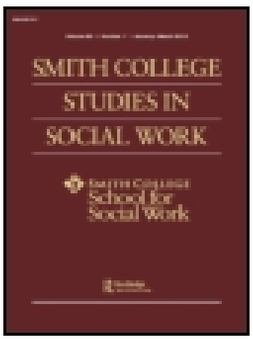

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Colorful Disclosures: Identifying Identity-Based Differences and Enhancing Critical Consciousness in Supervision

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ABSTRACT

Managing microaggressions and marginalizing experiences while negotiating the ongoing oppression that occurs in micro, mezzo, and macro settings can be particularly challenging for clinicians of color. Thus, supervision with clinicians of color must include affirmation, empowerment, and exploration of the intracultural/intercultural dynamics inherent in the treatment-providing process and clinical supervision. Through case studies, autoethnographic studies of our supervision experiences, and interviews with supervisors and supervisees, we reflect on how axes of identity, including race, power, and privilege, inform practitioners' clinical lenses and affect their vulnerability in treatment and the clinical supervision dyad. Special attention is placed on the clinical supervisor–clinician–client triad (the triple process) and the interpersonal dynamics of cultural sensitivity, cultural humility, and authentic responsiveness that supervisors aim to model and cultivate in the supervisory relationship. In addition to sustaining clinical growth for clinicians of color, adding this level of complexity to supervision supports equity in direct clinical practice, enhancing efficacy outcomes for clients and communities. Recommendations and pedagogical strategies are offered to support supervisors in initiating difficult dialogues and shifting the paradigm to promote this transformational perspective.

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Clinicians of color with intersecting identities bring inimitable experiences and needs to clinical supervision. Clinicians of color, or *racialized clinicians*, must balance clinical knowledge and skill with an identity that is consistently categorized within a racial context. Managing their own encounters with marginalization and microaggressions in conjunction with providing culturally relevant, clinically competent services in micro, mezzo, and macro settings are challenging and often competing tasks. Navigating through the complexities of client dilemmas, interpersonal struggles, and internal barriers is an intangible element that is an essential part of clinical supervision.

Clinical supervision, optimally a fundamental source of respite for clinicians, provides an environment for oversight, collaboration, guidance, education

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(including legal and ethical standards), support, clarity, accountability, and growth. However, supervision must include exploration of diversity, power, and privilege to provide cultural relevance for the racialized clinician. Cultural relevance promotes cultural humility, a core process-oriented approach that espouses self-awareness, flexibility, and identification of power imbalances in clinical work. Cultural humility within the supervisory relationship acknowledges the intersectionality of the client, supervisee, and supervisor and allows the space for power and privilege discourse while tackling client goals, strengths, and presenting problems. Supervision with a solid foundation of intersectionality bolstered by affirmation, empowerment, and exploration of the dynamics among client–therapist–supervisor and within the client's system has the capacity to promote effective supervision and socially just, transformative practice. Conversely, supervision that does not contain these core features is frequently experienced by the racialized clinician as unsupportive, ineffective, or offensive.

This study is aimed at raising critical consciousness, awareness, and visibility to the unique experiences and corresponding needs of clinicians of color with intersecting identities. We set out to explore the experiences of racialized therapists with intersecting identities who are providing clinical services to clients using various treatment modalities (i.e., couples, families, individuals, and group psychotherapy). We wondered: What are the experiences of racialized clinicians in supervision? Is supervision affected by diversity, power, and privilege dynamics? How have they identified the manifestation of power and privilege in clinical work, and how do they address power and privilege in supervision? How do they overcome barriers? Through case studies, autoethnographic studies of our own supervision experiences and interviews with supervisors and supervisees, we reflect on how axes of identity including race, power, and privilege, inform practitioners' clinical lenses and affect their vulnerability in treatment and the clinical supervision dyad. We use these data to explore the complexities inherent in supervision, address the impact of affirmation with clinicians of color, and develop strategies for clinical supervisors to initiate and maintain essential, yet difficult, dialogues with racialized clinicians.

Literature review

Supervision research literature is consistently bifurcated into two broad categories: (a) articles that clarify the definition, functions, and competencies involved in supervision while including cultural competence as an important factor (Bogo & McKnight, 2005; Falender & Shafranske, 2014; Tsui & Ho, 1997) and (b) articles that conceptualize cultural relevance as a critical, primary approach in effective clinical supervision (Burkard, Knox, Clarke, Phelps, & Inman, 2014; Hair, 2015; Hair & O'Donoghue, 2009; Young, 2004). While research regarding clinical supervision abounds, there is a limited amount of research regarding culturally

relevant supervision and a dearth of research regarding the specific supervision needs of clinicians of color.

One of the barriers facing the provision of culturally relevant supervision is balancing administrative oversight and agency requirements with competing client and clinician needs. Kadushin and Harkness (2002) assert that "a supervisor's ultimate objective is to deliver to agency clients the best possible service, quantitatively and qualitatively, in accordance with agency policies and procedures" (p. 23). Supervision within an agency context is frequently associated with authority and accountability and is often in contrast with clinical supervision, which focuses on client dynamics and clinical interventions (Young, 2004). Supervisors must maintain the responsibility for efficacious and productive client services while simultaneously directing, coordinating, and evaluating the performance of supervisees within a context of positive rapport (Kadushin & Harkness, 2002). Due to the frequent incompatibility and incongruence of the multiple functions of supervision, a number of studies recommend using an external supervisor to separate the organizational versus professional supervisory responsibilities (Beddoe, 2012; O'Donoghue & Tsui, 2015).

The integration of social justice into supervision is an additional challenge. While the actualization of socially just practice will likely result in positive outcomes for clients, the current managed care environment dominated by productivity and fiscal reductions adds complexity regarding the implementation of a social justice perspective (Hair, 2015). Although social justice is a core value in social work (designated as awareness of historical and social prejudice for marriage and family therapists [MFTs]) and cultural competence (termed cultural sensitivity for MFTs) is enumerated as an ethical responsibility for mental health practitioners, the integration of social justice and antioppressive practice into supervision is a relatively new phenomenon (Code of Ethics of National Association of Social Workers, 2008; Code of Ethics of California Association of Marriage and Family Therapists, 2011). Much of contemporary supervision literature refers to the awareness and acknowledgement of diversity and supports "culturally sensitive practice" (Munson, 2002, p. 414); however, the integration of cultural knowledge with a social justice lens requires specific skills, self-awareness, and positioning. Effective integration requires intentional focus on social justice issues and must take place within a protected space where supervisors and supervisees engage in a "collaborative, dialogic process of critical reflection and reflexivity"(Hair, 2015, p. 351). Managing fundamental supervisory tasks in conjunction with creating a culturally aware, collaborative, dialogic climate open to critical reflection and reflexivity is an ongoing endeavor for supervisors.

Traditional social work supervision refers to a triad of functions that are core supervisory responsibilities: educational supervision, supportive supervision and administrative supervision (Hair & O'Donoghue, 2009). Structurally, traditional supervision models conceptualize the supervisor as an omnipotent expert with the objective of guiding, educating, and overseeing the supervisee (Hair &

O'Donoghue, 2009). As a result, a power differential is created, placing supervisor and supervisee in dominant–subordinate roles within the supervision process and creating a "monitoring mechanism for administrative accountability" (Tsui, 1997, p. 197), potentially discounting the knowledge of the racialized clinician and excluding the larger social, political, and historical contexts. Hierarchical supervision relationships often render cultural differences invisible and contain racist or homophobic dynamics (Beddoe, 2012). For the clinician of color attempting to advocate for clients, navigate his or her own experiences, and develop a voice within the supervision dyad, this paradigm is oppressive and silencing.

A primary vehicle for culturally competent supervision referenced within social work research is self-awareness, specifically, supervisors being "alert to uniqueness, diversity, and difference in clients, practitioners and themselves as supervisors" (Munson, 2002, p. 415). However, much of this research is experienced, written, and explored from a dominant perspective with minimal information regarding how supervisors should integrate social justice into their supervisory practice (Hair & O'Donoghue, 2009). With racialized clinicians, social injustices may occur toward them (personally or professionally) within the client system or between clinician and supervisor. These layers of complexity have been referred to as "a three link chain" (Harkness & Hensley, 1991, p. 506), which we identify as the *triple process* (Figure 1).

The modification in terminology intentionally categorizes the supervisor–supervisee–client connection as less of an object or entity and more of a dynamic relational process. Awareness and analysis of diversity solely within a dominant perspective fail to acknowledge the depth of marginalization and cultural complexities that underlie oppression and social injustice. Thus, the

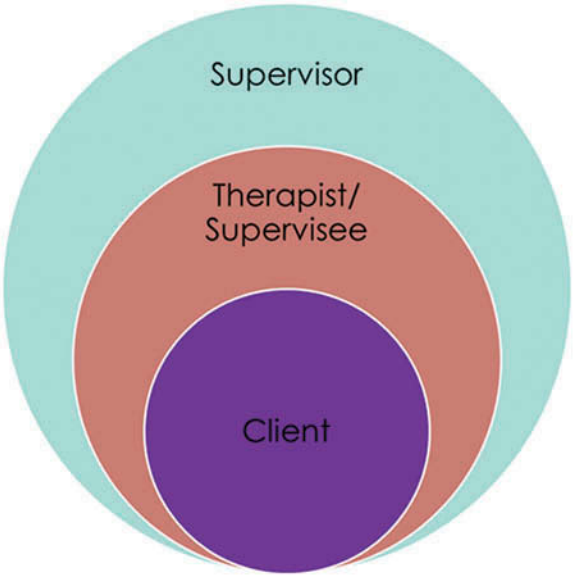

Figure 1. Triple process.

participation and perspective of the racialized clinician are critical for nuanced exploration of the triple process.

Within the triple process, supervisors are charged with providing feedback and guidance to clinicians while maintaining awareness of and promoting authentic discourse regarding power and privilege dynamics. Despite inherent privilege and power differences, it is the responsibility of supervisors to explore supervisees' perspectives, knowledge, and values within a context of diversity to cultivate effective supervision (Hair, 2015). There has been criticism that academic theory–informed supervision is incompatible with experiential knowledge (represented by personal narratives) and cannot be successfully integrated in supervision (Bernstein, 1999). It appears that balancing the educational, scholarly elements of supervision with the interpersonal, relational components requires a divergent perspective, experiences, and skills. Further, the presence of multicultural concerns and/or cultural differences between therapists and supervisors may add complexity to the process, generating apprehension about being perceived in stereotypical ways and making the provision of honest feedback difficult and uncomfortable (Burkard et al., 2014; Jordan, Lovett, & Sweeton, 2012).

To address these discrepancies in the provision of effective supervision, Beddoe (2012) and Bernstein (1999) recommend horizontal discourse, which is informally acquired through social contexts and activated by practice and includes the common, lived experiences and understandings of those who share a community. This approach manifests in supervision as authentic exchanges regarding multiple levels of the triple process with a critically conscious lens. Horizontal discourse includes exploration regarding the capacity of supervision to successfully encourage cultural relevancy and the pursuit of social justice, and cognizance of the cultural and socioeconomic oppression of nondominant groups for clinicians and clients (Beddoe, 2012; Hair & O'Donoghue, 2009). This approach highlights the significance of safety within the supervisor–supervisee dyad; the presence of a safe environment promotes the space and consciousness to explore intersectionality within the triple process. For racialized clinicians with their own experiences with marginalization and oppression, safety is perceived through the lens of the triple process as well. Thus, supervisors' safety is evaluated based on their ability to model an intersectionality grounded perspective, use of inclusive and pronoun appropriate language, and willingness to critique the dominant narrative and discourse that includes cultural relevance.

The research overwhelmingly identifies the inherent challenges in the provision of quality clinical supervision (Beddoe, 2012; Bogo & McKnight, 2005; Falender & Shafranske, 2014; Hair & O'Donoghue, 2009; Kadushin & Harkness, 2002; O'Donoghue & Tsui, 2015). Supervisors are expected to administer, educate, and support clinicians while establishing a safe environment, promoting social justice, engaging in power and privilege discourse, using a critical lens, and exploring cultural significance. Although the charge seems formidable,

supervisors make consistent efforts to balance their oversight responsibilities with authentic relational engagement. However, it is unclear if these efforts are effective. Much of the research literature on supervision focuses on the function, role, and responsibilities of the supervisor (Bogo & McKnight, 2005; Falender & Shafranske, 2014; Hair & O'Donoghue, 2009; Kadushin & Harkness, 2002; Munson, 2002; Tsui & Ho, 1997). To date, we have not found an article looking at the experiences of racialized clinicians. In this article, the authors used case studies, auto ethnographic studies of our supervision experiences, and interviews with racialized clinicians to identify and analyze the supervision needs specific to racialized clinicians. These comments generate a wealth of information about the diverse views, values, and perspectives of burgeoning clinicians of color. Strategies for enhancing supervision to include critical consciousness, cultural humility, and navigating transformative dialogues beyond basic administrative, educational, or supportive content are provided.

Case study narratives

Much of the research on clinical supervision has been done using a quantitative research methodology. While those research studies are highly informative, they do not always capture the lived experiences of racialized clinicians of color due to their reflection of the dominant narrative; as a result, attention to marginalization is frequently absent in the majority of supervision research. We approached this research using a qualitative interpretive method (Elliott, 1999) to seek those case study narratives and stories people of color do not often feel comfortable or safe sharing. These case studies and autoethnographic narratives were especially important for gaining access to the clinical experiences of clinicians of color, not only to the feelings and thoughts of the clinicians but also to the meanings and internalization of their unique clinical experiences. The following case studies include narratives, autoethnographic experiences, themes, and quotes from clinicians of colors' lived and ongoing experiences as racialized therapists. Their direct clinical work with clients and individual interpersonal exchanges in clinical supervision with their often White-identified clinical supervisors are highlighted. The participants were recruited via snowball sampling and were selected based on their willingness to share their narratives.

Through comprehensive interviews, participants were encouraged to provide in-depth expression of their experiences with supervision. Four self-identified clinicians of color offered detailed narratives describing their experiences. Participant demographics for these narratives are detailed in Table 1. Notes from these narratives and comments from other participants were extensively reviewed by the authors. Initial and thematic coding was used to identify several preliminary themes among the participants' responses (Charmaz, 2011). Final narrative and case study themes were established after each author independently, and then we collectively analyzed the materials for content analysis.

Table 1. Narrative Participant Demographics.

Demographic Characteristics	Clinician Participant 1	Clinician Participant 2	Clinician Participant 3	Clinician Participant 4
Ethnicity and race	Black/AA	Mexican American	Black/AA	Black/AA & White
Sexual orientation	Heterosexual	Heterosexual	Heterosexual	Heterosexual
Gender identity	Cis-gender female	Cis-gender female	Cis-gender male	Cis-gender female
Years of clinical experience	15 years	5 years	11 years	20 years
Ethnicity and gender of clinical supervisor	White female	Italian female	White female	Latina female

Content analysis traditionally provides some interpretation of a cultural product (Deese, 1985), which is critical to this exploration given the cultural significance of the research.

Case study themes, quotes, and narratives

Three themes identified by clinician participants—tokenization and invalidation, superficial supervision, and lack of safety and inability to be vulnerable—relate to the challenges faced by well-intentioned supervisors and are used to explore the experiences and needs of racialized clinicians. This information is useful to build on the one-size-fits-all theoretical supervision models currently in existence and move toward a culturally relevant, transformational approach to supervision.

Tokenization and invalidation

Tokenization can be defined as an individual involuntarily being placed to serve as a visible representation of the oppressed group and/or chosen to speak on behalf of the experience and feelings of the oppressed group (Haskins et al., 2013). While the perpetrator frequently acts in an effort to be inclusive, the tokenized person may experience the gesture as a symbolic pseudo-effort or a microaggression. Further, tokenization can also promote invalidation of experiences and decreased safety and curb authentic expression and disclosures during supervision. The following is a powerful example of tokenization and invalidation in the supervisory dyad.

The following narratives also speak to the lived experiences of tokenization and invalidation by clinicians of color. Pseudonyms have been provided to each case narrative to maintain confidentiality while humanizing the experience(s).

Fabiola: "Living with microaggressions from society, staff, and clients has made me hypersensitive to racism or perceived racism"

I went into my new job with an open mind and did my best to use my supervisor as a teaching tool. Early on, she tried to educate me on the first-generation Mexican American experience of my clients (she migrated from Argentina as an adult and I actually *am* a first-generation Mexican American with a very similar background to my clients). She did not do this to help me control countertransference; she was actually trying to make blanket statements that were offensive and untrue about this. I attempted to politely let her know that her assumptions were not accurate and she refused to hear me. When I asked her what her sources were, she told me, "I have been working in this area for 15 years!" Um, OK. I have been a part of this population my entire life but do tell me about my people's experience that I am so unfamiliar with . . . I attempted to let those kinds of experiences go. I attempted to resolve them in supervision; finally, I went to her supervisor with my concerns, which resulted in bullying in the workplace by my supervisor (she would make a big difference between how she treated me and her other supervisees; she wrote me up for following something she told me to do in supervision, and finally she told me I was "the worst clinician she has ever supervised in 25 years"). That supervisor was best friends with her supervisor and denied any of her behaviors; she was believed; I was not. It started with racial microaggressions and ended with personal attacks and me quitting.

I have been called racial slurs by patients in the psychiatric hospital where I work weekends, depending on the patient and their presenting symptoms, I often respond with humor when they ask questions like, "Where did you leave your five kids, you fat Mexican?!"

Living with microaggressions from society in general, but staff and clients as well has also made me hypersensitive to racism or perceived racism.

Marquiese: "Who wants to talk about race-related issues in private practice?"

As a Black male therapist, I have found it to be a challenge to be myself in clinical supervision—specifically with my White female supervisors. I constantly hold back in supervision talking about race-related challenges and issues that come up in clinical practice because I'm hyper-aware of not wanting to make my supervisor uncomfortable. As far as clinical skills and clinical interventions, my White supervisors by and large have been great with providing those skills and helpful interventions. However, talking about cultural and race-related countertransference issues that come up in our supervision has been nonexistent. There has been many times and supervision with my White female supervisors that it felt like they wanted me to give them permission to talk about Black-related stuff or to critique and criticize Black-related issues, and it was very uncomfortable to be in that environment. In addition, when my supervisors were trying extremely hard to overly relate with me because I was a Black male, it made me cringe. I often left supervision thinking and wondering why are they trying so hard to relate to me. All I ever wanted from my clinical supervisor was to be able to talk about race-related issues that come up with my clients and also race-related stuff that

come up in supervision without feeling as though I'm going to hurt their feelings. I would often wonder if what I said in supervision would come back to hurt me. For example, would this information be put in my HR file? I remember when I was providing clinical services to a woman (i.e., client), she asked me, "What are you?" And I said I am a clinical social worker, and she replied, "No, what race are you?" I replied, "I am Black." And she said, "No, you're not because you're not ugly, you haven't lied to me, and you haven't stolen from me. . . ." I immediately felt shocked and sad and by her stereotype of me and other Black men. Before I could go back and talk to my clinical supervisor about the experience I just had with my client, my client had already called my supervisor and asked to be changed to a different therapist. When I went into supervision that following week to talk about that exchange with my client, my supervisor said, "Don't worry… it's not gonna happen again because you no longer have to work with her anymore she's not on your caseload." This is one of many exchanges that I have had with my clients that were microaggressions that felt like macro-insults. I remember when I was working with a 55-year-old White man who asked me at the end of our first session, "I guess basketball didn't work out for you, huh?" I felt the same way that I had felt in the past … shocked and saddened by the stereotype. This time I was in private practice and had no one to consult with. After all, who wants to talk about race-related issues in clinical practice? Where is there a space to do this type of work and have this type of discussion? It hasn't existed in my previous clinical experience, and I'm not sure if it will exist in my future clinical experiences.

Superficial supervision

There is a desperate need for professional in-depth clinical supervision for clinicians of color. Within this context, depth is determined based on negotiation and collaboration between supervisor and clinician, not solely on the assessment or comfort of the supervisor. Surface-level discussions in supervision often create distance between the supervisor and the supervisee. The following are quotes taken from case studies exemplifying superficial supervision.

- My supervisor's approach is to make connections between her culture [White, Jewish] and mine [Latino], but it feels superficial, and we do not discuss cultural differences in any meaningful way, or very often.
- I have had a varied experience as an openly gay African American male intern who is seeking employment in the psychotherapy field, which has a predominantly older, White, female base. Now is a time when supporting diversity is deeply needed.
- My clinical supervisor never explicitly mentioned race, but she once referred to collectivist culture versus individualistic culture and suggested that I bring up this idea to my client to help her understand some of the conflicting pressures she was experiencing between her home life and at school.

- I had a few clients in South LA who were high school–aged males, who would sometimes describe tension that they experienced with law enforcement. I completely sympathized because I understand that internal biases impact the way law enforcement perceives and interacts with young men of color. When I related these experiences to my supervisor, she was not as impacted by these experiences as I was. When my clients would tell me about these instances, I would experience countertransference and become angry they had to experience those interactions. I would then retell these encounters to my supervisor, who more than likely gained something else out of the story. She might take a deep breath and seem somewhat concerned, but she would use the same content to go into another direction.
- She [my supervisor] would address power in terms of the parent and child relationship. Privilege was not addressed. I'm not sure why she did not address it. I think I was always waiting for her to bring it up, and when she didn't I felt like this topic may have been off limits. I regret that now. She was an excellent clinician and could make truly insightful connections between actions and emotions; however, it was rare to discuss environment and its impact on emotions. We did discuss it once with regard to a client who lived in a tiny home with a lot of sisters, a lot of nieces and nephews, and how that contributed to his anger issues. However, on a larger level, we never talked about the fact that his living conditions were a result of poverty and his parents' immigration status. When we talked about his anger toward his dad, we talked about the fact that dad wasn't around, but we never really went in depth about the fact that dad's absence was a result of being deported . . . . I always felt like we could have gone one layer deeper to make issues more culturally relevant, and while our analysis on various clients always went deep, it still did not get where I thought it could have. And honestly, I second guessed myself a lot. I thought, well, I'm brand new to clinical work, maybe that's what all this psychology is about, staying in touch with the emotions and ignoring the sociological aspects of the situation. I was so unsure.

The following narrative illustrates an additional example of superficial supervision. While the supervisor is valued and appears attentive to diversity, supervision is conveyed as an opportunity for the supervisee to share significant intersectional information with the supervisor obtained from other colleagues without consideration of how a *liking for diversity* affects supervision depth.

Nakeisha: "My supervisor has a liking for diversity."

> She [my supervisor] is open to hearing about cultural differences as she has a liking for diversity. I also intern with a refugee program, so I come across cultural differences constantly! We have a lot of case managers that work with the refugee that are native to

the countries which we get most of our refugees from. When I have questions or concerns, I go to the case managers and not usually my supervisor. For example, I was putting together a kit for a young boy with various toys and school supplies and such. I gave him some Ninja Turtle things, and the case manager told me that I cannot give him Ninja Turtles because green is for girls in Iraq, which is a culture tie to gender appropriate colors. This is something that I would have never known in a million years. It was nice to know that, as I never gave any young Iraqi boys anything green, and stuck to red and blue (as I was told was more appropriate). I felt that my supervisor would not have known this either and shared it with her. I felt comfortable to do so and didn't think of it as "she doesn't know anything so I have to tell her"; it was more of me being excited to share something new and interesting with someone else that could use some interesting information.

Lack of safety and inability to be vulnerable

Due to marginalization and decreased privilege, clinicians of color are more vulnerable than their White identified counterparts in supervision. As such, clinicians of color need more authentic investment and safety created by supervisors to feel safe in letting down their guard. How supervisors handle and manage the information expressed and shared in supervision matters. Clinicians of color must be allowed, encouraged, and supported to share all of their intersecting identities; there is a yearning among clinicians of color to be vulnerable and validated in supervision. The following are quotes taken from case studies.

- I feel slightly validated by my supervisor in terms of my clinical work but do not feel supported by her or the agency in any way. Forms and information that I need to complete assessments are not provided to me and instead I have to Google them to find them online. I am often chastised for not being an "independent learner" and have learned to just keep my mouth shut for fear of being retaliated against. I've learned to document everything and seek advice from a more experienced intern. There is no leadership at this agency. Case notes and progress notes that I have turned in from 3 weeks ago have not even been looked at, much less returned to me, so I am not able to get feedback on my work in a timely manner.
- I have experienced both ends of the spectrum in regards to quality of supervisor. For my learning style, I find it best to work with someone that allows me to be vulnerable and with whom I also feel open to speak directly and discuss everything and anything that is pertinent to the case.

The following is a narrative from a racialized clinician's experience with unsafe supervision.

Stephanie: "I understood that it was not OK for me to have a discrepant opinion from her."

One year I started working at an agency where the supervisor was a Latina woman, which was different for me because somehow most of the supervisors I've gotten over the years have been either African American or White. This supervisor identified as Latina, and I remember wondering if she was also queer (which she never acknowledged or addressed). She did look more White than brown, and I was super excited to have a supervisor who was brown like me—and I think in part of my internal experience was hoping that she was maybe like me, more than what she looked like, and there was more depth to her than what one could see. This woman was welcoming, and in my interview I was very excited about the prospect of working with her in supervision.

In the first couple of weeks of supervision, I felt like I got what I needed: she heard me, answered my questions, and inquired about my experiences consistently. One day I worked up my courage and decided to ask a culturally related question. What I realized is that up until that point we had never talked about anything cultural. What we talked about mostly was about client activities and interventions and philosophy. So it took courage because I was concerned that maybe this wasn't OK? Somehow, I reasoned with myself, it was OK if I asked about *her*. Not me, not clients, but if it was about her, it should be ok. And I thought, better to do it in group supervision where it will be a safe test. When a colleague brought up some example about a Latino client, she referred to them as Hispanic—and this was during the time when the word Hispanic was being touted as less politically correct. So, I tentatively asked if the word we are supposed to use was Hispanic or Latino. Everyone got quiet for several minutes. And I looked at her, and she looked at me with such disgust, but I thought I must be imagining it. Her response was unclear and pretty vague and she quickly changed the subject. In individual supervision later she brought it up and I was so excited because this validated my experience and it felt good knowing this indeed was a weird exchange. When she brought it up, she referenced my question and proceeded to tell me that my concern was both unnecessary and unimportant. Her tone, facial expression, and everything about her presentation was disgusted and shaming. She told me that the correct word was Hispanic and that the word Latino was not used and that she had no idea what I was talking about. And in that moment I didn't connect that she might've been saying that her understanding of her own perspective might be different than the things that I have been reading about. What I clearly understood was that I was wrong and she was right and I should ignore my own experience, feelings, and thoughts if they were in conflict with hers. Mostly, I understood that it was not OK for me to have a discrepant opinion from her. So what I did was I stopped asking questions that had any kind of cultural relevance. From that day on, I just asked clinical questions. What is interesting is that her tone and her presentation and her attitude towards me were decidedly different from that day forward. In group supervision I would raise my hand and she wouldn't call on me. I noticed that her face would scowl when she would look at me when I asked a question that she didn't agree with, which was frequently. I noticed that I didn't have any room to explore and grow, and it was obvious that who I wasn't acceptable or felt unpleasant to her.

Discussion

Supervision is a tripartite relationship between the supervisors, supervisees, and the clients, which we refer to as the triple process. The case study narratives provide a wealth of information, engendering supervisors and supervisees to push supervision into a place of growing beyond clinical skills and "superficial processing." There is a yearning for clinicians of color to have uplifting spaces to discuss, explore, challenge, and be challenged in supervision. Boundaries between therapy and supervision can be confusing for supervisees and for supervisors when in stagnate "gray areas." Supervisors may withhold feedback to avoid the discomfort of defensiveness, anxiety, anger, or embarrassment. Multicultural concerns or differences add a layer of complexity to the supervision process; it is exponentially increased when it exists across multiple dynamics (Young, 2004). It is imperative that clinicians of color do not feel as though they have to protect their supervisor from difficult race conversations. Clinicians feel the energy and discomfort from their supervisors leading to avoidance and superficial clinical supervision (Bernstein, 1999; Hair, 2015).

As indicated in the aforementioned case studies, these clinicians of color are struggling with wanting to feel safe and vulnerable in the supervision exchange. Racialized clinicians repeatedly expressed the desire to explore their own experiences and perspectives in a climate that maintained respect for their intersectional lens. Microaggressions, superficial supervision, and tokenization only exacerbate feelings of marginalization and invalidation to those whom are already oppressed and subordinated. There is an unspoken level of expectation from supervisees for supervisors who are supervising clinicians of color to be "woke"—racially, clinically, culturally, and ethically when supervising clinicians of color. "Woke" is an urban slang term referring to an awakened state where an individual uses critical thinking to consider the nuances of racial and social injustice (Foley, 2016). Translated into practice skills, supervisors must understand the larger macro-institutional underpinnings of gender, race, power, and privilege and how they enter into the micro supervisory exchanges. Supervisors should work toward pushing past defensiveness (intrapsychically and interpersonally) to make changes in their supervisory style. To truly effect change that affects clinicians and clients, we must challenge the homeostasis of superficial supervision. It is not enough for supervisors to merely recognize differences; they must recognize that these "differences" are parts of identities that shape the supervisees' lens, behavior, insight, and direct practice skills.

It is important that the supervisors not of color recognize that clinical practice and cultural competence theories are embedded in a cultural perspective laden with Eurocentric values, and it is challenging to fully differentiate cultural versus clinical values (Beddoe, 2012; Hair & O'Donoghue, 2009). It is difficult to be a learner as a supervisor when one feels responsible to guide the supervisee. Further, when supervisors are the ones to bring up the issues and engage them

in an internal or external review, supervisors are the ones leading; leading while learning is a learned process. Therefore, there needs to be more acceptance and tolerance for growing and learning as a supervisor. An immediate strategy to initiate this shift is for supervisors to be willing to learn and step out of their privilege comfort zone. Supervisors must recognize what brings discomfort, what do they not know already, and what can be learned.

Clinical supervision with a social justice lens

For supervisors to understand the larger social constructs facing racialized clinicians working with vulnerable clients, they must understand the larger societal systems that can affect clinical activities. Supervisors must look beyond the micro direct practice and direct administrative practice to develop a critical race lens by which to understand privilege, racism, and psychic reward [the psychological reward obtained from having privilege] (Better, 2008). It is up to the supervisors to acknowledge privilege and power differentials when commencing clinical supervision, which validates the reality of the racialized clinician, allows for acknowledgement by supervisees, and promotes space for privilege discourse in supervision. While this can be uncomfortable for the supervisor, in particular for those holding privilege, it is not the responsibility of the clinicians of color to lessen the discomfort of the supervisor. This dynamic is exponentially exacerbated when the supervisor is White. Clinicians need permission to release that burden which is put upon them by the larger racial caste system.

Dr. Shirley Better (2008) argues that racism is much larger than negative attitudes and that it touches the very core of our lives as Americans and individuals. Clinical practice for supervisees (therapists) will encompass racist-rooted behavior from clients. If racist-rooted behavior is not recognized and appropriately discussed and explored by the supervisor during supervision; the supervisee may put up a guard. The lack of awareness on the part of the supervisor can promote experiences of invisibility among clinicians of color during supervision. It is the supervisor's responsibility to assess for, explore, and address microaggressive experiences within the triple process.

Clinical supervisors allowing for resistance from supervisees

Certain knowledge becomes privileged discourse or a dominant narrative of assumed truth according to who can speak or practice, what can be said or thought, and with what authority. Supervisors must recognize that there is a thin line between pride and humility. They have to move past their pride and lower their self-importance in the supervision space. In other words, they must be accountable for their ego and how it shows up in the triple process. Supervisors must also understand when supervising clinicians of color that resistance to dominance in persistent narratives or the cultivation of alternative ideas is an

exercise of power in the supervision dyad (Hair, 2015). Thus, within this context, the clinician is viewed as empowered versus traditional paradigms that label them oppositional or resistant. There needs to be a conscious shift where desired conversations become dialogic–reflexive interactions where all knowledge and narratives are valued and vulnerable to critique, so the potential is present for dominant beliefs and practices to be challenged (Beddoe, 2012). With a focus on social justice, practice and supervision evolve to maintenance of a critical, dialectical position while exploring and constructing a range of possible explanations and meanings of human distress within a diverse landscape.

Appropriate affirmations, validations, and recognitions

Supervisors must create platforms of visibility as they are holding growth spaces. Supervisors must move past what is allowed or what is expected and look instead at what is actually happening in their experiences as clinicians of color. Supervisors must view client assessment, engagement, intervention, reactions, interpersonal dynamics, and oppressive experiences from the lens of the racialized clinician, which is a challenge when supervisors may not share their worldview or experiences of power and privilege or are not used to conducting and facilitating supervision with this paradigm shift. The supervision must shift from a binary focus (i.e., I am right as the supervisor and you are wrong) to a more exploratory focus (i.e., Help me understand what it is like for you as a clinician of color providing clinical services). This shift in framing supervision comments breeds understanding, sensitivity, and humility. Ultimately, it creates a culture and climate of increased comfort, safety, and authenticity.

Recommendation and pedagogical strategies

Supervision will benefit clinicians of color, clients, and supervisory relationships if supervisors can tolerate being informed by their supervisees and allowing for the not-knowing to happen in the supervisor–supervisee dyad. Supervisors must practice self-coaching to be courageous and curious and to manage their own discomfort. A critical skill lies in supervisors' ability to balance corrective feedback with supportive exploration of the unique individual experiences of all supervisees of color whom they are supervising.

The following are recommendations that supervisors can use and practice immediately in supervision. We recognize that this is not a simplistic process, and supervisors need to continue to seek education, support, and consultation around supervising clinicians of color. Initially, there are several things supervisors can give up to increase effectiveness. Supervisors must be willing to give up the role as the expert and adopt the role as a learner in the supervisory dyad. Similarly, supervisors must also get comfortable releasing power in the supervisory space. Supervisees of color might see the power positioning as oppressive and stifling to

the trusting relationship in supervision. And, finally, supervisors must move past their resistance around having difficult dialogues with the supervisee of color. True growth happens when supervisor and supervisee can have authentic—yet challenging—conversations and both parties are comfortable calling one another in versus calling out (Tran, 2013) or shutting down altogether in supervision.

Conversely, supervisors must be willing to take on new or unfamiliar roles and responsibilities to increase trust within the supervisory relationship. They must acknowledge microaggressions when they are presented by supervisees. They must learn to provide a genuine apology when clinicians experience microaggressive interactions with clients, colleagues, and with supervisor alike. Recognizing and admitting when you are wrong as a supervisor demonstrates humility, insight, and growth (e.g., supervisor misgendering the supervisee). Supervisors must be vigilant in their ability to recognize that identity goes far beyond phenotype and learn to see and hear the whole person before them in the supervisory space—not just aspects that are visible to the supervisor or those with which they are comfortable. Supervisors can model difficult conversations, with awareness that clinical skills can be cultivated within supervision. And, finally, supervisors can learn to lean into difficult conversations versus leaning away. Racialized clinicians are constantly looking for guidance in the areas of socially just clinical practice (i.e., which includes, but is not limited to, having difficult conversations about race, gender, sexual orientation, oppression, power, and privilege).

Conclusion

This study sought to raise critical consciousness, awareness, and visibility to the unique experiences and corresponding needs of racialized clinicians. As noted here, there continues to be a need for ongoing dialogue and training around discussing race in clinical practice. If this study has done nothing else, it has allowed clinicians of color and supervisors of noncolor (i.e., White identified) to see and read experiences that are similar, challenging, and often invisible. Additional research needs to be done in bridging the gap between clinical supervision and culturally affirming clinical supervision for clinicians of color.

"I have come to believe over and over again that what is most important to me must be spoken, made verbal and shared, even at the risk of having it bruised or misunderstood" (Lorde, 1984, p. 40).

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