Using a Systemic Framework to Treat Latina Women with Postpartum Depression

A graduate project submitted in partial fulfillment of the requirements
For the degree of Master of Science in Counseling,
Marriage and Family Therapy

By

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Dedication

This project is dedicated to my beautiful son, Joshua. I vividly remember the first time I looked into your eyes and knowing that I would never be the same again. The instant unconditional love that I felt for you was so intensely profound that it burst my frail heart’s capacity to contain all emotion. Before you I was alive, but after you I was not only alive, I was also awake. Everyday I am amazed by your selfless and kind ways. You continuously teach me about the kind of human being I want to be. Thank you my baby bear. I’ll love you forever I’ll like you for always, as long as I’m living my baby you’ll be.

To my amazing and adoring husband, there are no words to describe the ways you have enriched my life. I never feel alone when I’m with you. The safety, love, and laughter you provide fill me with joy and happiness. I will forever be grateful to you for the sacrifices you have had to make to help me fulfill my dreams. Te quiero mi amor!

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To Professor Luis Rubalcava, who has shown me the path to being a healer. If I could just become half the therapist you have been, then therapeutic world is in for a treat. It has been an honor to be trained by you.

Last but not least, to my dear friend Marie. I extend to you my gratitude for you unending support and encouragement. Your positivity and belief in me fueled me through this entire process. Thank you!
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ABSTRACT

USING A SYSTEMIC FRAMEWORK TO TREAT LATINA WOMEN WITH POSTPARTUM DEPRESSION

By

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Master of Science in Counseling
Marriage and Family Therapy

There is a scarce amount of information currently being disbursed on the topic of PPD. Due to its highly sensitive nature, PPD is often underreported by those who suffer from it; ultimately jeopardizing the well being of the mother and her infant. As the Latino population quickly becomes the majority, it is imperative for those in the counseling field to begin to understand how PPD affects this group and how to effectively treat them. This project is intended to assist therapeutic/counseling professionals to achieve positive treatment outcomes when working Latina women suffering with PPD by using a family therapy approach.
Chapter 1

Introduction

This girl I knew who lived next door but one…I said, “Oh, do you feel like that, do you?” and she’d say, “Oh, no, no, no,” and I said “Oh-oh, pull yourself together dummy…you’re all right.” And then I’d get home and think, “She doesn’t feel like that, perhaps it isn’t normal”…That was the one thing that really got to me through it all, that I couldn’t find anyone who felt like I did, and I felt like I was going through it on my own…I really thought I’d gone mental. I really thought that was the end of my life. I thought I’d flipped completely and I couldn’t find anyone who said, “Oh yes, I felt like that, don’t worry, you’ll get better”…I felt really isolated and lonely through it. (Mauthner, 2002, pg. 16)

Becoming a new mother is a pivotal moment in a woman’s life. It’s a time of complex emotions in which the woman often feels a deep sense of joy and excitement at the arrival of her new baby. What happens however when a new mother is unable to experience this expected sense of joy and instead feels an uncontrollable sadness and may even worry about hurting her baby? The above excerpt illustrates a woman’s struggle to reconcile her feelings when she does not experience the anticipated joy and happiness associated with the transition into motherhood. This narrative captures the grim reality of social isolation and emotional distress that occurs amongst women who suffer from postpartum depression [PPD].

According to Gotlib, Whiffen, Wallace, and Mount (1991), pregnancy and childbirth brings with it dramatic changes in routines, social roles, and all interpersonal relationships. Depression during this sensitive period is not only devastating to the mother but it can also be devastating to the child and the family (1991). Nylen, Moran, Franklin, & O’Hara (2006) indicate that although depression during this significant life transition affects all family members, treatment options often displays a disparity as the focus is placed on treating only the mother or the mother-infant dyad.
Statement of Need/Problem

In the United States [US] it is believed that there are between 6.5 and 12.9 percent of mothers who experience either a minor or major depression during the first year following the birth of their child (California Department of Health Services [CDHS], 2007). PPD is a mental health issue that affects many women today but often goes undiagnosed. According to Chaudron et al. (2005), primary care physicians often fail to properly diagnose less than half of mothers suffering from depression. Similarly, less than half of depressed women recognize that they are depressed (2005). Failing to identify and/or address the warning signs can have long lasting consequences as it not only effects the mental health of the mother but as a result can also have a damaging effect on the attachment and developmental well being of the infant (Munoz et al., 2007).

Chaudron et al. (2005) assert that early detection is critical for the prompt and effective treatment outcomes of PPD. According to CDHS (2007), minorities, including African American and Hispanic women, are less likely to reach out for mental health services. Researchers such as Padilla and Villalobos (2007) and Sheng, Le and Perry (2010) have conducted studies that suggest that there are cultural implications that create barriers for Latina women to seek help for their mental health struggles.

According to Le, Munoz, Soto, Delucchi and Ippen (2004), research on PPD has predominantly focused on European American women with little attention to the prevalence and risk within the ethnically diverse community. The U.S. Census Bureau (2010) reports that between 2000 and 2006, Hispanics accounted for one-half of the nation’s growth. As of July 2006, they represented 14.8 percent of the US population with 13 million residing in California alone. CDHS (2007) notes that in 2004, more than
half of California’s resident births were to Hispanic females. It is imperative to begin to recognize their need when it comes to this very salient mental health issue. Furthermore, it is time to understand how the role of the Latino culture may further impair the ability of the Latina woman to recognize and/or address the PPD warning signs as well as obtain the necessary treatment.

According to Nylen et al. (2006), it has been well documented that the risk of leaving PPD untreated can have detrimental consequences on the mental state of the mother and negatively impact the attachment of the child. As a result, most treatment on PPD has focused on reducing the maternal depressive symptoms of the mother and/or improving the mother-child attachment (2006). Gjerdingen (2003) purports that although there has been no general consensus for treating PPD, treatment methods similar to those used for non-postpartum major depressive disorder are typically implemented. These include psychopharmacology, individual psychotherapy, and group therapy (2003). Nylen et al. (2006) postulate that although these treatment models have been found to decrease the mother’s depressive symptomology, they may not increase the mother-child bond, which is so critical to the development of a secure attachment.

It is essential that Marriage and Family Therapy [MFT] Trainees and Interns begin to become familiar with the long range and complex effects of PPD. Furthermore, it is essential that the individual therapist understands and incorporates a culturally competent approach to conceptualizing treatment when working with the ethnically diverse community.

**Purpose of Graduate Project**

The purpose of this project is to develop a workshop that informs and educates
MFT Trainees and Interns on the impact that cultural and familial beliefs have on PPD. Furthermore, this awareness can be instrumental in developing preventative treatment approaches for women suffering from this mental health disorder. By utilizing a Systemic Approach to treat women suffering with PPD, it will offer a treatment that is more holistic in nature. Incorporating family members into the treatment allows PPD to be reframed as a social mental health issue rather than an individual one. By de-stigmatizing the woman as the carrier of the mental health disorder and by incorporating her support system (family and friends), improved treatment outcomes are expected.

**Significance**

This project will help to address the current disparity of information being disbursed to MFT Trainees and Interns about the Latino community regarding the very salient issue of PPD. By providing MFT Trainees and Interns with psychoeducation regarding PPD and incorporating the cultural framework, there is a strong potential to increase awareness of the warning signs and risk factors associated with PPD among Latinas.

McGoldrick, Giordano, and Garcia-Preto (2005), suggest that cultural competence is imperative in the field of mental health. When working with clients of the non-dominant culture, recognizing the importance of culture and incorporating it into one’s theoretical approach is essential to creating a therapeutic alliance with the client so that they do not feel perplexed, displaced, or lost (2005).

By using a systemic framework, events and relationships within the client’s life become related to the patterns of health and illness causing and perpetuating PPD. Postpartum depression will be seen within the familial context to assist in improving not
only the mother’s functioning but also improving familial and relational bonds that have been found to be so critical in maintaining a healthy transition into motherhood.

**Terminology**

For the purposes of this paper, the term Hispanic and Latino/a will be used interchangeably. The term Latino/Hispanic as it is currently being defined by the U.S. Census Bureau (2010): “Hispanic or Latino” refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race. (p. 2)

According to Leininger (2001), “Culture is defined as the learned, shared, and transmitted values, beliefs, norms, and lifeways of a particular group that guides their thinking, decisions, and actions in patterned ways” (p. 47)

A system, as defined by Goldenberg and Goldenberg (2007), is “a set of interacting units or component parts that together make up a whole arrangement or organization” (p. 472)

In order to better understand this issue, it is necessary to review previous studies and research regarding PPD in the Latino community. The literature review, which is presented in the following chapter, will demonstrate and explain the evidence and research supporting the need for this project.
Chapter 2

Literature Review

The following literature review will begin with a general examination of PPD. Major risk factors that contribute to the development of PPD as well as the barriers that limit individuals from obtaining mental health services will be examined. This will be followed by a discussion of the current issues associated with the proper diagnosis of PPD including the disparity of its information and diagnosis among ethnic minorities. Additionally, risks and consequences involved with failing to properly diagnose or self-identify PPD will be assessed. The role of culture and mental health will then be examined while at the same time highlighting the specific issues that arise due to the cultural perspective.

Existing theoretical perspectives used to treat PPD will be reviewed and evaluated. Systemic Therapy will be outlined and examined in detail. Lastly, the Latina family structure will be described and the familial/cultural beliefs pertaining to the role of women and motherhood will be reviewed.

Postpartum Depression

The period following childbirth is a sensitive time for new mothers. According to Lewis, Byers, Malard and Dawson (2010), many women may come to experience a fluctuation in mood that could be due to the hormonal, physical, emotional, social, and identity role changes happening within the new mother’s life. While it is important to understand what PPD is, it is of equal importance to understand what it is not. PPD lies between what is referred to as the “baby blues” and the more severe postpartum psychosis (2010).
Lewis et al. (2010) state that approximately 70 percent of women experience a fluctuation in mood within two weeks after giving childbirth. This is a transient period typically referred to as the “baby blues”. It does not impair functioning and is considered to be a part of the transition into motherhood (2010).

On the other end of the continuum is postpartum psychosis. Lewis et al., (2010) explain that this mood disorder may be present in as many as one in 500 mothers after the birth of a child. Postpartum psychosis primarily affects women who have had a mood disorder or postpartum mood disorder in the past. It is similar to the baby blues in that it appears within the first four weeks postpartum; however it is drastically different in that the women who are affected by it are often consumed with thoughts of harming the infant, seeing things that are not there, feeling confused, and/or having rapid mood swings. This is an incapacitating disorder that usually requires hospitalization (2010).

Ugarriza (2004) identifies postpartum depression as a mood disorder that becomes present during the first year after giving birth but usually between 2 weeks and 3 months of giving birth. The symptoms typically include tearfulness, mood swings, feelings of inadequacy, and guilt about the birth and performance as a mother (2004).

According to the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision (DSM-IV-TR; APA, 2000), PPD is classified as a mood disorder with an onset of symptoms within four weeks following childbirth. The symptomology is more severe and lasts longer than the baby blues (U.S. Department of Health and Human Services, 2009). Postpartum Support International (PSI, 2010) indicates that symptoms may include fluctuations in mood, lack of interest in the baby, changes in eating and sleeping habits, trouble concentrating, thoughts of hopelessness and sometimes even
thoughts of harming the baby or herself. Diagnosis is made as a specifier to describe features of the current or most recent mood episode (APA, 2000). O’Hara, Neunaber, Zekoski (1984) warn practitioners to proceed with caution when making a diagnosis as many normal physiological changes of pregnancy and the puerperium are similar to symptoms of depression.

As indicated previously, the DSM-IV-TR (APA, 2000) classifies the symptoms of the postpartum-onset episodes similar to those displayed in the non-postpartum mood episodes. Beck and Indman (2005) refer to this in their study and indicate that there is an existing debate on whether PPD is a distinct diagnosis from non-postpartum depression. They note that while some hold the position that PPD does not differ qualitatively from depression that is not triggered by childbirth, others posit that PPD has a biological root with different etiology that ultimately distinguishes it from non-postpartum depression.

In an attempt to provide a profile of women suffering from major postpartum depression, Beck and Indman (2005) sampled 133 women previously diagnosed with the disorder. Using the Postpartum Depression Screening Scale [PDSS] they found that the top three symptoms for PPD were emotional lability, mental confusion, and anxiety/insecurity. The researchers note that the difference between postpartum depression and major depression lay specifically in anxiety and irritability (2005).

**Risks Factors**

Beck (2001) indicates that because this mood disorder is often covertly suffered, early recognition is one of the most difficult challenges. The social stigma associated with PPD often blocks mothers from seeking professional help. In order to prevent this, mothers who are at risk of developing PPD need to be identified early, preferably during

In their meta-analysis of 59 studies, O’Hara and Swain (1996) synthesized the risk factors associated with the development of PPD. In an effort to identify the pregnant woman at risk for PPD they found that low socio economic status, pregnancy/delivery complications, anxiety and stressful life events during the pregnancy were clear risk factors. When exploring interpersonal relationships during pregnancy, the meta-analysis revealed that women undergoing marital distress along with the perception of low social support would be more likely to develop PPD. Although family history was not found to be a significant predictor of PPD, past history of psychopathology was found to be the single largest factor that placed women at risk for depression in the postpartum period. The researchers assert that the findings regarding past history of psychopathology and depression during pregnancy strongly suggest that there is a continuity of psychiatric disturbances that extends back many years before a woman’s pregnancy, through her pregnancy, and into the postpartum period (1996).

Beck (2010) further confirms some of the findings of the previous meta-analysis in her own meta-analysis of 84 studies published during the 1990s. In the studies sampled, 81 percent utilized self-report as the medium for measuring PPD. The thirteen predictor variables identified and examined as predisposing women to PPD were: prenatal depression, self esteem, childcare stress, prenatal anxiety, life stress, social support, marital relationship, history of depression, infant temperament, maternity blues, marital status, socioeconomic status [SES], and unplanned/unwanted pregnancy. Beck’s meta-analysis revealed self-esteem as being one of the strongest predictors of PPD followed by childcare stress, prenatal depression and prenatal anxiety (2010).
Latinas and Postpartum Depression

Yonkers et al. (2001) contend that because ethnic minority women are an inadequately studied population, it is important to evaluate whether the prevalence and risk factors pertaining to major depressive disorder continue to be as salient for them as indicated on most research relating to PPD. In their study, a total of 802 women were sampled with an ethnic background as follows: 75 percent Hispanic, 20 percent African American, 2 percent white non-Hispanic, and 1 percent immigrants of Asian decent. The women were selected from four inner-city maternal health clinics in Dallas. Utilizing the Edinburgh Postnatal Depression Scale, the Inventory Depressive Symptomatology, and the Quality of Life in Depression Scale, the women were screened three times during the puerperium period to evaluate for depressive symptoms and assign psychiatric diagnoses. The researchers found that the rate of Major Depressive Disorder during the postpartum period was between 6.5% and 8.5% with 50% reporting that they had developed depressive symptoms after delivery while 25% developed the symptoms during their pregnancy. The rates were consistent to those found in existing literature on PPD.

Prevalence rates for Latinas are shown to be similar to Caucasian and African American women. The study also indicated that living with a spouse or significant other decreased the likelihood that depressive symptoms would continue (2001).

Sheng, Le and Perry (2011) assert that there is limited research on social support as a risk factor for PPD on Latina women. Family members are considered to be a primary source of social support for Latinas. Due to the cultural concept of familism, social support can be perceived as a protective factor for Latina women. Some groups of Latinas, including Mexican and Mexican American immigrant women, have traditionally
taken to *la cuarentena* following childbirth. This is a 40-day rest period in which the woman recuperates by consuming a special diet and relies on the help of her family for handling the day-to-day household chores and caretaking of the new baby (2011).

In their attempt to address the disparity of information regarding the relationship between perinatal depressive symptoms and social support among Latinas, Sheng, Le and Perry (2011) conducted a secondary data analysis from a sample of 102 Latina participants recruited from two previous studies. The results revealed that perceived satisfaction with postnatal support from the baby’s father significantly predicted symptoms of depression in the postpartum period. Perceived lack of support and limited practical assistance from the baby’s father may make the experience of pregnancy and the transition into motherhood more stressful, thereby increasing the risk for PPD. Moreover, the study also revealed that dissatisfaction with the support received from one’s family during the postpartum period was correlated to elevated risk for depression. The researchers note that although the limitation of the study was its small sample size, the power analysis conducted in the study proved to show that the final sample size was sufficient to detect between group differences with large effect sizes but not those with medium and small effect sizes (2011).

In order to identify whether racial and ethnic differences exist in the utilization of mental health care benefits for the treatment of PPD, Kozhimannil, Trinacty, Busch, Huskamp and Adams (2011) examined administrative claims data from New Jersey’s Medicaid program. A total of 29,201 women who displayed new-onset depression symptoms after delivery and whom delivered between July 1, 2004 and October 31, 2007 were included in their sample. The participants were comprised of 13,001 Caucasian,
13,416 African American, and 3,184 Latina women. By focusing on the Medicaid beneficiaries, the researchers attempted to account for socioeconomic status [SES]. Primary outcomes included postpartum mental health treatment initiation, follow-up, and receipt of continued care. While researchers found low levels of PPD treatment among all low-income women, Caucasian women were twice as likely to initiate mental health treatment. Low treatment initiation rates were found for African American women (4%) and Latinas (5%). Among the African American and Latina women that did initiate care, the time from delivery to treatment initiation was significantly longer than for Caucasians. Furthermore, African American and Latina women had lower chances of receiving follow up or continued care as compared to Caucasian women (2011).

A disproportionate number of African American women and Latinas who suffer from PPD do not receive needed services. Kozhimannil, Trinacty, Busch, Huskamp and Adams (2011) posit that their results are indicative of possible under recognized and undertreated conditions for all low-income women, especially those belonging to racial and ethnic minority groups. The researchers do note that the limitation of their study lay in their inability to establish a depression diagnosis to define women who suffered with PPD. As New Jersey’s Medicaid program does not require diagnosis for payment, it has been found that depression is often under-coded. It is possible that the study included women with other mental health conditions (2011).

Postpartum Depression & Treatment

Mother infant psychotherapies

According to Nylen et al. (2006), there are two general approaches to the treatment of PPD, those that reduce depressive symptomology in the mother and those
that focus on improving the mother-infant bond. Nylen and her research team hypothesize that interventions that focus solely on reducing maternal depressive symptomology may not be enough to protect against negative child outcomes. The researchers explain that utilizing modalities that incorporate the infant offer a unique opportunity to repair ruptures in the mother-infant relationship. These modalities explore and illuminate mother-infant interactions by providing corrective supervision or guidance, and ultimately enhance maternal sensitivity and responsiveness. The researchers conclude that interventions that are designed to target the mother-infant relationship offer positive resolution to improving outcomes for children of depressed mothers and may also appear to provide a buffer against future episodes of depression (2006).

**Interpersonal psychotherapy**

Forman et al. (2007) indicate that interpersonal psychotherapy [IPT] is a short-term, time limited therapy that organizes depression from a biopsychosocial perspective and specifically addresses problems that are interpersonal in nature. Accordingly, this includes addressing interpersonal conflicts, such as those with a spouse and/or intimate other. In their study, 120 women who met the criteria for major depressive episode during the postpartum period were split between two groups, the treatment group who were assigned to receive 12 weeks of IPT, and the control group assigned to a waitlist. The results revealed that the participants of the treatment group exhibited a significant decrease in depressive symptoms relative those on the waitlist control group. Additionally, after the 12-weeks, many of the treated mothers were no longer classified as still meeting the full DSM-IV criteria for major depressive episode and improvements
were observed in their relationships with their partners (2007).

In addition to determining whether IPT improved the mother’s functioning, Forman and his research team (2007) attempted to evaluate whether effectively treating a group of depressed mothers also improved their infant outcomes. The results from the study revealed that mothers in the depressed groups were significantly less responsive to their infants than the mothers in the non-depressed control group. Although mothers in the depressed groups reported lower levels of parenting stress, treated mothers continued to report significantly higher levels of parenting stress than mothers in the non-depressed control group. Subsequently, no effect of treatment on maternal responsiveness was found. Although the psychotherapeutic treatment demonstrated to be effective at relieving the symptoms of depression, it had little or no significant impact on maternal responsiveness deficits (2007).

**Group therapy**

According to Ugarriza (2004), one of the reasons that group therapy works so effectively with women suffering with postpartum depression involves the sense of belonging. Members of the group are provided with a safe space to share and confide with others sharing a similar experience without feeling judged or reproached. In order to collect pilot data for a group therapy treatment utilizing the Gruen approach, Ugarriza held a 10-week therapeutic group with women diagnosed with PPD. Using the Beck Depression Inventory II, the women were assessed pre and post treatment for depression. The treatment group consisted of six women who participated in the weekly group therapy sessions while the control group consisted of eight women who were only screened for depression. The Gruen model of group therapy consists of three phases. The
first phase entails disbursing psychoeducation on PPD, providing stress management techniques, illuminating strategies for improving one’s support system, and demonstrating cognitive restructuring methods. Phase two builds on the strategies learned in phase one with the addition of an interpersonal focus designed to increase self-esteem. Phase three predominantly focuses on grief work over unmet expectations of birth and parenting, reconciling and acceptance of feelings, and providing more advanced support skills. The results of the study revealed no significant difference between pre and post test depression scores among the treatment and control group however there was a significant difference between pretest and posttest scores from the treatment group suggesting that the group went from mild depression to minimal or complete depression recovery.

Although the limitation of the study was its small sample size, Ugarriza indicates that the implication of the study points to the barriers of treatment when working with this population. Even with the small sample size and childcare/lunch being offered to improve attendance it became a barrier to treatment. The researcher explains that one of the well-known drawbacks of group therapy is that it takes place over a period of time when postpartum depressed mothers are overwhelmed with what they already “have to do” and are often reluctant to take on more activities, even if those activities are or may be beneficial to them (2004).

**Systemic Therapy**

A family is much more than a group of people that are related by blood. Goldenberg and Goldenberg (2007) indicate that a family is a complex network of relationships that have ascribed roles, organized power structures, and an intricate
communication styles. The relationships found amongst its members are joined together by their common history along with their shared beliefs and assumptions of how the world works. Each family system is interwoven among much larger systems, the community and society in which it resides. As such, it is susceptible to being influenced by these larger systems as well as other factors such as race, ethnicity, socioeconomic status, acculturation, religious affiliation, and education. (2007)

Goldenberg and Goldenberg (2007) explain that a family must include people who choose to spend their lives together in a kinship relationship regardless of their legal sanctions or bloodlines. Families are unique in that its members are irreplaceable and therefore family membership remains intact for life. No matter the distance, the family’s influence remains. Although individuation occurs, the individual continues to be tied to its family group not only for instrumental purposes, but also for emotional connection (2007).

Family continuity is maintained through narratives that are passed down from one generation to the next. These narratives have the power to impact functioning among its members as they provide meaning and understanding as to how the world should be viewed. Occasionally, narratives can serve as blind spots for its members when they stand rigidly by unchallenged irrational beliefs perpetuated through these narratives (2007).

Goldenberg and Goldenberg (2007) theorize that in order to facilitate the cohesive process, a family comes to develop overt and covert rules that guide the roles and functions of its members. These rules are often transmitted in collaborative, purposeful, and recurring patterns of interactive sequences that often go unnoticed by outsiders and
even the participants themselves. In general, families are resistant to change but in the face of external or internal adversity, they come develop their own strategies for coping and will engage in corrective actions to reestablish familiar interactive patterns. It is in the manner the family organizes itself, maintains cohesion, and communicates and problem solves that predicts its ability to recover. Families that are flexible at obtaining solutions and are adaptive to change are better equipped at recovering in times of crisis (2007).

Walsh (2012) indicates that it is those families that transmit a positive beliefs system, display strong organizational processes, and have a firm communication/problem solving process are more resilient. This describes a family that views challenges with optimism, remains flexible, united, and open to change, while simultaneously providing a climate of trust and safety. These family competencies should be channeled to facilitate rebound from disruptive challenges (2012).

**Paradigm Shift**

Under constant stress, a family as a whole or its individual members may begin to manifest dysfunctional behaviors. Goldenberg and Goldenberg (2007) explain that within the systemic framework, human problems are centered within the familial context. The focus is on the transactional patterns currently taking place within the family.

People and events are assumed to exist in a context of mutual influence and mutual interaction. The therapist’s focus is on the process of what they are observing. This process is best explained by what Goldenberg and Goldenberg (2007) identify as circular causality. Families exhibit a reciprocal process in which an action by one of its members affects all other members and the family as a whole. Consequently, each
member’s response prompts other responses that affect all other members whose further reactions create still other responses and so on. Every action provokes a circular sequence that in turn helps to change the original action. The family therapy perspective organizes problems as being part of an ongoing, interactive, mutually influencing family process. Adjusting the family’s structure, interactive patterns, or beliefs systems ultimately changes individual members within the family unit (2007).

Viewing the individual as part of a system, such as a family, provides the therapist with a wider frame of reference as to the recurring patterns of interaction that the person might participate. The focus is shifted to a broader context in which the person functions. When the locus of pathology is said to be internal, belonging to a single individual, the therapist focuses on individual processes and behavior patterns. If however, the maladaptive behavior is viewed as stemming from a dysfunctional relationship, then it is the relationship that becomes the center of therapeutic attention and the target of intervention strategies. It is the family as a functioning transactional system that provides the content for understanding individual functioning (2007).

**Identified Patient**

According to Minuchin (1974), the symptoms being expressed by one of its family members is what brings a family into therapy. This family member is referred to as the identified patient. The identified patient is the one that the family points to as having or being the problem. The symptoms displayed by the identified patient plays an indispensable role in identifying the family’s functioning. These symptoms are said to be either system-maintaining or system maintained devices. Minuchin explains that when the whole family agrees that one individual within the family unit is the owner of the
problem, on some level the family reinforces the symptoms being exhibited. This act of selecting one member to be the problem demonstrates the family unit’s way of maintaining a rigid and inadequate family structure (1974).

Minuchin (1974) further explains that the goal of family therapy is to transform the entire family unit. This is achieved when the therapist works collaboratively with the family to create therapeutic goals that improves their functioning as a whole. The target of all interventions is based on improving the operation of the family system. Although the focus is placed on the family system as a whole, all family members are individually affected, specifically the identified patient as the burden of the being the problem is no longer theirs to bear (1974).

Latino Family Structure

According to Falicov (2005), family life plays an essential role for Latinos. Family commitment, obligation, and responsibility are values that are instilled at a very young age. Emphasis is placed on the group rather than on the individual. As long as the individual member stays within the family system, caretaking and protection can be assured. In contrast to the American value of autonomy and independence, the process of separation and individuation is deemphasized in favor of close family connections, regardless of age, gender, or social class. The internalization of family as an integral part of one’s individual identity is useful in understanding Mexican’s dedication to family unity and family honor (2005).

Garcia-Preto (2005) indicates that Latino family boundaries are flexible and expansive. They can include not only those related by blood and marriage, but also compadres (godparents) and hijos de crianza (adopted children) whose adoption is not
necessarily legal. Typically, the nuclear family is embedded in a larger context of extended family relationships. Garcia-Preto (2005) notes that these extended family relationships need to be factored in to fully understand the presenting problem and its probable solutions (2005).

According to Falicov (1998), the inclusion and participation in large family networks, found in the Latino culture, is explained in the term familism or familismo. This term also suggests collectivism or interdependence as the emphasis is on cooperation rather than on individual responsibility. Family responsibilities such as taking care of the children, financial obligations, emotional support, and problem solving are all shared. Familismo increases in the face of poverty and family honor as it promotes stronger family connections as a survival safety net. Furthermore, Falicov (1998) asserts that family honor can have the ability of shielding family conflict, shame, or deviation from institutions and outsiders.

Falicov (1998) further explains that the high level of emotional connectedness and personal involvement found within family encounters is described in the term personalismo or familial self. Personalismo can come to explain how individuals function within a collectivist culture. The familial self is balanced with a private self that does not disclose certain feelings, secrets, and fantasies. In part, this inner separateness may come to explain how Latinos are able to individuate from their parents’ support and authority while at the same time maintaining emotional closeness and mutual dependency for a lifetime (1998).

The terms machismo and marianismo are constructs that tend to organize gender roles in the Latino culture. Machismo is a socialization role that denotes being a man.
According to Soto-Fulp and Del Campo (1994) in traditional Latino families, machismo often represents the provider and protective role of the male. As a result, the father/husband takes on the authoritative role as others within the family look to him for answers to the issues outside the family system. Falicov (2005) notes that this role can often be seen as an obstacle in the therapeutic relationship with the family as there may be a tendency for the male to take control or dominate the family’s interactions. Falicov suggests, however, that machismo should be seen more as a bridge to therapy as machismo involves a father/husband’s dedication to his children and his responsibility to his family’s well being (2005).

Marianismo, on the other hand, is the female complementary role to that of machismo. Soto-Fulp and Del Campo (1994) indicate that the term derives from Catholicism and references the Virgin Mary. She represents purity, selflessness, and sacrifice. This has set the tone in which Latina women are to exert their power through love and nurturance. In accordance with the idea of marianismo, Falicov (1998) further explains that the idealized role of the mother has been equated with self-denial and abnegation. In times of high stress, she is not expected to take time off or demand collective cooperation. During treatment, a therapist may be unable to convince a Latina mother to take time for herself. The value of being other-invested is deemed more important than being self-invested. As a consequence, Latina mothers may experience excessive amounts of responsibility and anxiety in regards to the well being of their children (1998).

According to Soto-Fulp and Del Campo (1994), age and gender are determinants of authority and respect. As a result, parents tend to hold a higher status than children,
including adult offspring. Children are often expected to obey the parental figures without question. This creates a deep sense of respect for authority making it challenging for Latino children and adult offspring to assert their rights and opinions.

To question a family rule is seen as disrespectful by the entire family system. Often, a cohesive family network can create issues for the individual family member. Soto-Fulp and DelCampo (1994) state that healthy interactions outside of the family system can be perceived negatively by the family system ultimately causing normal acculturation and socialization into the American mainstream to be halted or diminished. Acculturation at the expense of family traditions has the capacity to create negative tension between family members (1994).

Unlike the Western nuclear family, intergenerational bonds are greatly valued. Falicov (1998) indicates that the parent-child relationship takes center stage in family life often at the expense of the marital relationship. Latina women believe that maternal love is greater and more sacred than spousal love. Consequently, the marital unit comes to slowly lose its romantic ties. This family dynamic has the propensity to generate father-mother-child triangulations (1998).

The Latino style of communication is one that focuses on maintaining harmony. According to Falicov (1998) positive emotional expression is highly valued while negative expression such as interpersonal conflict, assertiveness, and/or demands are seen as rude and insensitive. Utilizing an indirect, implicit, or covert communication style is compatible with Latino’s desire to maintain family equanimity. To achieve this, the use of third person is commonly applied. Allusions, proverbs, analogies, and parables are used to convey thoughts or opinions however this communication style often translates as
vague, obscure, and guarded. Additionally, anger is often expressed with the use of indirectas. These take the forms of criticism by allusion rather than naming a person directly. Through the formation of “light” triangles, rapport-based alliances, especially when based along gender lines, provides an emotional outlet in the form of gossip and secrets (1998).

Falicov (1998) indicates that for therapists, the challenge lies in distinguishing the degree to which such patterns of indirect communication are maladaptive for a particular family. To establish a therapeutic alliance with the family, Falicov suggests that approaching the family with a tone of acceptance that joins with the family’s style of communication is to be maintained throughout the therapeutic process. Disclosure is facilitated when the therapist participates in the family’s use of storytelling, metaphor, and dichos, or sayings (1998).

**Folk Healing**

While culture is never the only factor used to determine a person’s behavior, it’s often the most crucial ingredient in multicultural interactions, especially between patient and healer. According to Maduro (1983), when working with an ethnically diverse population, such as Latinos, it is important to fully understand their preconceived ideas and expectations of what constitutes illness and what, in their point of view, are effective treatment procedures. Failure to recognize the importance of this is a common obstacle to positive treatment outcomes.

Maduro (1983) further explains that Curanderismo, is a general term used to describe a folk healing system popular in the Latin Americas. Curanderismo involves a comprehensive worldview of healing that has deep historical roots. It is based on a set of
values, underlying beliefs and premises that provide references to the cause of diseases and its associated cure. Maduro (1983) reports that there are eight reasons that Latinos seek Curanderos, folk healers.

The first premise is that folk healers are sought for physical, psychological, and social ailments that are believed to be followed by strong emotional states such as susto (fright), envidia (envy), nervios (anxiety), rage, fear, or mourning. In addition, disease or illness are said to follow physiological imbalances, such as a dislocation of body parts as in empacho (indigestion) or caida de mollera (sunken fontanel). It is believed, for example, that one can have an imbalance of "hot" and "cold" substances in the body, and the same holds true of human relations. To restore balance, patients in hospital often ask for cilantro believed to be a cold food. Women who have just given birth to a child, which is a hot condition, will not want to eat pork, which is considered to be a hot food (1983).

A third premises that follows maladjustment is due to magical or supernatural causes, such as punishment by a saint or a curse from negative forces, such as black magic, that have come to inflict personal harm. The fourth premise pertains to the underlying assumption in curanderismo that the body and soul can be separated. The person may often feel as if a part of the self is lost or derailed. A curandero (or, the feminine form, curandera) treats the personal holistically, fully discussing the physical body, but also focusing with detail on the psyche, or soul of the person (1983).

A fifth premise is related to the locus of responsibility in finding a cure. Although to some extent this always rests with the individual patient and the curandero, it can also involve the family participation. The nuclear and extended family comes to support and
reassure the ailing person. The extended family aids in the healing process because persons are able to use social, emotional and physical resources in times of stress (1983).

The sixth underlying assumption is that the natural world is not clearly differentiated from the supernatural. This is closely related to the fourth premise, the separation of the soul from the body. Due to this belief, activities such as penance, prayers, vows, and sacrifice are utilized in an attempt to sway the gods and saints into granting requests or miracles. The idea behind the interconnectedness of the natural and supernatural worlds are not always conscious, but they always to some extent underlie Latino thinking (1983).

The final underlying premise has to do with the interaction with the healer. In an ideal culturally patterned sense, a healer is expected to be warm, friendly and personal. There is also some emphasis on his or her education and training, but more attention is paid to a healer's connection to the sacred. This is often spoken of as their "gift" or "call" (llamada). Successfully treating Latinos requires an active, open and personal approach. Expectations, in other words, call for the active participation of both patient and healer, as person to person, not as subject to object (1983).

**Conclusion**

This literature review has examined PPD and the cultural implications for the Latina community. By developing a workshop that targets MFT trainees and interns it allows for early interventions treatments that can ultimately assist in reducing depressive symptoms and increase positive parent-child and familial interactions.
Chapter 3

Project Audience and Implementation Factors

Introduction

As has been made evident in the review of literature, there is a scarce amount of information currently being disbursed on the topic of PPD. Due to its highly sensitive nature, PPD is often underreported by those who suffer from it; ultimately jeopardizing the well being of the mother and her infant. As the Latino population quickly becomes the majority, it is imperative for those in the counseling field to begin to understand how PPD affects this group and how to effectively treat them. This project is intended to assist therapeutic/counseling professionals in achieving positive treatment outcomes when working Latina women suffering with PPD by using a family therapy approach.

This chapter will discuss the development of this project followed by the intended audience to whom it can be most beneficial. Clarification will be provided as to the qualifications needed of the professional who will be providing the workshop as well as the ideal environment required to present it in an effective manner. Finally, a brief outline of the project itself will be provided.

Development of Project

The development of this project all started with my own history with postpartum depression. In 2001, I was well on my way to becoming a high school math teacher. Admittedly, I had no idea what I was doing or getting myself into. I was following the path that was laid out in front of me by what I had heard all my life, “Antonia, you will go to college and become something important”. Being the first-born child of Mexican immigrants, I often felt the pressure to fully utilize the educational opportunities available
to me in this country. My mother, a homemaker, only had a sixth grade education while my father, a mechanic, only received a fifth grade education. My father was especially proud to see that I excelled academically and really pushed me to “become something important”. After he tragically passed away when I was only nine years old, I continued to push myself academically to become that something important he wanted me to be.

Being that no one in my family had gone to college, there was no one there to guide me through the educational process. I had the daunting task of figuring it all out on my own. The fact that I was completing my third year at a reputable college was a huge accomplishment for my family and I. To learn, however that I was pregnant out of wedlock appeared to be the end of all that I knew about myself. There I was, a 21-year old full time student working at a fast food restaurant expecting a child.

Two years earlier, I had moved out of my mother’s house due to unbearable family problems. Not only did I lack parental support, but also I was on minimal speaking terms with my mother. My only support was my now husband and my younger sister. At the time, the relationship between my husband and I was very unstable. We were both young and our financial problems were straining the already weakened relationship. With my sister, being that I was the oldest, I was unaccustomed to asking her for help. On top of everything, she was going through her own set of problems. At her primary care physician’s urging, she had recently started seeing a therapist and had been diagnosed with Major Depressive Disorder, a diagnosis that I had very little knowledge about. Fortunately, my sister was able to get me a full time position at her current job site and allowed us to rent her spare bedroom.

Although I physically felt well throughout my entire pregnancy, I had uncertain
thoughts about having the baby. There was a part of me that often thought that a miscarriage would be heaven sent. I felt ill equipped at becoming a mother. To make matters worse, the relationship between my husband and I started to further deteriorate. Our financial troubles worsened when at six months pregnant he lost his job. Our emotional connectedness was almost non-existent. I resented him for the pregnancy and found myself being disgusted by him. I, however, carried on. I had learned well that you don’t complain, you just keep on moving. As my mother says, “Ya ni llorar es bueno”, which translates to, there is no point in crying.

On January 12, 2002 at 11:55PM I laid my eyes upon the most beautiful baby boy I had ever seen. I was instantly consumed in love. The reality of having a child had finally sunken in. While getting his check up from the nurses, I had been left alone in the recovery room. I was overwhelmed with emotion. My body was in a state of shock from the labor, something that I had not anticipated. I had no idea what was happening to me as no one had explained the post partum experience. I remember thinking, “Shouldn’t I feel happy and great”? My only depictions of childbirth were the ones that I had seen on the television where the women appeared happy and full of life. On the contrary, I felt drained and lifeless. The next couple of hours I could barely sleep. Aside from the pricking and poking from the nurses, the adrenaline still running through my body kept me awake. When the nurses dropped off my son, I felt so responsible in ensuring that he did not cry. To me, his cries signified my incompetence as a mother. This set the tone for the emotional downturn that would take place during the next year.

Oftentimes, I felt like I had to be the “perfect” mother. This meant that I had to do everything right for my son. I had to dress him right, bathe him right, know what his
tears meant, soothe him, feed him the right foods, read to him, participate in mommy and me activities, stimulate him, etc. Any indication that this was not happening and I became devastated. Being around others often elicited this strong sense of needing to be this perfect mother. Sharing a two-bedroom apartment made things difficult, especially at night, when I didn’t want to wake my sister and her husband due to my son’s cries.

Slowly, I came to notice that I was very sensitive to my son’s tears. They would overwhelm and frustrate me to the point that soon these emotions evolved into an uncontrollable anger.

In order to make ends meet, I went back to work within five weeks of having my son. Even though shortly before my son’s birth my husband found a new job, he had to take on a second job to ensure we were financially stable. During the day, my son stayed at a daycare and in the evenings I took care of him. I was jealous of the babysitter’s time spent with my son. I was missing out on all of his developmental milestones. On top of everything else, in the evenings I was not fully present with him as I was often overcome with exhaustion. Just when my son was learning to crawl to explore his world, all I wanted to do was stay in my room and sleep. I had never felt so emotionally unstable in my life yet I also lacked the comprehension to even know what I was going through. I began to daydream of how wonderful it would be to get hit by a car and put all of the emotional turmoil to rest.

I began to fear being around my son. The emotional instability I was experiencing was disconcerting but I was extremely ashamed to let others know what I was feeling. I was desperately alone. My first attempt at help was by I asking my husband to quit his second job so he could be at home in the evenings. The reality was that we needed his
second job. He said that I would be fine. Little did he know what was manifesting inside of me.

When my son was about 9 months old, we got our own one-bedroom apartment. Although I felt more freedom at having our own space, I continued to have fears about being alone around my son. I had slowly gotten tangled in a spider web of emotions that I could no longer undo myself from. I was lost and displaced and could no longer trust myself as a mother.

Till this day, there are only less than a handful of people to which I have shared the true reasons why I sought mental health care for postpartum depression and even then, they are only variations of the truth. There is the story that I have told most people which is that I felt depressed and overwhelmed. There is the one that I told my primary care physician in which I said that ever since the birth of the baby I had been feeling emotionally overwhelmed and depressed. Then there is the one that I told my therapist which sounded similar to the one I told my primary care physician except it included my distrust about being around the baby an a blurb about how one day I hit my son in the hand when he knocked baby food out of my hand. This story triggered a report to the Department of Child and Protective Services [DCFS] that included taking my son to have pictures taken of his entire body to ensure that I was not physically abusing him.

Then there is the real reason of why I sought help. On top of what I have previously discussed, there was a pivotal moment that made me realize that if I didn’t seek help it could possible cost the life of my child. When my son was about 10 months old, as I was feeding him he started to spit out his food. He had only had a couple of spoonfuls so I knew he wasn’t yet full. I went to give him another spoonful when he
suddenly pushed my hand away causing the baby food to spill all over the kitchen floor. In that instant I lost it. I felt rage consume me. I grabbed his little hand and smacked it multiple times. His cries filled the entire apartment. When I looked at his throbbing red hand the rage instantly dissipated. I was mortified. I immediately picked him up from the high chair and began to soothe him. I had become the monster that I so feared. I knew then that I needed drastic help. Without telling my husband what had happened, I made an appointment with my primary care physician and started on the road to recovery.

Although it has been a treacherous journey, I have come out of it a better human being and mother. As I reviewed the literature, I recognized that postpartum depression and I were destined to meet. My plot in life had been such that I fit almost every single risk factor associated with PPD. It was this new knowledge about PPD that began to alleviate lingering guilt regarding my capabilities as a mother. Regardless of my resiliency or strength, the maternal depression I would succumb to was almost unavoidable.

My mental health treatment consisted of individual psychotherapy and antidepressants. Although this treatment was beneficial and successful, I continued to face my struggles alone. My family and support system had little to no knowledge of my experience. The review of the literature has brought with it a new awareness of the importance of one's support system during the transition into parenthood. Women suffering with this shaming and isolating disorder would greatly benefit from a therapeutic approach that relieves her of her guilt and bring her closer to her loved ones. By shifting the locus of pathology from the symptomatic individual to the family dynamics is healing to the mother suffering with PPD.
Intended Audience

This project was created for an intended to be presented to counseling professionals. Specifically, the project is to be utilized by MFT programs, trainee field sites, mental health agencies, and MFT professional associations to educate MFT trainees, interns, and licensed professionals on effective treatment options when working with the ethnically diverse community suffering with PPD. MFT professional of all ages, genders and races would benefit from being exposed to this project. Due to their direct involvement with the Latino population, the information presented is geared toward but not limited to those professionals who speak Spanish.

Personal Qualifications

At the present time, the creator of the project is the only professional qualified to execute the workshop. The professional is in the process of receiving her Masters of Science in Counseling, Marriage and Family Therapy. Once the required amount of hours has been achieved, the professional will commence the process of becoming a licensed MFT. It is at that point, that the necessary research will take place to run the workshop and ensure that it meets all qualifying criteria for Continuing Education Units [CEU’s].

Due to the professional’s training, research, and personal experience with the subject matter, she has the expertise necessary to effectively implement the workshop. Once trained, a therapist would also be able to present the workshop however a licensed professional would be preferred if the workshop is to count for CEU’s.

Environment and Equipment

The space required to conduct the workshop should be a quiet large room, such as a lecture hall or spacious conference room, that can accommodate an entire field site
staff, a classroom full of students, and/or counseling professionals. Necessary equipment will include a laptop, a projector, a screen, and adaptors for the set up and presentation of the PowerPoint slide. The material presented will also be printed and handed out to the attendants so as to facilitate the flow of the presentation and note taking. The attendees will be allowed to take the printed material with them to implement the knowledge they have acquired.

The estimated running time of the workshop is approximately one and a half to two hours. It is recommended that the presenter provide a 15 minute break half way through the presentation as well as to allow an additional 15 minutes at the conclusion of the presentation for questions and answers.

Project Outline

- **Introduction to Postpartum Depression [PPD]**
  - Workshop Goals

- **Postpartum Depression**
  - Transition into Motherhood
  - PPD Facts
    - Prevalence
  - Defining PPD
    - Baby Blues
    - Postpartum Psychosis
    - Postpartum Depression
    - PPD Diagnosis Criteria
  - PPD Risk Factors
- **Latinas and PPD**
  - Latino Community
  - Prevalence
  - Risk Factors
  - Treatment Initiation

- **PPD Treatment**
  - Psychotherapy
    - Mother and Infant Psychotherapies
    - Interpersonal Psychotherapy [IPT]
    - Group Therapy

- **Systemic Therapy**
  - An Overview
    - Family
    - Narratives
    - Resiliency
    - Circular Causality
    - Paradigm Shift
    - Identified Patient

- **Latino Family Structure**
  - Cultural Competence
    - Latino Family Structure Overview
      - Familismo
      - Machismo
- Marianismo
- Intergenerational Bonds
- Communication Style

- Folk Healing
  - Curanderismo, an Overview

- Summary

- Questions

- References
Chapter Four

Conclusion

Summary

This project was created to provide much needed information on the causes of PPD and how it affects Latina women. PPD is often suffered in silence due to the social stigma involved with its disclosure. On its own, mental health is often seen as belonging to those that are weak and “crazy”. In addition, due to society’s hero like view on the role of mothers, women suffering from this painful disorder have an added hurdle to overcome.

Given the rapid growth of the Latino population, it is imperative that counseling professionals stay current with the needs of this group. By utilizing a systemic approach, it is expected that depressed mothers, the identified patient, no longer continue to bear the burden of being the problem. This can facilitate the process of self-disclosure, which has been found critical for positive treatment outcomes. By incorporating the support system into the therapeutic process, they will cease to feel isolated and instead feel the safety necessary to speak openly about their needs to be effective in raising a healthy family.

Discussion or Conclusion

In my own most recent experience, after disclosing that I was researching PPD among the Latino population, a close friend of mine instinctively shrugged it off and very matter of fact stated that she was certain that most research on the subject would point to the fact that women who claim to suffer with PPD were only fetching for attention. Being that she was of Latin descent, I was taken aback by her remark. She then asked her father what his thoughts were on PPD. He stated that he believed that it did not exist and
that maybe these women were just crazy. It is responses such as these that make it
difficult for women to feel safely express their harrowing experience with PPD.

I must admit, that I too struggled with my own self-disclosure relating to my PPD
experience. My son is now 11 years old and until just about a month ago, I finally fully
disclosed to my husband the dire details of my ordeal. This self-disclosure was not an
easy feat. I found myself having difficulty uttering the words. Even after all these years,
as I looked into my husbands eyes, I was saturated with shame. His response was painful
as his instinct was to recall the well being of our son. I again felt so lonely and like that
evil monster that came to life on the dreadful day. Although I have done my fair share of
treatment, there is no role that is more important or dearer to my heart than that of being a
mother. To openly speak of my dark side has been a painful yet healing process. My
husband was able to see my pain and soothe me.

I had always been very quick to dismiss this facet of my life. Writing this thesis
project has provided a cathartic experience as it has forced me to review and explore the
details behind my own struggle. I have become aware of the shame and guilt I have held
on to for all of these years. Being that my son is now going through his own struggles, I
often wonder if his current predicament is due to our difficult beginnings. While
reviewing the literature, article after article is infused with facts about the negative child
outcomes. I often had to remind myself that I wasn’t all that bad. I did the best that I
could with the resources were available to me at that time. To seek help has been the
most courageous act I have ever performed.
References


Appendix

- **Introduction to Postpartum Depression [PPD]**
  - “This girl I knew who lived next door but one…I said, “Oh, do you feel like that, do you?’ and she’d say, “Oh, no, no, no,” and I said “Oh-oh, pull yourself together dummy…you’re all right.” And then I’d get home and think, “She doesn’t feel like that, perhaps it isn’t normal”…That was the one thing that really got to me through it all, that I couldn’t find anyone who felt like I did, and I felt like I was going through it on my own…I really thought I’d gone mental. I really thought that was the end of my life. I thought I’d flipped completely and I couldn’t find anyone who said, “Oh yes, I felt like that, don’t worry, you’ll get better”…I felt really isolated and lonely through it.”

- **Workshop Goals**
  - There is a scarce amount of information currently being disbursed on the topic of PPD. Due to its highly sensitive nature, PPD is often underreported by those who suffer from it; ultimately jeopardizing the well being of the mother and her infant. As the Latino population quickly becomes the majority, it is imperative for those in the counseling field to begin to understand how PPD affects this group and how to effectively treat them. This project is intended to assist therapeutic/counseling professionals to achieve positive treatment outcomes when working Latina women suffering with PPD by using a family therapy approach.

- **Postpartum Depression**
Transition into Motherhood

- Pregnancy and childbirth brings with it dramatic changes in routines, social roles, and all interpersonal relationships.
- Depression during this sensitive period is not only devastating to the mother but it can also be devastating to the child and the family.

PPD Facts

- In the United States [US] it is believed that there are between 6.5 and 12.9 percent of mothers who experience either a minor or major depression during the first year following the birth of their child. (California Department of Health Services [CDHS], 2007)
- Primary care physicians often fail to properly diagnose less than half of mothers suffering from depression. Similarly, less than half of depressed women recognize that they are depressed. (Chaudron et al., 2005)
- Failing to identify and/or address the warning signs can have long lasting consequences as it not only effects the mental health of the mother but as a result can also have a damaging effect on the attachment and developmental well being of the infant.

Defining PPD

- Many women may come to experience a fluctuation in mood that could be due to the hormonal, physical, emotional, social, and identity role changes happening within the new mother’s life.
- While it is important to understand what PPD is, it is of equal importance
to understand what it is not. PPD lies between what is referred to as the “baby blues” and the more severe postpartum psychosis.

- Baby Blues
- Postpartum Psychosis
- Postpartum Depression
- PPD Diagnosis Criteria
  - The symptoms of the postpartum onset do not differ from those of the non-postpartum mood disorders.
  - The specifier With Postpartum Onset can be applied to the current, or most recent mood disorder if onset is within 4 weeks after childbirth.
  - Major Depressive
  - Manic
  - Mixed Episode of Major Depressive
  - Bipolar II
  - Brief Psychotic Disorder
  - Specify if:
    - With Postpartum Onset

- **PPD Risk Factors**
  - Low socio economic status
  - Pregnancy/delivery complications - Anxiety and stressful life events during the pregnancy were found to be clear risk factors for the development of PPD.
- Poor self-esteem and/or lack of confidence is one’s parenting skills.
- When exploring interpersonal relationships during pregnancy, women undergoing marital distress along with the perception of low social support would be more likely to develop PPD.
- Past history of psychopathology was found to be the single largest factor that placed women at risk for depression in the postpartum period.

- **Latinas and PPD**
  - Latino Community
    - CDHS (2007) notes that in 2004, more than half of California’s resident births were to Hispanic females. It is imperative to begin to recognize their need when it comes to this very salient mental health issue.
  - Research on PPD has predominantly focused on European American women with little attention to the prevalence and risk within the ethnically diverse community.
  - It is important to evaluate whether the prevalence and risk factors pertaining to major depressive disorder continue to be as salient for them as indicated on most research relating to PPD.
  - Prevalence rates for Latinas are shown to be similar to Caucasian and
African American women.

- Rates of Major Depressive Disorder during the postpartum period are between 6.5% and 8.5%.
- 50% report that they had developed depressive symptoms after delivery while 25% developed the symptoms during their pregnancy.

- **Risk Factors**
  - Perceived satisfaction with postnatal support from the baby’s father significantly predicted symptoms of depression in the postpartum period.
  - Perceived lack of support and limited practical assistance from the baby’s father may make the experience of pregnancy and the transition into motherhood more stressful, thereby increasing the risk for PPD.
  - Moreover, dissatisfaction with the support received from one’s family during the postpartum period was correlated to elevated risk for depression.

- **Treatment Initiation**
  - A disproportionate number of Latinas who suffer from PPD do not receive needed services.
  - Caucasian women are twice as likely to initiate mental health treatment. Low treatment initiation rates were found among Latinas (5%).
  - Among Latina women that do initiate care, the time from delivery to treatment initiation was significantly longer than for Caucasians.
  - Furthermore, Latina women have lower chances of receiving follow up or
continued care as compared to Caucasian women.

- **PPD Treatment**
  - Although there is no general consensus for treating PPD, treatment methods similar to those used for non-postpartum major depressive disorder are typically implemented. These include:
    - Psychopharmacology
    - Individual Psychotherapy
    - Group Therapy
  - Psychotherapy
    - The risk of leaving PPD untreated can have detrimental consequences on the mental state of the mother and negatively impact the attachment of the child. As a result, most treatment on PPD focuses on reducing the maternal depressive symptoms of the mother and/or improving the mother-child attachment.
      - There are two general approaches to the treatment of PPD:
        - Those that reduce depressive symptomology in the mother.
        - Those that focus on improving the mother-infant bond.
          - Mother infant psychotherapies
          - Interpersonal psychotherapy
          - Group therapy

- **Systemic Therapy**
Family

- The relationships found amongst its members are joined together by their common history along with their shared beliefs and assumptions of how the world works.
- Family continuity is maintained through narratives that are passed down from one generation to the next. These narratives come to provide meaning and understanding as to how the world should be viewed. These narratives have the power to impact functioning among its members.

Occasionally, familial narratives come to serve as blind spots when the family stands rigidly by unchallenged irrational beliefs perpetuated through these narratives.

In order to facilitate the cohesive process, a family comes to develop overt and covert rules that guide the roles and functions of its members. These rules are often transmitted in collaborative, purposeful, and recurring patterns of interactive sequences that often go unnoticed by outsiders and even the participants themselves.

In general, families are resistant to change but in the face of external or internal adversity, they come develop their own strategies for coping and will engage in corrective actions to reestablish familiar interactive patterns.

Resiliency

- Families that transmit a positive beliefs system, display strong
organizational processes, and have a firm communication/problem solving process are more resilient.

- This describes a family that views challenges with optimism, remains flexible, united, and open to change, while simultaneously providing a climate of trust and safety. These family competencies should be channeled to facilitate rebound from disruptive challenges.

  - In times of persistent stress, a family as a whole or its individual members may begin to manifest dysfunctional behaviors.

  - Utilizing a systemic approach, human problems are centered within the familial context. The focus is on the transactional patterns currently taking place within the family.

  - Circular Causality
    - Within a family, any action by one of its members affects all other members and the family as a whole, and then in turn each member’s response prompts other responses that affect all other members whose further reactions create still other responses and so on.
    - Every action provokes a circular sequence that in turn helps to change the original action. The family therapy perspective organizes problems as being part of an ongoing, interactive, mutually influencing family processes. By altering the family’s structure, interactive patterns, or beliefs systems, its individual
members behaviors are also changed.

- **Paradigm Shift**
  - Viewing the individual as part of a system, such as a family, provides the therapist with more visibility into the recurring patterns of interaction in which the person might engage.
  - When the locus of pathology is said to be internal, belonging to a single individual, the therapist focuses on individual processes and behavior patterns.
  - If the maladaptive behavior is viewed as stemming from a dysfunctional relationship, then it is the relationship that becomes the center of therapeutic attention and the target of intervention strategies. It is the family as a functioning transactional system that provides the content for understanding individual functioning.

- **Identified Patient**
  - The symptoms being expressed by one of its family members is what brings a family into therapy. This family member is referred to as the identified patient. The identified patient is the one that the family points to as having or being the problem.

- When the whole family agrees that one individual within the family unit is the owner of the problem, on some level the family reinforces the symptoms being exhibited. This act of selecting one member to be the problem demonstrates the family unit’s way of maintaining a rigid and inadequate family structure.
Although the focus is placed on the family system as a whole, all family members are individually affected, specifically the identified patient as the burden of the being the problem is no longer theirs to bear.

**Latino Family Structure**

- Cultural Competence
  - Cultural competence is imperative in the field of mental health.
  - When working with clients of the non-dominant culture, recognizing the importance of culture and incorporating it into one’s theoretical approach is essential to creating a therapeutic alliance with the client so that they do not feel perplexed, displaced, or lost.

- Family commitment, obligation, and responsibility are values that are instilled at a very young age. Emphasis is placed on the group rather than on the individual.

- In contrast to the American value of autonomy and independence, the process of separation and individuation is deemphasized in favor of close family connections, regardless of age, gender, or social class.

- Latino family boundaries are flexible and expansive. They can include not only those related by blood and marriage, but also compadres (godparents) and hijos de crianza (adopted children) whose adoption is not necessarily legal.

- Familismo
  - The inclusion and participation in large family networks, found in
the Latino culture, is explained in the term *familism* or *familismo*.

This term also suggests collectivism or interdependence as the emphasis is on cooperation rather than on individual responsibility.

- **Machismo**
  - The terms *machismo* and *marianismo* are constructs that tend to organize gender roles in the Latino culture.
  - *Machismo* is a socialization role that denotes being a man.
  - In traditional Latino families, *machismo* often represents the provider and protective role of the male. As a result, the father/husband takes on the authoritative role as others within the family look to him for answers to the issues outside the family system.

- **Marianismo**
  - *Marianismo* is the female complementary role to that of machismo.
  - The term *marianismo* derives from Catholicism and references the Virgin Mary. She represents purity, selflessness, and sacrifice. This has set the tone in which Latina women are to exert their power through love and nurturance.
  - In accordance with the idea of *marianismo*, the idealized role of the mother has been equated with self-denial and abnegation.

- To question a family rule is seen as disrespectful by the entire family system. Often, a cohesive family network can create issues for the individual family member.
Healthy interactions outside of the family system can be perceived negatively by the family system ultimately causing normal acculturation and socialization into the American mainstream to be halted or diminished.

Unlike the Western nuclear family, intergenerational bonds are greatly valued.

Parent-child relationship takes center stage in family life often at the expense of the marital relationship. Latina women believe that maternal love is greater and more sacred than spousal love. Consequently, the marital unit comes to slowly lose its romantic ties. This family dynamic has the propensity to generate father-mother-child triangulations.

Communication Style

- The Latino style of communication is one that focuses on maintaining harmony.
- Positive emotional expression is highly valued while negative expression such as interpersonal conflict, assertiveness, and/or demands are seen as rude and insensitive.
- Utilizing an indirect, implicit, or covert communication style is compatible with Latino’s desire to maintain family equanimity.
- The use of third person is commonly applied. Allusions, proverbs, analogies, and parables are used to convey thoughts or opinions however this communication style often translates as vague, obscure, and guarded.
Additionally, anger is often expressed with the use of *indirectas*. These take the forms of criticism by allusion rather than naming a person directly.

Through the formation of “light” triangles, rapport-based alliances, especially when based along gender lines, provides an emotional outlet in the form of gossip and secrets.

**Folk Healing**

- When working with an ethnically diverse population, such as Latinos, it is important to fully understand their preconceived ideas and expectations of what constitutes illness and what, in their point of view, are effective treatment procedures. Failure to recognize the importance of this is a common obstacle to positive treatment outcomes.

  - **Curanderismo**

    - *Curanderismo* is a general term used to describe a folk healing system popular in the Latin Americas.
    - *Curanderismo* involves a comprehensive worldview of healing that has deep historical roots.
    - It is based on a set of values, underlying beliefs and premises that provide references to the cause of diseases and its associated cure.
    - The premises underlying seeking Curanderos, folk healers, are as follows:

**Summary**

- Given the rapid growth of the Latino population, it is imperative that
counseling professionals stay current with the needs of this group.

- By utilizing a systemic approach, it is expected that depressed mothers, the identified patient, no longer continue to bear the burden of being the problem. This can facilitate the process of self-disclosure, which has been found critical for positive treatment outcomes.

- By incorporating the support system into the therapeutic process, they will cease to feel isolated and instead feel the safety necessary to speak openly about their needs to be effective in raising a healthy family.

• Questions?
USING A SYSTEMIC FRAMEWORK TO TREAT LATINA WOMEN SUFFERING WITH POSTPARTUM DEPRESSION

Antonia Cardona
California State University, Northridge
Introduction to Postpartum Depression [PPD]

“This girl I knew who lived next door but one...I said, “Oh, do you feel like that, do you?’ and she’d say, “Oh, no, no, no,” and I said “Oh-oh, pull yourself together dummy...you’re all right.” And then I’d get home and think, “She doesn’t feel like that, perhaps it isn’t normal”...That was the one thing that really got to me through it all, that I couldn’t find anyone who felt like I did, and I felt like I was going through it on my own...I really thought I’d gone mental. I really thought that was the end of my life. I thought I’d flipped completely and I couldn’t find anyone who said, “Oh yes, I felt like that, don’t worry, you’ll get better”...I felt really isolated and lonely through it.”

(Mauthner, 2002, p. 16)
Workshop Goals

There is a scarce amount of information currently being disbursed on the topic of PPD. Due to its highly sensitive nature, PPD is often underreported by those who suffer from it; ultimately jeopardizing the well being of the mother and her infant. As the Latino population quickly becomes the majority, it is imperative for those in the counseling field to begin to understand how PPD affects this group and how to effectively treat them. This project is intended to assist therapeutic/counseling professionals to achieve positive treatment outcomes when working Latina women suffering with PPD by using a family therapy approach.
POSTPARTUM DEPRESSION
Transition into Motherhood

Pregnancy and childbirth brings with it dramatic changes in routines, social roles, and all interpersonal relationships. Depression during this sensitive period is not only devastating to the mother but it can also be devastating to the child and the family.

(Gotlib, Whiffen, Wallace, & Mount, 1991)
PPD Facts

- In the United States [US] it is believed that there are between 6.5 and 12.9 percent of mothers who experience either a minor or major depression during the first year following the birth of their child. (California Department of Health Services [CDHS], 2007)

- Primary care physicians often fail to properly diagnose less than half of mothers suffering from depression. Similarly, less than half of depressed women recognize that they are depressed. (Chaudron et al., 2005)
PPD Facts Cont.

• Failing to identify and/or address the warning signs can have long lasting consequences as it not only affects the mental health of the mother but as a result can also have a damaging effect on the attachment and developmental well being of the infant.

(Munoz et al., 2007)
Defining PPD

Many women may come to experience a fluctuation in mood that could be due to the hormonal, physical, emotional, social, and identity role changes happening within the new mother’s life.

While it is important to understand what PPD is, it is of equal importance to understand what it is not. PPD lies between what is referred to as the “baby blues” and the more severe postpartum psychosis.

(Lewis, Byers, Malard, & Dawson, 2010)
Defining PPD Cont.

BABY BLUES

- Approximately 70 percent of women experience a fluctuation in mood within two weeks after giving childbirth.
- This is a transient period.
- It does not impair functioning and is considered to be a part of the transition into motherhood.

(Lewis et al., 2010)
Defining PPD Cont.

POSTPARTUM PSYCHOSIS

- This mood disorder may be present in as many as one in 500 mothers after the birth of a child.
- Postpartum psychosis primarily affects women who have had a mood disorder or postpartum mood disorder in the past.
- It is similar to the baby blues in that it appears within the first four weeks postpartum; however it is drastically different in that the women who are affected by it are often consumed with thoughts of harming the infant, seeing things that are not there, feeling confused, and/or having rapid mood swings.
- This is an incapacitating disorder that usually requires hospitalization.

(Lewis et al., 2010)
Defining PPD Cont.

Postpartum Depression

- Postpartum depression as a mood disorder that becomes present during the first year after giving birth but usually between 2 weeks and 3 months of giving birth.
- The symptoms typically include tearfulness, mood swings, feelings of inadequacy, and guilt about the birth and performance as a mother.

(Ugarriza, 2004)
Defining PPD Cont.

PPD Diagnosis Criteria

The symptoms of the postpartum onset does not differ from those of the non-postpartum mood disorders.

The specifier With Postpartum Onset can be applied to the current, or most recent mood disorder if onset is within 4 weeks after childbirth.

- Major Depressive
- Manic
- Mixed Episode of Major Depressive
- Bipolar II
- Brief Psychotic Disorder

Specify if:
- With Postpartum Onset

(APA, 2000, p. 422-423)
PPD Risk Factors

- Low socio economic status
- Pregnancy/delivery complications - Anxiety and stressful life events during the pregnancy were found to be clear risk factors for the development of PPD.
- Poor self-esteem and/or lack of confidence is one’s parenting skills.
- When exploring interpersonal relationships during pregnancy, women undergoing marital distress along with the perception of low social support would be more likely to develop PPD.
- Past history of psychopathology was found to be the single largest factor that placed women at risk for depression in the postpartum period.

(O’Hara & Swain, 1996; Beck, 2010)
LATINAS AND PPD
Latino Community

The U.S. Census Bureau (2010) reports that between 2000 and 2006, Hispanics accounted for one-half of the nation’s growth. As of July 2006, they represented **14.8 percent** of the US population with **13 million** residing in California alone.

CDHS (2007) notes that in 2004, more than half of California’s resident births were to Hispanic females. It is imperative to begin to recognize their need when it comes to this very salient mental health issue.
Latinas and PPD

Research on PPD has predominantly focused on European American women with little attention to the prevalence and risk within the ethnically diverse community.

(Le, Munoz, Soto, Delucchi, & Ippen, 2004)

It is important to evaluate whether the prevalence and risk factors pertaining to major depressive disorder continue to be as salient for them as indicated on most research relating to PPD.

(Yonkers et al., 2010)
Latinas and PPD Cont.

**Prevalence** rates for Latinas are shown to be similar to Caucasian and African American women.

- Rates of Major Depressive Disorder during the postpartum period are between 6.5% and 8.5%.
- 50% report that they had developed depressive symptoms after delivery while 25% developed the symptoms during their pregnancy.

(Yonkers et al., 2010)
Latinas and PPD Cont.

Risk Factors

- Perceived satisfaction with postnatal support from the baby’s father significantly predicted symptoms of depression in the postpartum period.
- Perceived lack of support and limited practical assistance from the baby’s father may make the experience of pregnancy and the transition into motherhood more stressful, thereby increasing the risk for PPD.
- Moreover, dissatisfaction with the support received from one’s family during the postpartum period was correlated to elevated risk for depression.

(Sheng, Le & Perry, 2011)
Latinas and PPD Cont.

Treatment Initiation
A disproportionate number of Latinas who suffer from PPD do not receive needed services.

- Caucasian women are twice as likely to initiate mental health treatment. Low treatment initiation rates were found among Latinas (5%).
- Among Latina women that do initiate care, the time from delivery to treatment initiation was significantly longer than for Caucasians.
- Furthermore, Latina women have lower chances of receiving follow up or continued care as compared to Caucasian women.

(Kozhimannil, Trinacty, Busch, Huskamp, & Adams, 2011)
PPD TREATMENT
PPD Treatment

Although there is no general consensus for treating PPD, treatment methods similar to those used for non-postpartum major depressive disorder are typically implemented. These include:

- Psychopharmacology
- Individual Psychotherapy
- Group Therapy

(Gjerdingen, 2003)
PPD Treatment Cont.

Psychotherapy
The risk of leaving PPD untreated can have detrimental consequences on the mental state of the mother and negatively impact the attachment of the child. As a result, most treatment on PPD focuses on reducing the maternal depressive symptoms of the mother and/or improving the mother-child attachment.

There are two general approaches to the treatment of PPD
- Those that reduce depressive symptomology in the mother.
- Those that focus on improving the mother-infant bond.

(Nylen et al., 2006)
**PPD Treatment Cont.**

**Mother and Infant Psychotherapies**

The assumption is that interventions that focus solely on reducing maternal depressive symptomology may not be enough to protect against negative child outcomes.

- This modalities explores and illuminates mother-infant interactions by providing corrective supervision or guidance, and ultimately enhance maternal sensitivity and responsiveness.

- Interventions that are designed to target the mother-infant relationship offer positive resolution to improving outcomes for children of depressed mothers and may also appear to provide a buffer against future episodes of depression.

(Nylen et al., 2006)
Interpersonal Psychotherapy [IPT]

IPT is a short–term, time limited therapy that organizes depression from a biopsychosocial perspective and specifically addresses problems that are interpersonal in nature. Accordingly, this includes addressing interpersonal conflicts, such as those with a spouse and/or intimate other.

(Forman et al., 2007)
PPD Treatment Cont.

Interpersonal Psychotherapy Cont.

- In their study with women suffering from PPD, Forman et al. (2007) found a significant decrease in depressive symptomology and observed improvements in partner relationships.

- Furthermore, the study revealed limitations in that no effect of treatment on maternal responsiveness was found. Although mothers in the depressed groups reported lower levels of parenting stress, treated mothers continued to report significantly higher levels of parenting stress than mothers in the non-depressed control group.

  (Forman et al., 2007)
PPD Treatment Cont.

Group Therapy

- One of the reasons that group therapy works so effectively with women suffering with PPD involves the sense of belonging. Members of the group are provided with a safe space to share and confide with others sharing a similar experience without feeling judged or reproached.

- The limitations of group therapy however is that it takes place over a period of time when postpartum depressed mothers are overwhelmed with what they already “have to do” and are often reluctant to take on more activities, even if those activities are or may be beneficial to them.

(Ugarriza, 2004)
SYSTEMIC THERAPY
Systemic Therapy

Family
The relationships found amongst its members are joined together by their common history along with their shared beliefs and assumptions of how the world works.

Each family system is interwoven among much larger systems, the community and society in which it resides. As such, it is susceptible to being influenced by these larger systems as well as other factors such as race, ethnicity, socioeconomic status, acculturation, religious affiliation, and education.

(Goldenberg & Goldenberg, 2007)
Systemic Therapy Cont.

- Family continuity is maintained through narratives that are passed down from one generation to the next. These narratives come to provide meaning and understanding as to how the world should be viewed. These narratives have the power to impact functioning among its members.
- Occasionally, familial narratives come to serve as blind spots when the family stands rigidly by unchallenged irrational beliefs perpetuated through these narratives.

(Goldenberg & Goldenberg, 2007)
Systemic Therapy Cont.

- In order to facilitate the cohesive process, a family comes to develop overt and covert rules that guide the roles and functions of its members. These rules are often transmitted in collaborative, purposeful, and recurring patterns of interactive sequences that often go unnoticed by outsiders and even the participants themselves.

- In general, families are resistant to change but in the face of external or internal adversity, they come develop their own strategies for coping and will engage in corrective actions to reestablish familiar interactive patterns.

(Goldenberg & Goldenberg, 2007)
Systemic Therapy Cont.

Resiliency

Families that transmit a positive beliefs system, display strong organizational processes, and have a firm communication/problem solving process are more resilient. This describes a family that views challenges with optimism, remains flexible, united, and open to change, while simultaneously providing a climate of trust and safety. These family competencies should be channeled to facilitate rebound from disruptive challenges.

(Walsh, 2012)
Systemic Therapy Cont.

• In times of persistent stress, a family as a whole or its individual members may begin to manifest dysfunctional behaviors.

• Utilizing a systemic approach, human problems are centered within the familial context. The focus is on the transactional patterns currently taking place within the family.

(Goldenberg & Goldenberg, 2007)
Systemic Therapy Cont.

Circular Causality
Within a family, any action by one of its members affects all other members and the family as a whole, and then in turn each member’s response prompts other responses that affect all other members whose further reactions create still other responses and so on.
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When the whole family agrees that one individual within the family unit is the owner of the problem, on some level the family reinforces the symptoms being exhibited. This act of selecting one member to be the problem demonstrates the family unit’s way of maintaining a rigid and inadequate family structure.

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Although the focus is placed on the family system as a whole, all family members are individually affected, specifically the identified patient as the burden of the being the problem is no longer theirs to bear.

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LATINO FAMILY STRUCTURE
Cultural Competence

Cultural competence is imperative in the field of mental health. When working with clients of the non-dominant culture, recognizing the importance of culture and incorporating it into one’s theoretical approach is essential to creating a therapeutic alliance with the client so that they do not feel perplexed, displaced, or lost.

(McGoldrick, Giordano, & Garcia-Preto, 2005)
Latino Family Structure

- Family commitment, obligation, and responsibility are values that are instilled at a very young age. Emphasis is placed on the group rather than on the individual.

- In contrast to the American value of autonomy and independence, the process of separation and individuation is deemphasized in favor of close family connections, regardless of age, gender, or social class.

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(Soto-Fulp & DelCampo, 1994)
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  (Soto-Fulp & DelCampo, 1994)

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<thead>
<tr>
<th>(1) Strong emotional states</th>
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</tr>
</thead>
<tbody>
<tr>
<td>(2) Inbalance</td>
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</tr>
<tr>
<td>(3) Malevolent forces</td>
<td>Individual falls victim to negative forces, such as black magic</td>
</tr>
<tr>
<td>(4) Loss of soul</td>
<td>Part of the self is felt to be lost and needs to be reconnected</td>
</tr>
<tr>
<td>(5) Family Support</td>
<td>Family becomes united in the healing process</td>
</tr>
<tr>
<td>(6) Natural vs. Supernatural</td>
<td>Humans can control the supernatural</td>
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