**Week 5 Theory Review**

**Multicultural Theory**

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COUN 6110 / 8110 Personality and Counseling Theories

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August 7th 2022, Summer 2022

1. **Identification of Theory/Theorist**

*Describe the theorist*

While throughout the history of mainstream psychology the most important contributors have been middle and upper class White heterosexual males, little room, resources and attention was provided to so called minorities and marginalized groups (Prochaska & Norcross, 2018). That generalization of patients’ profiles where all would be treated therapeutically similarly regardless of their cultural background, ethnicity, culture, gender and sexual orientation is what stroke the three pioneers of Multicultural Therapy presented by Prochaska & Norcross. Indeed in a world of changing demographics and post-colonization dynamics, immigrants (or second generation immigrants) and minority members such as Lillian Comas-Diaz, Stanley Sue and Beverly Greene were at the forefront of questioning the uniqueness of a dominant model that wouldn’t and couldn’t fit the confluence of culture, ethnicity and gender found in individuals when it came to providing the best therapeutic plan (Prochaska & Norcross, 2018). Recognizing their inner experience and unique point of view over the needs that diversity creates when it comes to relate and perform in a cultural world that isn’t ones’ inherited ecosystem is what pushed each of them to dig deeper into why identity development, mental health theories and therapeutic interventions must involve social justice, respect to ethnic, gender, orientation diversity and other elements not being part of the mainstream dominant culture (Prochaska & Norcross, 2018).

*Describe the theory*

Culture is a major element of personality where the relationship between the individual and the group is ruled by the cultural context and cultural expectations. That generational transmission of cognitive, emotional and behavioral characteristics intersects with the experience of the individual creating a unique and ever changing pattern of ethnic, gender, age and sexual identity (Prochaska & Norcross, 2018 ; Singh et al., 2019). The multicultural theory is a way to respond to the myth of uniformity (all patients have to be treated similarly no matter their background and cultural identity) by embracing the unique, complex and interactive nature of a patient and validating his or her construction and the social and cultural context involved in the process. In other words, the ideal (and related issues) for a White Heterosexual middle or upper class isn’t as meaningful or relatable for another person with a different cultural identity, and that mental troubles might originate from beyond the person itself and its micro environment and rather be related to a systemic meso and macro experience of contextual framing such a racism, financial or educational limitations, maladaptive acculturation or assimilation, gender limitation or sexual orientation oppression (Sue et al., 2019 ; Prochaska & Norcross, 2018 ; Singh et al., 2019).

*Major concepts within the theory/theorist*

Every Culture has different key characteristics (thought still the unique experience of the individual will shape a unique identity within a larger cultural spectrum) and so is the response to mental worlds and therefore possible issues. Therefore psychology has to be seen as integrated in the larger systemic vision of ideals and values while keeping in mind that diversity doesn’t mean deviancy, pathology or inferiority. In that sense it is important for the practitioner to be aware of those cultural differences, its inner biases and all the possible discrimination, language issues, social roles hierarchies, individualistic/communistic values, stereotypes and message internalization, unconscious racism, overt or covert privilege, poverty, racial power and other rather seen as socio-cultural elements of disparities that are the source of mental issues as well as the context where to start and humbly contextualize the healing process (Sue et al., 2019 ; Prochaska & Norcross, 2018).

*Other key contributors and their backgrounds as it related to their contributions to the theory*

Major historical events such as the Civil Rights Movement, the Feminist Movement, the Decolonization (or post-colonial critical thinking) or LGTBQ Movement around the USA and the world nurtured the thoughts of many scholars in ethnology, philosophy, modern politics, and other social disciplines to understand and represent the different aspects of reality and the needed change to move from a dominant worldview to the integration of so called minorities’ perspective into most of human beings social realms and models, including psychotherapy. Authors and researchers such as Sue & Sue (Multicultural Theory –MCT), Baker Miller, Jordan and Stiver (Relational Cultural Theory – RCT) , Bell (Critical Race Theory – CRT), Crenshaw (Intersectionality Theory) or Martin-Baro (Liberation Psychology) are pioneers and key actors regarding ethnology and psychology, all of them insisting on the need for the cultural uniqueness of the patients as a cornerstone of the therapeutic plan and alliance (Sue et al., 2019 ; Singh et al., 2019 ; Wolf et al., 2018).

1. **Key Concepts**

*Nature of persons through the lens of the theory/theorist*

As in others theories, human beings reality is shaped by the environment and by the subjective experience of the world. Multicultural theory posits that unless all micro, meso and macro environments (and identity levels) of the individual are being taken into account in all therapeutic stages (from understanding, analyzing and proceeding to the therapeutic plan), not only the patient will be misdiagnosed, but it can as well increase anxiety and pathologies that are connected to the cultural context the individual experience (Sue et al., 2019 ; Prochaska & Norcross, 2018).

*Healthy versus problematic functioning through the lens of the theory/theorist*

A healthy functioning is the one where an individual is fully aware of its cultural identity and experiences its relationship to others and the world with the honesty, pride and consciousness of its inner identity and interpersonal mechanisms, knowledge of its locus of control and locus of responsibility in order to adaptively experience adversity in a world where its values and ideals are nondominant and often neglected (Sue et al., 2019). On the opposite, and because of systemic limitations as mentioned earlier, an unwanted unhealthy functioning emerges under the pressure of dominating and often discriminatory social forces eroding the identity of the patient (Prochaska & Norcross, 2018).

*The change process through the lens of the theory/theorist*

The Therapeutic relationship with an engaged, self-conscious, humble advocating trained therapist is a condition for a durable change, with a focus on validating of the patient’s identity, as this last one is experiencing a more or less positive acculturation that is the source of possible issues and conflicts (Sue et al., 2019 ; Jones et al., 2016 ; Dieser, 2021). This makes it even more crucial to have an ideal match between the sensitivity of both therapist and patient in order to change the single definition of abnormality to a healthy concept of multiple normality states and acceptance (Prochaska & Norcross, 2018 ; Cole et al., 2014). As a result the patient gains consciousness of its self-in-culture, exposes a healthy expression of anger, learns to make deliberate choices (with pros and cons) in line with its identity rather than anxiously having to acknowledge and embrace the dominant model and loose touch with its identity construction experiencing a loss of self (Prochaska & Norcross, 2018 ; Sue et al., 2019)

1. **The Therapeutic Process**

*Assessment within the context of the theory/theorist and Treatment within the context of the theory/theorist*

Through connecting, forging an alliance and a collaborative method with the client, the therapist possibly understands the level of acculturation and the micro, meso and macro identity elements of the patient. Gaining that cross-cultural competence in using the appropriate set of behaviors, attitudes, sensitivity and policies that fit a culture (Dieser, 2021), confidence, respect and validation are provided to the patient that reciprocally feels empowered and allowed to share in its preferred way, style and time its conflicting experience and issues (Sue et al., 2019). Strengthening the trust by giving the opportunity and the lead to the patient in unveiling its stand on personal and host culture is a possible way to get the clues and hints about its current and perceived acculturation status (Sue et al., 2019). Communication is a key element of understanding or misunderstanding and source of conflicts and problems. Expectations biases and prejudicial messages are intrinsically connected to both minority and dominant cultures creating a bias in the expression and understanding of needs. Self-esteem and meaning of life can be wrongly conceptualized and not bring the client where he or she is and wants to be. Therefore connecting with the full appreciation and cultural education, avoiding microaggressions and going beyond the standard curriculum cultural training is a task the consultant needs to take seriously and achieve on a continuous manner when it comes to assess and take care in a multicultural way, and this no matter then the type of therapy that is chosen, as multicultural sensitivity is the prerequisite to proceed with honesty and justice in a therapy (Sue et al., 2019 ; Prochaska & Norcross, 2018 ; Jones et al., 2016 ; ACA, 2014).

1. **Awareness of Contextual Variables**

*How come this theory might not work with some populations/diagnoses?*

As just mentioned, multicultural theory is a prerequisite and a needed skill to be developed, taught and infused in the curriculum and practices of therapists as it not only is a major influence in the quality of our professional values of Autonomy, Nonmaleficience, Beneficience, Justice, Fidelity and Veracity (ACA, 2014), but is a key element of retention of patients in therapy, or should we say the lack of multicultural competence is a proven reason for quitting a therapy (Sue et al., 2019 ; Jones et al., 2016 ; Cole et al., 2014). A population to focus on is definitely the therapist one. Indeed the dynamic of resistance that is encountered with multicultural training – that highlights the reality of each and everyone personal stand on multiculturalism and has been defined in three different forms as cognitive, emotional and behavioral resistance still is often perceived by students and practitioners (Sue et al., 2019). Denial and disbelief are natural responses to a possible overwhelming realization (like what does really color blind means or how microagressions are being unconsciously perpetrated) and the fabrication of a distorted rational helps in dealing with thoughts and feelings. Guilt, anger, anxiety are blocking the multicultural understanding as much as does fear: a challenging statement about one’s self-image will naturally, create a certain emotional level of distress. On top, feeling and behaving in a hopeless or helpless mode are covers that help the status quo, reduce the emotional hurt and enable the cognitive mechanism to remain unchallenged and perceived as correct in their logic, specially when we are in the situation of an expert or authority in people’s minds (Sue et al., 2019 ; Romig et al., 2017).

1. **Critique of the Theory**

*Clinical application*

If the multicultural theory is highly inclusive and validates with honesty, humility and justice the identity of each patient when starting a therapy, it could be seen as well as not really being a therapy and only a skill needed when a practitioner is in the situation to have to collaborate with patients that would be foreign to his own worldviews. In other words it is only a “nice to have” competence rather than a method and it could be dismissed in places that lack diversity or where the belief of diversity is not considered as an issue. The same perspective could be applied where assimilation vs. acculturation is required or cultural competence is recognized as a unidimensional concept and practitioners decide to work with only one resembling or echoing population (Sue et al., 2019 ; Cole et al., 2014). It could be as well seen as a mislead focus on only the meso and macro levels of an individual’s identity and missing the fact that the micro is where all happened and happens, with the expectation then to have an effective therapeutic similar outcome (Prochaska & Norcross, 2018). However in a fast pace changing demographics and cultural globalized world, those critics are out of time and diversity is part of our contemporary society and comprehension of human nature (Prochaska & Norcross, 2018 ; Singh et al., 2019).

*Personal application and Sports Performance Consulting application and counseling application*

Having access to an individual’s experiences and understanding the level of acculturation of a patient is a key element in mapping the underlying dynamics between the micro, meso and macro levels of a patient’s identity as well as to find where the tensions and frictions are truly located and to comprehend the real nature of the expression of any type of clinical symptom (Sue et al., 2019).

This matters even more in the realm of sports when a less acculturated athlete comes over: a fist positive encounter that is focusing on understanding the space the client needs to feel, express, question and reflect can help in building the sentiment of feeling true to oneself and therefore to be able and to feel comfortable in pursuing the consultation. Limitation and critics are often, in the realm of sports related to the fact that programs have a strong culture and every athlete, even locals, must embrace it, which neglects the systemic issues an immigrant is facing (Prochaska & Norcross, 2018). As well language can be an issue and if a translator is needed – specially in the clinical side -, it must preferably be a professional; when the notions of togetherness, familial bonds and other collectivist perspectives could require a relative or a member from the extended family to contribute as translator (like when the children are more acculturated than their parents), this needs to be assessed carefully in order to manage to keep every role, every word and every meaning respectfully owned and shared appropriately. Preserving the dynamics, the cornerstones of each individual and group is a key focus when using a translator, but could be a problem depending on the available resources or insurances plans (Sue et al., 2019)

*Similarities or differences from other theories or therapies*

Multicultural Theory leads (or initiates?) to what counseling is about: the possibility to willingly share a self assessment of a question in a personal manner, with a chosen content in the appropriate timing; trusting oneself enough to provide a possible partner in therapy the answer we have over a situation, and being curious about what the questions behind are. In that sense, it is just like any other therapy with the difference of being a needed contemporary preface. Pluralism is the current development of all Multicultural Theory , Relational Cultural Theory , Critical Race Theory , Intersectionality Theory, Liberation Psychology and Multicultural Theory. I believe it is not a coincidence that we question existing paradigms and accept their pluralistic characteristics vs. ethnocentric ones of the past, as these changes always occur in socially heated times. SO was it for the cited theories in the 60s and 70s, and so it is now (Prochaska & Norcross, 2018)  
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