FEATURE

Multicultural Clinical Supervision

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It was the beginning of the training year and each supervisor was starting supervision with the new trainees. Dr. Frank began his first supervision session asking his new supervisee, Marisa, to tell him everything about herself that might be relevant to treatment of the adolescents in the multiculturally diverse, primary care setting. Marisa was surprised by the question, so shared very little and Dr. Frank was disappointed that she was not forthcoming.

Dr. Ashland began his supervision with Artemis by welcoming her, describing the process of supervision, his expectations for her, and inquiring about her previous supervision experience. He referenced her self-assessment that she had completed on Competency Benchmarks (Fouad et al., 2009) and collaboratively reviewed with her areas of strength and those in development to identify supervision goals. Finally, he presented her with and discussed the supervision contract, contextualizing the specific expectations of the setting and the ethical and legal aspects, and the diversity domain of the guidelines (American Psychological Association, 2014; Association of State and Professional Boards, 2015). Describing the importance of personal experience in supervision (e.g., 7.04, APA, 2010), he informed her that as an older male, California native, he might see some client phenomena, particularly in adolescents, through a different prism than she would and that he welcomed her input and perspectives to enhance client care. She disclosed that her family migrated to the United States from Greece when she was three years old, and that her family's immigration experience, her own cultural identity, and struggles in school are important parts of why she was so excited to be at the adolescent treatment center that serves ethnically diverse children and families.

After their respective supervision hours, Drs. Frank and Ashland had lunch and compared notes. Dr. Frank was perplexed at how Dr. Ashland seemed to have gotten so much information and feel so positive about his new supervisee, while he seemed to have gotten off on the wrong foot. He wondered if Marisa was a problem supervisee. Dr. Ashland reminded Dr. Frank, his long time colleague, of the large and emerging literature on supervision practice, the new guidelines (e.g., APA, 2014) and of the necessity to step up to the plate. Dr. Frank still seemed convinced he had gotten "a bad apple" as he believed he had opened the door to a discussion of diversity and it had been slammed shut.

Such contrasting supervision styles and approaches are not unique. We are currently in an era in which there is recognition that clinical supervision is a distinct professional competency, requiring specific training and competence (Falender et al., 2004; Fouad et al., 2009). Drs. Frank and Ashland represent the extremes of the continuum of the belief that perhaps the personal experience of the supervisee is relevant, but the worldview of the supervisor is not.

Multicultural and diversity competence is an ethical standard and integral to the formation and lifelong journey to maintain clinical competence. However, it is not simply an ethical imperative to be conducted at one point in time during the supervisory relationship, but is infused into all aspects of clinical supervision. Unfortunately many supervisors remain unsure how to achieve this ethically and in keeping with supervision best practices. Well documented is the fact that supervisors who are not multiculturally self-aware and competent pose significant risks of harm to clients and to supervisees (i.e., Burkhard, Knox, Hess, & Schultz, 2009; Falender, Burnes, & Ellis, 2013). Therefore one central factor in competent multicultural supervision is in supervisors being self-reflective and willing to explore their own multicultural identities, perspectives, and worldviews, purposefully considering the client(s) presentation, cultural borderlands shared with the therapist and/or supervisor, and the worldviews of client, therapist, and supervisor. Additionally, acknowledging and describing the role of client, supervisor, and supervisees' worldviews on all aspects of assessment, treatment and ongoing evaluation of outcomes is essential. While keeping cultural nuances and cross-cultural interactions in consideration, supervisors also have to be mindful of the responsibility to model adherence to legal and ethical guidelines, including informed consent, attention to supervisee disclosure, confidentiality, and boundaries in the setting.

In the example at the beginning of the article, it is relatively easy to identify strengths of Dr. Ashland's approach to supervision. Consider the aspects of Dr. Ashland's behavior that served as a supervisory intervention. His goal was to establish the supervisory relationship and infuse diversity. Guidance on how to achieve this goal comes to us from two recently released sets of guidelines: Guidelines for Clinical Supervision in Health Service Psychology (APA, 2014, 2015) and Supervision Guidelines for Education and Training Leading to Licensure as a Health Service Provider (Association of State and Professional Psychology Boards (ASPPB), 2015). Dr. Ashland was welcoming, attended to Artemis' self-assessment, contextualized his inquiries in a professional framework and ultimately into the supervision contract. He self-disclosed to highlight the importance of perspective and personal experience in supervision. Implicitly, Dr. Ashland was thinking of multicultural borderlands (Falicov, 2014) or zones of overlap of similarity – by virtue of an identity (e.g., race, religion, ethnicity, socioeconomic status) shared by the client(s) (many recent immigrants and many close in age to the supervisees) and the therapist/supervisee and /or the supervisor. For example, Artemis would likely have borderlands with some of the adolescent clients in

EDITOR'S NOTE: Drs. Falender and Wood will be joined by other experts for the presentation, ***Mirrors on Multicultural Identities: A Reflecting Team Approach to Supervision***, Thursday, April 14 from 7:00 p.m. to 9:00 p.m. at the CPA 2016 convention.

areas of immigration, gender, and being closer in age/generation to clients than is her supervisor. These factors are important to consider as they impact the worldviews of client(s), supervisee/therapist, and supervisor, and the perspectives on assessment, relationship, trainee performance, and treatment. Inferring inferior performance on part of the trainee when in fact it is supervisor's behavior that does not facilitate effective supervision, is a significant supervisor error and can result in misunderstanding, worry for the supervisee about client care, and strain or rupture in the supervisory relationship.

Had Marisa been introduced to supervision through a similar approach to that which Dr. Ashland used, she might have said she looked forward to conducting treatment and assessment in Spanish and might have described how she is bilingual and bicultural but since her family came from Puerto Rico, she is less proficient with many of the Spanish speaking clients in Southern California due to idioms, vocabulary and lack of cultural familiarity as she grew up in New York City and went to college and graduate school there. Generally, there were mainly Dominican and Puerto Rican clients. Perhaps she would have expressed interest in some supervisory support for the transition to what she expects will be the clients who are mostly from Mexico and Central American. She might have expressed interest in her supervisor's experience and approaches with diverse clients and in supervision, supervising her work conducted in Spanish, and might have inquired gently about how his own perspectives or how his diversity identities have impacted his supervision previously.

How can Dr. Frank assist in the transformation of supervision to be in sync with the new guidelines and standards of practice? Dr. Ashland might refer to a paper on transforming the clinical setting to competency-based clinical supervision (Kaslow, Falender, & Grus, 2012) for guidance on steps to guide the process.

Prior to Marisa's first supervision session, she would receive a competency self-assessment to reflect on and self assess prior to beginning supervision including individual and cultural awareness. Dr. Frank would review Marisa's self-assessment and be familiar with her identified strengths and areas in development. He would let her know how important the worldviews and attitudes of supervisor and supervisee are in informing assessment, treatment, and all aspects of supervision. He would model this by reflecting on a difference or two, such as age or generation that might result in different lens through which the client, presenting problems, and context are viewed. Dr. Frank would ensure that Marisa was aware prior to even beginning her training in the setting that personal experience is an important part of clinical supervision, referencing the American Psychological Association ethical standard 7.04 (APA, 2010) regarding student disclosure of personal information which makes it clear that psychologists do not require students or supervises to disclose personal information, except if the program has clearly identified this requirement. When a personal inquiry is made it is only when there is a clear connection to the question and the well-being of the client.

Planful development of the supervisory relationship with the recognition of the integral role of diversity multicultural integration would aid in enhancing the communication he desired. Furthermore, formalizing this approach in the living supervision contract at the onset of supervision process would set the stage for a safe, mutually respectful, culturally sensitive supervisory relationship. ■