acronym PPACA or ACA (Patient Protection and Affordable Care Act or simply Affordable Care Act) lays out provisions that heavily impact Latinas, their families, and immigrant communities. We have been working hard to make sure that the voices of Latinas and their families are heard every step of the way. Recently the Latina community celebrated the second anniversary of the Affordable Care act (ACA) and noted that many Latino families have already benefited from this plan. The National Latina Institute for Reproductive Health (NLIRH) celebrates the second anniversary of the passage of the Affordable Care Act (ACA), which dramatically increased healthcare coverage and access to preventive care in this country. For Latinas, who are more likely than other groups to struggle with access to health insurance, the ACA has meant the potential to lead healthier, happier lives. The Affordable Care Act already expands health coverage for children and young people. The ACA both eliminates coverage discrimination against children with pre-existing conditions and requires insurance companies to cover


dependents until age 26. The Department of Health and Human Services estimates that 736,000 Latino/as have already benefited from the expansion for dependents.\textsuperscript{47}

\textit{II.4.2.c Ethnic Origins}

Racial and ethnic populations differ from one another and from the larger society with respect to culture. The term “culture” is used loosely to denote a common heritage and set of beliefs, norms, and values. The cultures with which members of minority racial and ethnic groups identify often are markedly different from industrial societies of the West. The phrase “cultural identity” specifies a reference group—an identifiable social entity with whom a person identifies and to whom he or she looks for standards of behavior.\textsuperscript{48}

Of course, within any given group, an individual’s cultural identity may also involve language, country of origin, acculturation gender, age, class, religious/spiritual beliefs, sexual orientation, and physical disabilities. Many people have multiple ethnic or cultural identities.\textsuperscript{49}.

In the United States, ethnic minorities are at a greater risk of suffering from mental health disorders than the population at large yet are less likely than whites to seek


\textsuperscript{49} Ibid.
treatments.\textsuperscript{50} Within the DHHS 2001 report minorities are more likely to receive mental health services via primary care.\textsuperscript{51}

Lastly, often minority groups may feel mistrust of the government based on previous events and circumstances in their country of origin, or they may fear deportation by government officials.\textsuperscript{52}

\textit{II.4.2.d Immigration Status}

Immigration is a stressful life event that can also significantly impact an individual’s mental health.\textsuperscript{53} Latinos/as face challenging immigration laws as the United States has restricted visas for any one country to seven percent of the total employment and family-based preference caps.\textsuperscript{54} This means for Latin American and the Caribbean degrees, exceptional abilities, or money to invest in U.S. industry as there are NO employment-based visas for less skilled laborers.\textsuperscript{55} Thus, U.S. legal immigration policies favor immigrants of high socioeconomic status.\textsuperscript{56}

\begin{itemize}
  \item \textsuperscript{50} Office of the Surgeon General; Center for Mental Health Services; National Institute of Mental Health, \textit{Mental Health: Culture, Race, and Ethnicity, A Supplement to Mental Health: A Report of the Surgeon General} (Rockville, MD: Substance Abuse and Mental Health Services Administration: 2001), \url{http://www.ncbi.nlm.nih.gov/books/NBK44243/} (accessed 12 February 2012).
  \item \textsuperscript{51} Ibid.
  \item \textsuperscript{52} Ibid.
  \item \textsuperscript{53} Ibid.
  \item \textsuperscript{55} Ibid., 102
  \item \textsuperscript{56} Ibid., 102.
\end{itemize}
The Immigration and Nationality Act (INA) and its amendments are the basis for most immigration laws in effect today. U.S. law gives priority for immigration status to foreign nationals who have a close family relationship with a U.S. citizen or LPR, who have needed job skills, who are from countries with relatively low levels of immigration to the United States, or who have refugee or asylee status.57

Since the U.S. favors high socioeconomic individuals this means that unauthorized Latinos/as face a myriad of issues that their wealthier counterparts do not. One of those issues is racism. Compounding the racial discrimination experienced generally is the institutional racism in health care that affects minority access to health care and the quality of health care received.58

In a report published last year one mother stated, “They send you to another person who is not aware of how to take care of the Hispanic culture. Then they say the woman is getting crazy over nothing, and then we do not receive the care that we really need.”59

Moreover, often immigrants may feel mistrust of the government (and therefore public health services) based on previous events and circumstances in their country of


origin, or they may fear deportation by government officials.\textsuperscript{60} Indeed, Latino subgroups have divergent levels of exposure to U.S. culture-perceived discrimination, acculturation, ethnic identity, cultural factors and human capital and therefore may vary on which factors influence variations in mental illness.\textsuperscript{61}

\textit{II.4.2.e Acculturation}

Acculturation is a process of cultural adaptation that happens when groups of persons from different cultures come in continuous contact with each other. Acculturation is not, however, a linear process because it does not necessarily lead to assimilation or loss of a person’s ethnic identity. It is a dynamic, ongoing process.\textsuperscript{62}

A 1998 study found that Latino/a immigrants who have lived in the United States for longer than 13 years reported more depressive symptoms than recent arrivals to the country.\textsuperscript{63} This fact is troubling; as some of these immigrants probably have their green cards are U.S. citizens working and paying taxes and yet are grouped into the Hispanic title where society assumes all Latino/as are the same exhibiting the same needs and problems.

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{60} Office of the Surgeon General; Center for Mental Health Services; National Institute of Mental Health, \textit{Mental Health: Culture, Race, and Ethnicity, A Supplement to Mental Health: A Report of the Surgeon General} (Rockville, MD: Substance Abuse and Mental Health Services Administration: 2001), \url{http://www.ncbi.nlm.nih.gov/books/NBK44243/} (accessed 23 March 2012).
\item \textsuperscript{61} Villarruel, Carlo, Grau, Azmitia, Cabrera, and Chahin, \textit{Handbook of U.S. Latino Psychology, Developmental and Community-Based Perspectives}, 17.
\end{itemize}
\end{footnotesize}
Recent immigrants tend to have better mental health status as compared to U.S.-born Latinos. This finding is commonly referred to as the epidemiological or immigrant paradox as immigrants tend to have better outcomes, although they often experience greater hardships than non-immigrants of similar socioeconomic characterizes.\(^{64}\)

**II.4.2.f Gender and Mental Health in the Latino/a Population**

Gender appears to have an impact upon experiences of depression, as Hispanic women experience higher levels of depression than Hispanic men, at 46 percent and 19.6 percent, respectively.\(^{65}\) A 32-year-old mother of twins said, “Hispanic women are very strong. It is difficult to say that we are sick. The family relies on the Hispanic mother and not the man. It is hard to accept that we need help.”\(^{66}\)

The focus of this paper is the Latina mother’s ability to seek treatment and her interaction with the mental health community. However, in outlining factors that inhibit her ability to seek mental health treatment we need to look quickly at the role her husband plays, as the Latina mother takes care of others first including her husband. Only recently have fathers been the subject of postpartum depression studies and research. These data are very new and very limited in addressing cultural backgrounds.

---


The rate of depression was highest among fathers with infants 3 months to 6 months old and among fathers with children in that age group, one in four were depressed. This data also showed that a child with a depressed mother was also more likely to have a depressed father. Fathers with depression may have sleep problems, low energy and general sadness or may seem irritable or withdrawn from family life. 67

Notably, 82 percent of the fathers in the pediatrics study had visited with the child’s pediatrician in the past year, including three out of four depressed fathers. 68

While there is much to be learned about PPD in men, one thing is certain: it is important for them to get help. Studies have shown that untreated PPD in men leads to marital problems, increased fighting in the home, and decreased bonding with the baby. In general, men are less likely to get help than women.

Unfortunately, it is challenging for men to seek treatment. Many healthcare providers do not realize that PPD can impact men. Further, the stigma for men is greater than for women. 69

II.4.2.g Family

Familism or Familismo is a powerful cultural value among Latinos/as, and family social networks ameliorate stress, 70 a cultural value referring to the importance of strong

---


68 Ibid.

family loyalty, closeness, and getting along with and contributing to the wellbeing of the nuclear family, extended family, and kinship networks. Interpersonal relationships are maintained and nurtured within a large network of family and friends.

In their study, Callister, Beckstrand, and Corbett noted that one reason Latina women do not seek mental health treatment is that their risk of experiencing PPD is greater during pregnancy and after the birth of the baby when the mother is without quality interpersonal relationships and adequate social support. There is a definite correlation between symptoms of PPD and lack of social support.

---


72 Derald Wing Sue and David Sue, Counseling the Culturally Different Theory and Practice, (New York, Wiley and Sons, Inc., 1999), 290.


73 Ibid.
II.4.2.h Community and Neighbors

In a qualitative descriptive study by Callister, Beckstrand, and Corbett they found some of the participants turned to one another (compadre system). One participant reports, “Even if they were not my direct family, they [said they] loved me and were going to help me with whatever I needed, that I should not feel alone. I needed that.

Another study participant identified as a Mexican mother commented: “in the Hispanic culture, the mother always do everything, like taking care of the children, cleaning the house. They are expected to do everything. And people really think less of them when they have expression. Some women [may] think they cannot take it anymore, and that she is going to explode her emotions, because she simply cannot do everything. There are many women that simply won’t say anything.” When Latina immigrant mothers arrive in to the U.S., they lose their familial and community network.

Ultimately they become vulnerable to U.S. society and the negative opinions and feelings surrounding their presence that are sometimes very openly expressed by neighbors, business people, and even the medical community. More intimately, they shoulder the frustrations of their husband’s life which often leads to spousal abuse. This chapter provides background information on the Latina community in four sections: (1)

75 Ibid.
76 Ibid.
demographics of the Latina communities; (2) mental health overview; (3) postpartum overview; and (4) factors inhibiting postpartum treatment and utilization of services.

II.1 Demographics on Latinos across the United States

II.5 Conclusion of Chapter

In closing this chapter it is important to note that the family plays an important role in the Latina mother’s ability to comfortably seek postpartum depression treatment. These familiar relationships and insulated resources hinder seeking outside help and which is generally not sought until advice is obtained from the extended family and close friends. For effective treatment and regular follow-up visits, the mental health practitioner will need to assess the immediate and extended family as well as the mother. The quality of the familial interpersonal relationships and access to adequate social support both contribute to a reduction in symptoms, possibly leading to a quicker recovery or lessening the intensity of PPD.

It is also important to note the number of factors that inhibit the Latina mother from seeking treatment of any kind, particularly mental health services. Perhaps the most inhibiting factor that mental health clinicians face in this regard is that Latina women do

---

78 Sue and Sue, *Counseling the Culturally Different Theory and Practice*, 290.

not disclose information to health care providers because they do not feel safe unless they sense compassion, caring, and genuine interest from them.\textsuperscript{80}

In thinking about ways to better serve the Latina mother with PPD it has been suggested that mental health services should be embedded with primary health care or obstetric care clinics to facilitate access.\textsuperscript{81}


\textsuperscript{81} Huynh-Nu Le, Ma. Asuncion Lara and Deborah F. Perry, “Recruiting Latino Women in the U.S. and Women in Mexico in Postpartum Depression Prevention Research,” \textit{Archives of Women’s Mental Health} 11, no. 2 (2008): 159-169.
CHAPTER III
THE MENTAL HEALTH SERVICES FOR LATINAS: ETHICAL AND CULTURAL COMPETENCY OF THERAPIST

III.1 Overview

This chapter describes mental health services available to the Latino/a community in the U.S. and assesses graduate school training in multicultural awareness of the Master’s-level counselor specifically to the Latina mother with postpartum depression.

Mental Health counseling programs prepare students to recognize symptoms of mental and emotional disorders and to use effective counseling strategies. Marriage and family therapy programs teach students about how marriages, families, and relationships function and how they affect mental and emotional disorders. Yet, as important as are ethical issues and cultural competency for counselors, each of the three Washington, D.C. area counseling graduate programs has only one course on multicultural awareness and only one course on ethics is required for program completion.

---


2 Loyola University Maryland, Loyola Catalogues, 2011-2012 Graduate Catalogue, [http://iggy.loyola.edu/catalogues/current/graduate/artsandsci/psych.html#PageLink1](http://iggy.loyola.edu/catalogues/current/graduate/artsandsci/psych.html#PageLink1) (accessed 4 April 2012).


This paper also includes a discussion of the current master’s level mental health cultural training and all that is entailed when working with a culture not one’s own. Since there are few licensed bilingual and/or bicultural therapists, the use of an interpreter is a necessary step with these guidelines.\(^5\)

Lastly, the master’s-level counselor’s ability to work with Latina mothers with postpartum depression is addressed.

### III.2 Mental Health Services in the United States

Mental disorders are common in the United States; in a given year, approximately one quarter of adults are diagnosable for one or more disorders\(^6\), and they affect some 44 million adults and 13.7 million children each year.\(^7\) While mental disorders are widespread in the population, the main burden of illness is concentrated among a much smaller proportion (about 6 percent, or 1 in 17) who suffer from a seriously debilitating mental illness.\(^8\)

The barriers to early diagnosis, treatment, and care are many: a shortage of mental health services and providers; a failure to link physical and mental health care and lack of

---


\(^7\) Ibid.

parity in the way these services are provided; lack of public awareness of effective treatments; lack of health insurance coverage and financial costs; and stigma. Stigma is particularly intense in rural communities, where anonymity is difficult to maintain. The negative attitudes attached to having a mental disorder in a rural area can lead to under-diagnosis and under-treatment of mental disorders among rural residents. The unmet need for treatment is greatest in traditionally underserved groups, including elderly persons, racial and ethnic minorities, those with low incomes, those without insurance, and residents of rural areas. Urban patients fare better in terms of mental health care access only because health professionals tend to be in urban, high-population, high-income counties.

---


11 Ibid.

12 Ibid.

A 2007 study showed there were 353,398 clinically active providers in six mental health professions: advanced practice psychiatric nurses, licensed professional counselors, marriage and family therapists, psychiatrists, psychologists, and social workers.\textsuperscript{14} Provider-to-population ratios varied greatly across the nation, both within professions and overall. Social workers and licensed professional counselors were the largest groups; psychiatrists and advanced practice psychiatric nurses were the smallest.

The National Institute of Mental Health (NIMH) reports that serious mental health illnesses—those disorders that are severely debilitating and affect about 6 percent of the adult population—are estimated to cost the U.S. in excess of $300 billion per year.\textsuperscript{15}

The estimated cost of mental health to the U.S. should be warning enough that the mental health industry is in need of service providers. The growing burden of mental illness and the huge unmet need presents an unprecedented challenge in organizing, financing, and delivering effective mental health services.\textsuperscript{16}

\footnotesize
\begin{itemize}
  
  \item \textsuperscript{15} National Institute of Mental Health, Any Disorder Among Adults, \url{http://www.nimh.nih.gov/statistics/1ANYDIS_ADULT.shtml} (accessed 7 April 2012).
  
  \item \textsuperscript{16} Lesley Russell, \textit{Mental Health Care Services in Primary Care, Tackling the Issues in the Context of Health Care Reform} (Center for American Progress: October 2010), \url{http://www.americanprogress.org/issues/2010/10/pdf/mentalhealth.pdf} (accessed 27 March 2012).
\end{itemize}
III.3 Mental Health Services for Latino/as

III.3.1 Mental Health Access for Latinos/as

Latino/a immigrants have less access to mental health services than other ethnic groups; less than one in twenty Latino/a immigrants uses services from mental health specialists.\(^{17}\) Another way of looking at this number is that the unmet need is most acute among immigrants; only about 4 percent with recent disorders have received mental health services.\(^{18}\) Spanish-monolingual Latinos/as were found to have less access to mental health services than other ethnic groups and US-born Latinos/as.\(^{19}\) Latinos/as are twice as likely to seek mental health care in non-mental health settings, such as a community organization or a family practitioner.\(^{20}\)

In terms of Latinos/as accessing mental health care one of the biggest challenges is identifying who receives private mental health care and referral into services.\(^{21}\) No information is available at this time.\(^{22}\) Another problem is in getting adequate data on

---


22 Ibid.
private mental health care is that many federal surveys are not conducted in Spanish and therefore miss a high proportion of potential respondents.\(^\text{23}\)

A small percentage of Latinos/as seek mental health assistance it is important to note that the current health system often greets Latinos/as with anti-immigrant attitudes, behaviors, and policies further keeping them from health care and sending them to the emergency room, which is not the best place to receive mental health care.\(^\text{24}\)

*Bilingual and bicultural Latino/a mental health clinicians*

It is well documented that the existing studies about language skills of mental health professionals reveal that there are few Spanish speaking and Latino providers.\(^\text{25}\)

The lower representation of minority physicians on medical school faculties can also be seen among mental health professionals. Latinos comprised 6.5 percent of psychiatry residents in the United States in 1999-2000.\(^\text{26}\)

In a recent national survey of licensed psychologists with an active clinical practice who are members of the American Psychological Association, only 1 percent of

\(^{21}\) Ibid.


the randomly selected sample identified themselves as Hispanic, whereas 96 percent identified themselves as White.27

III.3.2 Mental Health Access for Latinos/as immigrants

As noted in Chapter II, the Latino culture comprises persons of multiple countries of origin, including those located in Central and South America and the Caribbean,28 each arriving in the U.S. in varied status affecting who can access care and how care is sought. It is noted that these groups are not readily combined either in terms of mental health treatment or research without creating significant distortions. Moreover, level of acculturation and generations of residency play an important role in access to care. For example, Puerto Ricans and Cubans, may be more likely to be eligible for either publicly funded health services (Medicaid/Medicare) or private care than are individuals from Central America, whose patterns of migration to the U.S. are generally more recent—although there are important exceptions.29

Additionally, while Puerto Ricans have very high poverty rates, they are U.S. citizens at birth and entitled to publicly assisted health care benefits. It is likely that their use of mental health services within the public sector is considerably greater than among Mexican or Central America origin people because of the higher proportion of

27 Ibid.


immigrants, including who are undocumented, in the latter two groups. Cuban Americans have higher socioeconomic status than other Latinos, and many arrived in the United States with official refugee status. This made them eligible for public mental health care upon arrival in the U.S.  

**III.3.3 Mental Health Access for Latinas**

The Latino/a community, especially Latinas, may be particularly susceptible to risk factors that compound mental health diagnoses, or they may lack access to adequate mental health services. Latinas in the U.S. in general are twice as likely to be diagnosed with a mood or anxiety disorder as Latinos, but are less likely than women of other ethnic groups to use mental health services, even when given the same access. For example, only 50 percent of Latinas who perceived the need for mental health services sought those services, compared with 67 percent of white females.  

---

30 Ibid.  
31 Ibid.  
Another study of Latina immigrants from Central America found that only one-third of the Latina participants who had been referred for mental health services actually followed through with this referral and received care.  

III.4 Postpartum Mental Health Services for Latinas

Unfortunately, prenatal depression remains unrecognized in the United States: only 23 percent of women who are diagnosed with major depression or who report depressive symptoms during pregnancy received any kind of mental health care.  

Mental Health Care website reports that in a recent study of Hispanic women aged 18 and older in Los Angeles found that women who experienced domestic violence during pregnancy or within the 12 months prior to pregnancy were 5.4 times more likely to suffer postpartum depression than those who hadn't suffered recent abuse.  

First, there is a need to include routine screening for depression into routine prenatal care.  


gestational diabetes, most obstetricians screen all women with a glucose challenge test, regardless of whether they even have specific risk factors for that condition.  

Second, there is a need to expand the range of mental health services available to support women during the perinatal period. Our study underscores the wisdom of integrating behavioral health services into primary care settings, where the women feel comfortable and can access them without stigma.  

Lastly, our results underscore the need for all Maternal Child Health (MCH) practitioners to more systematically assess resilience as often as they assess risk—our field currently lacks the tools needed to develop a complete picture of the strengths and stressors these women bring to their role as a new mother parenting in a different context and culture.  

III.5 Therapist Education and Training  

III.5.1 Master's level Ethical Training  

Prior to practicing independently, a Master’s-level professional counselor must complete an accredited graduate program in counseling or marriage and family therapy. Counseling programs prepare students to recognize symptoms of mental and emotional disorders and to use effective counseling strategies. Marriage and family therapy programs teach students about how marriages, families, and relationships function and

---

39 Ibid.  
40 Ibid.  
41 Dr. Huynh-Nu Le, PI of this study is an Associate Professor of Clinical/Community Psychology at George Washington University.  
42 Ibid.
how they affect mental and emotional disorders. Both programs typically require a period of supervised experience, such as an internship.\textsuperscript{43}

Maryland, Virginia, and DC licensure boards require a minimum of 60 graduate credit course work completed as one of several steps required prior to taking the licensing exam.\textsuperscript{44,45,46} Virginia is the only state that lists a professional ethics course among course requirements for licensure\textsuperscript{47}.

In comparing course requirements for professional counseling, I reviewed the programs at Loyola University in Baltimore, MD, Marymount University in Arlington, VA, and my alma mater, Argosy University in Arlington, VA.


\textsuperscript{44} Maryland, Department of Health and Mental Hygiene, Board of Professional Counselors, Professional Counselor Licensure Requirements (LCPC), \url{http://dhmh.maryland.gov/bopc/SitePages/profcounselor.aspx} (accessed 4 April 2012).


\textsuperscript{46} Virginia Board of Counseling, Announcements, Attention, \url{http://www.dhp.virginia.gov/counseling/} (accessed 4 April 2012).

\textsuperscript{47} Ibid.
Loyola University’s program requires 48 credit course hours for licensure, which is 12 hours short for either MD, VA, or DC licensure, furthermore the catalog lists only one ethics course.\textsuperscript{48} Marymount University complies with Virginia licensing boards and requires 60 hours of graduate level coursework to be completed prior to graduation and in their course offerings is one ethics course.\textsuperscript{49} Argosy University’s program requires 48 credit course hours for licensure, which is 12 hours short of MD, VA, or DC licensure requirements\textsuperscript{50}; furthermore, their catalog lists only one ethics course.\textsuperscript{51}

Additional information learned in these classes explains the benefits of membership and usage of either the American Counseling Association (ACA) or the American Psychological Association (APA), which provide ethical guidelines for members and an adjudication process should a complaint be leveled against a counselor or psychologist.

While having the ability to find ethical codes and procedures is necessary and good, it does not always translate into better care for the client. As noted in a counseling

\textsuperscript{48} Loyola University Maryland, Loyola Catalogues, 2011-2012 Graduate Catalogue, \url{http://iggy.loyola.edu/catalogues/current/graduate/artsandsci/psych.html#PageLink1} (accessed 4 April 2012).

\textsuperscript{49} Marymount University, Academics, \url{http://www.marymount.edu/academics/programs/cmhc/programReq.aspx} (accessed 4 April 2012).


\textsuperscript{51} Ibid.
text, one thought regarding ACA and APA codes these codes by their very nature, tend to
be reactive, emerging from what has occurred rather than anticipating what may occur.\textsuperscript{52}

The U.S. Department of Labor’s \textit{Occupational Outlook Handbook} goes lists the
qualities of a counselor; however, these qualities are not specific to an ethnicity, but
rather a broad description of human interaction. These qualities include:

\textbf{Compassion}. Counselors and therapists often work with people who are dealing
with stressful and difficult situations, so they must be compassionate and
empathize with their clients.\textsuperscript{53}

\textbf{Listening skills}. Good listening skills are essential for mental health counselors
and marriage and family therapists, both of whom need to give their full attention
to their clients to understand their problems and values.

\textbf{Organizational skills}. Good organizational skills are especially important for
counselors and therapists in private practice, who must keep track of payments
and work with insurance companies.

\textbf{People skills}. Being able to work with different types of people is essential for
counselors and therapists, who spend most of their time working directly with
clients or other professionals and must be able to encourage good relationships.

\textbf{Speaking skills}. Mental health counselors and marriage and family therapists
need to be able to communicate with clients effectively. They must express ideas
and information in a way that clients can easily understand.\textsuperscript{54}

\begin{thebibliography}{100}

\item[52] Gerald Corey, Marianne Schneider Corey, and Patrick Callanan, \textit{Issues and Ethics in the

\item[53] United States Department of Labor, Bureau of Labor Statistics, \textit{Occupational Outlook
Handbook}, Mental Health Counselors and Marriage and Family Therapists, “How to Become a Mental
Health Counselor or Marriage and Family Therapist,” \url{http://www.bls.gov/ooh/community-and-social-

\item[54] Ibid.
\end{thebibliography}
In comparing each of the university programs included in the review for this thesis, the one ethics course required is similar in each school. Loyola University offers a course titled “Ethical, Legal, and Professional Issues in Counseling and Psychology”. Marymount University offers a course titled “Foundations, Ethics, and Professional Issues in Clinical Mental Health Counseling”. Lastly, Argosy University offers a course titled “Professional and Ethical Issues”.

The syllabus for the three courses was available for only one of them. In the absence of the other two syllabi, only an educated guess can be made regarding the substance of the courses. In the case of the syllabus available (for the course taken by the author of this thesis), the focus of the class was on educating new counselors on the use of the ACA Code of Ethics. The first assignment was to review the codes of the ACA. The second assignment was to read the introductory chapter to the book “Issues & Ethics in the Helping Professions,” which takes five pages to discuss principle and virtue ethics.

In reviewing this syllabus there was no complimentary written assignment required demonstrating the use of principle or virtue ethics. Subsequent chapters such as

---

55 Loyola University Maryland, Loyola Catalogues, 2011-2012 Graduate Catalogue, [http://iggy.loyola.edu/catalogues/current/graduate/artsandsci/psych.html#PageLink1](http://iggy.loyola.edu/catalogues/current/graduate/artsandsci/psych.html#PageLink1) (accessed 4 April 2012).


multiculturalism, client rights and counselor responsibilities did require written summaries on chapter topics.\(^{58}\)

In this author’s ethics class from the same Corey text two principles or levels of ethical practice were taught. The first was mandatory ethics and the second was aspirational ethics. Mandatory ethics are a level of ethical functioning wherein counselors merely act in compliance with minimal standards, acknowledging the basic “musts” and “must nots.”\(^{59}\) Aspirational ethics describes the highest standards of conduct to which professional counselors can aspire and requires that counselors do more than simply meet the letter of the ethics codes.\(^{60}\)

Counselors who find themselves in an ethical dilemma are advised to seek the guidance of the ethics boards of either the ACA or APA. The APA and ACA codes were designed to be similar, and often instructors will advise students to refer to either one for guidance. One course instructor referred to ACA and APA codes as the “cornerstones” of ethical decision making; this statement may have been derived from the “Practitioner’s Guide” found on the ACA website.\(^{61}\) However, the APA’s and ACA’s ethical guidelines tend to define ethics in terms of rules, checklists, principles, and guidelines for members to follow. In 1995, the American Counseling Association (ACA) Code of Ethics noted

\(^{58}\) Syllabus for Professional and Ethical Issues – Fall 2002, no longer available on line.

\(^{59}\) Corey, Corey and Callanan, Issues and Ethics in the Helping Professions, 12.

\(^{60}\) Ibid., 12.

the difference between mandatory and aspirational ethics. The ACA code of ethics was updated in 2005 and removed the words mandatory and aspirational ethics. This could signal the use of and need for philosophical ethics, formerly aspirational ethics.

Professional values are an important way of living out an ethical commitment. Values inform principles.\(^6^2\)

Inherently held values that guide our behaviors or exceed prescribed behaviors are deeply ingrained in the counselor and they are developed out of personal dedication rather than due to the mandatory requirements of an external organization.\(^6^3\)

If a newly-graduated or seasoned counselor were to go onto the ACA website seeking ethical guidelines for decision making, they would find a practitioner’s guide to ethical decision making written in 1996.\(^6^4\) The guide highlights five moral principles as the ACA’s cornerstone for decision making. Those principles are autonomy, nonmaleficence, beneficence, justice, and fidelity. These are words for guidance, but the foundations of these words and meanings are not on these websites or taught in mental health classes. Any philosophical insight into ethical codes and application is provided by an ethics board.


\(^6^3\) Ibid.

III.5.2 Current Training in Cultural Differences

In comparing the three Washington, D.C. area university programs mentioned previously, each online catalog lists one cultural competency course as a requirement for program completion. Loyola University offers a course titled “Diversity Issues in Psychology,” which is taught within their M.S. in clinical psychology, practitioner track. Marymount University offers a course titled “Multicultural Counseling.” Lastly, Argosy University offers a course titled “Social and Cultural Diversity.”

As with the ethics courses, the syllabus was available only for the course offered in the Master’s program completed by this author. In that case, the focus of the class was to educate new counselors on how to think about cultures other than our own and when to seek assistance to address cultural issues related to the mental health diagnosis and treatment.

By title alone, the courses do not indicate reference to a particular culture and the assumption is that the course covers several ethnicities. Also just as taking one ethics course is not a comprehensive study, covering any culture in depth would be difficult.

---


given the length of time and breadth of information needed to properly teach the intricacies of a culture in a single class term.

In this author’s one culture class, the book assigned that served as the basis for the course material was “Counseling the Culturally Different, Theory and Practice.” The book, copyrighted in 1999, is not substantially different from cultural opinions being written in 2012, nearly 15 years later. The chapter dedicated to “Hispanics” is rather brief, which did not reflect the substantial Hispanic population in the U.S. even in the late 1990s. Moreover, as is described in Chapter II, noted the term "Hispanics" is controversial for two reasons: 1) it does not indicate the influence of the indigenous cultures; and 2) although Hispanics share common characteristics, there are distinct differences between and within the different groups. If counselors treat Latinas the same as a majority rather than understanding their individual cultures the mental health profession diminishes the individual care their particular culture needs.

Strategies have been suggested for providing explicit ethical guidelines but still allowing room for interpretation of those guidelines in each cultural context, without unfairly imposing rules of the dominant culture on minorities.

---

68 Sue and Sue, Counseling the Culturally Different Theory and Practice, 286.

69 Ibid.


71 Ibid.
In the textbook, “Counseling the Culturally Different: Theory and Practice,” the authors Derald Wing Sue and David Sue suggest that the most important problem in current training of the mental health practitioner is that some believe that the most appropriate counselor would be bilingual and bicultural. This is a controversial perspective, and in any case, those who meet these criteria are far and few: approximately one percent of licensed psychologists with active clinical practices and who are members of the American Psychology Association identified themselves as Latinos. There are approximately 20 Latino mental health professionals for every 100,000 Latinos in the U.S. Additionally, graduate school training sometimes fails to teach how to apply the basic principles of therapy and counseling beyond the values and views of the majority culture.

Present day cultural training classes in counseling broadly suggest sensitivity to the culture one intends to work with. However, in leaving this training up to the mental health practitioner three things happen. First, students bring cultural sensitivity weaknesses to their jobs; however, this does allow for correct training and no bad habits to override. Secondly, if any they wish to work with a particular culture, they can focus

---

72 Sue and Sue, Counseling the Culturally Different Theory and Practice, 299.


74 Ibid.

on that ethnicity and seek appropriate training. Thirdly, the student does little to learn more about the culture they are serving, which means the counselor is probably operating from a mandatory ethical stance.

Entry-level counselors typically spend many hours after graduation under supervision, which is one part of state licensing requirements and this is often the first opportunity to work with other cultures. Each of the universities reviewed earlier in this chapter do require an externship or internship for graduation. Students are encouraged to seek externship locations of their choosing, but sometimes the student takes the location they can get to meet the graduation requirement.

When a new counselor works with an ethnic group outside of their own ethnic background, they lean on the supervisor and an interpreter, as these are logical and safe steps. However, it has been written that ACA ethical guidelines tend to define ethics in

76 Maryland, Department of Health and Mental Hygiene, Board of Professional Counselors, Professional Counselor Licensure Requirements (LCPC), http://dhmh.maryland.gov/bopc/SitePages/profcounselor.aspx (accessed 4 April 2012).


terms of rules, checklists, principles, and guidelines for members to follow. To the extent that these objective guidelines reflect the culturally learned perspective of a dominant culture, the universal application of those rules, checklists, and principles creates a dilemma for the conscientious minorities. Hence the reason, minority clients view mental health therapy suspiciously.82

Research suggests that Latina mothers are no less subject to domestic violence than are other racial/ethnic groups—this contributes to post-partum depression. In these circumstances it is important for new counselors to understand that decision making is complex. However, there are limited resources available for clinical ethics consultation, making it crucial for ethics training to be an integral part of psychiatric training.83

The lack of state resources for healthcare in most developing countries may exacerbate the problem of mental health consequences of domestic violence, incest, and sexual abuse of children,84 for the women who immigrate to the U.S. without having had these problems addressed. Moreover, they are, as has been described previously, less likely than others to have these issues addressed when new immigrants to the U.S.

III.6 Conclusion of Chapter

Academic institutions that specifically offer master’s-level degrees for counseling are not keeping pace with the need for greater cultural understanding nor do they give

---

82 Sue and Sue, “Counseling the Culturally Different, Theory and Practice,”, 5.


84 Ibid.
their students the benefit of in-depth philosophical ethical training to use when working with multicultural clients. For example, clients (or counselors) from an individualistic culture will interpret ethical guidelines about freedom and responsibility through different behaviors than clients (or counselors) from a collective culture. If these distinctions are not addressed in master’s level education, they cannot used by the counselor in practice.\textsuperscript{85}

Mental health counselors have great power to assist in creating change or helping individuals heal; however unless trained further than current graduate school programs strengthen their capacity to do so, they face cultural and ethical dilemmas with confusion and unknowingly create an environment in which behaviors that might be ethical in one cultural context may be judged unethical in a different cultural context.\textsuperscript{86}

It is clearly necessary for graduate mental health programs to increase in attention to Latina mental health issues. The Latino/a population has increased across the United States and the need for access to quality mental health care at either primary service level, the general medical practitioner or referrals to private practice, is needed. To better understand this demand a strategy is needed to increase the quantity and quality of Latino mental health research and researchers interested in the field.\textsuperscript{87}

Lastly, meeting Latinos’ mental health needs on a national scale cannot be done without (1) greater support for professional training, and (2) linking the future research


\textsuperscript{86} Ibid.

agenda to trends in patient care, including the reorganization and financing of services delivery.\textsuperscript{88}
CHAPTER IV
ETHICAL FRAMEWORKS

IV.1 Ethical Frameworks Overview

The three most used orientations in the mental health field are utilitarian ethics, virtue ethics, and care ethics. Each orientation is valuable and provides the mental health community with guidance for appropriate mental health therapy. They are useful in addition to, not in lieu of, the ACA and/or APA code of ethics.

In this chapter, I examine the use of utilitarianism, virtue and care ethics in a) the mental health field generally; b) in relation to postpartum depression specifically; and c) with regard to Latina mothers with postpartum depression.

Within each ethical framework will be an example of the framework in action using a recent case about a Latina mother named Sonia Hermasillo; the case is presented in Appendix: Case Study. This past August 2011 Ms. Hermasillo dropped her infant son from a hospital parking garage in San Diego, CA. According to her husband she suffered from postpartum depression and only days before dropping the child she had sought mental health treatment. Ms. Hermasillo is now being charged with murder.

IV.2 Utilitarian Ethics

IV.2.1 Utilitarian Ethics and Mental Health Practitioner

Definition of Utilitarianism

Utilitarianism is rooted in the premise that an action or practice is right, when compared to any alternative action or practice, if it leads to the greatest possible balance
of good consequences or to the least possible balance of bad consequences in the world as a whole.\textsuperscript{1} Those who agree with the Utilitarian framework hold that there is one and only one basic principle of ethics: the principle of utility, which asserts that we ought always to produce the maximal balance of good consequences over bad consequences.\textsuperscript{2}

Many of those who advocate for utilitarianism maintain that we ought to produce agent-neutral or intrinsic goods; that is goods such as happiness, freedom, and health that every rational person values.\textsuperscript{3} Moreover, utilitarianism concentrates on the value of well-being, which may be analyzed, for example, in terms of pleasure, happiness, welfare, or preference satisfaction.\textsuperscript{4}

Another way to assess utilitarianism is by considering the positive aspects and limitations of the ethical framework. The National Endowment for Financial Education posts on the website for its Daniel’ Fund a simple guide to utilitarian ethics.\textsuperscript{5}

The positive aspects of utilitarianism:
- Considers the pleasure and pain of every individual affected by an action.
- Considers everyone to be equal; does not permit an individual to put his or her interests or relationships first.


\textsuperscript{2} Ibid., 12.

\textsuperscript{3} Thomas Beauchamp and James F. Childress, “\textit{Principles of Biomedical Ethics},” New York, Oxford University Press (2009): 337.

\textsuperscript{4} Beauchamp and Childress, \textit{Principles of Biomedical Ethics}, 334.

Attempts to provide an objective, quantitative method for making moral decisions.

The limitations of utilitarianism:
- Cannot assign a quantitative measure to all pleasures and pains.
- Does not address the issue of some pleasures and pains that cannot or should not be measured—such as human life or human suffering.
- Suggests that ends justify means.
- Emphasizes the amount of pain an action causes—not to whom.
- Assumes outcomes can always be determined before an action is taken.⁶

Utilitarianism and Mental Health Practitioner

In the Journal of Ethics in Mental Health, author R. M. Hare advanced his version of utilitarianism as a workable basis for psychiatric ethics. He argued that utilitarian accounts of psychiatric ethics are often abandoned because of the perceived duties of psychiatrists to their patients. Hare suggested that psychiatrists:

“need not think like utilitarians; they can cleave to principles expressed in terms of rights and duties and may, if they do this, achieve better the aims that an omniscient utilitarian would than if they themselves did any utilitarian calculation”⁷

Rather than act automatically based on a simple calculation of maximized utility, the psychiatrist, as moral agent, acts on a utilitarian basis at the intuitive level, and reflects upon how rights and duties may be best served at a critical level.⁸

---

⁶ Ibid.


⁸ Ibid.
Chapter III notes that a new mental health counselor must have state required hours of supervision for licensure in the form of an externship or internship. Most often these locations are serving low-income communities such as jails or public health clinics. In these environments counselors might find themselves working in the interest of many people—social good—while focusing on the individual. This presents the new counselor with difficult choices over which s/he has little if any control and for which s/he is not prepared.

IV.2.2 Utilitarian Ethics and Cultural Sensitivity to Latinas

While a focus on the greatest good is admirable, the immigrant Latina community is very vulnerable and the individual women who do reach out to therapists and the medical community need as much support that can be offered. Often, when the woman presents for treatment—of her own initiative or in response to outreach by a mental health or other service agency—she has mental health conditions that have been undiagnosed for some time and that are the result of familial, social and other factors that make the mental health condition very complex. That is, the woman is in urgent need of, in some cases, intensive individualized care. However, because she is unlikely to receive this type of care, if any, the reported the odds of successfully managing postpartum depression are against Latina women are diminished.\(^9\)

Indeed, Melissa Murray, a UC Berkeley professor of family and criminal law, has suggested that the women thought to be most susceptible to postpartum psychosis, those with financial difficulties or stressful family relations, are the least likely to be noticed by medical professionals because they often lack health insurance for postnatal follow-up with doctors.¹⁰

IV.2.3 Utilitarian Ethics and Hermasillo Case

The Sonia Hermasillo case is an example of the importance of individual attention and the outcome that can result when a woman with post-partum depression does not receive such attention.

One of the primary goals of treating postpartum depression is to keep the mother and baby, as well as other members of the family, from harm. Treating this condition requires urgent and intensive intervention to meet this goal, rather than a longer-term goal focusing on “happiness. Doing so -- misplacing the happiness goal—can result in the therapist potentially putting the new mother, child and family in harm’s way.

The counselor treating Ms. Hermasillo acted in good faith, but was probably overloaded with other cases of varying need and could possibly have been the only or one of a few bilingual therapists available. Regardless, it is clear that Ms. Hermasillo did not receive the individual care that she needed.

Since utilitarianism is focused on happiness and the greatest good, it is not a good match for treating debilitating mental health disorders such as postpartum psychosis, the mental health condition from which Ms. Hermasillo suffers.

IV. 3 Virtue Ethics

IV.3.1 Virtue Ethics and Mental Health Practitioner

Definition of Virtue Ethics

Virtue ethics descends from the classical Greek tradition represented by Plato and Aristotle. In this framework, the cultivation of virtuous traits of character is viewed as morality’s primary function. Moral virtues are understood as morally praiseworthy character traits; these include courage, compassion, sincerity, reliability, and industry. In virtue ethics, the primary concern is with what sort of person is ideal, while action is considered to have secondary importance. Virtuous character is cultivated and made a part of the individual, much like a language or tradition. Indeed, Aristotle avowed that a person’s character is at the heart of moral deliberations.  

---


The general concept that underlies Virtue Ethics is that it focuses on what the individual should choose for his/her own personal inward behavior (character) rather than the individual relying solely on the external laws and customs of the person's culture, and if a person's character is good then so ought the person's choices and actions be good.\textsuperscript{13} The value in the ideals of Virtue Ethics lies in directing the individual's attention away from following popular opinion to the individual him/herself.\textsuperscript{14}

The National Endowment for Financial Education Daniel’s Fund website presents a list of pro and contra arguments for virtue ethics; these are:

The positive aspects of virtue ethics:
- Focuses on developing the habit of acting according to morals and principles instead of figuring out moral rules.
- Emphasizes character.
- Recognizes the importance of relationships in moral actions.

The limitations of virtue ethics
- Does not address how to act when our interests conflict with those of others.
- It is often harder to define what virtues are than what actions are right.
- Does not help us decide what a virtuous person would do in specific situations.\textsuperscript{15}

\textbf{Virtue Ethics and Mental Health Practitioner}

Based upon the recent viewpoints expressed in the field of psychology, the exclusive application of current ethical standards appears insufficient to accommodate the culture


\textsuperscript{14} Ibid.

and beliefs of ethnic, racial, religious, physically challenged, socioeconomic, and sexually oriented populations whose value systems are not tantamount to Western, mainstream culture.\textsuperscript{16} \textit{Virtue ethics} are a set of ethical beliefs that predispose persons to understand what should be done in the presence of an ethical dilemma, and increase the likelihood that they will act on moral ideals.\textsuperscript{17}

A disadvantage of virtue ethics is that virtue for one person or for one set of circumstances may be a vice for another.\textsuperscript{18} Additionally, if acting ethically depends on character, which is a central tenant of virtue ethics, then ethical reasoning and actions may be too individualized and idiosyncratic. This could lead to aberrant, if not problematic, resolutions of ethical conflicts.\textsuperscript{19}

As noted in Chapter III – Mental Health Therapist, most counselors find this profession not out of their desire to earn money, but to help. Professionals who follow virtue ethics are motivated to work on behalf of their clients (or students) by benevolence.\textsuperscript{20}

\begin{flushright}


\textsuperscript{19} Ibid.

\textsuperscript{20} Ibid.
\end{flushright}
IV.3.2 Virtue Ethics and Cultural Sensitivity to Latinas

One of the challenges that face counselors in treating any mental health disorder is the mental capacity of the client. Rita Suri, an associate clinical professor of psychiatry at UCLA was quoted in the Los Angeles Times as saying, “The cause of postpartum psychosis is still poorly understood. Besides previous mental illness, risk factors include past physical or mental abuse, stress, and little help from husbands, family or friends. Hormones are also thought to play a role. In the hours after childbirth, estrogen and progesterone fall sharply, which could be a trigger for the illness.”

Women with postpartum depression psychosis lose touch with reality, have hallucinations — often of a religious nature — and often fail to interact with or care for their babies. Given this, the counselor should be mindful or thoughtful of the patient’s inability to make clear decisions regarding her health, her baby's health, or even the health of her family. This implies that in order to effectively assess, treat, and monitor mothers with post-partum depression, the practitioner should have a moral and compassionate nature. As Dr. Edmund Pelligrino noted in a 1985 article, virtue is a character trait, an internal disposition, habitually to seek moral perfection, to live one's life in accord with the moral law, and to attain balance between noble intention and just

---


22 Ibid.
action. Or more recently, ingrained habits of behavior, virtues make up character, which is the key element of morality.

How does this apply to Latina mothers? According to an article by Sidney Block and Stephen A. Green, Latinas are viewed as strong women both by themselves and within their culture; they are perceived, in essence, as the core of a family unit. It is important to earn their trust, which may take time. A virtuous counselor would cultivate such right motives as honesty, courage, faithfulness, integrity and trustworthiness in order to follow the correct course in particular situations.

The theory is not rule-based, so there is flexibility in the application to cultural differences. However, it also bears risk, as we cannot know if a counselor is operating from a moral or virtuous framework. Unfortunately, the definition of virtue ethics leaves unanswered the question of whether every person has that innate capacity. The lack of rules frees a counselor to think more about the person, their circumstances, and holistically who all of the affected parties could be.

There is a saying, “virtues are caught as much as they are taught.” That is, virtues are habits or intuitions that evolve over a lifetime and are nurtured in the context of

---


26 Ibid.
communities and religions.\textsuperscript{27} This recognition of the situational nature of ethics is important for the diverse cultural, socioeconomic, familial and political experience of Latinas.

\textit{IV.3.3 Virtue Ethics and the Hermasillo Case}

Already noted in this chapter is that mothers with postpartum psychosis could lose touch with reality, possibly making decisions harder for her to reconcile and for the counselor to understand. In the absence of being able to reason rationally it might be difficult for the client to reason with her virtuous self. Effectively, her self-awareness, thinking process and behavior are off-kilter.

It then is necessary for the husband or other family member or caretaker, friend in the neighborhood, or mental health professional to intervene on behalf of this patient. Any one of these individual’s virtuous traits will be apparent when s/he, they take care of the mother. In Ms. Hermasillo’s case, although her husband tried to care for her and she had one visit with a mental health counselor, this was not sufficient.

\textit{IV.4 Ethics of Care}

\textit{IV.4.1 Ethics of Care and Mental Health Practitioner}

Definition of the Ethics of Care

Related to virtue ethics in some respects is a relatively new body of moral reflection often referred to as “ethics or care.” This theory uses some of the themes in

virtue ethics about the centrality of character, but the ethics of care focuses on a set of
care traits that people all deeply value in close personal relationships, including for
example, sympathy, compassion, fidelity, love, and friendship.28 Another definition of
care ethics is that it is a contemporary variant of virtue theory that draws also on
feminism and psychological constructs, particularly the role of emotion in moral
deliberation.29

Proponents of care ethics posit that the development of morals is not caused by
learning moral principles. Instead, people should learn norms and values in specific
contexts. Consideration of others is of fundamental importance here. By contacting other
people, and by placing yourself in their shoes, you learn what is good or bad at a
particular time. The solution of moral problems must always be focused on maintaining
the relationships between people. So, the connectedness of people is the key.30

Lastly, the ethics of care approach promotes sensitivity to the ‘moral’ emotions-
compassion, friendship, love and trustworthiness—since the interpersonal attachment
between a dimensional of moral conduct turns on psychological features.31

29 Sidney Bloch and Stephen A. Green, "An Ethical Framework for Psychiatry." *The British
2012).
31 Sidney Bloch and Stephen A. Green, "An Ethical Framework for Psychiatry." *The British
Care Ethics and Mental Health Practitioner

The ethics of care theory has been influential in social work environments reasoning, perhaps because in social work, the system relies on contextual factors to decide the right course of action. Furthermore, the ethics of care perspective posits that ethical decisions must be based on the context of human relationships. The nature of relationships themselves determines what actions are and are not ethical.

The mental health practitioner who uses this framework will need to consider the care perspective is especially important for roles such as parent, friend, physician, and nurse, where contextual response, attentiveness to subtle clues, and discernment are likely to be more important morally than impartial treatment.

In thinking about other cultures, the practitioner should be aware that cultural diversity and the range of perspectives on emotional awareness and expression that typify many contemporary communities may well contribute to inconsistent, even contradictory, appraisal of moral questions. To me this means the counselor should be well versed in the culture in which they are working with for best outcomes.

---

33 Ibid.
34 Beauchamp and Childress, Contemporary Issues in Bioethics, 19.
**IV.4.2 Ethics of Care and Cultural Sensitivity to Latinas**

Care ethics brings an emphasis to patients emotions in order to understand more clearly their fears, wishes and needs, and then shaping treatment according to a unique life narrative. The Latina culture – as is the case with any culture – has unique behaviors and actions. Latinas lean on their “familisma” for support and guidance; it is, in fact, a powerful cultural value --family and social networks are seen as vital to ameliorating stress in the Latino/a community.

In applying care ethics to a Latina mother the idea of building a relationship built on trust is a necessary action for both the client and practitioner. As noted in Chapter II Latina mothers who participated in research studies rarely completed the study. I wonder if taking the time prior to the study to build trust with these women might have affected Latina participation.

---

36 Ibid.


IV.4.3 Ethics of Care and the Hermasillo Case

Because the ethics of care framework focuses on the healer (in this case, the counselor) staying connected to the client, it values attachment and argues that too much morality may inhibit that relationship.\(^{39}\) In considering Ms. Hermasillo’s situation, we know very little about her family life, her relationship with her husband, or her neighbors. There is no indication that she has contact with her family of origin or if any family members live with or around her home in San Diego.

Sonia Hermasillo needed care for her ailing son, which he received. However, her demeanor and feelings seemed to have gone unnoticed by the medical community and only noted by her husband and neighbors. In the case summary listed at the end of Chapter II we know she finally sought mental health care, but there was only one session, during which it is clear from the outcome that she did not explore her emotions and reason with herself about action.

It is not clear if her OB/GYN followed her for depression or recognized signs regardless any possible medical interaction appears to have been distanced from Ms. Hermasillo the patient so received neither care nor justice.

In fact, Ms. Hermasillo’s human connectedness came from her family and neighbors – to some degree. While this interaction is more on par with how Latinas find comfort it does not demonstrate a connectedness to the mental health community or the medical community. The medical community seems to have \textit{de facto} ignored her mental

health, assuming she had control over her personal autonomy. Moreover, the medical and mental health community treated her physical and mental needs as equal to those of other patients being treated, rather than paying attention to Ms. Hermasillo as an individual in urgent need of intensive care.

**IV.5 Evaluate the Lack of Philosophical Ethical Training**

This discussion of the applicability of ethical framework yields the following question of the mental health field: why is ethical training lacking in master’s education of counselors? If a counselor is interested in understanding the foundations of ethical training, they often have to seek that information on their own both in time and with their own finances. Throughout the literature review for this paper, it was clear that ethical frameworks and their applicability to clinical decision making is offered more often to psychiatry students, who are trained in medical schools and use medical models of decision making. The majority of psychologists and mental health counselors are not presented with the same opportunities to learn the foundations of ethical frameworks.
This does not bode well for counselors, who, in good faith, often turn to authorities when they need to address an ethical dilemma in the context of providing clinical services. The law, a supervisor, the ethics code - all can provide invaluable help. We misuse these resources, however, if we allow them to short-circuit our ethical judgment. 40

There are sources for decision making and yet at times counselors find that they must face ethical dilemmas alone. The examples often used are counselors who are the only practitioners in small, remote locations with dual relationship roles. That is, they might be the only counselor in the town as well as a neighbor, friend or family member, or even customer of the only grocery store or post office in the town. As a result, the counselor can face considerable and frequent ethical dilemmas, particularly if s/he grew up in the town.

This is important for Latinas, many of whom live in small, rural areas or in large cities in which the Latino/a community is, effectively, a small town. The few licensed counselors working specifically with Latina mothers with postpartum depression or with mental health disorders generally may be known in the community, resulting in potential conflicts. The possibility for conflicting roles and misunderstandings is further complicated by the use of an interpreter who may unwittingly influence the therapeutic process by their very presence.

Working with the Latina community requires flexibility to socioeconomic, family, gender, religion, ethnic origin, and acculturation as previously noted. This means that each case is going to be different. Indeed, as Kenneth Pope suggested in the book “Ethics in Psychotherapy and Counseling A Practical Guide,” each new client, whatever his or her similarities to previous clients, is a unique individual. Each situation also is unique and is likely to change significantly over. With respect to Latina clients, their socioeconomic circumstances can change quickly. Pope also suggests that the explicit codes and principles may prohibit some acts as clearly unethical. They may call our attention to ethical concerns in different areas of practice, but they cannot tell us how these concerns will manifest themselves in a particular clinical situation. This is problematic for a new counselor working with a different culture, with a new skill set, and guidelines that do not have clear explanations of the application of ethical principles or frameworks.

It is important to assess not only our intellectual competence but also what our emotional competence for therapy. According to virtue ethics, counselors behave and think in ways that are morally and ethically appropriate in all situations, whereas ethical

---


43 Ibid., 229
principles suggest counselors to exhibit correct ethical behavior only when faced with a dilemma.  

IV.6 Suggestions for Including Philosophical Ethics in Mental Health Training

While social workers often do not conceptualize problems with managed care as ethical dilemmas, it is important to do so. Understanding Managed Health Care Organizations (MMHO) value system from a standpoint of good faith leads to a richer understanding of the health care system. However, the presentation of ethics codes from the ACA or APA does not usually include an explanation of essential tasks that must be carried out and the application of the ethics codes to these. As a consequence, the new counselor does not learn how to face unique client problems and to address ethical dilemmas.

---


Nonetheless, as mentioned previously, counselors depend on these ethics codes, as well as on peer groups and professional associations. In the Pope and Vasquez book, they have suggested that counselors should be cautious when leaning on these groups, and should not depend on them to shield the counselor from ethical struggles and the sense of ethical responsibility.47

A school counselor recently wrote a paper about virtue ethics and school counseling. She concluded that raising awareness about the moral dimensions of professional practice should start at a time of admission to graduate school. During the pre-admission interview, presenting an ethical dilemma for discussion among prospective students may help to ascertain the moral reasoning of a prospective student.48

The importance of the counselor’s need to consider the application of ethical frameworks to therapeutic services is addressed by Ghias and Ahmer, who suggest that, given the vulnerability of the patient population and the intimacy of the therapeutic relationship in psychiatry, there is a need for a higher degree of professional integrity as compared with other fields of medicine.49


IV.7 Conclusion of Chapter

In closing, it appears that mental health counselors, including the newly-graduated and those with many years of practice, lean on a variety of ethical frameworks to find the best answers to their clients’ needs. A newer counselor is more likely to address ethical dilemmas based on a “checklist approach” that filters the details of a case through various algorithms in an attempt to discern the best match; unfortunately, this process often leads to conflicting remedies.\textsuperscript{50}

Without a mentor or guidance, new counselors will dispense with any attempt to bring reasoning to the situation and report to personal preferences, which they may believe could be ill-founded.\textsuperscript{51} That is, a counselor will fall back onto mandatory ethical protocols to, at the very least; protect him or herself from legal action. However, in doing so, s/he misses the opportunity to truly practice the verb "help" in the profession.

During the course of preparing this thesis, developments have occurred in consideration of ethics codes. For example, the ACA website now has a blog section by counselors for counselors. In exploring the ACA website, this author learned that her position about ethical training is shared.

\textsuperscript{50} Ibid.

One blogger commented:

“Last but not least, as counselors we have an ethical responsibility to use our knowledge and wisdom to discern appropriate affiliations and memberships with organizations. We ought to be on the watch for inappropriate policies and practices in our surroundings, attempting to effect changes in such policies as our code of ethics calls for. By denouncing improper actions and hindering practices we demonstrate care, and our commitment to justice. My license plate is framed by the words, “Work for peace and social justice,” as a reminder of my duty. Again, nature has given us everything we need to be moral and to practice virtue. Wisdom calls for our ongoing revision of how it is that we sustain the responsibility bestowed on us when we are granted the professional identity of Licensed Professional Counselor, and a corresponding examination of the moral codes that guide and inform our professional personhood.”  

Counselors should be mindful of inappropriate policies and practices that impact on our clients. These include, for example, reductions in mental health service coverage, reduction in beneficiaries as a result of increasingly strict eligibility criteria, and changes in ethical requirements for counselors that may impact on the quality of care. By calling attention to and working again policies that can negatively impact on current or potential mental health clients, we demonstrate care, and our commitment to justice.”


53 Ibid.
CHAPTER V

CONCLUSION

Access to ethical, culturally appropriate and effective mental health care is vital for all, and critical for Latinas, given that Latinos/as have been shown to suffer from mental illnesses or emotional disturbances at a higher rate than other groups in the U.S.\(^1\)

Mental health services for Hispanics/ Latinos need to be responsive to cultural needs, and also provide appropriate linguistic support. With proper treatment, most symptoms of mental illnesses can be treated or controlled. If the possibility of mental illness is a concern for you or someone you care about consult your family doctor, psychiatrist or other mental health professional.\(^2\)

Post-partum depression is treatable when detected early and culturally appropriate screening is carried out and culturally appropriate services are provided.\(^3\)

For this reason, pediatricians, obstetricians, and midwives – those clinicians with the most contact with new mothers – should routinely screen new mothers for depression. Depression isn’t just harmful for new mothers; untreated depression can be harmful both to a mom and her baby.\(^4\) Moreover, health providers should not rely on Latina mothers to report depressive feelings. Because it may take longer for Latina mothers to disclose and


\(^2\) Ibid.


discuss their depression and for clinicians to recognize it, in particular if they have not
been educated to understand cultural nuances, more attention to screening for depression
is needed during both prenatal and postpartum visits; indeed, screening for depression
during well-baby visits should to become common practice.

As this paper has demonstrated, it is important for mental health counselors to not
limit their behavior to adhering to statutes and following ethical standards, but rather to
go beyond compliance to develop sensitivity to doing what is best for their clients by
working towards the best standards of practice. It is very important that they learn about
and integrate into their practice philosophy this ethical approach at the beginning of their
professional program.\(^5\)

In closing, the purpose of practicing ethically is to further the welfare of clients,\(^6\)
irrespective of their race/ethnicity and culture. As the participant of one qualitative
descriptive study participant reminds us:

"Even if they were not my direct family, they [said they] loved me and were
going to help me with whatever I needed, that I should not feel alone. I needed
that. They gave me a lot of support and love, and helped me with my children.
They never left me alone. This helped me a lot."\(^7\)

\(^5\) Gerald Corey, Marianne Schneider Corey, and Patrick Callanan, *Issues and Ethics in the Helping

\(^6\) Ibid.

\(^7\) Lynn Clark Callister, Renea L. Beckstrand, and Cheryl Corbett. "Postpartum Depression and
Help-Seeking Behaviors in Immigrant Hispanic Women," *Journal of Obstetric, Gynecologic, and Neonatal
APPENDIX: Case Study

Ethical and Cultural Complexities Mental Health Counseling: The Hermasillo Case

The case of Sonia Hermasillo is well-known to those who counsel recent mother. This is a case of infanticide and a severe form of postpartum depression called psychosis. This case occurred in August 2011 in San Diego, CA. It involves an immigrant mother named Sonia Hermasillo, her family of three children, and her husband. This case supports the findings on the Latina community and will be used to explain the use of utilitarian, virtue, and care ethics.

Hermasillo Postpartum Depression Case

ORANGE, Calif. — The husband of a woman accused of tossing her disabled 7-month-old son off the fourth story of a hospital parking structure said Wednesday that his wife suffered from postpartum depression and he doesn't blame her for her actions.

The baby, Noe Medina Jr., died of his injuries earlier in the day at the University of California, Irvine, Medical Center, the same day that his mother was charged with murder and felony child abuse.

Sonia Hermosillo, 31, made a brief court appearance but did not enter a plea. She is due back in court Thursday.

Prosecutors allege that Hermosillo removed a helmet that her son wore for a medical condition before tossing him from the parking structure at Children's Hospital of Orange County. She then went back inside the hospital to validate her parking before driving away late Monday, senior deputy district attorney Scott Simmons said.

Hermosillo's husband, Noe Medina, said in an emotional press conference that he didn't blame his wife and urged women to get treatment if they think they might have postpartum depression.

He previously told The Orange County Register that his wife was deeply distraught because their son was diagnosed with congenital muscular torticollis — a twisting of the neck to one side — and wore a helmet to help correct his plagiocephaly, also known as flat-head syndrome.
He had been receiving treatment at Children's Hospital but did not have an appointment the day of the incident.

"My wife was not in her five senses. She didn't know what she was doing," Medina said, choking back tears. "I don't know if many people know what postpartum depression is, but in reality it is something very serious and needs to be treated."

Simmons said Hermosillo's behavior showed she intended to kill her son, regardless of her mental state.

"It's not like she's in a fetal position when the police arrived," he said. "She picks a specific location, drives to the top of the building (and) takes the helmet off. I'm sure she's depressed, the post-partum blues, I'm sure she had some of that."

"It's going to be up to a jury to decide if she had the wherewithal to inform the intent to kill."

Hermosillo's arraignment has been postponed until Sept. 16. Orange County Superior Court Judge Joe Perez set bail at $1 million, but federal immigration officials have a no-bail hold to keep her in custody because she is in the U.S. illegally, said Jim Amormino, sheriff's spokesman.

Hermosillo was being held in the medical ward, where she is receiving a psychological evaluation, he said. The Mexican national is being kept in a cell by herself and wearing a protective gown so she can't injure herself, he added.

The judge appointed a public defender for Hermosillo. The attorney did not comment after the hearing, which was conducted in a jailhouse courtroom and relayed to spectators on a closed-circuit TV.

Farrah Emani, a spokeswoman for the Orange County district attorney's office, said prosecutors were not commenting on a motive.

"We're not going to speculate at this point as to why she may have done it. I don't think there will ever be a satisfactory answer as to why a mother would do something like this to her child," she said.

A witness on the ground saw the baby falling and several people, including a doctor, called 911, said Sgt. Dan Adams, a spokesman for Orange police.

Surveillance video showed Hermosillo's sport utility vehicle with an empty child seat leaving the parking structure a short time later, the sergeant said. The license plate was traced to Hermosillo's home.
During the investigation, La Habra police notified detectives that Medina had reported his wife and their son missing, Adams said.

An Orange police officer driving past Children's Hospital about four hours later spotted the SUV on a street about 100 yards from the crime scene and Hermosillo at the wheel, Adams said.

Both La Habra and Orange police agencies declined requests for the 911 tapes, citing the investigation.

County court records show Hermosillo has no major criminal record but pleaded guilty to four traffic violations in La Habra in 2008, including driving without a valid license and having no proof of insurance.¹

**Additional Case Information from Fox News Los Angeles**

This story was also reported on Fox News in Los Angeles and in their story they report – Hermosillo’s husband said his wife took medication after her hospitalization and had seen a therapist for the first time on Monday.²

There are subtle reporting differences between the Huffington Post article and the report from Fox News Latino. The Huffington Post points out that Ms. Hermosillo is an illegal immigrant. The district attorney in the article is quoted as saying “they do not know how a mother could do this.” Ms. Hermosillo is in a cell by herself and has received a psychological evaluation; results from that evaluation are not noted on the Huffington Post.

Fox News Latino discusses Ms. Hermosillo’s struggle with postpartum depression and highlights the cultural difference between the Latina community and other ethnic groups in Los Angeles. It also notes that women from Mexico are typically sheltered away for 40 days and 40 nights while they heal from childbirth.²

---


BIBLIOGRAPHY


Baby Center. “Hispanic Women and Pregnancy: Postpartum Depression.”


Beth Israel Deaconess Medical Center. Latino Mental Health.


Chapter Summaries & Conclusions.


85


University of California, San Francisco. Latino Mental Health Research Program.


Virginia Board of Counseling. Announcements, Attention.