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Notwithstanding that it is a core component of psychology training, diversity is one of the most neglected areas in supervision training and research. The majority of attention to diversity has been devoted to culture—just one particular aspect—rather than to the broader construct. Diversity includes culture in all its aspects, as well as socioeconomic status, race, religion, disabilities or ableness, age, gender, and sexual orientation, all of which may converge and intersect (Bingham, Porche-Burke, James, Sue, & Vasquez, 2002). As Ridley, Mendoza, and Kanitz (1994) stated, “educators with the best of intentions find themselves caught between the press to provide MCT (multicultural training) and the dual disadvantage of their own inadequate training and the embryonic state of the field” (p. 228). This is the case not only for culture but also for all areas of diversity. Clinicians report lower self-perceived competence levels in work with clients with motor and sensory impairment and with Hispanic, Black Hispanic, Asian American, and Native American clients (Allison, Echemendia, Crawford, & Robinson, 1996). That consideration of diversity is essential to psychology training is unequivocal.

In this chapter, we describe the required role of diversity in psychology training, the current state of the art, barriers to integration of diversity into psychology training, and definitions of multicultural competence. Conceptualizations of culture are considered as well as approaches to acculturation
as they apply to supervision. *Emic* (conceptions common to a particular ethnic or minority group and thus explicative) and *etic* (conceptions universal to people across culture) parameters are applied to training and to supervision. We then outline gender and sexual orientation as they have been approached in training models, providing a context to training efforts. We also review the relative deficits in training in disabilities and age as they affect supervision. The final sections focus on enhancing diversity competence and development of multicultural competence through understanding theories of racial and minority development and assessment techniques. These concepts serve as benchmarks and standards for diversity competency in programs such as internships and other training programs.

In “Domain D: Cultural and Individual Differences and Diversity,” the Committee on Accreditation of the American Psychological Association (APA) lays out a framework for internship programs:

> The program recognizes the importance of cultural and individual differences and diversity in the training of psychologists.

1. The program has made systematic, coherent, and long-term efforts to attract and retain interns and staff from differing ethnic, racial, and personal backgrounds into the program. Consistent with such efforts, it acts to ensure a supportive and encouraging learning environment appropriate for the training of diverse individuals and the provision of training opportunities for a wide spectrum of individuals. Further the program avoids any action that would restrict program access on grounds that are irrelevant to success in internship training or a career in professional psychology.

2. The program has a thoughtful and coherent plan to provide interns with relevant knowledge and experiences about the role of cultural and individual diversity in psychological phenomena and professional practice. It engages in positive efforts designed to ensure that interns will have opportunities to learn about cultural and individual diversity as they relate to the practice of psychology. The avenues by which these goals are achieved are to be developed by the program.” (APA, Committee on Accreditation, 2002e, p. 16).

The “Ethical Principles of Psychologists and Code of Conduct” (APA, 2002a) states the following:

> Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic
status is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals . . . (2.01, Boundaries of Competence, ¶ b)

MULTICULTURAL DIVERSITY

Sheer demographics indicate that attention to cultural diversity is a necessity, not an option. The meanings of the terms majority and minority are no longer clear, as so-called minorities have become pluralities. With these changes, the Eurocentric bias of the field of psychology is evolving, but not fast enough. Guthrie (1998) titled his text Even the Rat Was White: A Historical View of Psychology, documenting the history of racism in the development of the field of psychology. It is time for supervisors and supervisees to integrate the strengths of culture and diversity into pedagogy and conceptual frameworks.

Through the appreciation of and education about diversity in supervision, underlying racism, prejudice, and negative cultural attitudes, albeit subtle, are addressed. Education and exposure lead to increased understanding, which in turn results in frames of respect for difference. Rather than conformity, stereotypes, or assimilation, the diversity-competent psychologist considers the strengths of the individual, culture, and community and how these factors can be integrated into a plan for treatment and development. It is a given that the culturally competent psychologist is cognizant of his or her own cultural background, its strengths, and the unique perspectives it casts on his or her worldview.

STATE OF THE ART

Reports of student training in diversity issues reflect mediocre efforts in training on counseling ethnic minorities and a lack of cultural infusion into training in general. "Such a lack of systematic instruction and evaluation in ethnic minority issues is particularly disturbing when one considers they had seen ethnic minority clients during both pre-internship and internship training" (Mintz, Bartels, & Rideout, 1995, p. 319). These authors concluded that the results of their survey of APA-approved graduate training sites (46% response rate) showed that these sites do not reflect the spirit of APA accreditation criteria nor are they in line with the APA Ethical Standard 2.01(b; stated previously). Much of the research and theorizing
has focused on multiculturalism rather than on the broader realm of diversity. We would advocate a consideration of the entire spectrum of diversity; however, as multiculturalism has been a focus in the literature, we describe a significant amount of that research.

Mintz et al. (1995) reported that counseling-program interns were slightly better prepared than their clinical counterparts in coursework and examination of biases, a finding also reported by graduate students (Pope-Davis, Reynolds, Dings, & Nielson, 1995). However, Quintana and Bernal (1995) cautioned that any differences between the training given to the two groups are not meaningful, because both need to improve. Mintz et al. (1995) agreed. Bernal and Castro (1994) found that, among 104 APA-accredited doctoral programs, the “structural basics” (p. 803) are often lacking. Deficits exist in minority-related courses, faculty conducting minority mental health research, and use of off-campus clinical settings serving ethnic-minority students for practicum placement. In a study of psychology interns and their supervisors (57.4% response rate), 9 interns (30%) and 21 supervisors (70%) reported that they had never completed a course in multicultural or cross-cultural counseling (Constantine, 1997). A study of counseling, school, and clinical graduates who completed their training between 1985 and 1987 (48.7% response rate) revealed that small numbers of the respondents felt extremely or very competent to do clinical work with African Americans (37.5%), Asian Americans (15.8%), Black Hispanics (11.5%), Hispanics (25.9%), Native Americans (7.7%), gay men (34.8%), lesbians (38.6%), bisexual individuals (32.2%), and individuals with sensory impairments (18.9%), even though they reported that they worked with a significant number of members of these populations (Allison, Crawford, Echemendia, Robinson, & Knepp, 1994). Allison et al. reported low rates of coursework or relevant training in practicum and internship on providing services to diverse populations. Graduate students in APA-approved settings felt even less prepared to work with bisexual clients than with lesbian or gay clients (Phillips & Fischer, 1998). It is interesting that in the Allison et al. (1996) study of self-rated competence, psychologists (49% return rate) rated themselves most competent in treating European Americans, females, and economically disadvantaged clients and least competent in treating Asian American, Black Hispanic, and Native American clients. The authors reported a correlation between higher diversity of caseload carried and perceived self-competence. A small group of psychologists in that study reported (8% response rate) that, although they did not view themselves as competent to provide services to that client group, they continued to do so. It is extremely worrisome that, according to self-reports, psychologists are practicing in an area outside their self-perceived competence—an ethical infraction.
BARRIERS TO THE INTEGRATION OF DIVERSITY INTO PSYCHOLOGY TRAINING

We are increasingly aware of the pain inflicted by supervisors and supervisees who function with inadequate knowledge of diversity. The pain is reflected in the supervisee’s feeling hurt or misunderstood (Fukuyama, 1994a; McNeill et al., 1995; McRoy et al., 1986) client distress or withdrawal from treatment (Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991; Pope-Davis et al., 2002; Priest, 1994), and damage done by faulty assessments due to lack of a knowledge base (Goodman-Delahunty, 2000). In a small study of trainees in South Africa, Kleintjes and Swartz (1996) provide perspective on the difficulty of introducing race. Multiple reasons why Black students do not discuss color in supervision in a “White” university were presented. Trainees expressed difficulty with such discussion because they felt the setting was a “colourless zone (sic);” they felt that they could be perceived as making excuses for poor performance or be seen as using Blackness as a defense against other issues, or they feared being seen as pathologically preoccupied with color and discrimination. Also they may not have felt secure enough to raise the issue of color or may have wondered whether the issue should be dealt with personally. Without a structure for introduction of race as well as other aspects of diversity, these subjects may be ignored, at great cost.

One of the reasons that culture does not come up in supervision is that many supervisors are not meeting the minimum requirement of knowing at least as much as their trainees know about cultural competency (J. M. Bernard, 1994) or diversity. Graduate programs have a greater emphasis on cultural competence presently than was the case when most supervisors were themselves trained. Even in the current training climate, few curricula take an integrated cultural approach; most relegate culture to a single course or just a few courses (Yutzhinka, 1995). Although counseling-center training directors (49% return rate) reported that 88% of their centers offer a seminar on multicultural counseling, the mean duration of such seminars is nine sessions, and there is little emphasis on integrating multicultural issues into seminars and on religion (Lee et al., 1999). The low systematic emphasis on religion and spirituality was confirmed for counseling programs (Schulte, Skinner, & Claiborn, 2002) and for clinical training programs (Brawer, Handal, Fabricatore, Roberts, & Wajda-Johnston, 2002). Religion is reported highly salient by most persons (Gallup & Johnson, 2003; Gallup & Jones, 2000), as in many cultures spirituality and religion are inseparable from physical, mental, or health concerns (Fukuyama & Sevig, 1999). Transgender issues have been ignored or pathologized (Carroll & Gilroy, 2002), and gender has been dealt with mainly on a theoretical level (Granello, Beamish, & Davis, 1997). Nilsson, Berkel, Flores, Love, Wendler, & Mecklenburg

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(2003) reported low attention to sexual orientation and religion in their review of 11 years of Professional Psychology Research and Practice. The role of religion in training is explored by Shafranske (in press) and Shafranske and Falender (2004). The number of courses offered in graduate programs has actually decreased in the area of disability; such courses are now rare (Olkin, 2002).

A barrier to implementing this critical curriculum is the lack of empirical support for the few existing models of ethnic and cross-cultural training and their relationship to treatment efficacy (Yutzenka, 1995). Another is the lack of focus on self-knowledge and exploration, both cognitive and emotional, in psychology training (Carter, 2001). As a result, supervisors have an academic view of culture, distant from their own personal being. Supervisors who have less multicultural competence reinforce avoidance of racial issues in their White trainees (Steward, Wright, Jackson, & Jo, 1998), perhaps because race is not viewed as salient to their identities (T. L. Robinson, 1999). However, we are reminded that “cultural provincialism is not a disease that afflicts only Caucasians” (Myers, Echemendia, & Trimble, 1991, p. 9). That is, whatever the culture of the supervisor and supervisee, it is incumbent on the dyad to process and explore the implications of the cultural and diversity configuration among the client, supervisee—therapist, and supervisor and not to be complacent in one’s preconceptions. Any cultural group can make incorrect judgments about another.

Some believe that White people do not have a culture. On the contrary, Whites are as diverse a population as any other group, and greater consciousness needs to be raised among Whites that they do have a culture, a history, and a story. Richardson and Molinaro (1996) suggested that the White emphasis on exploring the differences of others rather than looking at their own characteristics may promote unintentional ethnocentrism. Other barriers are guilt over being White and the existence of multitudes of other pressing and critical areas of training, making it hard to implement all of them (Lee et al., 1999). These findings are disappointing given the profound and intrinsic impact of culture on every aspect of training and psychotherapy. It is imperative that cultural-competence training be valued (Carter, 2001).

Another barrier may lie in the process of diversity education itself. The processes of self-discovery and acknowledging one’s own cultural biases and prejudices may induce resistance, defensiveness, and inhibition (Abreu, 2001). Another problem has been the focus on particular groups as unitary, such as Black, White, Hispanic, gay, and lesbian. This unfortunate focus has resulted in increased stereotyping and less appreciation of the vast multitude of difference within groups when one considers the membership of each individual in other demographic groups. In fact, within-group differences have been shown to exceed between-group differences (Suzuki, McRae, & Short, 2001). The concept of “collective identities” derived from family,
gender, race, and ethnicity (Fukuyama & Ferguson, 2000, p. 82) has not received adequate attention even though multiple factors determine one's identity, not a single one.

In attempting to explain why simply recruiting diverse faculty and students does not automatically result in a functioning multicultural program, Pope-Davis, Liu, Toporek, and Brittan-Powell (2001) described the necessity of a "complete contextual change" that encompasses not only a commitment to multicultural issues but also the creation and maintenance of a positive environment in which to nurture them (p. 124). For example, insertion of various ethnic—racial and gay, lesbian, and bisexual (GLB) content in application materials is associated with obtaining higher numbers of students with those identities (Bidell, Turner, & Casas, 2002).

MULTICULTURAL COMPETENCE DEFINED

Multicultural-counseling competency has been defined in a number of ways. Fuertes (2002) identified 16 different conceptual and theoretical approaches to multicultural competency and discussed how the perspectives supplement, but do not supplant, a theoretical approach. The most influential approach, presented by D. W. Sue, Arredondo, and McDavis (1992) in an APA Division 17 position paper, defined multicultural competency as a "therapist's awareness of assumptions about human behavior, values, biases, preconceived notions, personal limitations; understanding the worldview of the culturally different client without negative judgments; and developing and practicing appropriate, relevant, and sensitive intervention strategies and skills in working with culturally different clients" (p. 481). Thus, multicultural competency is organized into the three categories of attitudes and beliefs, knowledge, and skills. This organization has served as the basis for much of the subsequent research and conceptualization in the field. However, factor-analytic studies have shown little support for a tridimensional conceptualization and may suggest a unitary-factor construct (Ponterotto, Rieger, Barrett, & Sparks, 1994). Some have also suggested that the role of the relationship between client and therapist—supervisee (Sodowsky, Taffe, Gutkin, & Wise, 1994), racial identity (Ponterotto et al., 1994), and racial-identity development be added to the framework. The relationship between client and therapist—supervisee would include client disclosure, counselor behavior and approach, and equity and power in the relationship (Pope-Davis et al., 2002). Racial-identity development refers to the stage of development of each of the participants in his or her racial identity.

Adding social justice to the definition, D. W. Sue (2001) redefined cultural competence as follows:
The ability to engage in actions or create conditions that maximize the optimal development of client and client systems. Multicultural counseling competence is defined as the counselor's acquisition of awareness, knowledge, and skills needed to function effectively in a pluralistic democratic society (ability to communicate, interact, negotiate, and intervene on behalf of clients from diverse backgrounds), and on an organizational/societal level, advocating effectively to develop new theories, practices, policies, and organizational structures that are more responsive to all groups. (p. 802)

A definition more operationalized to a training setting was proposed by Porterotto and Casas (1987):

Multicultural competence includes knowledge of clients' culture and status, actual experiences with these clients, and the ability to devise innovative strategies vis-a-vis the unique client's needs. A multiculturally competent program instills in its students these competencies, infuses minority issues into all program courses . . . , and has adequate representation of minority students and faculty members. (p. 433)

Although self-awareness is a component of cultural competence, incorporation of an integrated awareness, understanding, and competence with one's own cultural or multidiverse background has been slow to come in training environments. D. W. Sue et al. (1992) defined cultural self-awareness to include awareness of the influence of biases, awareness of personal limitations, awareness of how one's heritage affects definitions of normality and abnormality, awareness of one's individual racism, and ultimately an understanding of oneself as a racial and cultural being and movement to seek a nonracist identity. We believe that self-knowledge and awareness of one's own cultural self are critical preconditions to cultural awareness. Part of attaining awareness entails understanding the strengths inherent in one's own cultural heritage and how they translate into beliefs, values, and behavior. Until a supervisor has developed this level of competency, it is difficult, if not impossible, to be an excellent supervisor. Little, if any, attention is given to self-awareness in most psychology graduate training programs or in supervisor training. Thus, this vital precondition is usually not met.

The translation of the D. W. Sue et al. (1992) framework to interactions between the client and the therapist-supervisee has been problematic. S. Sue, Zane, and Young (1994) stated, "What is needed are approaches that propose specific hypotheses as to how the psychosocial experiences of ethnic minorities affect certain important processes in psychotherapy" (p. 809). Fischer, Jome, and Atkinson (1998) proposed common factors that contribute to client healing, including the therapeutic relationship, a shared worldview of client and therapist, meeting client's expectations, and use of rituals or interventions that both therapist and client view as appropriate.
These common factors are viewed as organizing factors of the trainee’s conceptualizations, integration of multiculturalism into interventions, and instruction.

Building on the work of Fischer et al. (1998), Constantine and Ladany (2001) incorporated the component of self-awareness by proposing an extension in which multicultural competency consists of six dimensions:

- self-awareness: understanding one’s own multiple cultural identities, personal biases, and how socialization affects values and attitudes;
- general knowledge of multicultural issues: general knowledge of psychological and social issues, prejudicial attitudes, discrimination, and knowledge of emics;
- multicultural-counseling self-efficacy: confidence in one’s ability to perform successfully, based on a behavior set—not simply a self-perception of competence;
- understanding of unique client variables: understanding how personal attributes, situations, and other factors affect client behavior;
- formation of an effective counseling working alliance: includes addressing multicultural issues within the working alliance;
- multicultural-counseling skills: the ability to approach multicultural issues effectively in therapy.

The Fisher et al. (1998) and Constantine and Ladany (2001) frameworks integrate etic, universalistic approaches, with emic, culture-specific knowledge, as well as general-counseling competency.

Another very comprehensive approach is provided by the 12 “minimal multicultural competencies for practice” (N. D. Hansen, Pepitone-Arreola-Rockwell, & Greene, 2000). The following is a summary of the competencies that Hansen et al. distilled from the literature:

- “[a]wareness of how one’s own cultural heritage, gender, class, ethnic-racial identity, sexual orientation, disability, and age cohort help shape personal values, assumptions, and biases related to identified groups;
- knowledge of the following factors:
  - historical and cultural embeddedness and change of psychological theory, inquiry methods, and professional practices,
  - history, manifestation, and psychological sequelae of oppression, prejudice, and discrimination,
  - sociopolitical influences (e.g., poverty, stereotyping, stigmatization, and marginalization) impinging on identified groups,
culture-specific diagnosis; normative values about illness, worldview, family structures, and gender roles; impacts on personality formation; developmental outcomes; and manifestation of illness, and
culture-specific assessment techniques;
ability to do the following:
evaluate emic and etic hypotheses,
self-assess multicultural competence,
modify assessment tools and qualify conclusions, and
design and implement nonbiased effective treatment plans and interventions for multiple groups (condensed from Hansen, Peptone-Areola-Rockwell, & Greene, 2000, p. 654, with permission; please refer to the article for the full listing of competencies).

Hansen et al. (2000) proposed that use of these competencies could infuse multiculturalism into the entire training curriculum.

Another consequential framework of knowledge regarding cultural competence is the “Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations” (American Psychological Association, 1993a). Among the myriad important aspects is the directive that the counselor has the responsibility to gain knowledge of the client's culture rather than rely on the client to explain his or her understanding of his or her culture. Also, “[p]sychologists [should] respect clients' religious and/or spiritual beliefs and values, including attributions and taboos, since they affect world view, psychosocial functioning, and expressions of distress” (APA, 1993a, p. 46).

In its entirety, this document is very important, as it outlines the importance of consideration of bias or racism; cultural belief and value systems; family-member and community structures, hierarchies, and cultural beliefs; resources to be identified in the family; religious and spiritual beliefs; the role of the psychologist; indigenous beliefs and practices; and inclusion of religious and spiritual leaders, essentially providing a roadmap to culturally sensitive practice. It should be required reading for all supervisees and supervisors.

APA’s “Guidelines on Multicultural Counseling Proficiency for Psychologists” (American Psychological Association, Division 45, Society for the Psychological Study of Ethnic Minority Issues, 2001) focus on racial and ethnic identity with an articulation of learning objectives and clinical-training guidelines in the areas of awareness, knowledge, and skills. These specific guidelines appear user-friendly for training, but are not yet empirically supported.
Ancis and Ladany (2001) proposed domains of multicultural supervision competencies that are exceptionally useful in guiding supervisors, assessing supervision, and directing supervisees in the development of competencies. Ancis and Ladany (2001) proposed domains of supervisor-focused personal development, supervisee-focused development, skills and interventions, process, and outcome evaluation. They described particular competencies in self-awareness and knowledge of other cultures and worldviews, facilitation of supervisee diversity identity development, understanding of racism and oppression as well as indigenous resources and the creation of a climate that generally facilitates diversity discussion and consideration.

Our Definition of Diversity Competence

Our definition of diversity competency draws on many of the others. We believe that diversity competency includes incorporation of self-awareness by both supervisor and supervisee and is an interactive process of the client or family, supervisee—therapist, and supervisor, using all of their diversity factors. It entails awareness, knowledge, and appreciation of the interaction among the client's, supervisee—therapist's, and supervisor's assumptions, values, biases, expectations, and worldviews; integration and practice of appropriate, relevant, and sensitive assessment and intervention strategies and skills; and consideration of the larger milieu of history, society, and sociopolitical variables.

Conceptualizations of Culture

Several frameworks address multiple dimensions of cultural and personal identity, including those of Phinney (1996), Arredondo and Glauner (1992), Falicov (1988), and Hays (2001). Moving toward a way of integrating conceptualization, Phinney (1996) defined ethnicity as consisting of at least three aspects: (a) cultural values, attitudes, and behaviors distinguishing ethnic groups; (b) the subjective sense of membership or belonging in an ethnic group or identity; and (c) experiences associated with minority status, including powerlessness, discrimination, and prejudice, and ways in which individuals have responded to these experiences. She urged consideration of ethnicity not as a categorical variable, but as clusters of dimensions that affect individuals differently and according to which individuals vary. This approach is similar in part to that of Falicov (1995), who also advocated a multidimensional approach to consideration of culture, incorporating the multitude of other variables influential in identity (e.g., gender, age, and religion). It would appear that the more we understand and respect difference and the more training we are able to give to enhance understanding of the
complexity, the more successful our efforts to build diversity competence will be.

Arredondo and Glauner (1992) addressed what they described as fixed and flexible dimensions contributing to identity and worldview. These dimensions are within a sociopolitical and historical context. Examples of fixed dimensions include age, gender, and race, whereas flexible dimensions include relationship status, hobbies, and educational background.

In contrast, Falicov (1988) described parameters of culture as jointly forming cultural membership. Her methodology elicits a kind of narrative regarding life experience in a variety of contexts. Falicov (1988) defined culture as the following:

[those sets of shared world views and adaptive behaviors derived from simultaneous membership in a variety of contexts, such as ecological setting (rural, urban, suburban), religious background, nationality and ethnicity, social, class, gender-related experiences, minority status, occupation, political leanings, migratory patterns and stage of acculturation, or values derived from belonging to the same generation, partaking of single historical moment, or particular ideologies. (p. 336)]

Arredondo et al. (1996) provided a comprehensive articulation of dimensions of personal identity with a fuller conceptualization of contributing variables. It is important not to isolate variables such as race or religion, but instead to provide a framework for consideration of the individual and the family. It is critical to use a “cultural lens” to approach culture with respectful curiosity. Falicov (1988) concluded, “Each family is unique precisely because of its specific ecological niche, which is that combination of the multiple settings in which it is embedded” (p. 336). “Ecological niche” refers to the overlapping views, values, power, and access that an individual experiences and represents a narrative of contexts replacing labels such as “Black” or “Jewish.” Emphasis is on interconnectedness as opposed to difference or separation of individuals by cultural group. One must consider the ecological niche of each member of the family, the therapist (trainee), and the supervisor.

Falicov (1995) described five parameters of culture, to which Wisnia and Falender (2004) added. Falicov’s (1995) parameters are as follows:

- ecological context, or how the family lives and fits in its environment;
- migration and acculturation, or where the members of the family came from, why they came, what their respective journeys entailed, and what their aspirations are;
- family organization or family arrangements and values attached to that structure;
• family life cycle, which entails diversity in the developmental stage and transitions and their cultural patterning;
• The concept of health, healing, and wellness.

We encourage the addition of worldview which may be defined as including factors such as optimism and pessimism, traditional beliefs, attitude toward the present, social relations, time, one's relationship with nature, and living in harmony with nature (Ibrahim & Kahn, 1987). We also include aspects such as values (e.g., competition versus cooperation, emotional restraint versus expressiveness), guiding beliefs (e.g., independence versus interdependence; control and dominance versus harmony and deference), epistemology (e.g., cognitive versus affective or combined) logic (reasoning process), nature of reality (e.g., objective material versus subjective, spiritual versus material), and one's concept of self (Brown & Landrum-Brown, 1995). Also direct attention to spirituality and religion should be highlighted.

We advocate the use of therapist maps (Falicov, 1998) and supervisor maps to define each of these areas, not simply for the clients but also for the therapist or supervisee and the supervisor. It helps us to approach differing attitudes and values. For example, the issue of shared worldviews is complex. Some research indicates that while even culturally diverse therapists may share a somewhat common worldview, ignorance of differing client worldviews may result in negative attributions (D. W. Sue & Sue, 1990; Mahalik, Worthington, & Crump, 1999).

The issue of shared worldviews is increasingly complex. Some research indicates that although even culturally diverse therapists may share a somewhat common worldview, ignorance of differing client worldviews may result in negative attributions (Mahalik, Worthington, & Crump, 1999; D. W. Sue & Sue, 1990).

Hays (2001) proposed a framework that is in some ways similar to Falicov’s (1995) method advocating approach of one’s own culture and the culture of others. Using the acronym “ADDRESSING,” the therapist lists one’s own age and generational influences (familial, political, or social events), developmental or acquired disabilities, religion and spiritual orientation, ethnicity, socioeconomic status, sexual orientation, indigenous heritage, national origin, and gender. Having completed this self-assessment, the therapist considers the role of privilege and culture on his or her clinical work and, finally, the role of values. Then the same process is followed to address the client’s culture, so that similarities and differences between client and therapist are explored.

Although the two frameworks emphasize slightly different areas of functioning, they are parallel in their emphasis on comparing the cultural complexity between the therapist and the client—and, we urge, among
therapist, client, and supervisor as well, as was advocated by Hird, Cavalieri, Dulkos, Felice, and Ho (2001). M. T. Brown and Landrum-Brown (1995) also urged comparison of worldview congruence stances in which the client, supervisee-therapist, and supervisor complement or conflict with each other with respect to such dimensions as cooperation and competition.

Multicultural supervision is defined as “a supervisor-supervisee relationship in which there are cultural differences based on race and ethnicity” (Fukuyama, 1994a, p. 142). Furthermore, the institutional setting and administration are operative factors (Peterson, 1991). We suggest including the client and the complexity of the client’s or family’s, therapist-supervisee’s, and supervisor’s interactive diversity variables with respect to differences, preconceptions, and interactions in the equation of diversity supervision.

ACCULTURATION

Acculturation is a factor deemed important to consider in selecting therapist roles and strategies with clients of racial or ethnic minorities (Atkinson, Thompson, & Grant, 1993). Brislin (2000, derived from Berry, 1990) described acculturation as whether (a) the family retains selected aspects of its first culture and (b) the family pursues relations with members of the donor or host culture. If a family has achieved cultural “integration,” it has done both (a) and (b). If a family has become “assimilated,” it has done only (b). If a family is culturally “separated,” it has done only (a). Finally, if a family is marginalized, it has done neither (a) nor (b). Another way of looking at acculturation is through the lens of ethnic identity, as a bidirectional process, with dimensions of degree of adoption of “Whiteness” and retention of one’s other ethnic identity (Sodowsky, Kwan, & Pannu, 1995). The family’s country of origin may be somewhat less important than where it is in this conceptual frame of assimilation, which encompasses ethnic identity. Acculturation across family members may be variable, with children’s perceptions of their parents’ acculturation (or relative lack thereof) affecting family acculturation conflict and acculturation stress. This point was highlighted by Roysircar-Sodowsky and Maestas (2000) as conflicts arising among traditional family kinship, traditional familial obligations, and deference to authority figures confronted with Westernized individualism, autonomy, egalitarianism, and assertiveness. Conflict can be intrapersonal as well, reflected in identity crisis, guilt, and anger. Greater complexity is added by the concept of “situational acculturation,” which refers to the phenomenon of different acculturation responses, depending on the situational context (Trimble, 2003).
Formulation of acculturation status is very relevant for both trainees and supervisors. This factor should be another demographic dimension to put into the formulation of culture of supervisor, supervisee, and client (or family) in the context of strengths of each. Interestingly, Handelsman, Gottlieb, and Knapp (2002) applied Berry’s (1990) cultural acculturation model to professional acculturation, or the socialization of trainees to integrate their personal morality with professional ethical standards so that they may acquire an ethical identity (see chap. 8, this volume).

EMIC PARAMETERS AND THEIR RELEVANCE TO TRAINING

Part of the difficulty of diversity competency lies in striking a balance between stereotyping and cultural knowledge. Understanding emic versus etic factors is essential to achieving this goal. An example of an emic factor is the concept of personalismo, or having a personal relationship with an individual, which is important in some Latino cultures. Another example is familialism—that is, emphasis on and value placed on family over the individual—a significant protective factor (Santisteban & Mitrani, 2003). Yet another example is nonverbal communication, including nuances of eye contact, how close individuals stand to each other during conversation, and other nonverbal cues that may have significant cultural loading. Turn exchange, or alternating dialogue typical of individuals conversing, may be uncomfortable for individuals from Latino or Asian cultural groups to engage in within therapy, as they may attribute a dominant role to the therapist and feel uncomfortable verbalizing in that cadence. They may also experience discomfort with the depth of disclosure required in initial intakes, especially if the expectation is a single-session intake. It may be that a longer time is required to establish rapport and proceed. The “I” emphasis in Eurocentric therapies may be problematic as well. A relationship or family focus rather than a focus on the individual may be more culturally syntonic for individuals from certain ethnic groups (Nwachuku & Ivey, 1991). Takushi and Uomoto (2001) urged consideration of environmental cues, including the general “cultural competence” of the setting, determined by factors such as the pictures on the wall of the counseling area and the ethnicities and languages highlighted by the magazines presented in the waiting area. Other areas of cultural incongruity may exist in the time orientation of the therapy: past, present, or future. However, to take any of the foregoing observations as set in stone would be stereotyping. Instead, knowledge can be used to provide a frame for reflection or to begin interpersonal understanding. Intensive coursework, reading, discussion, and multicultural life and therapy experience are necessities to increase one’s cultural comprehension.
Client-Therapist Factors

There are numerous other examples of emic factors that are important to training, as they relate to the client-therapist interaction. Supervisees should thus receive training on verbal and nonverbal taboos, areas fraught with misunderstanding, and variables that could positively affect therapy and outcome. An individual's understanding of emic parameters has a profound influence on his or her assumptions and belief systems, which influence, for example, whether a family enters treatment or whether a trainee can synthesize his or her own beliefs with those of psychological pedagogy. As a result, seemingly simple concepts are very complex. For example, it is counterproductive to ask an American Indian, "How are you?", as this question has an ever-changing answer and is thus not culturally possible to evaluate (Trimble, 1991). With African American clients, it is essential to show genuine respect for complaints of racism, discrimination, and the underlying cultural mistrust, to avoid negative bias in diagnosis and ensuing treatment by professionals (Whaley, 2001). With Asian Americans, public verbal expression of feelings, a hallmark of traditional therapy, can be culturally discordant, as can focusing on painful, negative thoughts or feelings. Credibility of the therapist was found to be the best, and only, predictor of intent to use therapy for Chinese students, whereas empathic involvement and credibility were crucial for Caucasians. Credibility could be affected by problem conceptualization, means for problem resolution, and treatment goals formulated. Each of these factors needs to be compatible with the client's belief system and family structure (Zane & Sue, 1991). A symptom-focused approach, endemic to mental health, may be incongruent with how parents of some cultural groups look at children's problems. For example, behavior (e.g., truancy or school failure) may be the family's focus, not feelings of anger or depression (Cauce et al., 2002). Similarly, there are variations across cultures in "distress thresholds" for mental health problems (Weisz & Weiss, 1991). Other critical issues to consider include emic-etic distinctions in clinical conceptualization, nonverbal communication, disclosure depth, time, and general environmental cues (Takushi & Uomoto, 2001).

Supervision Factors

Emic factors relating to the supervisor-supervisee interaction have been discussed much less frequently (M. T. Brown & Landrum-Brown, 1995). Suggested dimensions include value placed on verbal communication, which is central to traditional supervisory roles; ways language systems are similar or different, and response to the power differential and social- and economic-status imbalances (M. T. Brown & Landrum-Brown, 1995). Exam-
amples of factors given by Ryan and Hendricks (1989) include cognitive orientation, or patterns of thinking and problem solving; motivational orientation, including the role of rewards and emphasis of locus of control; and value orientation, including family-versus-group and hierarchical-versus-egalitarian approaches. It is useful to consider all of the areas on the amended Falicov (1995) framework, which allows one to compare the respective life experiences of client or family, supervisee, and supervisor as a way of processing and formulating proposed interventions and the emotional response to these interventions. Putting the Falicov dimensions together with developmental frameworks of ethnic-identity development would provide even better means to understand the factors operating in the relationship. Consider, for example, a Latino trainee assigned to a Latino case by a White supervisor. The supervisor’s expectation may be that the trainee and client or family will have much in common. However, the trainee may be a third-generation American who does not speak Spanish or identify with the Latino culture and has feelings of insecurity about this. The expectations of the supervisor and the family may thus impose a difficult burden on the supervisee—therapist who is struggling with issues of competence; these issues need to be addressed in supervision without stereotyping.

It has been suggested that for empirically supported treatments to be informed by multicultural thought, the treatments need to be decontextualized, to determine the cultural basis for the intervention, and then recontextualized according to relevant cultural features of the particular group (Quintana & Atkinson, 2002). To engage in this process, one would need to be well versed in emic understanding. Examples are available in Ancis (2004).

GENDER AND SEXUAL ORIENTATION IN TRAINING

Training in gender, sexual orientation, gender identity, and effective services for GLB (Bruss, Brack, Brack, Glickauf-Hughes, & O’Leary, 1997; Phillips & Fischer, 1998) and transgender clients (Carroll & Gilroy, 2002) has been neglected as well, although Murphy, Rawlings, and Howe (2002) raised the concern that perhaps training in GLB issues has not been adequately assessed and may be somewhat better than reported. Gender role identity may vary within and among cultural groups (Fassinger & Richie, 1997). The first step in addressing this area is to enhance supervisor self-awareness with respect to them so that supervisors take GLB issues into account when modeling for and training supervisees. Bruss et al. (1997) advocated a combination of didactic learning, encouragement of trainee independence in grappling with their value structure and possible homophobia, and ultimately learning to use “self-as-an-instrument” (p. 70). In the integration process, defenses are lowered and more self-disclosure can occur.
When working with a GLB trainee, one should not assume that the trainee will face no issues when working with the GLB population (Buhrke & Douce, 1991). Porter (1985) advocated exploration of internalized misogynist attitudes and described that facet as the most difficult part of feminist supervision. Understanding how one’s own sexism or other prejudices affect one’s work with clients is essential.

Biases revealed in an APA study of therapy with lesbians and gay men (Fassinger & Richie, 1997; Garnets et al., 1991) include pathologizing in assessment, focusing on sexual orientation when it is irrelevant, lacking understanding of identity development and the impact of its disclosure on others, minimizing the importance of same-sex intimate relationships, attributing poor parenting to sexual orientation, relying on the client for education, and teaching inaccurate information. One may not be conscious of one’s own biases and stereotypes (Stevens-Smith, 1995), so great scrutiny is necessary.

Although more attention has been devoted to female gender issues, it is not correct to assume that male gender issues are less important. Introduction of feminist theories of supervision (Cummings, 2000; Porter, 1985), male socialization and its impact on the male as a therapist, gender pairing, and a general enhancement of awareness are all essential to diversity-sensitive training. Traditional patterns of male socialization, including a focus on independence and self-reliance, restriction of emotional expressivity, and toughness and aggression as coping styles, have specific consequences in psychology training programs (Wester & Vogel, 2002). Consequences of gender role conflict, a result of male socialization, might include the triggering of countertransference or interference by discussion of transference and countertransference phenomena. Wester and Vogel (2002) advocated fostering historical understanding, forging understanding of socialization, and encouraging male challenging of those aspects of their own socialization that are problematic to practice of psychology and supervisory relationships while balancing encouragement of aspects fostering successful practice.

Feminist supervision theory provides a model in which the power differential is minimized. According to this theory, those in power create meaning; reducing their power causes the context to change. As in solution-focused therapy, where the client is the expert and is empowered, the supervisee is empowered. Supervision exists within the context of relationship, enabling the supervisor to challenge the therapist with respect and to value emotional reactions (Prouty, 2001). Contracting is used to increase shared responsibility (Zimmerman & Haddock, 2001).

Higher levels of overall supervisory satisfaction were associated with discussion of gender and sexual-orientation similarities and differences in supervision (return rate, 36%; Gatmon et al., 2001). However, very low levels of such discussion occurred or were initiated by supervisors. It is the
obligation of supervisors to keep abreast of changing demographics and dynamics. For example, in recent times, there is greater fluidity in gender and sexual identities in the gay male, lesbian, bisexual, and transgendered (GLBT) communities, and there is less identification of lesbian culture with feminism (DeAngelis, 2002). Current research directs trainees and supervisors to think of sexuality as a continuum with fluidity, not as sets of dichotomies or singular nouns (Reynolds & Hanjorgiris, 2000).

An interesting continuum between therapist attitudes and behavior toward GLB clients has been described. At one end are therapists with positive attitudes toward GLB clients; at the other extreme are therapists with negative attitudes, who have adopted judgmental or ignoring stances. However, even low levels of homophobia were associated with counselor avoidance of the topic of sexual orientation (Mohr, 2002). The outcome of avoidance of sexual orientation is a very serious consequence of therapist attitudes.

It is important to understand working models of sexual orientation. Heterosexuals may view individuals of all sexual orientations as essentially the same, where the only differences lie in the objects of sexual attraction and lifestyle. This approach is vulnerable to stereotyping and ignores differences in privilege, leading to assumptions by therapists that all clients are heterosexual. In compulsory heterosexuality, heterosexuality is the only acceptable sexual orientation, a view leading to the stigmatization of GLB individuals. It has been suggested that the most challenging aspect of working with GLB clients is dealing with the invisibility of the client's sexual orientation (Reynolds & Hanjorgiris, 2000). Thus, for a client with multiple identities—for example, GLB and another minority status (e.g., Latino, Black Hispanic, or African American)—the complexity and the likelihood of the therapist's focusing on only one of these factors, rather than multiple factors, increases.

Mohr (2002) proposed a series of supervisory questions to facilitate the competence of heterosexual supervisees in conducting therapy with GLB populations. These questions address the dominant working models that both supervisor and supervisee hold regarding sexual orientation and how these models might lead to errors or misconceptions.

TRAINING ISSUES IN DISABILITIES

The Americans With Disabilities Act of 1990 defines an individual's having a disability as

- having a physical or mental impairment that substantially limits one or more major life activities of such individual;
• having a record of such an impairment; or
• being regarded as having such impairment.

People with disabilities include individuals with limitations in walking, sight, hearing, speaking, learning, thinking, concentrating, or working; individuals who have a history of any of these limitations; individuals who experienced alcohol or substance addiction, but are in recovery; or individuals who suffer from any other type of impairment, such as facial scarring. There is a dearth of training for psychologists in working with clients who have disabilities, and APA has identified less than 2% of its membership as individuals with disabilities (Olkin, 2002). As a result, training programs provide little interaction with disabled individuals, even though approximately 15% of the U.S. population is disabled, making people with disabilities the largest minority group in the United States (Olkin, 2002). Olkin (2002) noted that the number of clinical-psychology graduate courses on disability decreased from 1989 to 1999: 24% of graduate programs offered disability courses in 1989, compared with 11% in 1999. In addition, the courses that were offered focused on cognitive impairment rather than physical, sensory, or psychiatric disabilities. As a result, “most able-bodied therapists are doing cross-cultural counseling with clients with disabilities without requisite training” (Olkin, 2002, p. 132). An additional unfortunate consequence is that inadequate evaluations are produced by mental health professionals who fail to understand disabilities or lack familiarity with the Americans With Disabilities Act of 1990 (Goodman-Delahunty, 2000). Specific prior training in disabilities results in more positive attitudes toward clients and prioritizing of extraneous variables in treatment, compared with treatment by therapists without such training (Kemp & Mallinckrodt, 1996).

AGE AS A DIVERSITY FACTOR

It has been predicted that, by the year 2020, more than 20% of the U.S. population will be over age 65. APA members surveyed (41% return rate) reported small numbers working with geriatric patients and little formal training (Qualls et al., 2002). As a result, aging and geriatric considerations will be significant for psychology training, as will combinations of all of the diversity factors with aging. Molinari et al. (2003) provided guidelines and recommendations regarding knowledge and skills required to work with these populations. These authors addressed seven competency areas, including normal aging, specialized assessment, diagnostic and treatment considerations, communication and interdisciplinary work, and special ethical concerns. Because of the significant constellations of cognitive physiological changes and negative life events unique to the population, specialized training is essential.
WHAT ENHANCES DIVERSITY COMPETENCE?

The study of a supervisee's abilities to conceptualize clients from a multicultural perspective has been neglected (Ladany, Inman, Constantine, & Hofheinz, 1997). Influences on interns' multicultural awareness has been studied following the finding that expression of the trainee's own perspectives and personal experiences increases the trainee's knowledge and skills, but is only slightly related to awareness on the Multicultural Counseling Awareness Scale (Pope-Davis, Reynolds, Dings, & Ottavi, 1994).

There is evidence that having had supervised training cases with individuals from a particular cultural group is associated with higher ratings of self-competence with that particular group (Allison et al., 1996). Ponterotto, Fuertes, and Chen (2000) concluded that personal experience combined with educational or training diversity experience results in higher competency scores. That is, life experience with diversity—one's own experiences and awareness and those of friends and family—combined with the formal training experience raises one's diversity competence. Pope-Davis et al. (1994) reported that supervision in a multicultural-counseling situation, completion of multicultural workshops, and a greater amount of multicultural coursework cumulatively contribute to greater knowledge and skills. However, Ladany, Inman, et al. (1997) found no relationship between multicultural case conceptualization skills and the trainee's completion of a graduate-level course on multicultural issues or experience with multietnic clients. The area of outcome assessment in multicultural competence, and its impact on client outcome, requires substantial investigation, including whether particular coursework or experience enhances multicultural competency.

Another preliminary finding is that general-counseling competence may be an overlapping or predictive factor of multicultural-counseling competence: "The presence of multicultural competence is synonymous with general counseling competence" (Coleman, 1998, p. 153). Attempts by the therapist to present as culturally neutral resulted in clients' perceptions that the therapist had a lower level of general-counseling competence (Coleman, 1998). These findings are supported by Constantine (2002), who reported an approximate 60% shared variance between clients' perceptions of counselors' general-counseling competence and clients' perceptions of counselors' multicultural-counseling competence. These findings indicate that one cannot be an effective therapist unless one is multicultural-competent.

Constantine (2002) suggested that competence factors are even more critical to clients of color. Although Fuertes and Brobst (2002) found a 50% overlap between general-counseling competency (defined as conveyed empathy and trustworthiness) and multicultural-counseling competency, multicultural-counseling competency accounted for a significant portion of
client satisfaction only for the ethnic-minority sample. In evaluation of the potential impact of multicultural-counseling training on White graduate-level trainees, the trainees demonstrated sustained increases in understanding of racism and Whiteness, identification of a nonracist definition of "White," and increased appreciation for multiculturalism after 45 hours of didactics and supplemental reading. The trainees reported that the most influential parts of the training were panels, guest speakers, and presentations, videotapes, and class discussion (Neville et al., 1996), with an emphasis on the opportunity to interact with racially and ethnically different individuals. Also, the more extensive the multicultural-counseling training that the White counseling trainees had received, the more differentiated were the ratings of culturally sensitive versus culturally insensitive videotapes of sessions and the more receptive were the trainees to the introduction of race as a critical issue (Steward et al., 1998). There is evidence that Black American and Latino American counseling trainees score higher than Whites on multicultural competency self-assessments, perhaps because of the salience of these issues in their lives (Constantine, 2001; Sodowsky, Kuo-Jackson, Richardson, & Corey, 1998). Increased intensive and personal understanding of individuals' cultural journeys and spiritual issues (Polanski, 2003), engenders more respect and competence in trainees. Also, the elements of knowledge of and self-respect for one's own cultural background constitute a core requirement of cultural competence. Paradigms for achieving this result will be discussed later in the chapter.

As previous multicultural training is predictive of self-assessment and other ratings of therapist multicultural competence, greater urgency is placed on the tasks of definition, conceptualization, and implementation of training to enhance multicultural competency (Constantine, 2001; Neville et al., 1996). Despite these findings, Gatmon et al. (2001) reported very low rates (12.5 to 37.9%) of actual discussion of ethnicity, gender, and sexual orientation in supervision, and a lack of initiation of such discussions by supervisors (response rate 36%). Initiation of discussion of race and other diversity issues is a supervisory competence. However, perceptions of whether these issues arise in supervision may differ between supervisee and supervisor. In a study of counseling-center cross-racial supervisory dyads (all containing one Caucasian member), over 93% of supervisors claimed that they had admitted to supervisees that they lacked cross-racial supervisory experience, but only 50% of the supervisees acknowledged being told. There were also differences in perceptions of supervisors' initiating discussions of cultural differences and of supervisors' efforts to understand the culture of the supervisee. Supervisees sensed that supervisors liked, valued, and respected them less than supervisors reported (Duan & Roehlke, 2001).
DEVELOPMENT OF MULTICULTURAL COMPETENCE

Supervisees

To understand the development of multicultural competence, one should consider multiple developmental theories: (a) the developmental model of multicultural-counseling competence (Carney & Kahn, 1984); (b) stages of effective multicultural supervision (Priest, 1994); (c) racial consciousness identity (Atkinson, Morten, & Sue, 1993; Helms, 1990; Sabnani et al., 1991); and (d) nonoppressive interpersonal development (Ancis & Ladany, 2001). In a developmental model paralleling those discussed in chapter 2 (this volume), Carney and Kahn (1984) proposed five stages of supervisee development of multicultural-counseling competence. In Stage 1, the supervisee has little knowledge of multicultural counseling and operates on assumptions based on ethnocentric attitudes. The supervisor focuses on structured and supportive approaches, trainee self-exploration, and exploration of how the client has been affected by membership in his cultural, ethnic, and racial group. Confrontation is avoided. In Stage 2, the supervisee’s awareness of ethnocentric attitudes and behaviors is increased, but he or she still has a limited understanding of how the client’s and counselor’s level of development affects the therapy process. Carney and Kahn (1984) referred to this limited understanding as the “halo of naiveté” (p. 114), as the trainee has acquired elementary knowledge and may accordingly grow overconfident in his or her own perceived cultural competence. (This factor might account for the elevated self-ratings of cultural competence in trainee studies for which there is no correlation with multicultural conceptualization.) The supervisory task is to continue to provide a supportive and structured environment that builds the trainee’s knowledge about barriers impeding intercultural communication, looks at ethnocentric belief structures, and examines client-held worldviews that differ from those of the trainee. Dissonance created in this stage may propel trainees toward Stage 3 or cause them to remain at Stage 2 through increasing resistance to change. In Stage 3, supervisees exhibit conflicting emotions about working with culturally different clients. They want to work in a respectful, culturally sensitive way, but are limited by their own biases, value conflicts, and previous training. This factor may result in a downplaying of the importance of race and culture. Supervisors are encouraged to support the trainees in their frustration, acknowledge their own awareness of the dissonance, and encourage incorporation of new cultural knowledge and skills. Supervisors may emphasize transformation of prejudice about cultural differences to respect through education and exposure.
At Stage 4, supervisees internalize a new professional identity as a competent multicultural therapist with validation of the worldview of others. They are in the process of incorporating their own ethnic-racial identity with an understanding of that of the client. At this stage, supervisors assist supervisees in understanding their own impact on clients and integrating all the operative, but disparate, components of culture. Supervisees should be taking a lead in supervision discussions of the rationale for particular culturally competent interventions. During Stage 5, supervisees advocate for the rights of individuals from diverse groups and take actions to promote and protect cultural pluralism and social equality. The supervisor moves to more of a consultant role. In this capacity, the supervisor assists in clarifying personal commitment and action strategies and understanding how to be an effective agent of change.

Although this model is developmentally based (à la Stoltenberg et al., 1998, for example), it omits the designation of the supervisor’s level of cultural competency and the relationship of the myriad cultural variables of the client-supervisee-supervisor constellation. However, it is explicative of the finding that multicultural issues are integrated into conceptualizations later in training; it the rare novice who completes this process (J. M. Bernard, 1994; Falender, 2001).

Supervisors

Priest (1994) described stages for achieving effective multicultural supervision competency. The first stage is the supervisor’s denial of cultural differences that affect supervision. The second stage is the supervisor’s recognition that differences exist, but a lack of competence about what to do about it, possibly resulting in the supervisor’s feeling overwhelmed. In stage three, the supervisor makes an attempt to identify similarities and differences among cultures that affect the supervisory relationship. In stage four, the supervisor determines where he or she fits in the cultural framework. In stage five, the supervisor develops a beginning appreciation of cultural distinctiveness, resulting in an enhanced supervisory process. In stage six, the supervisor can formulate methodologies that are respectful of the supervisee’s culture and interaction while acquiring new skills. The client or family is not directly considered in this framework; however, this set of stages provides a useful outline for supervisors who are moving through the acquisition of cultural competence.

RACIAL AND IDENTITY DEVELOPMENT

Awareness of one’s own racial identity and ethnocentric biases has been described as a developmental task (Sabnani et al., 1991) and as critical
in understanding multicultural supervision (D’Andrea & Daniels, 1997). Most of the literature has focused on White and Black or African American identity development, overlooking the preponderance of other cultural groups. We now describe a model of White racial-identity development and a model of Minority Identity Development. The White racial-identity model put forth by Sabnani et al. (1991) provides an integration of previous models and a progression through stages. Cognizance of the supervisee and supervisor’s stage of development is an oft forgotten ingredient of multicultural competence, accentuated by the fact that White individuals are at varying levels of readiness to assimilate multicultural training. Stage 1 is preexposure/precontact, which requires cultural emic knowledge acquisition and beginning etic counseling skills. Stage 2 is the conflict stage, in which the individual confronts the dilemma of conforming to White norms while upholding humanitarian values and beliefs. This stage requires a greater understanding of prejudice and racism and their emotional impact, definition of barriers to counseling, and development of counseling techniques more appropriate to individuals in particular cultural groups. Stage 3 is marked by a promotivity and antiracism stance through which paternal attitudes of Whites are scrutinized; this stage requires cultural immersion and study. Role-playing and communication skills training are advocated in this stage as well. In Stage 4, “Retreat into White Culture,” the focus is on fear or anger elicited during Stage 3. Emphasis on etic over emic approaches may facilitate dealing with the negative feelings aroused. Stage 5, or “Redefinition and Integration,” entails the integration of “Whiteness” and its value as part of the supervisee or supervisor’s identity. Enhanced respect for varying worldviews and deepening of culturally emic approaches are indicated. Sabnani et al. (1991) provided references for skill development exercises.

The model for Minority Identity Development (Atkinson et al., 1993) describes stages of integrating dominant White or Western values with the values of one’s own racial group. Initially, at the “Conformity Stage,” individuals prefer values and norms of the dominant group and express self-deprecating attitudes about their own ethnic–racial group as well as other non-White groups. They choose White colleagues to relate to, as they depreciate the value of the non-Whites. Moving to the “Resistance/Immersion Stage,” there is an increase in ethnic pride and positivity combined with increased suspicion of White Americans. Next, in the “Synergistic Stage,” a sense of self-fulfillment is associated with the individual’s own ethnic, cultural, or racial identity, but the individual does not achieve a complete acceptance of all aspects. He or she may become an activist against oppression and discrimination, and the supervisor is well served to communicate respect for the synergy.

Dominance appears to be a significant difference between these two models. In the White racial-identity development model, one moves from
ethnocentrism and overvaluing one's own culture to greater cultural aware-
ness and integration, whereas in the minority racial-identity development
model, movement is from overadoption of White values toward integration
of one's own cultural identity. In the White model, the individual is overly
dominant and wears blinders to others, whereas in the minority model, the
individual is overly nondominant and wears blinders to his or her own
culture, ethnicity, or race.

Helms (1990) proposed a way to conceptualize racial-identity develop-
ment as a cognitive development continuum. There are two phases: Phase 1
involves relatively less complex strategies and lower levels of racial-identity
development. Ethnocentrism and conformity are elements of this phase.
Phase 2 involves more complex strategies and higher levels of racial-identity
development. This phase includes elements such as resistance, pseudoin-
dependence, immersion, and autonomy. This continuum may be a particularly
useful way of conceptualizing the development of trainees, as it takes into
account the cognitive complexity and ability to integrate disparate infor-
maton, concepts, and feelings.

Ancis and Ladany (2001) described a model of nonoppressive interper-
sonal development that integrates some of the previously discussed themes.
In this model, levels of identity are integrated with respect to multiple
demographic variables. There is also a strong emotional component to the
responses. Individuals are identified as belonging to a socially oppressed
group or a socially privileged group. Some individuals might belong to both
types of group, based on different demographic variables (e.g., sex and
socioeconomic status). At the heart of the theory is a progression through
developing “means of interpersonal functioning,” (p. 67) or thoughts, feel-
ings, and behaviors based on feelings toward self and identification with
particular demographic factors. The first level of interpersonal functioning
is adaptation, or conformity, complacency, and apathy with a very superficial
understanding of cultural difference; stereotyping attitudes; and limited emo-
tional awareness. This stage is marked by denial and resistance. In the
supervision context, supervisors in this stage minimize the trainee's expres-
sion of multicultural competence, use inaccurate stereotypes, and perceive
themselves as multicantly competent. They have very limited ability to
integrate multicultural factors into the conceptualization, to address issues
of culture within the supervisor-supervisee or supervisee-client relationship,
and to assess strengths or weaknesses in this area. Supervisees at the adapta-
tion level ignore the environment and miss cultural influences and issues
that substantially affect client behavior. The second stage is incongruence,
or a feeling that previously held beliefs of privilege and oppression are
inconsistent with their experience. Minimization and rationalization are
the operant defense mechanisms, and there are still remnants of the adapta-
tion phase, such as stereotyping. Movement to this level could be precipitated
by a major event in which one could not longer overlook oppression. For supervisors in this phase, minimal, but some, attention is devoted to multicultural aspects. Supervisees may be aware of multicultural issues, but do not directly raise them in supervision. The third stage, exploration, is marked by anger regarding recognition of oppression, guilt and shame for not having seen it before, and increased insight. Ancis and Ladany (2001) emphasized that the following problem may occur in this stage of the supervisor–supervisee fit: As the supervisor increasingly raises multicultural issues, a supervisee in the adaptation or incongruence stage will resist. They cautioned that the zeal of this stage may result in an overemphasis on cultural factors. In the fourth and final stage, integration, proficiency and insight occur. Multicultural formulations are integrated into conceptualizations. Trainees use accurate empathy, analyze their own biases, and separate countertransfer from transference phenomena.

Ancis and Ladany (2001) described supervisor–supervisee interactions in terms of whether each member is at the same or a different level or stage of development. The most effective combination in terms of client outcome, they posited, is when both are in the exploration or integration phase. The next best combination occurs when the trainee, at the integration level, is more advanced than the supervisor, at the adaptation level. They suggested that this combination may be the most frequent constellation at present. It is unclear exactly how the privilege or oppression on the part of the supervisor or supervisee plays out in the framework. Also, it seems that there is an abundance of other motivators to progress in sophistication beyond critical incidents. These motivators might include continuing education, clinical material, or personal life experience. In addition, it would be ideal if a model of development could also encompass the client or family, including their level of acculturation and their ethnic/racial/cultural identity.

All of the models that have been proposed fail to fully integrate trainee development of multicultural competence with that of the supervisor, as well as the multicultural competence reflected in the relationship (Ancis & Ladany, 2001). A major limitation is thinking that, to become culturally competent, one need only acquire knowledge and skills. “One cannot merely memorize cultural competence, but must learn and demonstrate it through a variety of active self-involving strategies and procedures” (Helms & Richardson, 1997, p. 69). Instead, one needs to assess the impact of cultural and racial attitudes of the therapist on the client–therapist interaction (Sodowsky et al., 1994).

The proposed models also lack empirical support and consideration of personality dynamics (Leong & Wagner, 1994) and are not typically concerned with the triad of client, supervisee (therapist), and supervisor, all of whom may be from different ethnic, racial, socioeconomic status, acculturation, religious, gender, gender-identity, and age categories.
Leong and Wagner (1994) concluded that we know very little about cross-cultural counseling supervision. However, they determined that empirical support has confirmed the following:

1. Race can profoundly influence supervision, including trainee expectations for supervisor “empathy, respect, and congruence” (p. 128).
2. Race can influence the supervisee’s perception of whether the supervisor likes him or her.
3. Under some circumstances, race does not appear to influence supervision.

They resolved that we still need to know whether the evolution of cross-cultural supervision is in fact a developmental process and how specific the process is to race. That is, can we use a culture-general model, or do we need specific models for each racial–ethnic pair? Cook (1994) suggested that pairing of supervisors and supervisees with differing levels of racial-identity attitudes may lead to power differentials that result in lesser or greater expression and competency in “racial acknowledgement” (p. 136), especially if the acknowledgment remains unspoken and intellectualized. Cook (1994) encouraged more routine discussion of race of all (supervisee, supervisor, and client) participants in supervision.

**STEPS TOWARD SUPERVISORY COMPETENCE**

To achieve multicultural competency, one must complete a series of steps. First is the determination of the supervisor’s self-competency, the competency of the program and site, and the supervisee’s level of cultural competency. As described in the section on competency in ethics and legal considerations in chapter 7, it is incumbent on the supervisor to ascertain his or her own level of cultural and diversity competence. It is difficult, if not impossible, simply to remove oneself from supervision for clients in categories with which one feels less competent in a community setting. Therefore, the onus is on the supervisor to increase his or her cultural and diversity competence.

**Program Assessment**

Assessing the programmatic “internal climate” (Suzuki et al., 2001, p. 848), including faculty, students, and administrators, is an essential step. An environment of openness with attitudes, values, and behaviors that exemplify administrative and clinical faculty support for respectful, culturally competent interchanges is desired (Priest, 1994). Challenges, input, and questions relating to culture are encouraged.
A tool for assessment of multicultural-counseling training settings, at least structurally, can be administered (D'Andrea & Daniels, 1991). The stages into which training settings are classified are “Culturally Entrenched,” where multicultural training is rarely incorporated; “Cross-Cultural Awakening,” where there is a developing awareness and some discussion of issues; “Cultural Integrity,” where increased attention is given to culture and there are separate courses on various issues related to culture; and “Infusion,” where multiculturalism is integrated into the whole curriculum. D'Andrea and Daniels (1991) found most counseling programs to be at the Cross-Cultural Awakening stage, although some programs were assessed to be at the Cultural Integrity or Infusion stage. This model provides a structure for determining a starting point and an aspirational end point for achieving cultural competency. It is reminiscent of Lefley’s (1986) concern that training could be additive (new concepts are added to the standard clinical training), substitutive (new concepts replace traditional clinical content), or integrative (new concepts are integral to mental health training). Those who argue that they do not have space or time to add so many new components like cultural competency are missing the point of the integrative curriculum.

Alternatively, the Multicultural Competency Checklist (see Appendix E), developed for counseling-psychology programs, includes consideration of minority representation (a minimum benchmark of 30% racial and ethnic-minority students, faculty, and staff), curricular issues (the addressing of multicultural issues in coursework and evaluation), counseling practice and supervision (competency promoted through training and supervision experiences), research (faculty research on multiculturalism being conducted and encouraged), student and faculty competency evaluation (staff and trainees being evaluated on multiculturally competent behavior), and physical environment (an environment reflective of multicultural appreciation) (Ponterotto, Alexander, & Grieger, 1995). Because of the importance of student and faculty diversity, and the broader spectrum this checklist analyzes, it would be useful to administer it in internship and other training settings. Both trainees and faculty should complete it, as there is some concern that student perceptions may differ from those of faculty members with respect to degree of cultural competence, with students perceiving less program competency in several areas (Constantine, Ladany, Inman, & Ponterotto, 1996).

**Individual Multicultural Competency Assessment**

Assisting supervisees to assess and work on the development of cultural self-awareness is an important step. Students feel more comfortable considering the culture, race, ethnicity, and differences of others than looking at
themselves. They also are more eager to address cognitive-level aspects of what to do in situations with particular clients of particular ethnicities (Tomlinson-Clarke, 2000). Flexibility, openness, and adaptability to cultural difference and nuance seem to be predictors of success in multicultural competence (Tomlinson-Clarke, 2000).

To obtain at least a preliminary measure of individual multicultural-counseling competency, one of several measures should be applied for supervisors as well as supervisees. The Multicultural Awareness Knowledge and Skills Survey (D'Andrea, Daniels, & Heck, 1991), the Multicultural Counseling Inventory (Sodowsky et al., 1994), the Multicultural Counseling Knowledge and Awareness Scale (see Appendix D; Ponterotto, Gretchem, Ursey, Rieger, & Austin, 2002), and the Cross-Cultural Counseling Inventory—Revised (supervisor report form; see Appendix C; LaFromboise, Coleman, & Hernandez, 1991) are several that have been reviewed (Ponterotto & Alexander, 1995). The first three are self-report measures and have a social-desirability component (Constantine & Ladany, 2000; R. L. Worthington, Mobley, Franks, Tan, & Andreas, 2000), but perhaps less social desirability for those who rate themselves as high in multicultural competence (Ponterotto et al., 2002). That is, those who have high multicultural awareness may have a low need to appear socially desirable (Constantine & Ladany, 2000). Respondents rated themselves as more multiculturally competent than was reflected in their written multicultural conceptualization sophistication (Constantine & Ladany, 2000; Ladany, Inman, et al., 1997). Social desirability itself has cultural determinants; for example, Sodowsky et al. (1998) found that Asians generally had higher “multicultural social desirability” scores than their White, Black, and Hispanic peers. Sodowsky et al. explained this finding in terms of face saving in social situations or a desire to be less confrontational. In other words, to avoid confrontation, Asians in this sample responded as they thought the researcher wanted them to. Constantine and Ladany (2000) suggested use of the LaFromboise et al. (1991) supervisor-report measure of trainees as an alternative, assuming that supervisors are culturally competent enough to assess trainees (Constantine & Ladany, 2001).

Self-reported multicultural competence by trainees was not related to multicultural case conceptualization, which was contrary to expectation (Constantine, 2001; Constantine & Ladany, 2000) and may in fact be two theoretically divergent constructs (Constantine, 2001). Alternatively, self-reported multicultural-competence ratings might reflect anticipated rather than actual competency (Constantine, 2001). However, in an analog study, R. L. Worthington et al. (2000) reported a positive correlation between multicultural verbal content (verbal reference to culture, race, ethnicity, and other factors relating to culture, environment, and social conditions) and higher scores on the LaFromboise et al. (1991) scale, rated by graduate
student judges based on transcripts of counselor verbal responses. For supervisors, it is important not to rely solely on supervisee self-report (Ladany, Inman, et al., 1997). The R. L. Worthington et al. (2000) study provides a potential methodology for describing multicultural competency in verbal content. As Torres-Rivera, Phan, Maddux, Wilbur, and Garrett (2001) summarized, multicultural competence involves self-knowledge of cultural (diversity) heritage; knowledge of how these personal factors affect attitudes, values, and beliefs related to the therapy process; recognition of limitations of one’s own multicultural competency; and recognition of sources and instances of discomfort relating to clients of differing backgrounds. A more flexible worldview, a sense of personal adequacy, and belief in societal combating of racism are all associated with multicultural competency (Sodowsky et al., 1998). Constantine and Ladany (2001) proposed that empathy and interpersonal sensitivity may be correlates of multicultural counseling competence. Although there is need for additional reliability, validity, standardization, and treatment outcome data (Ponterotto & Alexander, 1995), it is still valuable to use one or more of the aforementioned measures to establish a baseline understanding of cultural competency and to begin to discuss and integrate culture into the training curriculum.

Another possible assessment device that has been proposed is portfolios, or collections of work (videos of sessions, reports, etc.) demonstrating the development of competence, even though they have been criticized as lacking in reliability in evaluation and as extremely time consuming (Coleman, 1997; Constantine & Ladany, 2001).

MULTICULTURAL-COMPETENCY IMPLEMENTATION

Once the cultural competency of a program, supervisor, and supervisee has been assessed, the next step is to implement a program to enhance competencies to reach the Infusion stage posited by D’Andrea and Daniels (1991). Use of a comprehensive model is imperative, such as the model defining competencies for multicultural counseling developed by D. W. Sue et al. (1992) and comprehensively operationalized by Arredondo et al. (1996). Their model articulates cultural attitudes and beliefs, knowledge, and skills. The first area of the model encompasses the therapist’s awareness of his or her own cultural values and biases. For example, “Culturally skilled counselors believe that cultural self-awareness and sensitivity to one’s own cultural heritage is essential” (Arredondo et al., 1996, p. 57). The second area involves the therapist’s awareness of the client’s worldview. “Culturally skilled counselors understand and have knowledge about sociopolitical influences that impinge on the life of racial and ethnic minorities” (Arredondo et al., 1996, pp. 64–65). The third area involves culturally appropriate
intervention strategies. Although the component parts of each area of the model are operationalized, it is still necessary to translate them into a training curriculum. As Abreu (2001) concluded, “these conceptualizations do not clearly suggest the content of training needed to help . . . students achieve this competency” (p. 488). Fuertes, Mueller, Chauhan, Walker, and Ladany (2002) suggested an operationalizing step of measuring the introduction of the discussion of race into the therapeutic interaction at an early point.

Pope-Davis et al. (2002) presented some general direction for training. They suggested the importance of increasing one’s cultural knowledge base; teaching counselors to disclose intentions and plans to clients, especially when cultural information is being collected or an intervention is being planned; training in the use of restraint in making assumptions based on cultural knowledge, to safeguard against stereotyping. For example, instead of making a blanket generalization about a cultural group, one could state the assumption and ask if it is one that applies to the particular client or family.

Experiential activities, including the labeling exercise (attaching stereotypic labels to individuals’ backs), making implicit associations to words associated with race, and pairing up culturally different partners to share cultural information, have all been suggested (Abreu, 2001).

Wisnia and Falender (1999) described a specific training sequence for enhancing cultural competency, composed of a series of activities (all of which is described in program recruitment materials). Initially, several movies involving cultural passage or cultural assimilation are viewed and discussed in a Falicov (1995) or Hays (2001) framework. Another activity is the construction of supervisory and therapist (supervisee) maps such as the one illustrated in Figure 6.1. The task is to build a prioritized listing of considerations on the mind of the supervisor when he or she goes into the supervisory hour. The supervisor is to imagine a trainee with whom he or she is working and formulate a hierarchy of priorities approaching the next supervisory hour with that trainee: Exactly what areas of supervisory intervention are most critical, and in what order are they prioritized? The trainee constructs his or her own map as well. Then the supervisor and supervisee can compare these maps and discuss discrepancies and how they affect the supervisory relationship, the therapeutic relationship, and outcome. Contrasting priorities may exist for issues of safety, pragmatics, ethics and legalities, or may other possible considerations, many of which may be seen through the prism of diversity. Highlighting and discussing personal views on these issues adds perspective and enhances communication. This technique may also be useful in assisting a problematic trainee to address the substantial differences in approach to a particular client’s situation. These maps are supplemental to maps constructed around dimensions

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Safety of Client, Family and Therapist

Legal and Ethical Considerations

Cultural Overlay: Emic Considerations

Theoretical Orientation
Attention to Process Versus Content
View of Therapeutic Process
Role of Therapist
Attention to Past, Present, Integration of Two
Articulation of Treatment Goals

Transference-Countertransference Considerations

Responsiveness to Client
Cues
Affect
Nonverbal Communication
Process
Cultural Variables
Respect and Perspective Regarding These
Consistent Respect for Boundaries

Focus on Strengths

Interaction Between Supervisee and Supervisor
Open
Respectful
Access to and Responsiveness to Therapeutic Data
Responsiveness to Supervisory Input
Cultural Respect

Looking Ahead
Integration of current data into plan for future intervention
Ability to foresee possible consequences of particular interventions and plan ahead

Look for Matches and Mismatches
Contrast Map of Supervisor with Supervisee and Family/Client

Figure 6.1. An example of supervisor maps constructed by a supervisor.
described earlier in this chapter in conceptualizations of culture, the frameworks of Falicov (1995) and Hays (2001).

Next, the supervisors and supervisees describe an aspect of their own particular upbringing and personal cultural identification and development through one of four contexts: Falicov's journey of migration and culture change, an ecological context, family organization, or transitions in the structure of family life cycles. The supervisors and supervisees arrange these presentations around particular cultural variables or identity niches that are reflective of their cultural identity and comfortable for them to present. Presenters use food, music, poetry, photographic albums, video, or objects of significance to share their culture. The processing by the group includes reactions, expression of feelings elicited, and the forging of a sense of connectedness with aspects of each other's and one's own cultural experience. Next, the framework is applied to clinical material with discussion of how the maps of supervisor, supervisee, and client or family interface and influence the process. Myths, misconceptions, or stereotypes are discussed as awareness of some similarity of experience emerges. In the final portion of the seminar, personal and experiential understandings of prejudice and stereotyping are processed. In follow-ups, elaborate case analysis is conducted using Falicov's (1995) model and self-knowledge gleaned during the seminar about the cultural maps of supervisors and supervisees.

Zimmerman and Haddock (2001) presented a modified "In-the-box/Out-of-the-box" exercise (which they derived from Creighton and Kivel, 1992). In this activity, boxes are drawn on a board. One box is labeled male, and the other box is labeled female. Trainees brainstorm traits, attitudes, characteristics, and behaviors associated with each gender by society. These factors are "in-the-box" behaviors. Then the trainees describe consequences of "out-of-the-box" behaviors for men and women. For example, men could be considered "gay," "weak," or "passive" for exhibiting out-of-the-box behaviors, whereas women might be considered to "wear the pants in the family" as a result of their exhibiting out-of-box behaviors. Trainees also consider shared, or "common-box," behaviors that could occur, such as sharing of life tasks.

The appendices of Arredondo et al. (1996) provide excellent activities to enhance understanding of worldviews. These activities include readings, workshops and conferences, and strategies.

Simply training supervisees to raise the issue of race and diversity early in supervision is a preliminary step (Hird et al., 2001). The next step is to fully incorporate diversity into the supervisory process, which is the responsibility of the supervisor (Constantine, 1997). Particular processes, such as addressing the supervisor's or supervisee's feelings at the moment they occur, using video review to deal with assumptions and feelings elicited during the session, and determining what prompted particular interventions,
are all useful in integrating affect, genuineness, and openness into discussions of diversity (Garrett et al., 2001). It is important to model and describe examples of what GLB and multiculturally competent therapists say or do in relevant situations—and what they tend not to say or do (Phillips, 2000). Awareness of the impact of language and assumptions is another critical part of supervision teaching. For example, use of words like “partner” rather than “boyfriend” helps the trainee avoid assumptions of sexual orientation.

Competencies

Cultural competencies required for supervisors include the following:

- Possesses a working knowledge of the factors that affect worldview (e.g., optimism and pessimism, the value of tradition, and relationship with nature)
- Possesses self-identity awareness and competence with respect to diversity in the context of self, supervisee, and client or family
- Exhibits competence in multimodal assessment of the multicultural competence of trainees, including self-ratings, observational ratings, and supervisor and client ratings
- Models diversity and multicultural conceptualizations throughout the supervision process
- Models respect, openness, and curiosity toward all aspects of diversity and its impact on behavior, interaction, and the therapy and supervision processes
- Initiates discussion of diversity factors in supervision