

Diversity, Hegemony, Poverty, and the Emergence of Counseling Psychology in Ecuador

Diversidad, Hegemonía, Pobreza y Surgimiento de la Consejería Psicológica en el Ecuador

MARÍA-CRISTINA CRUZA-GUET, ARNOLD R. SPOKANE,
CARLOS LEÓN-ANDRADE, AND TERESA BORJA

Ecuador is a country of 13.75 million (65% *mestizo* or mixed indigenous-white, 25% indigenous or Amerindian, 7% Spanish, and 3% black; 95% Roman Catholic) lying directly across the equator (*Ecuador* means equator) with an area about the size of Nevada. Bordered by Colombia to the north and Peru to the south and east, Ecuador is a small (by South American standards) but highly diverse country. Ecuador encompasses three geographically and climatically distinct regions (i.e., the Coast, the Andean Highlands, and the Amazon), as well as the Galapagos Islands, an ecosystem with more than 480 species of marine life alone. Indeed, Ecuador is the birthplace of the term *diversity of species* by way of Charles Darwin's laboratory on the Galapagos.

Because the geography of Ecuador is so diverse, the lifestyles, principal work, and economic status of its population are also diverse. There are fishermen along the coasts, cattlemen in the southern highlands, farmers on central highland slopes, and oil workers in the Amazon. The country exports some 400,000 barrels of oil daily in addition to coffee, bananas, flowers, and other marine and agricultural products that form the basis of its developing economy. In its metropolitan areas, there are zones that resemble European communities for the appearance of their construction and the lifestyles of their residents; in stark contrast, there are also urban slums in the major cities, such as in Quito and Guayaquil, where many Ecuadorians live in putrid conditions.

Despite these differences, several cultural values unite the Ecuadorian population. Among these values, *familism*, or the maintenance of strong interdependent ties with nuclear and extended family members, is perhaps the most important (Zubieta, Fernandez, Vergara, Martinez, & Candia, 1998). Similarly, Ecuadorians strive to maintain harmony in their relationships as their sense of well-being is so closely connected with the support and appreciation of their social network. As such, Ecuadorians have been characterized not only for the polite manner in which they communicate (Placencia, 2007) but also for their tendency to perceive the “expression of individual character . . . [as] transgressive” (Tousignant & Maldonado, 1989, p. 900). Furthermore, Ecuadorians’ social organizations are eminently patriarchal. Men are typically the breadwinners of their households, whereas women largely function as housewives and caretakers.

In addition to these values, one of the enduring influences on Ecuadorian life is the resistance against the historical domination or hegemony of outside cultural groups. The native peoples of Ecuador were first conquered by the Inca Empire and thereafter, in the 1500s, became a colony of Spain following Francisco Pizarro’s invasion and conquest. Although Ecuador became an independent democracy in 1809 with help from Simon Bolivar, traces of these two conquests remain significant and have discernable effects on many aspects of everyday life, not least on the practice of mental health (León-Andrade & Lozano, 1997). Indeed Ecuadorian culture, including the attitudes and behaviors of its population with respect to mental health issues, reflects a pervasive tension between what is foreign and what is perceived to be authentically Ecuadorian. Although the majority of the population identifies itself as *mestizo* or *mestiza*, a racial admixture of Spanish and native Indian, there is no universal agreement on what mestizo values are or on how to promote them at different levels (Beck & Mijeski, 2000) despite efforts made by multicultural activists to embrace a mestizo worldview.

On one hand, there has been a powerful movement directed toward “modernizing” the country (Whitten,

1981) by abandoning everything that is aboriginal and adopting secular and Western values. This movement has influenced the emergence of imported models of psychological practice as well as more tolerant attitudes toward seeking help from formally trained mental health professionals—particularly with respect to youth conduct learning difficulties or when a mental health referral is made by a physician. In contrast, there has been an ongoing struggle by the indigenous population living in rural areas to both “assert . . . (their) dignity and autonomy as . . . member(s) of a proud ethnic group” (Beck & Mijeski, 2000, p. 120) and strive to preserve their native cultural customs and spiritual beliefs. Religious influences, a mixture of Incasic and pre-Incasic polytheistic creeds and Roman Catholic beliefs, are, in fact, often evoked by Ecuadorians, both indigenous and mestizos/as, to explain life and health outcomes. The success of even the most advanced and highly specialized medical procedures, such as in vitro fertilization, is commonly attributed to God’s presence in the laboratory (Roberts, 2006). Thus, the roots of local healing practices can be traced to an amalgam of pre-colonial and Catholic doctrines and rituals (León-Andrade & Lozano, 1997), where either the priest or the *curandero* (i.e., healer) is sought to provide help and treatment for psychological problems. It is in the context of these two seemingly antagonistic attitudes toward mental health issues that Ecuadorians tend to navigate, frequently holding ambivalent feelings about seeking help from either source or at times mixing forms of treatment.

Another critical social issue that has hindered the development of psychology in Ecuador is the country’s overall low socioeconomic status. According to estimates from the World Bank (2007), 40.8% of Ecuadorians lived on less than \$2 a day between 1990 and 2005. Moreover, Ecuador has the highest population density in South America, along with related urban crowding and substandard living conditions. Ecuadorian’s governmental resources are therefore allocated to support the most basic needs (i.e., nutrition, physical health, elementary education) of a majority of its inhabitants, with little left to invest in mental health programs.

MENTAL HEALTH PROFESSIONS EVOLVING

As is typical in most developing nations and was the case in the United States in the early 1900s, psychology in Ecuador evolves as mental health issues in need of focused attention appear. A few of these issues, particularly those for which published data exist, are addressed in the following paragraphs. Additionally, we provide information about Ecuador with respect to the three major domains of contemporary counseling (education and training, professional practice, and research) (Leong & Ponterotto, 2003). Finally, we briefly describe indigenous healing practices, and we discuss the potential emergence of counseling psychology in Ecuador and the implications of this emergence for American counseling psychology.

Mental Health Issues in Ecuador¹

In Ecuador, work and unemployment concerns, migration-related problems, teen suicide, and women's issues appear to be the major mental health issues motivating the emergence of the counseling professions.

Unemployment

Vocational and career counseling has received limited attention within Ecuador's psychology professions; paradoxically, work-related concerns have become one of the main presenting problems among those who seek counseling in Ecuador. This is due to the high rates of unemployment and underemployment that ascend to 10.6% and 47%, respectively (U.S. Central Intelligence Agency, n.d.), and force many Ecuadorians to migrate in search of job opportunities.

Migration-Related Problems

In response to an ongoing economic crisis that deepened during the late 1990s, hundreds of thousands of Ecuadorians, hopeful of improving the socioeconomic status of their families, have moved from rural to urban areas or left the country. It is

estimated that in 2001 more than 500,000 individuals emigrated (Saad, Saad, Cueva, & Hinojosa, 2004). As a result, countless families have disintegrated and many children have been left to be cared for by their grandparents. This, in turn, has led to a number of dysfunctional behaviors among those separated by migration, including alcoholism, domestic violence, youth gangs, and depression, particularly among adolescents (Saad et al., 2004).

Teen Suicide

Adolescents in Ecuador are not only the victims of depression but also the victims of suicide. In a recent investigation of global suicide rates among 15- to 19-year-olds, only a handful of countries (among the 90 that were studied) reported higher suicide rates in women than in men; Ecuador was among them (Wasserman, Cheng, & Jiang, 2005). Despite uncertainty as to the root causes for the high rate of suicide among young Ecuadorian women, there is speculation that separation from family due to migration, underreporting of suicide for males due to *machista* attitudes, and conflicts that stem from gender issues contribute to the problem.

Women's Issues

Ecuadorian women, especially mothers, hold a revered status within their home (Mealy, Stephan, & Abalakina-Paap, 2006). Yet concurrently they are subject to discriminatory practices and face considerable impediments to educational and economic opportunities. Moreover, women are victims of violence from parents or partners. Indeed, violence against women in Ecuador is a problem that is both rampant and underrecognized. Estimates suggest that among women between the ages of 15 and 49 who have been married or cohabit with a partner, the prevalence of psychological, physical, and sexual abuse reaches 40.7%, 31%, and 11.5%, respectively (Center for Population Studies and Social Development [CEPAR], 2004). These gender-related problems as well as the other issues

previously described (i.e., unemployment, migration-related problems, and teen suicide) may shape the way psychology in Ecuador is taught, applied, and researched. We describe the current status of these domains—training, practice, and research—in the following section.

Major Domains of Contemporary Counseling

Education and Training

In Ecuador (as in other South American countries—notably Colombia, Argentina, Brazil), imported theoretical counseling paradigms have influenced the practice of psychotherapy and training available for mental health professionals (Ardila, 2004). Most educational programs embrace psychoanalysis (i.e., Freudian, Ego Psychology, Lacanian and Jungian orientations), behaviorism, and, more recently, systemic and humanistic theories as the core for curriculum development. Though more than 25 specialties in psychology exist across Latin America (Sierra & Bermudez, 2005), three areas have dominated the field in Ecuador: clinical, educational/school, and organizational/industrial. “Counseling psychology,” as conceived in the United States, does not yet formally exist in Ecuador.

As in the European educational system, the typical training program, in any of the three specialties just described, admits students immediately after high school. Most of these programs consist of approximately 5 years of course work (Hereford, 1966; Sierra & Bermudez, 2005), the first 3 of which are devoted to general psychology, followed by 2 years of specialized mental health education, professional practice (internship), and thesis work. On completion of these requirements, trainees are certified to perform the same professional tasks (i.e., individual, group and family counseling) as graduates with a U.S. master’s degree in clinical psychology or counseling. They may also conduct psychological testing (including personality, cognitive, and projective assessments) at the level of a U.S. doctorate in psychology. These trainees obtain the title of either *Psicólogo*

(psychologist)² or *Licenciado en Psicología* (degree in psychology) and are commonly referred to as *psicoterapeutas* (psychotherapists). The term *consejero* (counselor) is not used to describe university graduates with a degree in mental health, and it is not part of the psychology vernacular. Nonetheless, as previously mentioned, Ecuadorian mental health professionals perform functions comparable with those of counselors in the United States.

There are approximately 15 psychology programs in the clinical area, 14 in organizational and industrial psychology, and more than 30 in the school or educational specialization (Consejo Nacional de Educacion Superior [CONESUP], 2008; El Universo, n.d.). Very few schools offer master’s degrees in psychology, and doctoral degrees are a rare occurrence; they are offered by certain schools on a periodic basis only. Currently, only one university offers a doctorate in clinical psychology (El Universo, n.d.). This doctorate is the equivalent of a PsyD. Programs awarding the degree of doctor of philosophy in psychology do not exist.

In most of the existing educational programs, multicultural issues are not integrated as a core aspect of the curriculum. In general, students become proficient in the use of assessment tools normed in other Spanish-speaking countries and learn the theories and techniques of the psychotherapeutic model adopted by a particular training program. Typically, however, these programs incorporate neither information about the values and needs of Ecuador’s diverse cultural groups nor a discussion of how these values and needs be addressed in the therapeutic milieu. Moreover, in these educational contexts, indigenous healing practices tend to be ignored, and those who seek this type of service are regarded as “ignorant.”

Although little is known vis-à-vis the efficacy of the imported models of therapy as it pertains to the Ecuadorian population, it seems reasonable to conceive that practices that disregard clients’ worldviews may also hinder the therapeutic process. Interventions rooted in individualistic values, for instance, may conflict with the interdependent relationships that Ecuadorians maintain with nuclear and extended family members. Similarly, therapeutic strategies that

overlook clients' faith in indigenous healing may be regarded with distrust or reluctance or interpreted as a sign of rejection. By and large, the schism previously described between interventions and clients' worldviews recapitulates the history of subjugation of Ecuadorians to the Inca and the Spaniard, and the ensuing imposition of foreign values brought about by these two conquests. Unfortunately, in the absence of a multicultural perspective in the educational field, this schism is perpetuated in professional mental health practices, to which we now turn.

Psychological Practice in Ecuador

In this section, we summarize information on the practice of adopted forms of psychotherapy (i.e., those conducted by psychology professionals) as well as those of indigenous healing practices—as both represent the types of mental health treatments used by Ecuadorians.

Professional Practice

Graduating from a program that is accredited or legitimized by the Ecuadorian Ministry of Education is a prerequisite for practicing all the psychological specialties. On graduation, psychology professionals have the option to join one of several regional or national associations of psychologists (i.e., Asociación Ecuatoriana de Psicología, Federación Ecuatoriana de Psicología Clínica, Colegios de Psicólogos, etc.) that exist in Ecuador. These organizations promote the rights of psychology professionals and provide their members with opportunities for educational advancement and professional networking. Nonetheless, they do not play a formal regulatory or licensing role over practitioners. In the absence of any such regulatory agencies, it is difficult to accurately estimate the sum total of psychology professionals currently in practice. According to World Health Organization (WHO, 2005) statistics, however, there are approximately 29.1 psychologists per 100,000 inhabitants in Ecuador.

In general, psychologists with clinical expertise are either hired by health (i.e., general hospitals and

community mental health centers) and nonprofit organizations or are self-employed. A major challenge that most of these professionals face relates to the scarcity of financial resources, which limits the availability of both job options and career opportunities. A majority of the population is medically insured by the Instituto Ecuatoriano de Seguridad Social (Ecuadorian Institute of Social Security), which hires a marginal number of psychology professionals and pays only for those services provided by their network of hospitals. Access to private insurance is limited to the upper-middle and upper-socioeconomic strata, and in most cases, insurance does not cover the cost of mental health services. As a result, psychological treatment is mostly self-paid and generally regarded as a luxury. Consider that while the minimum monthly wage in Ecuador is only \$170 (Ministerio de Trabajo y Empleo [Ministry of Labor and Employment], n.d.), the cost of an hour of psychotherapy session ranges between \$10 and \$20. Under these circumstances, establishing and sustaining profitable private practices becomes possible only for those very few psychology professionals who have access to the resources (i.e., loans) needed to invest in a practice and who successfully market their services among high socioeconomic status groups.

Most clinical practitioners reside and provide their services in metropolitan areas. Even though 40% of the Ecuadorian population lives in rural zones (United Nations Populations Fund [UNFPA], 2005), there are few incentives for psychology professionals to relocate outside the country's major cities, thereby leaving the countryside with limited access to formal mental health services. It is in these rural areas, where the majority of the indigenous peoples, who preserve close cultural links with their pre-Hispanic roots (León-Andrade & Lozano, 1997; Pribilsky, 2001), live and, consequently, where indigenous healing practices are the most popular.

Indigenous Healing Practices

These forms of treatment, rooted in the spiritual beliefs of the Amerindian population, are known as *curanderismo* and *chamanismo*, given that they are

performed by popular aboriginal leaders—the *curandero* and *chaman*, respectively. Although there are variations among indigenous groups, healers in general reason that mental illnesses are caused by either (a) supernatural causes, which refer to the intrusion of negative energies or evil spirits into a person's body (León-Andrade & Lozano, 1997), or (b) a disruption of an individual's harmony within himself or herself or with his or her natural and/or social environment (Chelada, 2007). Thus, treatment is viewed as a process that purifies the individual and restores his or her harmony with the cosmos (Chelada, 2007; León-Andrade & Lozano, 1997). This is attained through a combination of practices, such as the use of herbal medicines and hallucinogenic beverages, revered ritual objects, suggestions that invoke spiritual or sacred meanings, and even interpersonal interventions that involve the sufferer's community (Chelada, 2007; León-Andrade & Lozano, 1997; Tousignant & Maldonado, 1989). Curandero and chaman provide basically the same types of treatment; however, they differ in that the latter, typically a male, is supposed to naturally possess divine powers that allow him to foresee the future (*chaman*—the one who knows), whereas the curandero or curandera attains his or her skills through learning (“Ecuador entre brujas,” 2006).

Examples of mental ailments (i.e., culture-bound syndromes) that are treated by chamans and curanderos or curanderas are *espanto* (fright) and *pena* (sorrow), among many others. *Espanto* is a condition characterized by a state of fright that afflicts children who have gone through a haunting or shocking experience, such as witnessing a serious fight between their parents (McKee, 1987). Symptoms of *espanto* include emotional lability, noise intolerance, hypersensitivity to certain stimuli, night terrors, insomnia, social isolation, trembling and sweating, heart palpitations, anorexia, and gastrointestinal disturbances (León-Andrade & Lozano, 1997). *Pena*, on the other hand, is a syndrome that resembles the Western diagnosis of clinical depression (Tousignant & Maldonado, 1989) but presents other peculiar somatic symptoms, such as *ataques* (convulsions not related to epilepsy) and upper chest sensations; the

latter have a metaphorical meaning: heart pain. Indeed, the indigenous peoples of highland Ecuador associate *pena* with some sort of loss, particularly with that which entails a social reciprocity failure as it occurs in the context of marital problems, the death of a loved one, and so on (Tousignant & Maldonado, 1989).

The treatment of *pena* exemplifies the multidimensional nature of the healing practices used in the aboriginal communities of Ecuador. On one hand,

The healer rubs the patient's body with eggs, flowers, plants, a young guinea pig and other miscellaneous objects. Calls are made to mountains, springs of water and Christian saints. Suctions in the epigastric area lead to the extraction of impurities like black frogs and tadpoles, and bloody secretions mixed to the healer's saliva. (Tousignant & Maldonado, 1989, p. 903)

On the other, the sufferer of *pena* is encouraged to improve his or her relationships with family and friends, an intervention that is endorsed by both the indigenous healer and the entire community in light of the underlying social significance of this ailment (Tousignant & Maldonado, 1989). Furthermore, in some severe cases, individuals afflicted with *pena* are referred to a psychologist or a psychiatrist who can prescribe antidepressants.

It is not uncommon for those who seek the assistance of an indigenous healer to also consult with a psychology professional about the same problem. In general, however, the provision of traditional healing practices and provision of Westernized treatments have been independent of one another. Recently, an integrative approach that blends indigenous and modern practices has been proposed as a feasible alternative that could better meet the needs of the Ecuadorian population. At least one community organization, the Jambi Huasi (House of Health) in Otavalo, a predominantly indigenous town located 70 miles north of Quito, the capital, has already implemented this new modality and claims to be producing positive outcomes (Chelada, 2007). It is worth noting, nonetheless, that with the exception of case study reports, information

about the efficacy of indigenous healing practices, imported models of psychotherapy, or a combination of the two with Ecuadorian populations is scant. In fact, there has been limited mental health research in Ecuador, as will be made evident in the following paragraph.

Research

Of the three major domains of contemporary counseling (education, practice, and research), research has received the least attention, in large part due to a lack of funding and given that psychology in Ecuador has emerged as an applied field rather than as an investigative one (Ardila, 2004). Nonetheless, there are a few research initiatives under way conducted by some of the major hospitals (i.e., Hospital Psiquiátrico Lorenzo Ponce, Hospital Carlos Andrade Marin), by university faculty, and by independent researchers—oftentimes in collaboration with American scientists. Examples of these initiatives include studies on the mental health consequences of migration (Saad et al., 2004), disasters (Lima et al., 1989), alcoholism (Ayala Loor & Galera, 2004), and smoking (Ockene, Chiriboga, & Zevallos, 1996; Ramirez Ruiz & Andrade, 2005). Results of a selected number of these investigative endeavors were summarized earlier in the section “Mental Health Issues in Ecuador.”

EMERGENCE OF COUNSELING PSYCHOLOGY IN ECUADOR AND IMPLICATIONS FOR U.S. COUNSELING PSYCHOLOGY

Given Ecuador’s diversity, its long-standing social issues, and the pervasive dissociation between its professional mental health practices and its cultural values and indigenous forms of healing, there seems to be a profound need to develop a model of counseling that addresses the necessities of its varied populations. Such a model may need to take into account Ecuadorians’ collectivistic orientation and long-standing socioeconomic plight so as to conceptualize human behaviors as the byproduct of familial and

societal influences (i.e., unemployment, migration, etc.). In the context of such a model, psychologists could intervene at multiple levels of the social environment and act as agents of social change. Moreover, Ecuadorian psychology may benefit from establishing a model of psychotherapy that recognizes Ecuadorians’ deep-rooted spiritual beliefs and reliance on indigenous healing practices. This may be possible by developing an interdisciplinary mode of community practice that incorporates the chaman or curandero (León-Andrade & Lozano, 1997). Furthermore, there is a need to develop a research plan that evaluates the therapeutic efficacy of this and other models of counseling, thereby promoting the advancement of a true Ecuadorian psychology.

In the milieu of Ecuador’s rich and deep-rooted complexity, counseling psychology may find fertile ground to develop. Because of its emphasis on multiculturalism and social justice practices (Heppner, Casas, Carter, & Stone, 2000; Toporek, Gerstein, Fouad, Roysircar, & Israel, 2006), counseling psychology could contribute to the development of a model of counseling that, as we have proposed, is consistent with the worldviews and social problems of the Ecuadorian population. In such a way, counseling psychology could assist Ecuadorian mental health professionals in finding appropriate ways of meeting the needs of their clients. Furthermore, as the economy in Ecuador grows, life options and choices will increase as well. As Amartya Sen (2000) has so eloquently observed, development both presages and produces freedom. As development progresses, individuals and families are increasingly faced with more complex and vexing educational, occupational, marital, and lifestyle choices—precisely the day-to-day issues about which counseling psychology is most concerned (Tyler, 1961). Thus, we can expect that counseling psychology may spread in developing nations, such as Ecuador, much as it did in the United States and Europe during the past century. The unique culture and social ecology of Ecuador will shape this emergence in predictable ways (e.g., more family and community emphases, less expert and more indigenously derived forms of assistance). Although models,

theories, and interventions will need to be adapted, revised, and in some cases discarded entirely, much of what we know in counseling psychology may have applicability and value in countries such as Ecuador.

In a similar vein, the professional worldviews and practices of Ecuadorian psychology practitioners may serve U.S. counseling psychologists not only “to counter the dominance and hegemony of Western psychology” (Leong & Ponterotto, 2003, p. 384) but also to improve the efficacy of their treatment and assessment models with the rapidly growing Hispanic immigrant populations. The use of psychological treatments that combine indigenous healing practices with modern forms of psychotherapy (i.e., the model adopted in the Jambi Huasi community center) provides, in this sense, a unique learning opportunity for U.S. psychologists. The emergence of counseling psychology in Ecuador can indeed be a source of potential growth for Ecuadorian psychology as well as for this specialty in the United States.

NOTES

1. There is a dearth of empirical and epidemiological information describing the types of psychological disorders that are most prevalent among the Ecuadorian population. Informal data provided by several mental health professionals reveal that the most common problems include depression, anxiety disorders (particularly panic attacks), and substance abuse and employment concerns. According to Pan American Health Organization (PAHO, 1998), the prevalence of alcoholism is 7.7% among individuals older than 15.

2. In Ecuador, the term *psychologist* is not specific to those who have obtained a doctorate degree.

REFERENCES

- Ardila, R. (2004). La psicología latinoamericana: El primer medio siglo [Psychology from Latin America: The first half century]. *Revista Interamericana de Psicología*, 38, 317–322.
- Ayala Loo, E., & Galera, S. A. F. (2004). Percepción sobre el uso de alcohol y tabaco en familiares de niños enfermos. Consulta externa del hospital materno infantil del Guasmo Sur, Guayaquil [Perceptions about the use of alcohol and tobacco in families of sick children. Outpatient services of the mother and infant hospital from South Guasmo, Ecuador]. *Revista Latino-am Enfermagem*, 12, 340–344.
- Beck, S. H., & Mijeski, K. J. (2000). Indígena self-identity in Ecuador and the rejection of Mestizaje. *Latin American Research Review*, 35, 119–137.
- Center for Population Studies and Social Development. (2004). *Encuesta demográfica y de salud materna e infantil—ENDEMAIN* [Demographic and mother and infant health survey]. Retrieved January 30, 2008, from <http://www.cepar.org.ec/publicaciones/publi.htm>
- Chelala, C. (2007, July 7). Health in the Andes. *Américas*. Retrieved January 10, 2008, from <http://www.mywire.com/pubs/Americas/2007/07/01/4352070/print/>
- Consejo Nacional de Educación Superior. (2008). *Consulta de Carreras—Universidad* [Career: University consultation]. Retrieved April 25, 2008, from http://www.conesup.net/buscar_carreras_universidad.php?pagina=7
- Ecuador entre brujas, magias y hechiceros [Ecuador between witches, magic and wizards]. (2006, December 10). *Noticias del Ecuador y del Mundo Hoy Online*. [News from Ecuador and the *Mundo Hoy Online*]. Retrieved October 7, 2007, from http://www.hoy.com.ec/NoticiaNue.asp?row_id=253075
- El Universo. (n.d.). *Guía de Carreras Universitarias y Postgrados—Ecuador 2006* [Guide to university and graduate careers—Ecuador 2006]. Retrieved November 14, 2007, from <http://especiales.eluniverso.com/especiales/guiaeCarreras/listadoPosgrados.asp>
- Heppner, P. P., Casas, J. M., Carter, J. A., & Stone, G. L. (2000). The maturation of counseling psychology: Multifaceted perspectives, 1978–1998. In S. D. Brown & R. W. Lent (Eds.), *Handbook of counseling psychology* (pp. 3–49). New York: Wiley.
- Hereford, C. F. (1966). Current status of psychology in Latin America. *Latin American Research Review*, 1, 97–108.
- León-Andrade, C., & Lozano, A. (1997). Raíces culturales de la psiquiatría en el Ecuador [Cultural roots of psychiatry in Ecuador]. *Revista Electrónica de Psiquiatría*. Retrieved June 28, 2007, from http://www.psiquiatria.com/psiquiatria/v011num2/artic_2.htm

- Leong, F. T. L., & Ponterotto, J. G. (2003). A proposal for internationalizing counseling psychology in the United States: Rationale, recommendations, and challenges. *The Counseling Psychologist, 31*, 381–395.
- Lima, B., Pai, S., Santacruz, H., Lozano, J., Chavez, H., & Samaniego, N. (1989). Conducting research on disaster mental health in developing countries: A proposed model. *Disasters, 13*, 177–184.
- McKee, L. (1987). Ethnomedical treatment of children's diarrheal illnesses in the highlands of Ecuador. *Social Science & Medicine, 25*, 1147–1155.
- Mealy, M., Stephan, W. G., & Abalakina-Paap, M. (2006). Reverence for mothers in Ecuadorian and Euro-American Culture. *Journal of Cross-Cultural Psychology, 37*, 465–484.
- Ministerio de Trabajo y Empleo de la República del Ecuador [Ministry of Labor and Employment of the Republic of Ecuador]. (n.d.). *Salario Mínimo* [Minimum salary]. Retrieved December 1, 2007, from <http://www.mintrab.gov.ec/MinisterioDeTrabajo/index.htm>
- Ockene, J. K., Chiriboga, D. E., & Zevallos, J. C. (1996). Smoking in Ecuador: Prevalence, knowledge, and attitudes. *Tobacco Control, 5*, 121–126.
- Pan American Health Organization. (1998). Ecuador. *Health in the Americas*. Retrieved January 28, 2007, from http://www.paho.org/english/hia_1998ed.htm
- Placencia, M. (2007). Studies on politeness in Colombian, Ecuadorian, and Peruvian Spanish. In M. Placencia & C. Garcia (Eds.), *Research on politeness in the Spanish-speaking world* (pp. 59–89). Mahwah, NJ: Lawrence Erlbaum.
- Pribilsky, J. (2001). Nervios and modern childhood: Migration and shifting contexts of child life in the Ecuadorian Andes. *Childhood: A Global Journal of Child Research Special Issue: Capitalizing on Concern, 8*, 251–273.
- Ramirez Ruiz, M., & Andrade, D. (2005). Family and risk factors related to alcohol consumption and smoking among children and adolescents (Guayaquil-Ecuador). *Revista Latino Americana Enfermagem, 13*, 813–818.
- Roberts, E. F. S. (2006). God's laboratory: Religious rationalities and modernity in Ecuadorian in vitro fertilization. *Culture, Medicine & Psychiatry, 30*, 507–536.
- Saad, E., Saad, J., Cueva, E., & Hinostrroza, W. (2004). La emigración masiva en el Ecuador como factor etiológico de la depresión en los adolescentes [The mass migration in Ecuador as an etiological factor of depression in adolescents]. *Interpsiquis*. Retrieved June 28, 2007, from <http://www.psiquiatria.com/articulos/psiqsocial/15139/>
- Sen, A. (2000). *Development as freedom*. New York: Anchor.
- Sierra, J. C., & Bermudez, M. P. (2005). Hacia el título Iberoamericano de psicología: análisis de los programas docentes de las carreras de psicología en Iberoamérica [Toward the Iberoamerican degree in psychology: Analysis of teaching programs in Iberoamerican careers in psychology]. *Revista Mexicana de Psicología, 22*, 224–242.
- Toporek, R. L., Gerstein, L. H., Fouad, N. A., Roysircar, G., & Israel, T. (2006). *Handbook for social justice in counseling psychology: Leadership, vision, and action*. Thousand Oaks, CA: Sage.
- Tousignant, M., & Maldonado, M. (1989). Sadness, depression and social reciprocity in highland Ecuador. *Social Science and Medicine, 28*, 899–904.
- Tyler, L. (1961). Research explorations in the realm of choice. *Journal of Counseling Psychology, 8*, 195–201.
- United Nations Population Fund & Population Reference Bureau. (2005). *Country profiles for population and reproductive health, policy developments and indicators*. Retrieved January 24, 2008, from <http://www.unfpa.org/worldwide/countryprofiles.html>
- U.S. Central Intelligence Agency. (n.d.). *CIA world factbook*. Retrieved November 1, 2007, from http://www.indexmundi.com/ecuador/unemployment_rate.html
- Wasserman, D., Cheng, Q., & Jiang, G. (2005). Global suicide rates among young people. *World Psychiatry, 4*, 114–120.
- Whitten, N. E. (1981). *Cultural transformations and ethnicity in modern Ecuador*. Urbana: University of Illinois Press.
- World Bank. (2007). *World development indicators 2007*. Washington, DC: Author.
- World Health Organization. (2005). *Mental health atlas*. Retrieved January 27, 2008, from http://www.who.int/mental_health/evidence/atlas/profiles_countries_e_i.pdf
- Zubieta, E., Fernandez, I., Vergara, A. I., Martinez, M. D., & Candia, L. (1998). Cultura y emoción en América [Culture and emotion in America]. *Boletín de Psicología, 61*, 65–89.