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Racially aware supervision : examining how White mental health clinicians address cultural competency with their White supervisors

Elizabeth Hammond
Smith College

Elizabeth Sweeney Hammond
Racially Aware Supervision:
Examining How White Mental
Health Clinicians Address
Cultural Competency with
Their White Supervisors

ABSTRACT

This research examines how multicultural competency and racial difference are addressed in supervision between White mental health clinicians and their White supervisors in mental health settings that serve primarily clients of color. The researcher completed a qualitative case study analysis of five participants who were asked to discuss the content and nature of their supervision with their White supervisors. Three research questions served as the foundation to explore supervisors' and clinicians' attention to cultural competence in the supervisory relationship: (1) How are multicultural issues, race, and racism addressed in supervision? (2) How does attention to clinician-client cultural issues in supervision impact the supervisory relationship? and (3) How do clinicians conceptualize the development of cultural competence and their own White racial identity? For participants in the study race, racism, and cultural competency was not often addressed in supervision. All five participants felt that they had to initiate conversations about race, racism, and cultural competency with their White supervisors. The participants also felt that when they did raise issues of cultural competency that their supervisors were supportive. Many participants reported that addressing race, racism, and cultural competency was not a priority neither at their organization nor in their work with their supervisor. Many felt limited time in supervision impacted the frequency of these conversations. Participants shared a perception that training and supervision about

cultural competency was most often found in their graduate education and not in their professional organizations or supervision. This research suggests the need for intentional discussions with clinicians about addressing race, racism, and cultural difference in academic institutions, organizations, and in supervision, and that more research is needed on how addressing such issues impact treatment.

RACIALLY AWARE SUPERVISION: EXAMINING HOW WHITE MENTAL HEALTH

CLINICIANS ADDRESS CULTURAL COMPETENCY WITH THEIR WHITE

SUPERVISORS

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

Elizabeth Sweeney Hammond

Smith College School for Social Work
Northampton, Massachusetts 01063
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TABLE OF CONTENTS

LIST OF TABLES

Table

CHAPTER I

INTRODUCTION

This research examines how multicultural competency and racial difference are addressed in supervision between White mental health clinicians and their White supervisors in mental health settings that serve primarily clients of color. The researcher completed a qualitative case study analysis of five participants who were asked to discuss the content and nature of their supervision with their White supervisors. This approach was used to explore the level of cultural sensitivity and responsiveness that exists in same race supervisory relationships.

Three research questions served as the foundation to explore supervisors' and clinicians' attention to cultural competence in the supervisory relationship: (1) How are multicultural issues, race, and racism addressed in supervision? (2) How does attention to clinician-client cultural issues in supervision impact the supervisory relationship? and (3) How do clinicians conceptualize the development of cultural competence and their own White racial identity? Question 1 examined how attention is given to cultural issues, race, and racism in supervision and ultimately speaks to supervisor cultural competence. This was important because nearly all supervisory and client relationships encounter some aspect of multiculturalism and diversity; thus supervisors' cultural competence is important in fostering clinicians' development of cultural competence. Question 2 and Question 3 explored the impact of clinician-supervisor experiences when cultural issues were addressed in supervision, and is important because positive supervisory relationships support supervisee risk taking and growth. Questions 2 and 3 build upon previous research studies that examined cultural issues in supervision, and supervisory relationships and supervisee development of multicultural competence (Burkard et al., 2006; Constantine & Sue, 2007; Fukuyama, 1994; Toporek et al., 2004). Question 3 also

examined how clinicians conceptualize the development of cultural competence and White racial identity, which has significant implications for training.

These questions allowed the researcher to identify how cultural competence 'plays out' in the supervisory relationship, and whether clinicians feel that they or their supervisors are culturally responsive during their supervision. Burkard et al's definition of cultural responsiveness in supervision (2006), a modification of Atkinson and Lowe's (1995) definition, is used for this study:

> "Supervisor responses that acknowledge the existence of, show interest in, demonstrate knowledge of, and express appreciation for the client's [and supervisee's] ethnic and culture and that place the client's [and supervisee's] problem in cultural context." (Burkard et al, 2006, p. 288).

The term "cultural competency" has been used broadly throughout the mental health profession, research, and literature. The definition of cultural competency in this study is that of NASW:

> "Cultural competence refers to the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, religions, and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families, and communities and protects and preserves the dignity of each" (NASW Standards for Cultural Competency in Social Work Practice, 2001, p. 11).

The policies and values that the Social Work Code of Ethics promotes are mandates that should be demonstrated in conscious and evolving ways to reflect clinician awareness of cultural competence, and should be felt by clients who seek services from these clinicians. Therefore it is

important to know how self-identified White social workers use cultural competence in their work in organizations that may or may not support this NASW cultural standard. It also is important to know whether self-identified White clinicians that work with clients from a different ethnic, racial, and cultural identity than their own reflect upon these differences as they work with clients inside and outside of the therapeutic relationship.

Organizations that support their clinicians' work through open dialogue about racial differences when discussing the clinical support of their clients promote more positive mental health outcomes for both clinician and client, as well as create a healthier clinician-client relationship. Wade and Bernstein (1991) stated that "persons of color report more satisfaction with counseling and return for more counseling sessions when counselors are more culturally responsive in therapy than culturally unresponsive" (Ponteretto et al., 2003, p. 466). A clear understanding of how cultural responsiveness is achieved in the therapeutic alliance with cross-racial clients and clinicians is important for the betterment and improvement of therapeutic outcomes.

Examining the nature of educationally and clinically supervised sessions between supervisors and clinicians is an important aspect of mental health training and practice. The current researcher posits that there is a large discrepancy between the composition of the social work labor force and the ethnic, racial, and cultural demographic profile of clients served. It is possible that this racial difference and its impact on the client-clinician relationship are not often addressed directly in supervision. Mental health organizations have instituted cultural competency trainings within their organization, but where and how this dialogue continues is not well documented. While a likely place for this dialogue to occur is in the supervisory relationship, the reality is that often it does not. Bernard and Goodyear (1998) explain there are

explicit differences between training and supervision and yet they are often seen as interchangeable in the mental health field. Supervision is one component of training. In this study Bernard and Goodyear's (1998) description of supervision as cited by Jernigan et al (2010) will be used:

> "An evaluative relationship between a junior and senior member of the counseling profession in which the senior member's task was to enhance the professional functioning of the junior member, monitor the quality of professional services for clients that are being serviced, and to service as a gatekeeper for those who are entering the profession of psychology" (Jernigan et al, 2010, p.63).

The NASW Code of Ethics requires that organizations address cultural competence with their clinicians, but how they accomplish this is unknown and largely unregulated. It is important to document how the field of social work and other clinical practitioners address cultural competency, and to identify best practices so that clinicians can better understand clients that have different racial, ethnic, and cultural identities from their own. Findings from this research improves knowledge of the extent to which White Supervisors and supervisees address cultural competence and racism in their supervisory sessions with White clinicians who work primarily with clients of color. These findings also may suggest patterns of behavior and insight into how to more effectively address cultural competence and racism in supervisory relationships between same race supervisor and supervisee.

There are several limitations to this study. First, findings from this study are generalizable only to the participants in this study and do not apply to all White supervisors or supervisees. There were five participants in this study, and the findings will only illuminate their experiences. Second, the sample is restricted to clinicians in the state of Connecticut, which

presents different demographics and characteristics from other states. Third, even though the study was open to psychiatrists and psychologists, all five participants have Master's in Social Work, which limits the findings to the social workers' experience for these five participants. Fourth, there are some limitations to exploratory studies; they seldom provide conclusive answers to research questions: "They can only hint at the answers and give insights into the research methods that would provide definitive answers" (Rubin and Babbie, 2013, p. 51). These limitations are barriers to the current study because these findings are not generalizable to all supervisors, communities, organizations, and clinicians. Finally, the kinds of research methods used in the study rely on self-reporting, and Ladany, Inman, Constantine, and Hofheinz (1997) found that their participants overestimated the extent of their multicultural competence, and so this must be kept in mind as it may have influenced how the participants in this study answered this researcher's questions. Despite these limitations, the study has merit. Research on cultural competence and racism and same race supervisor-supervisee relationships is thus far scant.   This study will add to that body of knowledge. Also findings of this research may offer reflection on how to create a more effective and supportive balance when addressing cultural competency in supervision and service delivery.

CHAPTER II

LITERATURE REVIEW

This literature review examines cultural competency in mental health supervisors and supervisees, as well as cultural responsiveness in supervision. It also explores how clients and their therapists perceive race, racism, or cultural difference in cross-racial clinician-client dyads. Research has shown that addressing cultural and racial difference both in supervision and in therapy influences the supervisor-supervisee relationship and clinician-client alliance, and can impact therapeutic outcomes.

Cultural Competency in Training and Organizations

Multicultural training in psychotherapy has evolved over the past 30 years. Gil and Drewes (2005) explored the history of what was called "cultural issues" in therapy, and found that in the 1970s theoretical discussions largely gave "cookbook" formulations that did not address the nuances of racial and ethnic differences and their impact on the therapeutic alliance. The idea exists that cultural competency is achieved when a clinician reads a book or watches a documentary about the "population" with whom they are working. This notion however does not account for nuance and the uniqueness that individuals from varying cultures bring to the therapeutic relationship. It also is void of clinician's personal reflection and acknowledgement of culture in context and in relationship with the client whose culture or race may be similar or different from their own. Utsey, S. O. and Gernat, C. A. (2002) reported that it is only recently that scholars have recognized the limited scope of support in counselor training programs for White counselor trainees who work with clients from diverse racial and ethnic backgrounds (Helms and Cook, 1999; Richardson and Molinaro, 1996; Sue, Ivey, and Pedersen, 1996; Thompson and Carter, 1997). Traditional training programs focus on learning cultural nuances

specific to ethnic groups and gaining specific skill sets like understanding that direct eye contact is not a sign of respect in certain cultures. These programs foster nonracist attitudes towards racial and ethnic minority clients, but they often do not explore the anxiety White clinicians may feel as they may confront their "Whiteness" and struggle with acknowledging the ways they collude or benefit from racism. Allen and Majidi-Ahi (1998) explained that this can sometimes lead to conversations about culture were clinicians have a "a tendency either to deny that race is an issue in the interaction [with clients] or to over compensate by attributing all of the client's problems to cultural and racial conflict" (Allen and Majidi-Ahi, 1998, p. 153).

Knox, Burkard, Johnson, Suzuki, and Ponterotto (2003) explored therapists past educational experiences and found that both African American and European American therapists shared largely similar graduate school didactic experiences that focused on race, and that both groups took classes, workshops, and special trainings when they examined the curriculums. In terms of perception, however, "only European American therapists reported receiving minimal or no didactic training that addressed race" (Knox, Burkard, Johnson, Suzuki, and Ponterotto, 2003, p. 476). They also found that European American therapists, after their graduate education, did not attend multicultural workshops or conferences while the African American therapists did. Knox et al (2003) suggested "European American psychologists had comparatively fewer experiences that focused on race which may contribute to their greater reported discomfort addressing race in the cross-racial dyad they described" (Knox, Burkard, Johnson, Suzuki, and Ponterotto, 2003, p. 476). This study was limited to 12 participants but the exploration of the impact of graduate education and post-graduation education allows for continued discussion about how training is perceived by participants who were African American and those who were European American. It also shows that in this sample there was a

difference in comfort and skill level as the European American therapists reported feeling fear and hesitation when race or racial difference surfaced in therapy and were not grounded in knowing how the conversation would go, and felt unprepared to have that conversation with their client.

Darnell and Kupermic (2006) used "hierarchical linear modeling to indicate that agencies with culturally competent mission statements and training had significantly higher member perceptions of cultural competence within the organization" (Darnell and Kupermic, 2006, p. 194). In this study the researchers interviewed 350 participants in 12 public mental institutions in Atlanta. Fung et al. (2012) did another study that examined institutional and direct service cultural competence. "The institution's documents, including policies, procedures, and patient demographic information, were reviewed. Focus groups involving 133 participants and in-depth interviews with 26 individuals were conducted, targeting five groups: (a) senior management; (b) program heads and managers; (c) frontline staff; (d) consumers; and (e) community stakeholders" (Fung, 2012, p. 169). Their findings revealed a relationship between culturally competent care and effective patient outcomes that were strengthened by the relationship between the supervisor and supervisee.

Cultural Competency through Self-Reflection

Leary (1995) reported that the literature on cultural competency increasingly asks clinicians and clients to explore the meaning of race as it may facilitate psychotherapeutic work and promote clinician-client success. This perspective supports the current research as it suggests there is merit to examining racial differences in the therapists and clients' relationships. Maiter (2009) explained that cultural competency is not enough, and believes that clinicians should be using an anti-racist framework to address race and racism with clients, instead of just a broad

cultural framework in order to better serve patients of traditionally oppressed ethno-racial backgrounds. She asserted that "when the central element of our work with members of diverse ethno-racial groups is culture, we may then tend to inadvertently exclude the effects of race and racism in the lives of people of color while at the same time clients themselves will not bring up issues relating to race" (Maiter, 2009, p. 269). She examined errors in her own clinical understanding because of her focus on culture rather than the effects of race and racism.

Dyche and Zayas (2001) focused on cultural empathy when creating trainings and educational objectives for cultural competence in the mental health field and reported that this can be a more effective way to teach appropriate skills to clinicians. They also focused on the value of self-reflection for clinicians, and the importance of examining and re-examining their own ethno-cultural and racial identities. When this is done, it may be possible that clinicians are better able to address cultural and racial differences in an open way and will find understanding in the unique experiences of the client.

Addressing Difference in Therapy

Carter (1995) reported that the literature suggests that racial and cultural attitudes of both the therapist and client affect therapy. He further stated that it is unclear, however, how race influences the interactional dynamics during therapy, and that it is difficult to determine the specific ways in which a client may experience race or culture and how each may influence their personal identity, their identity within their family, their racial attitudes, and therapy (Carter, 1995, p.65). A few researchers have taken on this task of learning how attitudes, perceptions, and cultural and ethnic beliefs influence the therapeutic relationship.

Research on clients' perceptions of the significance of race in cross-racial therapy relationships shows that racial, ethnic and cultural difference has an effect on the therapeutic

relationship. Chang and Yoon (2011) did a qualitative study interviewing clients of color about their experience in a yearlong therapeutic work with non-Hispanic White clinicians. Noting that there are limitations to asking for retrospective accounts of the therapeutic relationship, they found that clients felt that race was a "salient aspect of the participant's experience of cross-racial therapy, affecting decisions regarding self-preservation and self-disclosure, as well as feelings of trust and comfort in the relationship" (Chang and Yoon, 2011, p. 578). This impact was found in clients who reported both satisfaction and dissatisfaction with their overall experience in therapy. Chang and Yoon (2011) found that participants felt that White therapists could not appreciate how their minority status and culture shaped their psychological development, and the reality of discriminatory treatment. Alternatively the research also discovered that a few clients felt more comfortable addressing what may be perceived as culturally incongruent with their White therapist, who they perceived were more open and understanding than a therapist of their own race or culture. One Hispanic male also talked about when he addressed discrimination he experienced his White therapist responded with a level of concern and interest that he imagined a therapist from his own culture might have normalized. Chang and Yoon found that "70% of the participants felt that racial difference receded in importance if the therapist was perceived as compassionate, unconditionally accepting, and comfortable talking about REC [race, ethnic, and culture] differences" (Chang and Yoon, 2011, p. 579). Vasquez (2007) highlighted that therapeutic alliance is an important place to work on interventions for better cross-racial therapy. Clients of color rate therapists who are perceived to convey cultural responsiveness in treatment as more credible and competent (Atkinson, Casas, Abreu, 1992; Constantine, 2002; Gim et al. 1991).

The impact of "racial or ethnic match" of a therapist and their client is beginning to be explored by scholars in the field. Sue, Fujino, Hu, Tekeuchi, and Zane, (1991) research was consistent with earlier findings of Jones (1982), that suggested "ethnic match is an important consideration in length of treatment, and number of therapy sessions, but does not affect symptom reports and clinicians ratings of adjustment" (Sanders Thompson, and Alexander, 2006, p. 100). Maramba and Hall (2002), however, found that ethnic match was not a significant predictor of dropout rates, utilization of therapy, or improvement in psychotherapy. Knox, Burkard, Johnson, Suzuki, and Ponterotto (2003) did a qualitative research study with 12 psychologists (5 African American, and 7 European American) examining the discussion of race in their therapy sessions with ethnically or racially different clients. The research indicated that European American therapists typically did not address race with racially different clients, and more African American therapists reported feeling comfortable addressing race in their cross-racial dyads than did European American therapists.

Research on clients' reactions to therapy when race or cultural difference is addressed in therapy is limited. Sanders Thompson, and Alexander's (2006) research examined interviews from 44 African American clients, who were randomly assigned an African American or European American therapist. Half of these therapists had a "no therapist-initiated discussion of race" condition where the therapist was instructed to address racial issues "when initiated by the client or as deemed appropriate by therapeutic content" (Sanders Thompson, and Alexander, 2006, p. 103). The other therapists were designated a "therapist-initiated discussion of race" condition, and given a protocol for their first session to acknowledge "the existence of racial difference and the role that race could play in the interpersonal reactions" (Sanders Thompson, and Alexander, 2006, p.104). They also asked about the client's reaction to racial difference, and

responded to all of the client's questions or concerns. They also expressed a willingness to discuss race at any time during treatment process. These therapists provided ten problem solving or interpersonal therapy sessions, and the therapy type did not influence the ratings of understanding and acceptance of therapeutic goals. The only marked difference was the addition of conversation about an openness to discuss race in therapy. They found that there were only four instances of client-initiated discussions of race, and they were in same race clinician-client dyads, and cross-racial clinician-client dyads. The data "did not provide support for predictions of more positive ratings of therapy among European American therapists who acknowledged racial difference in the initial session" (Sanders Thompson, and Alexander, 2006, p.108). The researchers did report that the potential benefit of early discussion of race in therapy was not measured in this study, and the conclusion of the researchers in this case was that more study should be done with special attention to the training and supervision of new therapists, and to whether early discussion of race in therapy does in fact impact the therapeutic relationship.

Some research has shown that clinicians prefer to take a "neutral" approach, defined as waiting for a patient to bring up issues of race, racism or cultural difference. Hoffer (1985) reported that neutrality has undergone a metamorphosis since the beginning of psychoanalysis. In clinical practice it too often prevents exploration of critical aspects of the client's psyche. Tummala-Narra (2004) suggested that the rapid increase in racial/ethnic minority populations in the United States requires implementing new approaches to the training of psychologists. Neutrality is no longer appropriate and Tummala-Narra proposed that the integration of racial and cultural diversity related issues in clinical supervision is an essential component of clinical and teaching competence, and has important implications for the provision of services to ethnic minorities, and more broadly to better addressing the full realm of clients' intrapsychic and

interpersonal worlds (Tummala-Narra, 2004, p. 300). Neutrality is not helpful if it is used to disregard the issues of race or cultural differences, which are a part of the history of oppression and institutional racism. Such barriers exist in any organization in the United States and are something that both clients and clinicians alike experience daily.

Cultural Responsiveness in Supervision

There is limited research on effective supervision largely because it is a difficult topic to research and because there are limited ways of measuring the effectiveness of a supervisor. Bernard and Goodyear (1998) explained that there is relatively little theory-driven research in supervision, and that there are few efficacy studies because typically these types of studies are done by examining adherence to and proficiency with supervision manuals and protocols. These manuals, however, are few to none with the exception of the Neufeldt, Iverson, and Juntunen (1995) manual that was developed for training and not to articulate a model. It also is difficult to design a study that protects clients and trainees. Creating control groups endanger clients who would receiving "an (unmonitored) active intervention" (Bernard and Goodyear, 1998, p. 2). Another barrier to determining supervision's effectiveness is the widespread reliance on self-reported satisfaction measures to assess supervision outcomes. Holloway and Neufeldt (1995) and Borders (1989) made a strong case for reducing reliance on this method.

The difficulties in addressing race, racism, and cultural difference in supervision and its effect on the supervisee and client relationship has begun to enter the literature by examining supervision through the lens of multicultural competence. Jernigan et al (2010) examined people of color supervision dyads, and found a continued reliance on the supervisees' racial designation as a substitute for expertise or knowledge about addressing race and racism in the therapeutic alliance. Wong (2006), in describing current research and theorists, speculated that many

13

experienced supervisors entered the field prior to the multicultural movement in psychology. Jernigan et al (2010) cited Estrada, Frame, and Williams (2004) research, stating "regardless of one's identified racial background, if a supervisor has never been taught how to meaningfully integrate racial and cultural variables into the process of supervision, the inability to pass on such knowledge and skills inevitably poses a challenge" (Jernigan et al, 2010, p. 63). This lack of experience and framework to address race and racism in supervision is problematic for both the client and supervisee.

Research shows that when there is a dearth of discussion around cultural competence in supervision, there is significant negative impact upon clinicians and clients. Burkard et al. (2006) examined the experiences of thirteen supervisees of color and 13 European American supervisees in order to determine the impact of culturally responsive and unresponsive cross-cultural supervision. They found that in culturally responsive supervision, all supervisees felt supported for exploring cultural issues, which positively affected the supervisee, the supervision relationship, and client outcomes. One of the issues Burkard et al. (2006) addressed was the gap between younger clinicians who were trained in multicultural approaches and their supervisors who were not. Constantine (1997) found that 70% of supervisees had received training in multicultural counseling in graduate school, whereas only 30% of supervisors had received such training in their academic programs. Knowing this, it is important to ask supervisors and supervisees with what frequency their supervision/clinical meetings address multiculturalism. This researcher is mindful that Burkard may be assuming that clinicians of color are automatically culturally competent based on their race, since Burkard's study only interviewed clinicians of color with White supervisors. Therefore, it is important to examine these potential assumptions about cultural competence based on race or ethno-cultural experience.

It is possible that a change in the cultural responsiveness in supervision will come as the racial identity of the population of mental health workers changes. Jernigan et al (2010) state that the Commission on Ethnic Minority Recruitment, Retention, and Training in Psychology Task Force reported that graduation rates in psychology for ethnic minorities has increased during the years 1996 to 2004. "More specifically, there was a 36% increase in psychology degrees conferred on undergraduates of color, and a 91% increase in the number of people earning masters degrees in psychology." (Jernigan et al., 2010, p. 62). These changes provide an opportunity for supervisors and supervisees to address the ways they are prepared or unprepared to support cross-racial supervision, as well as developing better ways to support clinicians of color who are in same-race therapeutic relationships. As the mental health profession grows and changes, there must be a continued focus on increasing self-awareness by individual supervisors and an increase in examining the perspectives and experiences of race and racism for supervisees and clients.

Much of the current literature that examines cultural competency comes from the perspective of White clinicians trying to learn more from clinicians of color, and placing the burden of cultural competence on these 'token' clinicians found in organizational environments. Negy (2004) stated that therapists should acknowledge openly that they have little knowledge or experience with the client's culture, and encourages therapists to "seek ongoing consultation or supervision from someone who is more knowledgeable or had more experience providing services to individuals belonging to that culture" (Negy, 2004, p. 5). Negy's statement puts the responsibility of educating the "other" on the supervisor or clinician of color who may or may not have similar experiences to the client of color. This behavior neither accounts for nor encourages therapists to listen to the unique experience that clients bring to the therapeutic

relationship. Porter (1994) also assumed that the racial designation (i.e. Black, Latino, Asian, Native American) of the supervisees automatically aids their ability to address race and racism with their clients. Porter (1994) commented, "If the supervisee and client share a Latino background, this stage provides an opportunity for the supervisor to validate the supervisee's knowledge and experience base, which could surpass that of a non-Latino supervisor" (Porter, 1994, p. 46). This method of equating racial characteristics to knowledge about addressing race and racism with a client limits the expansion of knowledge that this Latino supervisee might desire, and unfairly limits the exploration of the diversity of individual experiences that the supervisee and client may have experienced. It also does not account for some of the voices from clients who felt they did not want their therapist to be their mirror image (Sanders Thompson, V., & Alexander, H., 2006).

Ladany, Inman, and Constantine (1997) examined whether multicultural case conceptualization ability and self-reported multicultural competence are influenced by supervisees' racial identity and a supervisor's instruction to focus on multicultural issues. In this study they had a sample of 116 doctoral level and masters level counseling trainees who were asked to respond to a series of measures: the Cultural Identity Attitude Scale (CIAS) (Helms and Carter, 1999); the White Racial Identity Attitude Scale (WRIAS) (Helms and Carter, 1990); and the Cross-Cultural Counseling Inventory – Revised (CCCI-R) (LaFromboise, Coleman, and Hernandez, 1991). Participants also completed a case conceptualization where half of the sample was told in the directions that their "supervisor" has instructed them to "be sure to include issues pertaining to race in their case conceptualization" and the other half were not given this direction (Ladany, Inman, and Constantine, 1997, p. 287). Ladany, Inman, and Constantine (1997) discovered that self-reported multicultural competence was not found to be significantly related

16

to multicultural case conceptualization, but they did find a correlation between those participants who were instructed by a "supervisor" to focus on multicultural issues and their written conceptualizations of multicultural treatment strategy.

Racial Identity Development

Other theorists and researchers have pushed this understanding of cultural competence further by examining Racial Identity Development. Sabnani, Ponterotto, and Borodovsky (1991) posited that most of the writing on racial-identity development prior to 1990 focused on minority clients and especially African Americans. Less attention has been placed on White Racial Identity development, although there have been a few researchers who in the last 20 years have dedicated their research to exploring this topic. Sabnani, Ponterotto, and Borodovsky (1991) explained that developing a deeper understanding of the impact of White Racial Identity development is necessary considering that the majority of counselors and counselor trainees are from White middle class backgrounds (Cameron, Galassi, Birk & Waggner, 1989).

Helms (1984), Hardiman (1982), and Ponterotto (1988) examined White racial identity development and its impact on clinicians' ability to be more culturally competent. All three of these researchers developed a White racial identity model that has a stage progression, or what more recently has been renamed schemas (Helms, 1995). Sabnani et al. (1991) identified common themes in these models, which mark the progression of the development of White racial identity. Sabnani summarizes and combines the three models into 5 stages: Stage 1, lack of awareness of self as a racial being; Stage 2, expansion of knowledge regarding race and racial matters, acknowledging whiteness, and colorblindness; Stage 3, breakdown of former knowledge about race and feelings of guilt and/or rejection of internalized racist beliefs; Stage 4, retreat into white culture, moving cognitively and behaviorally away from intercultural contact because of

rejection from minority group members; and Stage 5, movement toward the clear development of White racial identity and balancing multicultural interests and respect for cultural differences (Sabnani et al., 1991, p.81-82). This process of self-awareness and racial identity development can take a long time, and individuals can get stuck in certain stages. Getting stuck can limit both supervisors' and supervisees' ability to do culturally competent work.

Constantine, Warren and Miville (2005), who used Helms (1984, 1990, 1995) to study White racial identity dyadic interactions, explored the influence of a supervisor over a supervisee's ability to address multicultural issues in treatment. They mentioned that Constantine (2002); Evans & Foster (2000), Ladany, Inman, Constantine & Hofheinz (1997); and Neville et al. (1996) all found that supervisors with more advanced White racial identity schemas were "positively related to having both prior multicultural counseling training and self-reported multicultural counseling competence" (Constantine, Warren and Miville, 2005, p. 491). Constantine, Warren and Miville (2005) categorized supervisor and supervisee relationships into progressive and regressive racial identity development schemas. They discovered that the supervisor's advanced (progressive) or not advanced (regressive) racial identity had more influence on the professional development and multicultural case conceptualization ability than their racial or ethnic background. As an example, they noted that "A White supervisor working with a Black supervisee within a progressive supervisory relationship may be more effective in promoting this supervisee's multicultural counseling competence than a Black supervisor working with a Black supervisee within a regressive supervisory dyad" (Constantine, Warren and Miville, 2005, p. 495). Burkard et al. (2006) examined cross-cultural supervision relationships using a qualitative approach to examine the experiences of thirteen supervisees of color and thirteen European American supervisees concerning the impact of culturally

responsive and unresponsive cross-cultural supervision. This study did not address the ways organizations chose to create a culturally competent staff, but did allow for clinicians and supervisors to self-report if they felt they were culturally responsive. However, Burkard et al. (2006) found that in culturally responsive supervision, all supervisees felt supported for exploring cultural issues, which positively affected the supervisee, the supervision relationship, and client outcomes. These discoveries help to inform mental health professionals of the importance of culturally responsive supervision. Although the study did not seek to generalize precise and objective findings to a larger population, it did help clinicians better understand how dynamics might play a role in the supervisor and client relationship with the therapist.

Ancis and Ladany (2001) developed a specific framework that gives insight and a technique to support the development of multicultural supervision competencies to address racial and ethnic issues in supervision. They emphasized addressing Multicultural Supervision Competencies through a six-step process: "(a) Supervisor-Focused Personal Development, (b) Supervisee-Focused Personal Development, (c) Conceptualization, (d) Skills, (e) Process, and (f) Outcome/Evaluation" (Singh and Chun, 2012, p. 38). This model discusses how supervisors first must develop their own competency, and then learn how to support their supervisees as well as to co-create and evaluate their progress in becoming more culturally competent. One of the limitations of the Ancis and Ladany (2001) model cited by Singh and Chun (2012) is that this model, and others like it (Constantine, 1997; Inman, 2008), focus on race and ethnicity, and overlook other aspects of diversity. Their model offers no acknowledgement of the intersectionality of race and gender identity. The previous studies often highlight the ways the supervisee can gain multicultural competence, but do not focus on the continued learning necessary for a supervisor's competence. They also point out through Inman's (2008) critique

that there is a "lack of recognition of the supervisory relationship as a vehicle in which

supervisory process and outcomes can be improved" (Singh and Chun, 2012, p. 39). This lack of

recognition and focus on the power of the supervisory relationship as it relates to cultural

competence supports the need for the current study.

CHAPTER III

METHODOLOGY

The purpose of this research study is to examine how multicultural competency and racial difference are addressed in supervision between White mental health clinicians and their White supervisors in mental health settings that serve primarily clients of color. This purpose underlies the study's three overriding research questions which explore supervisors' and clinicians' attention to cultural competence in the supervisory relationship: (1) How are multicultural issues, race, and racism addressed in supervision? (2) How does attention to clinician-client cultural issues in supervision impact the supervisory relationship? and (3) How do clinicians conceptualize the development of cultural competence?

Research Method and Design

This study used the case study method of research, allowing for a close examination of participants' experience addressing cultural competency in supervision, and with their clients. This methodology also allows for meaningful interpretation of the five participant interviews contained in this study. Case studies "draw on the ability of the qualitative research to extract depth and meaning in context" (Padget, 2008, p.33). The focus on individual cases allows for in depth analysis of participant perspectives, and a unique view of the questions this researcher was exploring. Case studies can play an important role in evaluation, and this study attempted to approach the broad topic of supervision with a specific lens. Through a case study approach this researcher examined the ways the mental health field uses supervision, and its proposed role in education and training, but also examined the reality within supervision for the five participants of this study.

This was not the intended format for this study, but due to the difficulty in recruiting volunteers, the researcher decided to focus on the five participants who did volunteer to participate. It is possible that the difficulty in finding participants was due to the time commitment and the study's requirement of in-person interviews in a small Northeastern city. Clinicians' reluctance to address issues, positive or negative, within their supervisory relationships may have played a role. Potential participants may not have had enough supervision hours required to participate in the study due to the dramatic decrease in offered supervision hours in their current positions post graduation. Potential participants may have been hesitant to discuss race, cultural difference, and racism, knowing that these topics can be emotionally charged and difficult to address. It also is possible that when potential participants reflected on how they discuss cultural competency in supervision, they determined that this does not occur, and therefore felt they had nothing to contribute to the study. The current method of data collection, however, may have yielded richer content with a close examination of each interview.

This research uses an exploratory qualitative method to examine how White clinicians experience and address cultural competency, race, and racism in supervision. This method was chosen because it allowed the researcher to hear and understand research participant responses rather than to isolate their responses into predetermined categories with little room for qualifying or explaining their responses. McLeod (2001) reported that qualitative research requires an informed awareness of philosophical perspectives. Ponterotto (2010) argues that more research about multicultural responsiveness should be done with qualitative methods. He explains that qualitative research

"Promote[s] meaningful, collaborative, and prolonged contact between researchers and study participants. Such an epistemology breaks the dualism (researchers and participants

are independent entities) mantra at the heart of positivist and postpositivist anchored

research, and therefore promotes participant understanding and empowerment within

their cultural contexts. In this way, qualitative research itself may serve as a tool for

social justice and improving intergroup relations" (Ponterotto, 2010, p. 588).

The exploratory method was used in this study to seek understanding of how clinicians

learn and implement cultural competency in their work with clients. Descriptive research

techniques allowed the researcher to ascertain how each clinician perceived that cultural

competence and issues of race and racism were handled in supervision. Five participant

interviews were analyzed and used to explore and describe how clinicians examined their own

White racial identities as they related to their work with clients whose racial identity was

different from their own. Qualitative research methods also tap the deeper meanings of particular

human experiences, and generate theoretically richer observations that are not easily reduced to

numbers (Rubin and Babbie, 2013, p. 40). It is these theoretically rich conversations that

Ponterotto (2010) describes to be the most useful for the current research as they allow the

conversations about cultural and racial responsiveness to achieve some depth, and because they

allow greater reflection by both the researcher and the participant.

Sample Population

The sample population for this study is built upon a case study design that includes five

participants. The inclusionary criteria for study participants was: mental health clinicians with 2

to 10 years practice experience post graduation, with or without a license in the fields of Clinical

Social Work, Marriage and Family Therapy, Mental Health Counseling, and Clinical

Psychology. All clinicians in the study had to self-identify as White and the majority of their

client population must be clients of color. Participants must be fluent in English. At the time of

this study participants were practicing inpatient or outpatient psychotherapy at various levels of care. Practice settings for this study could include social service agencies, hospital inpatient and outpatient clinics, school counseling centers, court, private practice, and/or home-based service. All participants were required to engage in regular supervision hours, averaging minimally 4 hours per month.

Supervision was defined as weekly meetings or group supervision where clients and case needs were discussed with a licensed clinical supervisor. Participants also were required to have had supervision with a White supervisor for at least one year in order to talk about this supervisory experience as it related to the current research.

The five participants who did volunteer for the study met these requirements. All five participants self-identified as White and had a graduate degree in social work (M.S.W.) or mental health counseling (M.S.). The participants had between 2 to 6 years of clinical practice experience. Two of the participants identified as female, and three participants identified as male. All participants reported that 50% or more of the individuals with whom they worked were clients of color. All five participants reported working in urban environments and there was overlap in clients served: one in a hospital outpatient clinic, three in an agency or community mental health center, and one in clients' homes. Three reported working with the general population, and three reported working more directly with mentally and physically disabled individuals, and one participant within this group worked specifically with the veteran population. When asked the question, what percentage of your supervisors identified as White or Caucasian, four participants reported more than 50% to 100%; and one participant reported less than 50%. Participants discussed experiences in supervision during their training and internships

while in school, as well as work and supervision experiences post-graduation during the in-person interview.

Participant demographics are presented in Table 1:

Table 1: Responses to Participant Demographics Questionnaire

Participant

P1	P2	P3	P4	P5

What is your discipline?

P1	P2	P3	P4	P5
Clinical Social Worker	Clinical Social Worker	Clinical Social Worker	Mental Health Counselor	Clinical Social Worker

Please list your degrees, certifications, and license(s). If you are not licensed, please write, "Not licensed."

P1	P2	P3	P4	P5
• Not licensed	• LCSW	• MSW • not licensed	• MS, NCC • not licensed	• MA, Public Policy and Management • MSW • LCSW (CT) • LISW (OH) • Child Development Site Supervisor (CA)

How many years have you been practicing psychotherapy? Please round to the nearest year.

P1	P2	P3	P4	P5
2	6	2	2	4

How do you identify racially/ethnically?

P1	P2	P3	P4	P5
White or Caucasian	White or Caucasian	White or Caucasian	White or Caucasian	White or Caucasian

Please select the gender you most identify with.

P1	P2	P3	P4	P5
Man	Woman	Man	Man	Woman

Approximately what percentage of your caseload are clients or patients of color?

P1	P2	P3	P4	P5
More than 50%	More than 50%	More than 50%	More than 50%	About 50%

In which type of geographical area do you primarily practice psychotherapy?

P1	P2	P3	P4	P5
Urban	Urban	Urban	Urban	Urban

In which of the following settings do you primarily practice?

P1	P2	P3	P4	P5
• Agency or community mental health center	• Clients' homes	• Hospital outpatient clinic • Clients' homes • in community	• Agency or community mental health center	• Agency or community mental health center

Are you involved in clinical or advocacy work with any particular special interest or sociocultural group(s)?

P1	P2	P3	P4	P5
• Physically or mentally disabled community	• Community of color, • Physically or mentally disabled community	• Community of color • Physically or mentally disabled community • Veterans	• No; I work only with a general population	• No; I work only with a general population

How many supervisors have you had while working in the mental health profession?

P1	P2	P3	P4	P5
3	5	5	4	6 (post graduation)

How many hours do you spend in supervision per month?

P1	P2	P3	P4	P5
4 hours	More than 4 hours	More than 4 hours	4 hours	4 hours

Approximately what percentage of your supervisors identified as White or Caucasian?

P1	P2	P3	P4	P5
More than 50%	All (100%)	All (100%)	Less than 50%	More than 50%

Data Collection

A demographics questionnaire and recorded interviews were the primary sources of data collection. Each participant received a formal request to participate in the study via email (See Appendix A). If they remained interested after seeing this request the researcher sent an additional email with the study's inclusionary criteria (See Appendix B). If a participant expressed continued interest in participating the study and met the inclusionary criteria, the researcher sent them an informed consent form (See Appendix C). Once this form was signed and returned to the researcher, the participant was sent a demographics questionnaire, and the participants were given three questions to contemplate before meeting in person (See Appendix D).

This researcher conducted face-to-face, semi-structured interviews with each participant. Each semi-structured interview ranged from 45 – 70 minutes in duration. An interview protocol was used to guide each interview (See Appendix E). Neutral probes were used, when necessary, for clarification or to elicit elaboration of responses without biasing the data (Rubin and Babbie, 2013). In order to capture the interviews with accuracy, all interviews were recorded using a digital voice recorder. Padget (2008) reported that "Audio recording allows the interviewer to concentrate on what is being said. Recording also has an advantage over note-taking and captures laughter, sighs, and sarcasm – aural aspects of the interview that are vivid and revealing" (Padget, 2008, 121). The semi-structured interview contained three basic questions and six probing questions.

The following research questions served as the foundation for this study and focused on how, when, and what happens when issues of cultural competency and racial difference come into the supervisory relationship between a White supervisor and a White supervisee.

(1)　　　What exposure, if any, have you had to developing cultural competency in

psychotherapy? (Trainings, workshops, classes, casework?)

(2)　　　How are multicultural issues and race addressed in supervision?

a. Who initiates cultural and race discussions in supervision?

b. What is the frequency of these discussions?

(3)　　　How does attention to clinician: client cultural and race issues in supervision impact the

supervisory relationship?

a. What has been your experience in supervision when addressing issues related to

culture and race with your supervisor, i.e., level of comfort, empowerment?

(4)　　　How do clinicians conceptualize the development of cultural competence?

a. How does your supervisor aid your development, i.e., case conceptualization, process,

assignment, techniques?

b. How do you learn cultural competence through supervision? What does multicultural

supervision mean to you?

(5)　　　How do you address racism with your clients and in supervision?

a. Do you believe you have developed a sense of your own White racial identity? If yes,

how have you developed this?

Confidentiality

All interviews and comments from the participants were coded and reported in such a

way as to ensure complete confidentiality of participants, and will remain confidential and coded

to ensure confidentiality and privacy. All identifying information about participant, supervisor,

and clients was treated confidentially and names were removed or changed to ensure

confidentiality. The researcher and research advisor were the only individuals to see the initial

data. All data from the interview conversations is placed in a secure location for a period of three years as required by Federal guidelines, and data stored electronically is fully protected. If the data is needed beyond the three-year period, it will remain in a secure location and will be destroyed when it is no longer needed.

Data Analysis

Interview questions were transcribed by the researcher, and analyzed with the program Dedoose in order to interpret the data and any emerging patterns or themes. The researcher completed coding and discussed thematic development with her research advisor. Coding allowed for the isolation of comments and themes into analytically relevant ways to interpret the data. Notes from observations throughout the interviews were used at the discretion of the researcher when they brought relevance and greater insight to the data. Careful interpretation of the research data provided answers to the research question of how multicultural competency and racial difference are addressed in supervision between White mental health clinicians and their White supervisors in mental health settings that serve primarily clients of color.

Recruitment Process

A purposive sample was used to recruit study participants. The researcher contacted her professional network of social workers and clinicians in mental health agencies in Connecticut to inform them of the study and to ask for their assistance in participant referrals. Outreach and recruitment emails were used to connect to every local community mental health agency, and a letter format was distributed to agencies with clinicians interested in distributing paper versions of the request for participants. The researcher also used a snowball approach to locate additional volunteers by asking participants if they had additional potential participants in mind after completing the study. The researcher did in-person presentations to two different large mental

health agencies in the community. The researcher also partnered with a local university's mental health cultural competency trainer, who distributed fifty copies of the recruitment letter to mental health clinicians she interacts with through monthly meetings. Every effort was made to solicit diversity within the study. Diversity included gender, education, age, years of experience in practice, and type of work setting. These efforts capitalized upon collegial relationships, referrals through clinicians in varied mental health organizations, professional networks like the National Association of Social Workers- CT, and professional social media networks.

Risks and Benefits to Participation

All participants signed an informed consent form, and understood that their participation was voluntary before participating in the study. This was restated verbally before each in-person interview, and participants were told they may withdraw from the study at any point until May 1st, 2013, when the data analysis was to begin. There was no financial incentive to participate in this study. Prior to the implementation of this study, the Smith College School for Social Work Human Subjects Review Board approved this study (See Appendix F). The benefits of participation included opportunities for self-reflection and contributing to research that addresses culturally competent social work practice in supervision. Participants were encouraged to think critically about their training, their education, and their organization's commitment to and implementation of culturally competent practice. A potential risk of this study was that the experience might have created some level of disappointment or anxiety in participants if they felt that they received inadequate supervision or that cultural competence was not broached with their supervisors. The benefit, however, may have been a positive influence upon the clinician to seek more training to gain greater insight and skills to practice culturally appropriate clinical

practice. It also may have influenced participants to discuss how to increase the focus of cultural competency and address race and racism in their supervision sessions.

Limitations of the Study

The major limitation of this study is the reliance on the five case studies, which does not allow for generalizing conclusions, and which points to another limitation, which was the time constraints to complete the study. Another limitation is that the researcher's intensive involvement in the study and topic may have led to bias during participant interviews or data analysis. Volunteers who self-selected to participate may have been biased towards wanting to address how they approach race and cultural competency in supervision, which may impact the findings. Participants self-reported their experiences addressing race and cultural competency in supervision, which may not always be reliable as previously discussed in the literature review. Future studies on this topic could include case study interviews with pairs of supervisors and supervisees to understand both perspectives of how they each perceive cultural competency is addressed in supervision. It also would be valuable to attempt this study with a larger number of participants that include mental health clinicians in the field of psychology and psychiatry as their perspective may be different than social workers and mental health counselors. However, there are strong benefits from this study despite its limitations. Findings from this study offer an in depth perspective into the ways five White supervisees and their White supervisors use supervision time to discuss cultural competency, race, and racism, and the impact of their own white racial identity on their relation to their clients.

CHAPTER IV

FINDINGS

Three research questions served as the foundation to explore supervisors' and clinicians' attention to cultural competence in the supervisory relationship: (1) How are multicultural issues, race, and racism addressed in supervision? (2) How does attention to clinician-client cultural issues in supervision impact the supervisory relationship? and (3) How do clinicians conceptualize the development of cultural competence and their own White racial identity? These questions allowed the researcher to examine how multicultural competency and racial difference are addressed in supervision between White mental health clinicians and their White supervisors in mental health settings that serve primarily clients of color. Findings from this study population suggest that there are both barriers and catalysts that impede or encourage discussions of race, racism, and cultural difference while working with clients in different mental health settings. These barriers and catalysts play a large role in determining how or whether the clinician addresses race, racism, and cultural difference directly with their supervisors and subsequently their clients.

Four of the five participants in this study reported that race, racism, and multicultural issues do not come up in supervision unless the participant initiates the conversation. Three out of the five participants reported bringing up a discussion about racial or cultural difference with their supervisor, and two reported never addressing the topic in supervision. These two participants, however, did report asking questions about cultural difference with their colleagues; and all five participants reported that they felt there would be value in addressing race, racism, and cultural issues within their supervision. Every participant reported that when they were in school they were encouraged to reflect on issues of discrimination and oppression more

frequently, and this had since changed when they entered the workforce. When asked about the impact on the supervisory relationship, each of the participants reported that talking about racial and cultural differences within supervision had no impact, positive or negative. Three out of five participants reported feeling that their supervisor would be comfortable addressing these topics if they brought them up. The majority of the participants reported a reliance on personal reflection to develop their own cultural competency and White racial identity, and did not report growing in their identity understanding through discussions with their supervisors.

How each participant conceptualized cultural competency was answered in a variety of ways, but often participants focused on the value of continued learning. Two participants discussed how cultural competency is a "moving target" and never with an endpoint. They reported life-long learning to develop their cultural competence as long as they continue to work. Participant Five (P5) explained, "But when I think about cultural competency…it's not something that you can ever totally master competency at, so that's the frame that I come at it." P4 reported that developing cultural competency requires "experience, knowledge, and comfort. And I think that being comfortable [is] the more important part." Being open and being comfortable working with people who are different than yourself also was something that P1 and P2 addressed, but with a focus on having the client explain cultural differences to the clinician. P1 described having a sense of openness and willingness to say things to clients like, "you gotta teach me how to do this … I'm a white guy." P2 described her work environment promoting a "multicultural module, where the message has just been acknowledging differences, and when you are meeting with clients saying, 'I don't understand that.'" This "tell me more" approach puts the burden of the teaching on the client, but also allows for a conversation about difference to occur in a more direct way. Three out of the five participants directly addressed this

acknowledgement of difference, and the value in being comfortable with pointing out racial difference between themselves and their client, and these same participants reported having conversations about these incidents with their supervisors.

Every participant began with a story about how their social work or mental health counseling graduate education played a large role in their own development of cultural competency. P1 and P3 talked about the value of diversity in their student body, and specific classes, which they felt enriched the conversations about culture and discrimination and aided their development of cultural competency. P1 expressed that in training for his masters degree, "I felt like I could understand some of the issues around discrimination and cultural competency, because I did go over [it] in my schooling." He reported feeling at times that his studies included "a far more mixed student body…which added a lot." P3 explained that it was during his master's education in classes on oppression and discrimination that he really began to examine cultural difference. P3 explained, "When we were in school I still felt like I was trying to figure out what type of person I am, and what type of social worker I am…We had the classes that were kind of dedicated to this stuff [cultural difference], and processing all that." Two other participants discussed specific mentors who helped them integrate their learning to become more culturally competent in their work with clients. P4 explained that his school did not integrate cultural competency into all of his classes, but he had one professor who did this in all of the classes she taught. He felt that she was able to create an intentionally safe place where all students were able to discuss their concerns and open fears about addressing issues around cultural competence with clients. P4 explained, "Cuz if you had sort of, … what you could call a racist thought, or whatever, … she wouldn't like, there was no, … she wouldn't pass judgment on that. She really would [say] this is what the research shows, this is what the facts are, this is what

probably clinically is the best way to approach the situation. Without kind of passing any sort of judgment, so it felt very safe to bring these things up." P4 was clear, however, that this was the only professor with whom he felt this level of comfort, and although he did take a lot of her classes he did not feel this intentional environment or these kinds of discussions took place in other classrooms. In contrast to the other participants, P5 felt her graduate program made many efforts to "disperse [cultural competency training] throughout," and she did not feel that the message was you take this one class on cultural competency and that was enough.

The theme of unsafe and safe environments to bring up questions and thoughts about racial or cultural difference came up often as participants were asked about the environments where they do bring up difference as it relates to working with their clients. Three participants discussed how these safer environments were harder to find once they entered the workplace. P5 talked about how, while she was in training, she felt like her supervisors asked questions about the impact of race or cultural difference more than post training, by stating, "Potentially postgrad people [supervisors] are like, 'Do your thing!'" P4 stated that he had not found another environment like that since his experience with this professor that helped him learn and grow in his own cultural competency. He explained, "But that kind of safety doesn't, that's really intentional, that doesn't just happen anywhere...I've never been in another environment where somebody's put such time and effort to making it safe for that." P2 reported feeling that the race of her clients and cultural competency was discussed in her working environment during a weekly supervision group where she is being trained as a new supervisor. She explained, "We've started focusing more about how to bring up cultural competence in supervision, so that's a place where we are finding that we can talk more about it. However, in my individual supervision, it's kind of the last place that it's coming up." P2 did report a change over the last six years of her

employment post graduation, and reported that her workplace is starting to have the conversation more about culture and difference and its impact on treatment.

Three participants talked about the safety of the environment being an important aspect of how and when racial difference was addressed, especially in the context of group supervision. P5 reported an experience with a client where the client rejected her ideas about parenting style changes saying she was living in her "white girl world" and not understanding the reality of her family. P5 was able to discuss this incident one-on-one with her supervisor, but when asked about how or whether it would have come up in-group supervision she explained,

> "I do think group supervision makes a big difference, like I'm pretty outspoken and I'll say whatever, but I know not everyone is like that. So I think it would be harder in a group setting to be like, this is what is going on for me, or this mom, or that experience that I'd had with the mom, that I just talked about, told me I live in my 'white girl world.' I think I would have a little more hesitancy to talk about it in a group setting, potentially than one-on-one. I'm not sure."

P5 described more how in group supervision there are usually a lot of tasks and issues to cover as clinicians go over their work with clients, and talking about the racial or cultural aspects of the relationship is not conducive to this environment. P5 also acknowledged that clinicians want to appear knowledgeable and when a clinician is explaining what happened or admitting they didn't know what to say in the moment it can be difficult. P5 shared she thought this was "because I think in a group setting, you, everyone has more of a tendency to want to appear knowledgeable, and that I have my shit together." Some participants reported feeling uncomfortable at times talking about race and racial difference, because of concern about not knowing what was or is

the appropriate response to the client in the moment. This fear of presenting their incompetence they recognized could prevent deeper conversations about addressing race and racial difference.

One participant rooted this fear of talking about race or racial difference as a part of a larger fear of being perceived as racist. During a part of the interview P4 and this researcher discussed potential assumptions or stereotypes he may have had about his clients coming into his work setting. This researcher asked if he had talked to anyone at work about these assumptions; he reported that he had not, and had mostly been personally reflective on these issues. P4 explained his hesitation:

> "But it's hard because there's also this sort of the, the idea that, especially as a white person, nobody wants to be called a racist. And everybody, they have, or are racist to whatever degree. But I think it's kind of fear that keeps you from having these conversations. And especially you don't want to be the one person who, to go out on a limb. And I think that probably exists to a large degree where I work, where any, any kind of, or nobody wants to be the first person to bring up a topic, or say the wrong thing, or out yourself as whatever."

P2 did not have this hesitation, and shared that she felt comfortable addressing racially based assumptions that clients would make in her group therapy sessions. She felt that this lack of fear while addressing stereotypes directly came from a long-standing relationship with this group of women she had worked with for several years. She explained that this would be harder with new clients or newer groups because "You know that fear, … is, … you know if I said something, what would they do with that information!" Her worry seemed grounded in how might the clients join or separate from the therapist if she chose to directly address racist remarks or cultural differences with them as you are building rapport.

Three out of the five participants spoke about addressing race, racism, and cultural difference with their supervisor. P2 explained two scenarios where she addressed race with a supervisor. One of them was in a group therapy situation where Black clients in the group brought up a concern with P2 that favoritism was being placed on a White member of the group. In this scenario P2 reported feeling unsupported by her supervisor as the reflection of the Black members comments was met with what she perceived as her supervisor's defenses. In a separate scenario with the same supervisor she did state that her supervisor was able to give her important and needed support while working with an African American teenager:

"In thinking about another case where it's an African American teenage boy who I work with, and he's always been drawn to white middle class families. And so what has my role been with him? … and that's a place where we could talk about, how does he view me? … and why has he joined with me? … how would he have joined if it was somebody of the same race? um. And that's where my supervisor has been supportive."

P2 reported that these conversations that she initiated with her supervisor were very helpful in thinking about her continued work with this client.

P5 was another participant who reported several incidents where she initiated a conversation about race or racism as it affects her work with her clients with her supervisor. She shared feeling very comfortable initiating conversations with her supervisor about specific moments in therapy where she feels like cultural difference, race, or racism may be playing a role in the therapy. She shared:

"I've always had, overall, had really great experiences in supervision…It's [Racial difference] going to impact your clinical work - how can it not? So I've felt like any time I've brought something up I've never had like an awkward conversation like, I felt like

my supervisors were all across the board overall very, really open to having that conversation."

P3 talked about an experience in his first internship year where he worked at an organization where aside from his supervisor he was the only White person, and only White male at the organization, and was leading group therapy where all the participants were African American and Hispanic males. He talked about his initial realization that he was uncomfortable with his whiteness in the room, and talked about recognizing this out loud with his clients and verbalized that he recognized that he was the only White person in the room. P3 did bring up this moment with his supervisor, who helped him think through why he chose to do this in that group. He explained his supervisor's response: "I mean I think she kind of, I think she encouraged me to do it, but she acknowledged that it definitely was something that I did more for myself than the, … than for the benefit of people in the group." P3 shared feeling badly that he had felt uncomfortable being the only White person in the room, and having to bring it up to the group just to make himself feel more comfortable. He remembered the group response being, "I mean it was very much, just kind of like, ok, that's fine. Let's do this." P3 did share that in general if race was addressed in supervision he would initiate it, and he felt like bringing up cultural competency or difference was well received.

One of the biggest barriers to talking about race, racism, and cultural difference in supervision that seemed to come up for four of the five participants was restricted time in supervision. Time limits and priorities in discussions with supervisors seemed to be perceived as taking time away from talking about race or cultural difference. P2 explained that with such a high caseload when the participant is in supervision "you are trying to get [to] these main issues, and maybe culture is a main issue we are missing. But you know there is x, y, z, going on and

there is not always time to … I think … to really focus in on what else might be going on." She talked about resource issues, and the immediate needs of many of the clients she works with, which often include economic difficulties like access to food, housing, employment, and healthcare. P2 even suggested, "You know, maybe if we designated a certain amount of time every supervision to talk about some cultural issues that might be coming up would be a way to really make sure that we focused on that." P3 focused on securing housing for his clients, which is his role in his position helping veterans. He explained that often race and culture do not come into the conversation when his priority is trying to get this veteran housing, although he did confirm that many veterans with mental health and substance abuse issues face discrimination as they attempt to get housing. He shared that with his high caseload, it is hard to address cultural or racial difference: "I mean our program has a really high caseload. I'm in the 30's. I have an hour a week, … people are in crisis a lot. I mean I can easily spend the whole hour talking about three people." He explained that talking about cultural competency in supervision is not his priority when he only has an hour of supervision a week.

Crisis management and how it affects the amount of time there is to address cultural and racial difference also was discussed by P4, who works in a substance abuse program. He explained that often his office is dealing with the possibility of clients overdosing, and the immediate needs trump conversations about race. When asked if his supervisor would be open to discussing a specific potentially racist incident in the lunchroom he shared,

"You know, I don't know that my supervisors would be open to talking about that. (pause) And I think there might be some of the just not wanting to deal with it, but it is, it's when you are dealing with people who are in intense poverty, there is such this, this every second counts, every moment of your day is like really valuable. And it's sort of

like what people perceive is worthwhile. Um, and like every, the ambulance comes to

work a few times a week."

P4 lamented this reality at his workplace and later changed his mind in the interview and stated

that he does believe supervisors want to address cultural difference as it relates to his work with

clients. He explained about his supervisors: "I don't think it's that they don't want to address

those kinds of things [cultural difference]. I think it's that you know, the amount of hours that we

have and the needs of the community that we serve, um, it's just not time. There is not time for a

lot of things. It's really sad." This feeling of awareness that there is value in talking about issues

of race and racial difference with clients, but feeling stuck in the work culture or systems that

seem to create time limits, and specific priorities that do not include addressing racial difference,

was a theme for many of the participants.

Four out of the five participants did talk about how racial and cultural difference was

directly addressed in group supervision and one-on-one supervision when the clients were recent

immigrants or not born in America. This discussion of focusing on learning foreigners' cultural

norms included an awareness of an absence of discussion about the cultural norms in Hispanic

and Black communities for three of the five participants. Two participants discussed the ways

they felt their work place and supervisors made assumptions about their knowledge of cultural

difference in American Black and Hispanic communities, when they felt just as in need of

support and discussion about these differences as they did when working with clients from

different countries. P2 shared how when she spoke to her supervisor about working with a family

from Iraq who are refugees there was a response, "Oh you should read this or get this book…

And their culture is a part of the conversation all the time. There is a language barrier, and there

are a lot of other things going on with this family, so it's really present." But she felt that in

working with this family she was also noticing an absence of discussion about culture with the families in the city she worked in. She explains, "but [if] we got a family that lived in [northeastern city] for multiple generations, we're not saying, oh you should watch this movie to understand things better." She mentioned that the focus on culture in supervision happens most often "when it's a family who's culture is really unknown." P4 shared this notion that when they had a client come in who was from Iran, "that was discussed, in like the group or the team meeting as to how their culture and especially cultural attitudes towards addiction. I guess that's the biggest thing that we talk about for obvious reasons." When the researcher asked about why this becomes obvious when the person they are working with was not born in America, he explained it was because it was more unusual and the majority of their clients are Black or Hispanic. He added, "Because it's not, I think it's, part of the reason why it's brought up is because it's so unusual. We had somebody who came in, who was a Hasidic Jew who came in, so we talk about that." The discussion of difference and using it as a way to get a more complete understanding of the client appeared to be coming up more in the realm of cultural or religious difference as ways to better understand immigrants or refugees.

The researcher's final question was about whether the participants felt they had developed their own sense of their White racial identity. Four out of the five participants believed that they were still developing and working on understanding this part of themselves. P2 did not give an answer to this question. P5 talked about exploring her white racial identity as it related to her work with clients, and wanting to think that her White racial identity doesn't change the work that she does with her clients; but she also acknowledged that there are moments where her whiteness is very much in the working relationship:

"I don't know if I've fully developed a sense of my whiteness or how that impacts the, …
because I want to have this kind of Pollyanna-outlook that it shouldn't matter and it's just
about doing the work. But obviously I do recognize that it does come into play, and does
need to be acknowledged, and I guess based on my experience in supervision…. So I was
like, if it comes up then I'll address it."

P4 discussed how his own family has Polish roots, but slowly these cultural norms or parts of
their White Polish identity has been removed from his family history and replaced with what he
described as a culture of consumerism. He explained:

"There is also a thing of absence in White racial identity…I think that, so the dominant
culture, [is] kind of capitalist culture, slowly like picking part, yeah, capitalist entities are
picking apart all cultures, and kind of separating people from their cultures. And I think
that White people are really separated from getting any kind of sense of cultural identity,
and makes us very vulnerable to like, where, sort of white culture is becoming the culture
of consumption…So I don't really know what white racial identity is. I don't want to say
that it's the gap, though sometimes it feels that way."

P3 talked about the development of his White racial identity in relation to his first internship
experience where he realized he was uncomfortable playing the role of the facilitator while being
the only White man in a room with Hispanic and African American males. For him this
experience made him take the opportunity to self-reflect and think more about what was making
him feel uncomfortable in this situation. He shared,

"So I had to kind of re-look at what that was about. And work on ways to, I'm trying to
think, like, figure out a way, figure out the words used to address it and how do I look at
this…being the only White guy in a room full of African American and Hispanic people.

You know. So it was kind of like, I kind of had to figure out the language of how to

address it. Cuz, I didn't think it would be something that would throw me off really. But

then faced with them. What is this discomfort about right now?"

P1 talked about his developing sense of privilege and how he realizes that because he is White he

could "go almost anywhere and not worry, because I'm White." In a comment following his

statement I mentioned how some people seem to have an awareness of their whiteness and some

don't. P1 offered, "Yeah. I think the ones that don't are probably the more dangerous ones

because they are not, … they don't have insight. Insight can be used, for good or for evil. And I

feel like I try to use it for good I guess, but I can benefit at the same time. And I have benefited."

This awareness of the benefits of White privilege came up the most after the researcher asked

about how or if the participants had developed their own White racial identity.

One of the unintentional findings in this research was discovering that at the end of each

interview four out of five participants explained that through our discussion, they realized how

much conversations about race and cultural difference were not happening in supervision. P1

asked about the future of this research and explained, "I hope that I've been helpful, because

what you have shown is that this really hasn't ever come up directly in my supervision." P3

reflected on how racial difference and cultural difference "definitely came up in the practice. Not

in supervision so much." P4 spoke in the beginning of the interview that he felt he did not have

many examples of times where he had addressed race, racism, or cultural difference in

supervision; and at the end of the interview when I asked again if he could think of any moments

that may have come up through the conversation, he explained, "Um, you know, I didn't even

realize how much it wasn't addressed until this interview." P2 reflected on how addressing racial

or cultural difference can absolutely affect the treatment, and how it is important to talk about

these issues in order to best serve clients. She explained that in case presentations at her work she has noticed that sometimes a family's race or culture is not even a part of the case presentation. She explained, "More and more it's noticed as an absence, when it's [racial or cultural identity] not there, but I think it's because of them having these conversations in different places. Without that, I think it's something that can easily be missed. Which is not good, because it can have a lot to do with the treatment." P5, who talked about consistently initiating conversations about race and cultural difference with her supervisor and addressing it with clients, talked about the value of having the conversation about it through our interview, and how her focus on race may be a little stronger when she went back to work the following week. She shared,

> "I think it's helpful to have this [interview], to have the ongoing conversation. Because now that I'm thinking about it, I mean I know could do a better job, even as I start a new case, which I've done a couple times in the last week or so, like it didn't really cross my mind. Ok, like, it's nice to meet you, without really having a more of a culturally competent, culture: race lens…But maybe I kind of should be a little more in tune to that and that could certainly potentially help the work. I'm not sure. I would say yes. But I wouldn't have had any of these thoughts if you and I hadn't sat down today and talked about it."

All of the participants saw value in examining race and culture in relation to their work with clients of color, as it could help them better understand the client within their racial and cultural context. But it was clear that the ways that these conversations begin and are being supported is inconsistent in each participant's experience.

CHAPTER V

DISCUSSION

The objective of this qualitative study was to explore clinicians' perspectives on how multicultural competency and racial difference are addressed in supervision between White mental health clinicians and their White supervisors in mental health settings that serve primarily clients of color. The researcher completed a qualitative case study analysis of five white clinicians, who were asked to discuss the content and nature of their supervision with their White supervisors. This approach was used to explore the level of cultural sensitivity and responsiveness that exists in same race supervisory relationships. This chapter reviews the study's findings in the following order: 1) key findings, 2) limitations, and 3) implications and conclusion.

Key Findings

The key findings in this study focus on the participants' responses to how race, racism, and cultural difference are addressed in supervision. For the five participants in this study, they most often initiated conversations about race and cultural difference. Their supervisors supported them when race and cultural difference within supervision were raised, yet this subject was rarely explored. Each of the participants agreed that race, racism, and cultural difference were important issues to discuss and could benefit the therapeutic relationship with clients. However, they were divided in their perceptions of their supervisors openly addressing these issues in supervision. These findings support Leary (1995), Maiter (2009), and Carter (1995) conclusions of the need to explore the meaning of race and ethno-racial background in the therapeutic settings, as it facilitates better psychotherapeutic work and clinician-client success.

On the other hand, there is some debate as to whether racial difference should be addressed quickly and directly with clients. There are a few studies to directly measure the impact of addressing racial difference early in the client-clinician relationship (Knox, Burkard, Johnson, Suzuki, and Ponterotto 2003; Sanders Thompson and Alexander, 2006); and when racial difference is addressed, is it client focused. For example, one participant in this study described addressing his whiteness at the beginning of his work with an all men of color fathers group, but reflected that this openness was more about making himself [clinician] feel comfortable than for any member of the group. There also is the issue of timing and dealing with immediacy as was reflected in one participant's 'missed moment'. In a previous session with a client, the clinician was told: "You live in your white girl world; you don't know anything about my world, and my life." When the clinician attempted to address this client's comment later, she was told: "Oh, no. We're good," and would not discuss the issue further. The clinician's failure to address race when the client brought it up led to dismissal of the client by the clinician, and potential damage to the therapeutic relationship. Situations such as these are important teaching moments in the supervisory relationship, and should be addressed directly. Failure to address these important issues in supervision can impact how clinicians address race, racism and difference in future therapeutic relationships.

Frequent explanations offered by clinicians in this study regarding barriers to conversations about racial and cultural difference were worry about not having enough time to discuss these issues and feeling that they already were supposed to know how to handle these situations. Some participants reported that race and cultural difference did not seem to be a priority, especially when more 'crisis issues' were present for their clients. These comments imply that race and culture are not important issues in therapy, that some white supervisors and

clinicians lack knowledge about race or cultural competence, and that race and racism continue to provoke levels of discomfort in some white supervisors and clinicians. These findings are consistent with Allen and Majidi-Ahi (1998), who found that some White clinicians feel anxious when they confront their "Whiteness" and may struggle with acknowledging how they collude or benefit from racism. It also appears that the participants in this study were more likely to address race indirectly, such as through the use of multicultural case conceptualization, when asked the race of their clients. These participants were more likely to include race as part of their case conceptualization in decisions about how to help the family, and that the omission of this content would be addressed during case presentations. It appears from the discussions of these clinicians that core consultations about race, racism and difference occurred between colleagues, away from work and or in group supervision. One participant used the following illustration.

> "More and more it's noticed as an absence, when it's not there, but I think it's because of them having these conversations in different places. Without that, I think it's something that can easily be missed. Which is not good, because it can have a lot to do with the treatment."

This is an example of the need to shift organizational culture in ways that place emphasis on cultural and racial difference as a piece of the client's identity and a factor that can impact treatment outcomes. Fung (2012) and Darnell and Kupermic's (2006) research confirms the value of examining and shifting organizational culture to become more culturally competent, as they found a relationship between culturally competent care and effective patient outcomes. These findings substantiate the need for future research to examine how organizational culture impacts supervisees' desire to initiate conversations in supervision, and supervisor's frequency in initiating conversations about race and racial difference into supervision.

The five participants stated that their supervisors were able or even willing, to discuss racial and cultural difference in supervision, but placed the responsibility on them to initiate the discussion. Age and training were not variables for the participants in this study. This is consistent with Burkard et al (2006) and Constantine's (1997) research, which found supervisees training around cultural competency to be very different than the training their supervisors received, and attributed this to an age difference and timing of degree completion. Current programs in social work and psychology include more classes in cultural competency, compared to 15 years ago. The participants in this study felt that their supervisors were able to have conversations about race and racism and cultural difference, but did distinguish a difference in level of comfort discussing these issues while in training versus once employed. This is consistent with research by Knox, Burkard, Johnson, Suzuki, and Ponterotto (2003), which found that African American and White clinicians had more cultural competency training available to them while in school, but that White clinicians felt there was less didactic training than the African American clinicians they interviewed. Knox, Burkard, Johnson, Suzuki, and Ponterotto (2003) also found that the White clinicians were less likely to seek out additional cultural competency training after graduate school and while in practice. Two of the five participants in this study did discuss seeking out additional cultural competency training post-graduation, but because of the small sample size it cannot be considered part of a larger trend or different than the findings by Knox et al (2003).

Participants also discussed how race was not the only factor that leads to issues of discrimination in clients' lives. The impact of poverty from difficulties with safety, housing, food, and basic needs were more pronounced than race and cultural difference even though these are intertwined. Two participants were asked to discuss whether they consciously use their White

privilege to support clients, and both gave examples where they did this. One participant described stepping in during a school expulsion hearing when she felt her client was being misrepresented and mistreated when the parent reported 'feeling frozen and unable to speak up for her child in a setting where she was African American and everyone around her making decisions about her child was White and more educated than her'. In this precise moment this participant addressed the potentially race related power dynamics in the room, and its impact upon the client. Another participant discussed his work with Veterans who often report racism or discrimination as they are looking for housing, for example stating a landlord will not rent to them based on the sound of their voice. This participant reported a consciousness about using his connections and White privilege to help those Veterans secure housing. This is an area for additional research to examine how White clinicians choose to use their White privilege when working with clients of color, and how this intervention impacts the therapeutic relationship, including how their clients perceive this type of action.

As a result of their involvement in this study, all five participants acknowledged that racial and cultural differences were not discussed as frequently in supervision as they had assumed. This may address the lack of cultural competence among clinicians and supervisors who work with clients of color. If this indeed is the case, it addresses the issue of clients of color level of comfort and willingness to disclose in therapeutic relationships with White clinicians. Also the lack of discussion around these issues may infer the lack of clinician and supervisor knowledge about culture and environment and how these two variables impact clients of color behavior. This realization prompted some of the participants in this study to commit to increasing the amount of conversations in which they will discuss racial difference in supervision.

Limitations

This study did not examine the White clinicians' perceptions of advantage or disadvantage of racial or ethnic match of the client-clinician pair, but rather how multicultural competency and racial difference are addressed in supervision between White clinician-supervisor pairing. Based upon the findings of this study, examining perceptions of advantage and racial match by White clinicians may be equally important. There is research that suggests racial and ethnic match can affect symptom report, clinician's ratings, and client length of stay in treatment (Jones, 1982; Sue, Fujino, Hu, Tekeuchi, and Zane, 1991). However, Sanders Thompson and Alexander (2006) and Maramba and Hall (2002) found that ethnic match was not a significant predictor of dropout rates or utilization of therapy. More research in this area could help the mental health field better predict how to better support racial and ethnic differences, which are bound to be a part of many clients' treatment experiences.

Findings from the current study refuted research by Knox, Burkard, Johnson, Suzuki, and Ponterotto (2003), who found that White clinicians typically do not address racial difference with their clients. A distinction, however, was that Knox et al. (2003) compared the White clinicians to a group of African American clinicians, who more frequently did address racial difference in the therapeutic relationship. The current study did not use a comparison group of clinicians of color, which is a limitation of this study. Yet, three of the five participants in this study did address racial difference directly with their clients, differing from the findings of Knox et al (2003).

This study also did not ask study participants to talk about supervision experiences with supervisors of color. There already is research on the impact of cross-racial supervision (Burkard et al, 2006; Wong, 2006; Jernigan, 2010). Burkard et al (2006) examined the supervisory

relationship of supervisors of color and their white supervisees and found that culturally responsive supervision positively affected the supervisee-supervisor relationships as well as client outcomes. This study did not measure client outcomes. This study's participants differed from Burkard et al.'s (2006) findings because participants did not report any positive or negative impact on their supervisory relationship when race, racism, or cultural competencies were addressed in supervision. It is unclear if this perceived lack of impact was because both clinician and client were White.

It is recommended that the theme of 'lack of time in supervision' to discuss and prioritize race or race difference be examined in depth. This study broached this topic by asking participants to address their understanding of their White Racial Identity; however future studies can examine this issue more fully by using Helms (1984), Hardiman (1982), Ponterotto (1988), and Sabnani's (1991) work on stage development of White Racial Identity and its impact on White clinicians' perceived ability to prioritize or find time to discuss racial difference in supervision, including in their work with the client. Research also could explore the theory in anti-racist training about White resistance. It would be valuable to learn whether this issue of not having enough time to discuss or prioritize conversations about racial difference is, in part, about organizational culture or the history of oppression of people of color in the United States and the ways this allows White people to avoid topics stemming from fear, guilt, or discomfort. Goodman (2011) explains,

> "When people are resistant, they are unable to seriously engage in the material. They refuse to consider alternative perspectives that challenge the dominant ideology that maintains the status quo. They resist information or experiences that may cause them to question their worldview. They may dismiss the idea that oppression or systemic

inequalities are real…Resistance is not the same as prejudice. Prejudices are pre-judgments – attitudes or beliefs about particular social groups. Resistance is not about people's specific views, but their openness to consider other perspectives" (Goodman, 2011, p. 52).

This potential resistance is not something that the participants in this study were asked and it would be valuable for future studies to include discussions about how race, racism and cultural difference may create resistance for certain clinicians, supervisors, and clients.

This research was restricted to the perspective of clinicians' use of supervision to understand how race, racism, and cultural difference are addressed in supervision with same race clinician-supervisor. More thorough investigations could be done by interviewing connected trios of the client, clinician, and supervisor, in order to gain better understanding of each participant's perception on how or if racial or cultural difference are discussed, as well as insight into the perceived and real impact on supervision and treatment.

Despite these limitations, the study has merit. Research on cultural competence and racism and same race supervisor-supervisee relationships is critically needed. This study specifically sheds light on three critical issues: (1) the need for White clinicians and supervisors to recognize race, racism and culture as factors that impact therapy with clients of color; (2) the need for supervisors, whether White or African American, to address these issues with their supervisees; and (3) the need to understand how White privilege can be an advantage as well as a disadvantage in therapeutic relationships with clients of color. Hence, findings from this research offer a reflection on how to create more effective and supportive balance in same-race supervision and cross-cultural mental health treatment.

Implications

It is important to recognize the impact that supervisors have in training clinicians in cultural competency within cross-cultural psychotherapy. The evolving training and teaching of cultural competency for clinicians, and cultural responsiveness in supervision, has an impact on same-race clinician-client dyads. There is evidence from this study that clinicians believe that their supervisors are willing to talk about race, racism, and cultural difference in supervision, and yet it rarely comes up unless addressed by the clinician. If supervision remains a significant training place for clinicians, it is important that the barriers and catalysts to addressing racial difference are examined and addressed in supervision in order for clinicians to feel better prepared and able to address these differences with their clients. Participants perceived that race or cultural difference was addressed in their graduate work and one-time "diversity" trainings, but not always in practice or individual supervision. Determining the appropriate response to any admission or challenge by a client can be difficult, and it appears that addressing those challenges when they are about race, racism, or cultural difference can be even more difficult. There are several factors that may influence this difficulty such as organizational culture, time to address all client's needs in supervision, supervisor's perceived openness, White resistance, lack of didactic training, and fear and discomfort with racism or racial difference. What this suggests is the need for intentional discussions with clinicians about race, racism and cultural difference and full understanding of how such issues impact potential benefits of treatment. More importantly, from this information is the awareness that academic institutions, organizations, and supervisory groups should make a concerted effort to address these issues in the learning environments of all clinicians.

Recruitment Email for Colleagues and Professional Networks

Dear Mental Health Professional,

  My name is Liz Hammond and I am a graduate student at Smith College School of Social Work. I am in my final year of study and I am conducting research for my Master's thesis. I am doing a qualitative research study to examine how multicultural competency and racial difference are addressed in supervision between White mental health clinicians and their White supervisors in mental health settings that serve primarily clients of color.

  I invite you to participate in this study. The benefits of participation include opportunities for self-reflection and contributing to research that addresses culturally competent mental health practice in supervision. Participants are encouraged to think critically about their training, their education, and their organization's commitment to and implementation of culturally competent practice. I will meet eligible participants in person at a mutually agreed upon site, and will ask five questions for a 45-60 minute interview. Participation in this study is strictly voluntary and all answers will be kept confidential in accordance to Federal guidelines.

  Eligibility requirements for participation include a mental health clinician with 2 to 10 years practice experience post graduation, with or without a license in the fields of Clinical Social Work, Marriage and Family Therapy, Mental Health Counseling, and Clinical Psychology. All participants in this study must self-identify as White and the majority of their client population must be clients of color. All participants must be engaged in regular supervision hours, averaging minimally 4 hours per month. Participants also must have had supervision with a White supervisor for at least one year in order to talk about this supervisory experience for purposes of this research.

  If you meet criteria for participating, I encourage you to take part in my study. Please contact me if you think you might be eligible and interested in participating, and I will send you an informed consent form and preliminary survey, and we can begin to coordinate the interview. If you do not meet criteria, please consider forwarding this email to any acquaintances or colleagues you know who may be eligible to participate. If you have any questions about my research or the nature of participation, please feel free to contact me at (ehammond@smith.edu) or Smith College Human Subjects Review Board at Laura Wyman at lwyman@smith.edu.

Thank you for your time and interest in my research topic.
Sincerely,
Elizabeth Hammond
MSW Intern, Yale Child Study Center, Childhood Violent Trauma Clinic
MSW Candidate, Smith College School for Social Work

Appendix B

Dear interested party,

Thank you for your interest in participating in my research. In order to participate, I must find out if you meet the eligibility requirements for participation. Please read this list, and let me know if you meet all of the criteria.

1. You are a mental health clinician with 2 to 10 years practice experience, with or without a license in the fields of Clinical Social Work, Marriage and Family Therapy, Mental Health Counseling, and Clinical Psychology.

2. You self-identify as White or Caucasian.

3. The majority of your client population are clients of color.

4. You are practicing inpatient or outpatient psychotherapy at various levels of care?

5. You practice mental health services in a social service agencies, hospital inpatient and outpatient clinics, school counseling centers, court, private practice, and/or home-based service.

6. You engage in regular supervision hours, averaging minimally 4 hours per month?

7. You had supervision with a White supervisor for at least one year in order to talk about this supervisory experience for purposes of this research.

8. You practice in the state of Connecticut.

If you DO NOT meet all the criteria on this list, please consider passing on my original recruitment email to colleagues whom you feel are eligible to participate.

If you DO meet the criteria for all eight statements above, please reply to ehammond@smith.edu, and I look forward to discussing your eligibility and further participation.

Thank you again for your time and interest in this study.
Sincerely,

Elizabeth Hammond
MSW Intern, Yale Child Study Center, Childhood Violent Trauma Clinic
MSW Candidate, Smith College School for Social Work

Informed Consent Form

Dear Participant,

       My name is Liz Hammond, and I am a graduate student at Smith College School of Social Work. I am conducting research for my Master's thesis, which examines how multicultural competency and racial difference are addressed in supervision between White mental health clinicians and their White supervisors in mental health settings that serve primarily clients of color. The results from this research will be used for presentation and publication.

       You have been asked to participate in this study because you meet the following criteria: You are a mental health clinician with 2 to 10 years practice experience post graduation, with or without a license in the fields of Clinical Social Work, Marriage and Family Therapy, Mental Health Counseling, and Clinical Psychology. You self-identify as White and the majority of your client population consist of clients of color. You are practicing inpatient or outpatient psychotherapy at various levels of care. Practice settings for this study include social service agencies, hospital inpatient and outpatient clinics, school counseling centers, court, private practice, and/or home-based service. You are engaged in regular supervision hours, averaging minimally 4 hours per month. You have had supervision with a White supervisor for at least one year and are willing to voluntarily talk about this supervisory experience for the purposes of this research.

       As soon as you complete this consent form I will send you a demographics questionnaire that will ask you questions about yourself and the places you have practiced. Then we will set up a time and place to meet for an in-person semi-structured interview will require 45-60 minutes of your time. The interview will include five core questions about how racial difference and multicultural competency issues are addressed in supervision. We will discuss the nature of these conversations in supervision, and how they impact your experience in working with clients of color. I will audio record these interviews and be transcribing them myself. Unfortunately, I will not be able to pay or compensate you monetarily for your participation in this research.

       There are minimal risks to participating in this study, but because the questions in the interview will ask you to reflect on how multicultural competency comes into your supervision, mixed or negative emotions could surface. If this happens you may want to discuss your feelings outside the interview with individuals in your own private support network. Participation in this study is completely voluntary. At any time during the interview you may choose to not answer a question and/or remove yourself from the study entirely. You may withdraw by contacting me via email or verbally. If you withdraw, I will immediately destroy all materials related to your participation. Even if you have completed the interview you may choose to remove yourself from the study by contacting me prior to April 1ˢᵗ, 2013, when the research analysis will begin. The benefits to participating in this research include opportunities for self-reflection and contributing to a better understanding of multicultural competency in mental health practice and supervision. You will be encouraged to think critically about your training, education, and your organization's commitment and implementation of culturally competent work. This may influence you to discuss how to increase the focus of cultural sensitivity during supervision sessions or clinical staff meetings. Overall, participation in this study will help contribute to the body of knowledge on cultural competence in mental health settings and practice.

       It is important to emphasize that all information shared in the interview will be confidential, and all responses will be coded. Any identifying information about yourself, your

supervisor, and your clients will be treated confidentially and removed or identifying information changed to ensure confidentiality. I also ask that in the interview you do not disclose any identifying information about your supervisor or your clients. There will be no mention of the agency where you work, or will there be any reference to specific location of the agency. Initial data will only be seen by myself, and may be seen my research advisor, though the research advisor will view data only after all identifying information is removed and coded. All data from the interview conversation will be kept in a secure location for a period of three years as required by Federal guidelines, and data stored electronically will be fully protected. If the material is needed beyond a three year period, it will continue to be kept in a secure location and will be destroyed when it is no longer needed.

If you have any additional questions, please feel free to contact me directly at ehammond@smith.edu or by phone. Should you have any concerns about your rights or any aspect of the study, you are encouraged to contact me or the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

_____ I agree _____I disagree

_____
Subject signature/Date

_____
Researcher signature/Date

Please email this consent form back to ehammond@smith.edu with an electronic signature or mail to Elizabeth Hammond.

Appendix D

Demographics Questionnaire

Please respond to the following demographic questions.

1. What is your discipline?
   o Clinical Social Worker
   o Mental Health Counselor
   o Psychologist
   o Marriage and Family Therapist
   o Psychiatrist
   o Psychiatric Nurse Specialist

2. Please list your degrees, certifications, and license(s). If you are not licensed, please write, "Not licensed." _____

3. How many years have you been practicing psychotherapy? Please round to the nearest year?
   _____

4. How do you identify racially/ethnically?
   o Black or African American
   o Hispanic, Latino, or Spanish origin
   o Asian
   o Middle Eastern
   o Native American or Alaskan Native
   o Pacific Islander
   o Mixed Race or Biracial
   o White or Caucasian
   o Other (please specify) _____

5. Please select the gender you most identify with.
   o Woman
   o Man
   o Transgender
   o Other (please specify) _____

6. Approximately what percentage of your caseload are clients or patients of color?
   o None (0%)
   o Less than 50%
   o About 50%
   o More than 50%
   o All (100%)

7. In which type of geographical area do you primarily practice psychotherapy?
   o Urban
   o Suburban
   o Rural

8. In which of the following settings do you primarily practice?

- Agency or community mental health center
- Hospital outpatient clinic
- Hospital inpatient
- School setting
- Rented office space outside my home
- Office space inside my home
- Clients' homes
- Other (please specify) _____

9. Are you involved in clinical or advocacy work with any particular special interest or sociocultural group(s)? Please choose all that apply.
- No; I work only with a general population
- College or school community
- LGBT community
- Community of color
- Multilingual community
- Religious community
- Physically or mentally disabled community
- Other (please specify) _____

10. How many supervisors have you had while working in the mental health profession?
_____

11. How many hours do you spend in supervision per month?
- Less than 4 hours
- 4 hours
- More than 4 hours

12. Approximately what percentage of your supervisor's identified as White or Caucasian?
- None (0%)
- Less than 50%
- About 50%
- More than 50%
- All (100%)

Thank you for answering these demographic questions. Before we meet I would like to give you three questions to consider before the interview, as they will be the focus of our discussion.

1. How are multicultural issues and race addressed in supervision?
2. How does attention to clinician: client cultural and race issues in supervision impact the supervisory relationship?
3. How do clinicians conceptualize the development of cultural competence?
   a) How does your supervisor aid your development, i.e., case conceptualization, process assignment, techniques?

Appendix E

Interview Protocol

The following research questions will focus on how, when, and what happens when issues of cultural competency and racial difference come into the supervisory relationship between a White supervisor and a White supervisee. The secondary or probing questions will be used for clarification and to illicit elaboration of responses.

I have reviewed your signed informed consent form. Please remember that participation in this study is completely voluntary. At any time during the interview the participants may choose to not answer a question and/or remove themselves from the study entirely. A participant may withdraw by contacting the researcher via email or verbally. If the participate withdraws, this researcher will immediately destroy all materials related to their participation. The participants may choose to completely remove themselves from the study following the interview, by contacting the researcher prior to April 1, 2013, when the research analysis will begin.

(1)   What exposure, if any, have you had to developing cultural competency in psychotherapy? (Trainings, workshops, classes, casework?)
(2)   How are multicultural issues and race addressed in supervision?
    c.   Who initiates cultural and race discussions in supervision?
    d.   What is the frequency of these discussions?
(3)   How does attention to clinician: client cultural and race issues in supervision impact the supervisory relationship?
    a.   What has been your experience in supervision when addressing issues related to culture and race with your supervisor, i.e., level of comfort, empowerment?
(4)   How do clinicians conceptualize the development of cultural competence?
    a.   How does your supervisor aid your development, i.e., case conceptualization, process, assignment, techniques?
    b.   How do you learn cultural competence through supervision? What does multicultural supervision mean to you?
(5)   How do you address racism with your clients and in supervision?
    a. Do you believe you have developed a sense of your own White racial identity? If yes, how have you developed this?

Appendix F: HSR approval letter

SMITH COLLEGE

School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950   F (413) 585-7994

February 5, 2013

Elizabeth Hammond

Dear Elizabeth,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your very interesting study.

Sincerely,

Marsha Kline Pruett, M.S., Ph.D., M.S.L.
Vice Chair, Human Subjects Review Committee

CC: Narviar Barker, Research Advisor

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