The role of clinical supervision in moving cultural awareness to cultural competence through case conceptualization

Cheryl B. Warner
Ph.D. Director, Mental Health Counseling, Associate Professor of Psychology, Division of Science Indiana University-Purdue University Columbus, Columbus, IN USA. E-mail: warnerch@iupuc.edu

Abstract: Cultural competence extends beyond awareness and sensitivity to include implementation of culturally-appropriate treatment strategies. Studies exploring self-reported multicultural competence with applied skills revealed a small portion of mental health professionals and trainees actually integrated cultural factors into their assessment, case conceptualization, and treatment strategies (Hansen et al., 2007; Ladany, Inman, Constantine, & Holheinz, 1997; Sehgal et al., 2011; Schomburg & Prieto, 2011). Case conceptualization is the precursor to implementing treatment strategies and when accurately applied, integrates culture throughout the therapeutic process. Professional training must directly target case conceptualization skills to improve psychotherapists’ cultural competence. Clinical supervision, with the explicit goals of exploring culture, plays a critical role in developing case conceptualization skills. The supervision environment offers supervisees space to explore culture and conceptualize a therapeutic path culturally congruent with clients’ lives. The author offers best practice strategies in the areas of a) supervisor characteristics, b) supervision skills, and c) supervisory relationship to ensure clinical supervision is facilitating case conceptualization skills and, ultimately, cultural competence.

Keywords: clinical supervision, cultural competence, case conceptualization, best practices, supervision skills, multicultural competence.

Cultural competent psychotherapy is a client-centered process that facilitates and contributes to case conceptualization. Brown (2009) wrote, “Cultural competent psychotherapy practice thus begins with the client at the center of conceptualization, not with the diagnosis, not with a treatment manual, not with the therapist’s idea of what to do next” (p. 349). However, studies exploring self-reported multicultural competencies by mental health professionals and trainees revealed a small portion of participants actually integrated cultural factors into their clinical practice, specifically into assessment, case conceptualization, and treatment strategies (Hansen et al., 2006; Ladany et al., 1997; Sehgal et al., 2011; Schomburg & Prieto, 2011). Another study found that clinicians, independent of their professional status, tended to identify cultural themes if and only if clients made explicit statements or references to the cultural themes (Lee, Sheridan, Rosen, & Jones, 2013). These findings imply a disconnection between perceived cultural competence and actual clinical practice.

Sperry (2012) defined cultural competence as a multidimensional construct that possesses moderate to high levels of competence in four areas: cultural knowledge, cultural awareness, cultural sensitivity, and skillful actions. This theory provides an explanation for the presence of high self-reported multicultural competence with lower rates of applied skills and strategies that address cultural factors in simulated cases (Hansen et al., 2006; Ladany et al., 1997; Sehgal et al., 2011; Schomburg & Prieto, 2011). Low level of competence may exist in the area of skillful actions; whereas, higher levels of competence are present in cultural awareness and cultural sensitivity. This imbalance between perceptions and actions may occur because of (a) the focus on multiculturalism and diversity issues in research and clinical practice (Sue & Sue, 2008), (b) the psychometrics of the self-reported assessments of multicultural competence, and (c) other characteristics, such as cultural factors (e.g., a member of an ethnic minority group, cultural awareness, cultural aspect), educational level (master’s versus doctoral), and job position (administrator versus clinician) (Gloria, Hird, & Tao, 2008; Holcomb-McCoy & Myers, 1999; Schomburg & Prieto, 2011; Spanierman, Poteat, Wang, & Oh, 2008; Sue & Sue, 2008).
Whaley (2008) conducted a multivariate analysis to understand the association between cultural sensitivity and cultural competence and discovered cultural sensitivity provides the foundation for cultural competence. In other words, cultural sensitivity alone is not enough, but is necessary, for cultural competence to develop. Studies (Lee, Sheridan, Rosen, & Jones, 2013; Sehgal et al., 2011; Schomburg & Prieto, 2011) utilizing different methodologies illustrate Whaley’s assertion that cultural sensitivity is the foundation for cultural competent behaviors but not sufficient for cultural competence. The implications directly impact training. Whaley’s (2008) recommended a two-step process for training: The first step builds or increases cultural sensitivity and the second step advances cultural competence. This recommendation resembles what occurs in training programs. However, most training programs emphasize cultural awareness and knowledge, placing less focus on culturally applied skills (Sehgal et al., 2011; Sperry, 2012). Additionally, multicultural courses provide marginal to adequate covered of content that professionals, in retrospect, believe were critical to their clinical practice (Hastings, & Cohen, 2013; Holcomb-McCoy & Myers, 1999).

As an instructor of a multicultural course, this is troubling news. It is imperative we begin to understand the gap between self-perceptions and cultural competence and the developmental trajectory of cultural competence. Returning to Whaley’s (2008) recommendation, redistributing training efforts to culturally applied skills and strategies can reduce the gap between self-reported cultural competence and the actual demonstration of cultural competence in clinical practice. The thesis of this paper emphasizes that clinical supervision is a critical training modality in developing cultural competence, especially when utilizing case conceptualization skills.

Clinical Supervision

If formal learning or training enhances cultural knowledge, cultural awareness and cultural sensitivity, then clinical supervision can merge these elements into developing case conceptualization skills and further enhance cultural competence (Bernard & Goodyear, 2013). Clinical supervision provides an ideal learning environment for merging theory and practice, allowing for strategic assessment and customization of supervisees’ training needs. The supervisory relationship fosters an environment that allows supervisees to shift from talking about how they may work with clients to actually demonstrating their work. As a learning environment, supervision encourages greater transparency into supervisees’ internal processes about how they perceive themselves, their clients, and their work as psychotherapists. It facilitates supervisee’s growth in their confidence and feelings of autonomy as emerging professionals.

The formation of the supervisory relationship is based on the parties agreeing to the boundaries and expectations of the relationship and negotiating their shared goals (Rosenbaum & Ronen, 1998). This leads to establishing a working alliance similar to the therapeutic relationship. Developing cultural competence through supervision must be explicitly identified as a goal and consistently addressed throughout the process (Inman, 2006). Hence, it is important for supervisors to acknowledge the relevancy of culture in practice and establish the foundation for creating an open and receptive environment for exploring cultural information and dynamics. The responsibility of creating an environment for the development of cultural competence lies with supervisors not with supervisees (Fukuyama, 1994; Fong & Lease, 1997, cited in Inman, 2006). This is critical due to the inherent imbalance of relational power existing in supervisory relationships, which also parallels the power dynamics between therapist and client. In both cases, individuals with less power (clients and supervisees) may defer to unspoken rules (intentional or unintentional) of what is acceptable content for the relationship. The intentional behavior of broaching cultural content offsets the silence or waiting for client or supervisee to initiate dialogue by having the therapist or, in the case of supervision, supervisor acknowledge and invite open dialogues on culture (Day-Vine, et al., 2007).

Day-Vine et al. (2007) described five broaching styles employed by therapists while addressing culture with clients: (a) avoidant, (b) isolating, (c) continuing/incongruent, (d) integrated/congruent, and (e) infusing. These styles are also applicable to supervision. A word of caution: Broaching is necessary but not sufficient to develop or demonstrate cultural competence. For instance, two broaching styles, isolating and continuing/incongruent, involve talking about culture but fail to demonstrate how culture influences human development or can be integrated into conceptualization or treatment. Supervisors’ styles that reflect the integrated/congruent and infusing styles, contrary to the isolating or continuing/incongruent styles, exhibit a more advanced understanding of culture, its meaning in the client’s life, and its application to therapeutic practice.

Lastly, supervision occurs in dyads, triads, or small groups, warranting a different relational structure and level of intimacy in supervisor-supervisee interactions than what is usually experienced in the traditional classroom. Thus, the supervisory relationship encourages exploration of content that may trigger feelings of vulnerability, often associated with genuine dialogues exploring cultural dynamics or cultural development (Cashwell, Looby, & Housley, 1997). Studies have linked cultural variables with multicultural competence, noting psychotherapists at higher levels of cultural identity are more culturally sensitive, open to interacting with diverse groups of individuals, engage in broaching behaviors, and
promote multiculturalism and social justice (Day-Vine et al., 2007; Neville, Spanierman, & Doan, 2006). Thus, supervisors who have higher levels of cultural identity will broach culture, be more open in their discussions, and will explicitly engage supervisees in the development of cultural competence. Furthermore, cultural identity impacts the relational dynamics of the supervisory relationship (Constantine, Warren, & Miville, 2005; Inman & Kreider, 2013). A supervisory relationship that facilitates cultural competence occurs when the supervisor’s cultural identity is at a higher level than the supervisee’s (progressive) or the cultural identity levels of both individuals are high (parallel-advanced). Conversely, relationships where the supervisor’s cultural identity is lower than the supervisee’s (parallel-delayed) or both individuals possess low cultural identity levels (regressive) are less likely to facilitate cultural competence. Interestingly, supervisees rated their supervision as more positive and with greater satisfaction when they perceived their supervisors as open to discussions about culture (Inman, 2006).

Although research shows strong support for a positive relationship between supervisor’s level of cultural competence and supervisee’s satisfaction with supervision, Inman (2006) discovered a negative correlation between supervisor’s cultural competence and supervisee’s development of cultural competence on etiology conceptualization skills. Inman hypothesized time affected the findings, noting participants’ average time in supervision was approximately 10.66 weeks, ranging from one to 60 weeks. The findings implied shorter time in supervision might require different supervision strategies than the strategies useful for facilitating advanced clinical skills, such as integration of cultural factors into case conceptualization. This is consistent with the recommendations of developmental model of supervision that varies supervision strategies with the developmental levels and needs of supervisees (Bernard & Goodyear, 2013).

**Case Conceptualization**

The prominent skills of clinical practice involve assessment, diagnosis, and treatment. These skills link to case conceptualization (Sue & Sue, 2008). Case conceptualization involves gathering and making meaning of client information to (a) identify client’s presenting issues, (b) understand client’s dynamics and worldview, (c) determine treatment strategies, and (d) assess the progress of treatment. Sue and Sue (2008) wrote, “[c]ase conceptualization is an ongoing process that begins with the initial intake interview, assessment, and continues throughout the course of therapy” (p. 77). Furthermore, conceptualization allows psychotherapists to work with more thought and intentionality (Halibur & Halibur, 2011). Case conceptualization is both informational and explanatory. Sperry (2005) identified three types of conceptualization: (a) symptom-focused (highlights symptomatology, impairment, treatment goals and outcomes); (b) theory-focused (identifies symptoms and impairment and provides theoretical explanation of “why”); primarily therapist-centered); and (c) client-focused (based on phenomenological approach; aim to “fit” client needs and dynamics with treatment). In practice, case conceptualization tends to be more about theoretical orientation and diagnoses and less about explanations and treatment decisions (Groenier, Pieters, Witteman, & Lehmann, 2014; Sperry, 2005). Sue and Sue (2008) believe conceptualization can overlook clients’ perspectives on their presenting problems and be influenced by psychotherapists’ “values, worldview, and beliefs on their practice.” (p. 81). Thus, they recommend a collaborative conceptualization approach that involves including clients’ input in determining the problem definition and formulation of clinical hypotheses.

Theorists believe conceptualization is an advanced cognitive and clinical skill (Bernard & Goodyear, 2013) that is challenging for many students and novice psychotherapists to learn (Falvey, Bray, & Hebert, 2005). It builds on a hierarchy of cognitive processes that moves from “simplistic, concrete, and dichotomous thinking to complex, abstract, and relativistic thinking processes” (Ellis, Hutman, & Deihl, 2013, p. 247). The inclusion of cultural factors and dynamics adds another level of complexity to conceptualization skills. However, there is caution in believing conceptualization is an objective clinical skill (Sue & Sue, 2008). Researchers (Falvey et al., 2005; Mayfield, Kardash, & Kivlghan, 1999) discovered novice and experienced professionals use different cognitive processes to derive their conceptualization. Clinicians’ ideas about wellness and psychopathology, lifestyles and cultural factors affect what they deem as relevant clinical information and the interpretation and application of the information to clients’ lives (Sue & Sue, 2008). Conceptualizing clinical cases integrated with cultural factors is a challenge for students and psychotherapists who (a) are uncomfortable broaching culture with clients, (b) are working from a culturally universal perspective (or color-blind ideology), or (c) have limited experience or working knowledge of integrating cultural information into their conceptualization skills (Day-Vine et al., 2007; Spanierman et al., 2008). Case conceptualization has a tremendous impact in our clinical work since it reflects what and how we think about our clients and affects our diagnostic and treatment decisions.

**The Role of Clinical Supervision in Developing Cultural Competence**

Psychotherapists who are culturally competent are “culturally self-aware, aware of the client’s culture, and willing to bring culture into the discussion during interactions with clients (Sue, Arredondo, & McDavis, 1994).” (Ahmed,
Wilson, Henriksen, & Jones, 2011, p. 22). They are able to integrate various dimensions of culture (e.g., personal, institutional, societal) with clients’ uniqueness to understand clients’ experiences and problems. Culturally competent psychotherapists also adapt strategies and interventions that are culturally relevant and beneficial to clients (refer to Hays, 2009; Nápoles-Springer, Santoyo, Houston, Pérez-Stable, & Stewart, 2005; Whaley & Davis, 2007 for examples). As previously stated, case conceptualization is an advanced skill. The integration of cultural factors into case conceptualization adds another level of complexity and is essential for cultural competence. The achievement of this complex skill occurs through a steep learning curve for novice therapists or those with low or minimum levels of cultural awareness, cultural sensitivity, or cultural knowledge. Furthermore, cultural awareness and cultural knowledge as specific training goals are not enough (Sehgal et al., 2011; Weatherford & Spokane, 2013) to ensure culturally competent behaviors.

There are several models that provide a framework to implement supervision strategies to assist supervisees’ development of cultural competence (refer to Inman & Kreider, 2013; Ober, Granello, & Henfield, 2009; Stoltenberg, 2005; Stoltenberg & McNeill, 2010) or conceptualization skills (see Bob, 1999; Ellis et al., 2013; Sarnat, 2010). Many of the early models identify cultural awareness and cultural knowledge as supervision goals but few provide guidance for helping supervisees move from cultural awareness to skillful actions. For these reasons, utilizing a developmental model of supervision can assist supervisors to (a) assess supervisees’ personal characteristics and knowledge and skills levels, (b) link their levels to cultural knowledge, and (c) determine supervisory strategies for integrating cultural understanding in building conceptualization skills.

Recommended Strategies for Developing Cultural Competence through Case Conceptualization

The development of cultural competence through case conceptualization skills must be nurtured and practiced through a different learning process than provided in traditional classroom environments. Clinical supervision occurs in dyads, triads, and small groups, face-to-face or electronically through the variety of available communication technologies. In any format, research has documented strategies that provide supervisors with a blueprint of best practices. This paper separates the strategies into three areas that collectively contribute to the effectiveness of supervision in developing cultural competence. The areas are: (a) supervisor characteristics, (b) supervision skills, and (c) supervisory relationship.

Supervisor Characteristics

1. Exhibit self-awareness about your cultural heritage and understand the meaning of culture in your personal and professional development.
2. Display transparency of your cultural development with supervisees by discussing your own cultural development.
3. Possess knowledge of cultural identity development models and the intersectionality of multiple identities on human development.
4. Possess knowledge of sociopolitical influences on culture, such as the presence of “isms”, power and privilege, oppression, marginalization and discrimination and understand their implications on organizations, institutions, and individuals ( Warner, Phelps, Pittman, & Moore, 2013).
5. Realize you are modeling openness, willingness to be “imperfect”, and continual learning about self and others.

Supervision Skills

1. Assess supervisee characteristics, such as self-awareness, openness, cognitive process, cultural empathy, broaching styles, and clinical skills (Day-Vines et al., 2009; Ellis et al., 2013; Glosoff & Durham, 2010; Weatherford & Spokane, 2013)
2. Utilize concept mapping models to assist supervisees in developing conceptualization skills (Ellis et al., 2013).
3. Possess knowledge about supervision models (Bernard & Goodyear, 2013; Ober et al., 2009; Stoltenberg, 2005).
4. Develop a supervision philosophy that explicitly explains how you integrate culture into supervision style.
5. Incorporate activities to encourage dialogue and awareness about culture (Berkel, Constantine, & Olson, 2007; Cashwell et al., 1997; Davis, 2007; Schomburg & Prieto, 2011).
6. Challenge supervisees to explore the sociopolitical influences on culture, such as the presence of “isms”, power and privilege, oppression, marginalization and discrimination, and assist them in applying this knowledge to organizations, institutions, and individuals ( Warner et al., 2013).
7. Utilize supervision interventions and strategies applicable to supervisees’ developmental levels and intended goals (Loganbill, Hardy, & Delworth, 1982 cited in Stoltenberg, 2005).
8. Share your conceptualizations of client presenting concerns, emphasis cultural information and implications.
9. Encourage supervisees to practice verbalizing and writing their case conceptualizations.
10. Link learning from didactic classroom training directly to the practice of psychotherapy (Schomburg & Prieto, 2011).
Supervisory Relationship

1. Establish working alliance to establish a collaborative agreement on the structure, expectations (including evaluation component), and goals of supervision (Inman, 2006; Inman & Kreider, 2013).

2. Establish norms earlier in the supervisory relationship for open discussions and exploration of cultural dimensions and dynamics.

3. Attend to the relational dynamics of the relationship.

4. Explore cultural dynamics occurring in the therapeutic relationship that mirror the supervision process.

5. Attend to supervisees’ emotional responses to cultural context and dynamics (Spanierman et al., 2008; Sarnat, 2010).

6. Recognize and understand the types of interpersonal interactions as a function of culture that can occur in the therapeutic and supervision relationship (Ancis & Ladany, 2010 cited in Inman & Kreider, 2013).

7. Embrace discourse and conflict and demonstrate how to navigate them by modeling the process.

8. Understand the cultural and power dynamics within the supervision relationship and discuss them openly with supervisees.

Conclusion

Didactic learning activities are effective in developing cultural awareness, cultural sensitivity, and cultural knowledge. However, they fall short in developing culturally skillful actions that are demonstrated in clinical practice. Thus, research on cultural competence as demonstrated through case conceptualization unveiled a negative association between self-perceived cultural competence and the clinical skills of case conceptualization.

Case conceptualization is an advanced cognitive and clinical skill that is generated from psychotherapists’ internal processing of client information (refer to Ellis et al., 2013 for a description of the cognitive process). The inclusion of cultural information adds another level of complexity to effectively acquiring case conceptualization skills. There are many personal and professional characteristics and variables associated with cultural competence and conceptualization.

Clinical supervision provides a different learning environment than didactic learning to assess and integrate these variables and address case conceptualization skills. It relies on the working alliance of the supervisory relationship to facilitate learning with targeted goals of addressing culture in clinical practice. This paper provided specific recommendations from the literature to facilitate culturally competent case conceptualization skills in supervisees’ development through clinical supervision. The recommendations can help supervisors become more intentional about their style of supervision and, conversely, assist supervisees in knowing the expectations from supervisors who emphasize cultural competence as supervision goals.

References


