# Section I

Conceptual Frameworks

This section contains three chapters. Chapter 1 is entitled Multiculturalism, Theory, and Competence. Chapter 2 covers Oppression and Resilience, and Chapter 3 is entitled Self in Context. These chapters explore the theoretical frameworks usually encountered in the syllabi of multicultural theory, multicultural counseling, and diversity theory courses. They can be read independently. They can also be assigned concurrently with the chapters in Sections II through VI that contain the life stories.
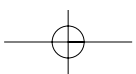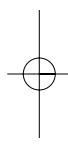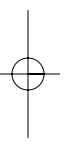
Multiculturalism, Theory, and Competence

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Individuals are like all persons, like some persons, and like no persons (Sue & Sue, 2003). That is, individuals share universal human traits, such as the ability to love, express, and understand emotions, the ability to communicate, and develop intimate relationships. Individuals also have unique personality traits, characteristics, and features based on temperament, life experiences, socialization experiences, and family structure. In addition, individuals share values, beliefs, behaviors, traditions, and customs based on membership, affiliation, and attachment to particular groups. These groups are usually based upon cultural factors, such as race, ethnicity, nationality, immigration status, gender, social class, sexual orientation, and spirituality. To understand any individual, it is necessary to understand the expression of universal traits, the unique traits of the individual, and the cultural affiliations, as these factors operate in a recursive fashion (Speight, Myers, Cox, & Highlen, 1991; Sue & Sue, 2003). To focus on one particular aspect limits full understanding of the individual, including choice of behaviors, worldview, beliefs, and decision-making abilities, as it fails to consider the complexity of human lives.

Psychologists, counselors, and social workers are increasingly working with diverse clients, clients who differ in background from the therapist on a number of factors, including race/ethnicity, gender, social class, immigration, spirituality, and sexual orientation. The demographics in the United States are changing, such that ethnic minorities or persons of color will become the numerical majority by the year 2035 (U.S. Bureau of the Census, 2000). In order to provide effective services, psychologists, counselors, and social workers should be culturally competent (Arredondo, Toporek, Brown, Jones, Locke, Sanchez, & Stadler, 1996). The training that most future providers receive, however, does not adequately prepare them to be culturally competent, for two reasons. First, a Western perspective of mental health and counseling is emphasized in most training programs

that focus on traditional approaches to work with clients. Second, the training that incorporates multicultural concerns primarily focuses on race, racial identity, or ethnicity, to the exclusion of other important cultural factors. The programs also tend to focus on helping students to develop multicultural awareness and knowledge, but often do not incorporate training in multicultural skills or culturally sensitive techniques and interventions. The training also does not help trainees to understand the vast intragroup differences, and to understand the interactional effects of multiple cultural factors.

History of Psychotherapy

Psychology and counseling have focused as fields on the complexities of human behavior. This focus has included an examination of individual functioning, especially intrapsychic and interpersonal influences in human behavior. Traditionally, psychology and counseling have focused on understanding human universals and individual characteristics and traits, but have neglected understanding the role of shared customs, traditions, values, and beliefs from cultural influences. The traditional psychotherapy orientations—psychodynamic, behavioral, and humanistic approaches—also have focused on universal traits and unique characteristics without considering the influences of culture (Katz, 1985). Although the emphasis on the traditional approaches is supposed to focus on universal traits and be applicable to all individuals, the theories are embedded within a specific cultural context. The theoretical approaches were developed with White, middle-class clients and are suited for individuals with dominant or Western values, beliefs, and behaviors. The science of multicultural theory has attempted to correct this imbalance by encouraging social service professionals to reconsider the importance of culture on human functioning. Multicultural theory has highlighted the two shortcomings of traditional approaches: the sociopolitical context of traditional counseling and psychotherapy approaches, and the conceptualization of culturally diverse clients.

Traditional psychotherapy approaches are value laden with a Western perspective and tend to favor clients who have dominant values, beliefs, and attitudes. For example, when clients do not present with a strong self-agency or self-improvement orientation, they might be labeled resistant or dependent, and when clients' nonverbal expressions are more predominant that their verbal ones, they may be pathologized. These conclusions can be understood as deriving from the traditional approaches. Examining the worldview embedded in each theoretical orientation will help to understand their inherent cultural values. Worldview is a holistic concept that ties together the belief systems, values, lifestyles, and modes of problem

solving for a particular cultural group (Sue & Sue, 2003). There are five dimensions to worldview: view of human nature (good, bad, neutral); perspective on time (past, present, future); human activity (being, being-in-becoming, doing); social relationships (lineal, collateral, individualistic); and relationships with nature (harmony with, mastery over, subjugated by). Psychodynamic approaches espouse a worldview in which there is a negative view of human nature (drives and instincts, annihilation fantasies), an emphasis on the past (early childhood experiences), a doing orientation, an individualistic focus, and mastery over nature (the importance of intrapsychic functioning). Behavioral approaches have a neutral view of human nature (blank slate); a present time focus (observable behaviors); a doing orientation (behavior modification and token systems); an individualistic focus, and a belief in mastery over nature (internal controls over behaviors). Humanistic approaches have a positive view of human behavior (capacity for growth and self-actualization); present time orientation (emphasis on the here and now), being-in-becoming orientation, an individualistic focus, and a belief in mastery over nature. Katz (1985) has stated that essentially, the three major orientations focus on the individual, promote a Protestant work ethic, and hold that individuals can master and control their own environment. They also tend to be goal-oriented, rely heavily on verbal communication, follow linear causality models, highlight the importance of insight, and value the scientific method, observable and concrete behaviors, and a literal time perspective (50-minute sessions).

Multicultural Theory as a Fourth Force

Clients with a worldview that is a different than the one postulated by traditional psychotherapy models are often not helped in treatment. In fact, the biased perspective of the traditional approaches has historically labeled ethnic minority clients as deviant and deficient, and has tended to blame them for "dysfunctional" behaviors or the failure to be responsive in treatment. Historically, there are two phases of the pathological view of ethnic minority clients: the genetic deficiency model and the culturally deficient model. According to the genetic deficiency model, ethnic minorities are viewed as pathological due to their physiological makeup and genes. This model was most widely used to explore differences in intelligence across racial groups (Katz, 1985; Trickett, Watts, & Berman, 1994), which was measured with diverse methods, from cranial size and the size and shape of the brain, to intelligence tests. Ethnic minorities were viewed as inferior because they did not have the gene structure to function appropriately and successfully within society and were seen as helpless. During the Civil Rights movement, ethnic minority psychologists highlighted the role

of oppression and racism on the functioning of ethnic minorities. The mental health field began to view diverse clients from the culturally deficient model. Although the standard of comparison was still the Eurocentric mainstream perspective, psychologists began to view differences as due not to genetic factors, but to environmental factors, particularly those related to poverty; gender socialization patterns, and racism.

Influenced by developments of the Civil Rights and feminist movements, and the disciplines of anthropology and sociology, the science of multicultural theory has attempted to correct this imbalance of emphasizing human universals and the Western perspective by encouraging social service professionals to consider the effect of culture on human functioning without considering diverse clients as deviant or deficient. Multicultural theory is supposed to counteract the extremes of universalism and relativism by focusing on unique socialization experiences of members in various cultural groups (Speight, Myers, Cox, & Highlen, 1991).

Another factor that led to the development of multicultural theory was the examination of premature termination of clients in treatment (Sue & Sue, 2003). Process and outcome research suggested that many clients of color were leaving treatment after the first and second session, and it was assumed that for many, the reason was that they did not feel understood by their counselors. While results were mixed regarding whether client-therapist match makes a difference to maintaining a therapeutic relationship, it was clear that therapists needed to become more aware of and attend to cultural values and that providers needed to understand how culture influences values, beliefs, and behaviors in order to understand the functioning of the clients. There was also a realization that cultural values are related to the development of the helping relationship, to the nature of presenting problems, and to expectations of the therapeutic process. For example, people of color often attribute credibility to clinicians in ways that differ from the way White clients attribute credibility. Due to the mistreatment and discrimination individuals have faced from medical professionals (i.e., the Tuskegee syphilis studies), from social service professionals (i.e., involvement in an often oppressive social service system), and from the legal system (i.e., minorities of color with less money have fewer access to legal resources) people of color may approach the relationship cautiously. They may mistrust White therapists or assume that the counselor does not understand issues of oppression. Asian clients may immediately treat the clinician with respect due to the therapist's role as authority figure (Sue & Sue, 2003). Latino and Latina clients may expect a "treatment" after the talking, following a medical model, and may find it difficult to relate matters of intimate content to strangers to whom they are not related (Falicov, 1998a).

Once the need to understand culture was established within the field of multicultural psychology and diversity, several notable historical trends occurred. First, the focus of the theoretical formulations in multicultural

theory as a discipline as well as the ideas for training multicultural competent clinicians have changed since its introduction into the mental health field as a fourth force in the 1980s. Initially, the multicultural competency literature focused on the importance of knowledge, awareness, and skills in working with diverse populations. These competencies are still central to the training of clinicians (Arredondo, et al., 1996). The inclusion of the perspectives of social justice (Vera & Speight, 2003), community psychology (Nelson & Prilleltensky, 2005), and critical psychology (Prilleltensky & Prilleltensky, 2003) in the multicultural literature has accrued salience in a field that initially focused on the individual and group interventions as a way to deal with oppression. The importance of training for social justice is being increasingly recognized as a need inherent in the multicultural competency of any clinician (Fouad, Gerstein, & Toporek, 2006).

Second, the multicultural literature tended to focus in the early 1980s primarily on oppression related to ethnicity and race and their relative importance for identity formation. Later scholarship included other dimensions of diversity, such as social class, religious background, geographic origin, sexual orientation, and others (Hays, 2001). Discussions in the field ensued as to the relative importance of these dimensions. Which is more important? Which affects people more? Recent literature points in the direction of multiple intersecting identities and their concomitant multiple oppressions, recognizing the constrictions inherent in focusing on one single factor (Hays, 2001). Similarly, the dimensions of identity formation were initially conceptualized as discrete, describing individuals fitting into one or another category. People were viewed as primarily White or primarily African American or Latino, for example. More recently, however, individuals are being described using a multiplicity of dimensions, their relationship to each other, and the differing weight these dimensions may have in the construction of an individual's cultural identity. Individuals are now understood as having a complex identity that includes their ethnicity, social class, geographic origin, religious background, or sexual orientation without assuming that one (ethnicity or sexual orientation) is necessarily more important than the others (Fuertes & Gretchen, 2001). Individuals may give more salience to one dimension than to another according to their personal experiences, but that is not to be assumed.

Third, there has been a language shift from the use of the terms "minority" and "majority" to the use of the terms "dominant" or "subordinate," which coincided with the examination of privilege, power, and oppression in the multicultural literature (Adams, 2000). It is now considered that individuals have ". . . social identities, some are dominant or agent such as male, White, heterosexual, able bodied or upper class and others are subordinate or target (female, black or Latino/a, gay or lesbian, disabled or working poor). These distinctions help to understand social privilege and power" (Adams, 2000, p. 6).

Fourth, there has been a refining of the term "diversity" as having two meanings: One refers to the different worldviews and experiences that we learn as we are socialized within our social groupings. "The nuances of these differences are infinite in their complexity, given our socialization within specific, intersecting social communities and cultures" (Adams, 2000, p. 7). The other meaning of the term "diversity" refers to social groups that not only are different but also unequal, which are not equally valued and occupy different places in a social hierarchy. Diversity is often equated with deficiency and with the poor in our society (Parham, 2001).

Multicultural theory has benefited the practices of psychology, counseling, and social work as it has developed and evolved. First, understanding diversity and cultural factors helps therapists to shift beyond the focus of universal traits and factors (Breunlin, Schwartz, & Mac Kune-Karrer, 1997). Multicultural theory allows counselors to understand both intercultural issues—concerns between cultural beliefs and behaviors based on commonalities and similarities of experience—as well as intracultural issues, including concerns within recognizable cultural groups. Second, multicultural theory has placed an emphasis on oppression and the difficulties that often occur in identity development and the development of positive self-concept in an oppressive society (Fukuyama, 1990). Multicultural theory has also highlighted issues of language and communication (Ibrahim, 1991). The approach has been so influential that it has been labeled as the fourth force behind psychodynamic, behavioral, and humanistic approaches (Pedersen, 1991). There are three areas that are of focus within multiculturalism: multicultural theory, multicultural competency, and social justice.

Multicultural Theory

Multicultural theory developed in response to the need to provide more culturally sensitive treatment. Because the traditional psychotherapy approaches have a Western perspective, they are sometimes limited in their effectiveness in work with nondominant clients. Sue, Ivey, and Pedersen (1996) developed multicultural theory, which is a metaframework or approach for working with culturally diverse clients. The theory holds six propositions, with supporting corollaries.

Proposition 1 states that Multicultural Theory (MCT) is a metatheory of psychotherapy. The corollaries hold that theories are grounded in particular cultural contexts, which makes them biased and therefore suitable for the particular population for which they were designed. While MCT is a metatheory, it combines and utilizes materials from other theoretical approaches. It is important for therapists to be "coconstructionists" with their clients and to help them find new ways of adaptive living.

Proposition 2 holds that both clients and counselors develop identities within multiple contexts and layers, and that the totality of these experiences and layers needs to be considered in a clinical encounter. Corollaries state that individuals develop identities in individual and group contexts, and that as contexts shift and change, identities are also fluid and adjust to contextual factors. Counselors and clients share cultural similarities despite overt dissimilarities. It is important to consider the culture of both client and counselor, as counselor identity and values affect the relationship. Because culture and identity change and are fluid, the cultural influence and factors that are important will also vary within the counseling process.

Proposition 3 holds that for clients and counselors, the development of cultural identity influences attitudes for both the self and for other groups, including the dominant group. Corollaries include the notion that identity represents cognitive, behavioral, and emotional progression, and that the rates of progression may differ. It is important for therapists to understand identity development, to work with clients within social contexts, and to recognize intragroup differences. Behavior needs to be interpreted within contexts, and counselors need to be cognizant of the dangers of assumptions and racist beliefs.

Proposition 4 states that counselors are more effective when using MCT when they are using multiple modalities in their work with clients. Corollaries note the importance of recognizing universal and culturally specific frameworks for treatment, and generating new theories based on cultural context. The counseling process can be blocked or enhanced by recognition and acknowledgment of culture, and interventions need to be selected according to the cultural context.

Proposition 5 stresses the importance of using multiple forms of interventions, including group, community interventions, or work with larger systems. The importance of nontraditional therapeutic settings, accurate and appropriate diagnosis and treatment, and two-directional counseling, which includes dialectical issues, is stressed in the corollaries.

Finally, Proposition 6 stresses the liberation of consciousness as the basic goal of MCT. Corollaries stress critical consciousness, helping clients to become aware of their cultural identity, and the importance of using both Western and Eastern approaches.

Multicultural Competency

In order to treat clients effectively, counselors must have a level of multicultural competency (Arredondo, et al., 1996). Cultural competence is the ability to use skills, behaviors, or interventions to respectfully provide services to individuals through the appropriate systems, agencies, and

organizations. "'Cultural competence' demands that clinicians develop flexibility in thinking and behavior, because they must learn to adapt professional tasks and work styles to the values, expectations, and preferences of specific clients. This means that practitioners must choose from a variety of strategies that are useful for the range of cultural groups and social classes, levels of education, and levels of acculturation that exist among clients" (Pinderhughes, 1989, p. 163). The content of competencies has changed and expanded as the field of multicultural theory has grown, from suggestions by leaders of the field to endorsement of policy statements by the major social service professional organizations. Basic multicultural competence requires awareness of the importance of culture, self-awareness, knowledge of cultural groups, and skills for working with diverse clients. Pedersen (1991) indicated that therapists must have an awareness of cultural differences and similarities of behaviors, attitudes, and values. In addition, counselors must have knowledge of cultural groups, including facts and information on values, beliefs, behaviors, communication styles, and social preferences. Finally, counselors should develop culturally sensitive skills, including methods for efficient and effective action with diverse clients. Counselors need to have the ability to present a solution that matches the client's language and cultural framework.

The professional organizations developed competencies for practice, research, and training. The first major position paper was published in 1982 by the American Psychological Association (APA), and required that clinicians have awareness, knowledge, and skills for working with culturally diverse clients (Casas, Ponterotto, & Gutierrez, 1986). While the competencies were drafted specifically by counseling psychologists, they were applied and adopted by psychologists of all specializations. These competencies were expanded in 1992 to include research and training by counseling psychologists and presented to and adopted by the American Counseling Association and the APA. In 1992, Sue, Arredondo, and McDavis (1992) developed a conceptual framework that outlined cultural competence. The model, which was represented by concentric circles, included dimensions of identity, worldview, and culturally sensitive interventions and strategies. It was a comprehensive model that included not only the importance of counselor self-awareness, but the notion of multiple components within identity, the importance of assessment of cultural variables, and the need for culturally sensitive interventions. This model was widely followed by counseling psychologists, counselor educators, and counselors. In 1998, a group of counseling psychologists expanded competencies to be used across an ecosystem at micro, meso, and macro levels, and these were expanded and adopted by APA. In 2003, *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* was adopted as a policy statement. The policy includes six guidelines for psychologists.

Guideline 1 states that psychologists are aware of themselves as cultural beings with attitudes and beliefs that influence functioning, beliefs, and their work. These attitudes may detrimentally affect work with clients.

Guideline 2 states that psychologists understand the importance of multicultural sensitivity, and knowledge and understanding of ethnically and culturally diverse clients. Guideline 3 encourages educators to include multiculturalism in education.

Guideline 4 provides suggestions for the inclusion of cultural issues in research. Guideline 5 encourages the use of culturally relevant skills and applied work, and Guideline 6 promotes the use of organizational change processes to influence and change policies and organizational development. (The complete guidelines may be found at http://www.apa.org/pi/multiculturalguidelines/homepage.html.)

Social workers also developed competencies for their work. Lum (2006) developed a cultural competence framework for social workers. In 1996, the Council on Social Work Education Board of Directors, Cultural Diversity Subcommittee presented a proposal for a conference examining cultural issues and developing guidelines. Two conferences were held, one on social work education in 1998, and the second on child welfare practice in 2001 (Lum, 2006). In 2005, the National Association of Social Workers (NASW) published the *Standards for Cultural Competence in Social Work Practice,* which provided 10 standards. Standard 1 states that social workers who follow ethical guidelines of the profession recognize that personal and professional values may conflict with the needs of diverse clients. Standard 2 states that social workers have self-awareness, Standard 3 promotes cross-cultural knowledge, and Standard 4 encourages cross-cultural skills. Standard 5 suggests that social workers are knowledgeable of services provided within the community and society and make appropriate referrals. Standard 6 refers to the importance of understanding the influence of policy on clients and engaging in advocacy and empowerment as necessary. Standard 7 recommends the promotion of a diverse workforce in social service agencies. Standard 8 upholds the importance of education and training in cultural competence. Standard 9 advocates for providing services in the language of the clients. Standard 10 promotes social workers as leaders in cultural competence with other professional groups. (The complete guidelines may be found at http://www.socialworkers.org/sections/credentials/cultural_comp.asp.)

Oppression and Social Justice

A discussion regarding the redefinition of what it means to be a multiculturally competent clinician is taking place in the scholarly literature and among practitioners (Arredondo & Perez, 2003; Vera & Speight, 2003).

Multicultural competency is not always defined solely in terms of the ability of the provider of services to engage in a relationship with an individual or a family, and often includes the ability to function as a change agent in agencies, organizations and institutions (Vera & Speight, 2003). In many cases, multicultural competency is viewed not only as including the ability to recognize oppression, but also as the ability to enact alternatives that attempt to eliminate it (Prilleltensky & Prilleltensky, 2003). Although this discussion is not new (Arredondo & Perez, 2003), it has taken a renewed emphasis in the field of psychology and counseling.

Counseling and psychotherapy are two possible ways to provide services for the oppressed but certainly not the only ways (Vera & Speight, 2003). The restoration of social justice is the real aspiration of those who are committed to the elimination of oppression, inequality, and injustice, both for individuals and for the society at large. But despite good intentions, many clinicians often reinforce oppression when they seek to categorize, pacify, or otherwise adjust the people to whom they provide services (Fox, 2003). A professional who is interested in developing the skills to engage in social justice work would be interested in the elimination of oppression, and attempt to dismantle oppressive environments, systems, and structures.

Social justice work can include the practice of advocacy, prevention, and social activism to combat poverty, racism, homophobia, domestic or community violence, and other oppressive practices. It can also include an examination of the ethics of managed care, the ethics of social control of poor families, inequalities in education or access to health care, and others (Fouad, Gerstein, & Toporek, 2006). In this context, the main goals of social justice advocacy are to help disadvantaged or marginalized groups gain access to self-determination and to help them become participants in the decisions that affect their lives (Toporek & Williams, 2006).

Conclusion

Multicultural theory has highlighted the importance of understanding diversity in work with clients. Today's culturally competent clinician has awareness of the importance of culture on psychological functioning, and has an awareness of his or her own cultural identity, socialization experiences, and the influence of culture on functioning and the therapeutic relationship. Culturally competent professionals have a good knowledge base of various cultural factors and skills to translate this to the therapeutic relationship. Competencies developed by the American Counseling Association (ACA), APA, and NASW also promote cultural competence in training and education, as well as in standards for research, testing, and assessment. Finally, a social justice perspective is important to consider in the interest of working toward eliminating oppression, inequality, and injustice.