When Dominant Culture Values Meet Diverse Clinical Settings: Perspectives from an African American Supervisor

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Clinical supervision becomes more complex when interns and trainees provide therapy to people from significantly different cultural and ethnic backgrounds (Sue & Sue, 2003, p. 267). Each culture and ethnicity has created its own view of therapy and that view often does not match dominant culture definitions for solving human dilemmas. Another level of complexity is added when the cultural backgrounds of trainees and interns are different than their supervisors. When such differences exist, there may be very little intersection between worldviews. While there has been some attention given to supervisors training supervisees from different ethnicities and cultures (Gardner, 2002; McDowell, 2004; Weiling & Marshall, 1999), very little has been said about how the dominant culture trainee may be impacted by the culturally different supervisor's worldview or how these different social locations and power positions impact the supervisory relationship.

Discrepancies in worldview are particularly likely when clients are court-mandated (Pope & Kang, 2011). These clients are generally coerced into therapy by contingency plans that leave little room for refusal of treatment; they may lose their freedom or their children if they do not agree to enter into therapy (Kemps, Marcenko, Hoagwood, & Vesneski, 2009; Pope & Kang, 2011). Many mandated persons are low-income and cultural or ethnic minorities who do not necessarily accept that "talking" about your problems will be helpful (Epperson, Roberts,

Editor's Note

Norma Scarborough passed away unexpectedly early in 2016. Norma was a tireless advocate for families and family therapy, a bright light. She supervised countless family therapy interns and was an articulate voice for families of color and those marginalized by the dominant culture. Her high energy, positive spirit, and ringing laughter enriched all who knew her (and many who did not). Fortunately, her draft of this chapter was already completed. We are grateful that we can include her wisdom in this volume.

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Ivanoff, Tripodi, & Gilmer, 2013). They come from worldviews that value other ways of coping with problems (Smith, 2013). Most supervisors are likely to be from European backgrounds where talk therapy is highly valued. This may also be true of the majority of clinical supervisees. Their views of the therapeutic world may be significantly different than that of their racially and/or culturally different client (Hanna & Cordova, 2013). It is at this intersection of values and beliefs that supervisors need to be aware of the multiple realities that could significantly impact how interns and trainees deliver therapeutic interventions to culturally and ethnically diverse populations.

In my experience as an African American female, Couple and Family Therapist, and supervisor for more than 20 years, I have heard many questions and concerns voiced by supervisees that originate from differences in worldview. It is from this social location that I share perspectives drawn from my experiences as a supervisor.

As I look back over many supervisory sessions, some of the values and beliefs in question were those about time and its meaning to therapy sessions; building relationship; boundaries; poverty and its impact on clinical issues; and involvement with larger systems such as the welfare system, child protective services, the immigration system, the probation system, the police system, and the educational system, anyone of which could influence therapeutic issues. In addition, there are ethical issues about parenting and discipline that also challenged Eurocentric worldviews of dominant culture trainees and interns. Finally, there is the issue of power distribution between supervisor and supervisee. The importance of this distribution became important when trainees were asked to follow my instructions when those instructions were different from those of their dominant culture practicum instructors.

Time

In the world of the dominant culture clinician, time is not only very important, but also highly valued. It can determine how financially successful you are, as it allows you to see many clients in a day. Time is often interpreted by some trainees/interns as a way to measure the commitment of the client to therapy. This worldview about time is one that does not necessarily intersect with other cultures or the needs of clients from diverse populations. European culture believes that "time is money," "time waits for no man," and that time can be "wasted," all of which speak of the importance of time to the dominant culture. Many other cultures do not experience time as "money," but rather see it as something they have for their use (Sue & Sue, 2000, p. 269). One such miscommunication around time occurred when one trainee was seeing a Latina mother who was given an appointment from 10 am to 11 am. She arrived at the session 40 min late, still expecting to have time to meet. When the supervisee from a different worldview reported this behavior to the supervisor from a Eurocentric worldview, the mother was seen as disinterested and assessed "a resistant client." As a minority supervisor, my understanding of time was supportive of the client.

Trainees have been surprised when I have advised them to be more relaxed about time and discuss its meaning with their clients rather than make assumptions about what their client's use of time means. One trainee's response to my directions was: "But Dr. Scarborough isn't the client acting irresponsibly? Aren't I neglecting to set limits when I accept her being late?" The supervisee was encouraged to discuss the situation with the client and find out what meanings the client attached to the time rather than assume that the same understanding of time used by the supervisee was also used by the client. By having the discussion with the client, the supervisee was able to discover that the Latina mom wanted to come to therapy and believed she would be able to accomplish taking her children to school, finish dinner, and still get to the appointment. Her definition of time was based on what could be accomplished and that it all could be done. It was not defined by her desire to participate in therapy. Once the trainee understood the client's meaning of time, they were able to build relationship and open space for therapeutic work to begin. The client stated that she felt the counselor was interested in her life because of the willingness to discuss the situation. The client and the therapist were able to work out a time that worked for both of them and they understood each other better.

Another issue that trainees face about time is that many of their clients will miss a session for a couple of weeks and then show up as if they had been attending regularly. Trainees are usually puzzled by this behavior and decide that the clients have no respect for the time of the trainee. As a minority supervisor, I understood that the explanation may be somewhat different than what the trainee believed. It could be as simple as the client not understanding that the trainee is only there on certain days and does not work at the site regularly. Clients are not always aware that trainees are not "working" for the agencies in which they are being seen. The client's view of the world of traineeship is different than that of the trainee and does not necessarily represent disrespect.

It is important that the trainee develop a more positive interpretation of the client's motives, otherwise there may be a decision to discontinue treatment, with serious consequences for the client. In order to prevent a premature termination, I encouraged the trainee to engage the client in an open discussion about the trainee's concerns, their schedule, and collaborate with the client to develop a solution. Although different from the dominant culture attitudes about time constraints for therapy, creative solutions may be in order. For example, bi-weekly sessions might be better managed by the client. Clients who are mandated to therapy often have other activities and programs they are required to attend. They sometimes have difficulty managing work, home, and multiple appointments. Because these clients have been ordered to keep all their scheduled appointments, they may feel that they do not have a choice about when they are required to attend. They may believe that therapy is another class that they have to take in order to meet their contingency plan. Explaining the therapeutic process and inviting a discussion about what type of schedule would work best for the client can help to build a relationship with the client that will assist in engaging them in effective therapy.

Building Therapeutic Relationships

One of the most common concerns comes up in the beginning phases of therapy, the relationship, rapport building, or joining phase. Beginning clinicians value clients opening up and letting them in on many personal issues, even when the client has not had a chance to get to know the therapist. The new trainee often becomes concerned when diverse clients do not "open up" and may interpret this behavior as "resistance." As an African American woman, I generally understand the hesitancy of a minority client to disclose information. There are many factors that contribute to taking a protective stance with any therapist. Many have experienced being treated unfairly by larger systems such as the police or child protective services. As a minority person who has seen people in similar circumstances, it is from that vantage point that I could support the trainee and encourage them to engage clients in discussions about their experiences with mental health and other systems, without labeling the client as "resistant."

From the worldview of a mandated client, being cautious with someone who has the power to influence a judge or a social worker, probation officer, or a court case is a good decision. Anyone experiencing similar circumstances would agree that taking a protective stance with therapists and other larger systems representatives is not only reasonable but imperative. A supervisor who understands the client's world would encourage the trainee to ask questions such as "who referred you?" "What is your understanding of why you are here?" "What is your understanding of what therapists do?" A client might also benefit from hearing about the trainee and their therapeutic philosophy, i.e., how they see their work and the people they serve.

One trainee met with an African American male who was approximately 23 years old. His probation officer referred the young man because he felt that the young man was secretive and would return to prison if he did not receive help. The young man presented as anxious, guarded, and only responded in monosyllabic sentences. The male trainee, a 32-year-old Caucasian, was very frustrated and thought the young man may have been a drug abuser. He had seen the young man for three sessions and did not see any "progress." When the trainee was encouraged to explore the origins of his perceptions about his client, he realized that he had no experience with that population and most of his perceptions were informed by stereotypes and biases.

Once the trainee became aware of his worldview and how it influenced his interactions with his client, the man was able to open up and be transparent. I encouraged the trainee to begin by letting his client know that the client was his focus and that other than reporting attendance, goals, and progress to the probation officer, the trainee had no further obligations and all other information would be confidential. I suggested he express interest and curiosity about how the client came to be at this place in his life. As the client began to see genuine interest rather than pressure to "tell the therapist everything," he began to share his story. This marked the beginning of their work together. When their time together was completed, the client expressed gratitude for the trainee's ability to listen without judging and deciding how the client should live his life.

The Impact of Larger Systems

Low income may be the number one indicator of how many community systems will be involved in a client's life. In the legal system, the foster care system and the remedial education system minorities are overrepresented (Alexander, 2012; Smith, 2013). Clients who have to navigate circumstances created by not having enough money to meet basic needs often find themselves under the scrutiny of larger systems. The societal narrative about "poverty" is that it is the fault of the individual if they have limited income (Smith, 2013). Trainees from the dominant culture are often unaware of the realities of living with few economic resources. Circumstances like getting to appointments on time, not taking children to the doctor when they are ill, or working three jobs to make basic ends meet may be unfamiliar to them. Some clients often have to choose between buying food and paying the utility bills or the rent, and many times will find themselves in dire situations. Clients can present with stress related to upcoming evictions, disconnection of utilities, or a serious shortage of food. There also may be need to visit a doctor.

Therapists in training often do not feel that helping clients cope with life situations is what they should be doing and will say they do not feel like they are doing "real" therapy. As a minority supervisor, I have had experience living in low socioeconomic situations and understand the impact of prejudices and biases that influence larger system interactions with low-income persons. I understand that addressing stress from living in deprived environments and helping clients locate resources is very therapeutic. Exploring feelings and patterns of behavior will be more likely to be effective when survival issues are discussed. A trainee from the dominant culture may want to examine beliefs they hold about low-income, minorities, and their own beliefs about poverty. If they do not, they may find themselves blaming the clients for situations beyond their control. That may lead to feelings of superiority in the trainee, and the dominant culture supervisor may unintentionally reinforce those feelings.

One trainee reported working with a family that was consistently late to appointments in spite of repeated discussions with the family about the importance of being on time. The family frequently was so late that the appointment had to be rescheduled. The trainee did not explore the reasons the family was having such difficulty beyond the lack of transportation, about which they were directed to work harder to find a way to the clinic, because his supervisor only instructed him to address the lateness to appointments. The clinic had a waiting list and the supervisor wanted to discharge any clients who were not consistent with their attendance.

Because of my long history of working with families undergoing multiple stressors, I recommended listening to the families' narrative about their current circumstances. If the trainee had listened for the family's narratives he would have discovered that the family was homeless because the father, Jorge (names changed), had lost his job and had not been able to pay rent for more than 6 months. Since he was undocumented, he did not feel that he could talk to anyone about the problems he was having at his job because he had to miss so much time to attend classes.

His wife did not work and was currently 4 months pregnant with their fifth child. Their four children, aged 2, 3, 4, and 6, were placed with his mother but, because of the domestic violence case, Jorge was not allowed to stay with them. His wife, Marissa, had no family in the Unites States and nowhere to stay, so she remained with him. With no income and no real resources, Jorge and Marissa did not always have the money to pay for the bus they had to take to the clinic. They were anxious and did everything they could to get to the appointments on time because they desperately wanted to have their family back together.

Some flexibility and understanding on the part of the trainee and the supervisor may have made the difference for the couple. The trainee may have been able to advocate for them with CPS and get resources such as bus tokens and maybe hotel vouchers for them, while Jorge continued to look for work. Helping the couple change their class schedules may have enabled more time to finish the classes without feeling overwhelmed. The trainee would then have had a unique opportunity to work with the couple on the domestic violence concerns and the subsequent depression, helplessness, and anger. But unfortunately none of those steps were taken, the couple stopped comings and the case was closed.

Boundaries

Trainees frequently expressed feeling intimidated if a culturally different client asked about their personal lives; they were not sure what to say. Many have been taught by their agencies not to answer personal questions under any circumstances. They will quickly change the subject or ask the client why they want to know. A simple question like, "are you married?" can create anxiety for a trainee. Rather than subscribe to Euro-normative ways of defining boundaries, as a minority supervisor, I recognized the ways that some non-dominant culture persons may attempt to engage the therapist. The trainee's response may be used to determine if they are trustworthy to receive very private information. The response may also be used to gauge the degree of friendliness or fear a trainee may have towards them.

I advised trainees to understand that asking for personal information is a way for many ethnic minorities to build a connection to the therapist. The trainee may try being transparent about feelings of discomfort about revealing personal information. An honest explanation would help the client understand the trainee's reticence and not misinterpret it as the trainee looking down on the client. Guidance by the trainee's supervisor is important, and the supervisor is encouraged to understand the motivations of ethnic or cultural groups to know something about the therapist.

New clinicians may need to understand that since boundaries for therapy are defined by European values, other ethnicities may not have the same definition. My experience has been that when clients ask questions, they are asking if the therapist is comfortable enough with the client to answer. It is often a way to gage whether a therapist is prejudiced or biased. Openness about trainee's thoughts, i.e., in school we were taught not to reveal personal information or say "I am not really comfort-

able talking about myself in a session that I should use to find out more about your needs," could be helpful in helping clients relax. They will be able to determine that the trainee does not have disdain for them and their decision not to answer personal questions is not because the trainee thinks that the client is inferior. Trainees may also be encouraged to share personal experiences and emotions as a way to build two-way relationship (Elias-Juarez & Knudson-Martin, 2016).

Parenting and Discipline

There are many styles of parenting and many minorities have their own unique ways of raising and disciplining children. The issues around parenting arise when one culture defines good parenting and appropriate discipline. Embedded in the definition is also the understanding of what constitutes bad parenting. Corporal punishment is not acceptable in the minds of most therapists, even though there are many ethnic groups that use it. The use of corporal punishment is often confused with child abuse. Child abuse implies deliberate intention to harm a child. Parents who use corporal punishment are using it to teach their children right from wrong. Spanking in and of itself is not child abuse. Leaving injuries on a child as a result of spanking is reportable. Rather than treating parents as child abusers, working with them to find alternative disciplines is appropriate for cultures that believe in corporal punishments.

As a minority supervisor, I would recommend talking with the parent if a remark is made about "whipping" their child to determine discipline habits. If such a conversation occurs, a trainee may discover that a mother was embarrassed by her child's behavior and did not want the trainee to think that she could not control her child. It is very possible that a client would never injure her child and often threatened but never followed through. A trainee may discuss the frustration of parenting a young child and work on ways to parent children that would address both the needs of the child and the concerns of the parents. It is an opportunity to build relationship and trust needed to bring about effective change.

Power Distribution in Supervision

The concept of privilege cannot be omitted when discussing the location of power in supervisory relationships. I initially believed that an education in the field would place me on equal footing with my peers. I did not experience myself as inferior or as having inadequate ability. However, when working with dominant culture supervisees, I often found that my concepts and recommendations were challenged. I would be asked if there were any articles or readings that would back up what I was telling them or they would check with their practicum instructors and tell me how the instructor disagreed with what I said.

Either way, I felt my trainees did not trust what I was teaching and I was not sure, at first, why. I began to understand what W.E.B. Du Bois meant when he asked "how does it feel to be the problem" (Du Bois, 1903). One incident in particular was very disheartening. In a foster family agency setting, I was supervising two dominant culture trainees to whom I had explained the differences and expectations of in-home work. I invited them to several meetings at the agency *before* they signed the agreement to start their practicum training. After several weeks of observing and working with others who were involved, they decided that they wanted to start. Initially, they reported that they were fine with the work. In supervision, I challenged several perceptions about foster parents and the trainees' role with them. Apparently, they were unhappy and spoke to their clinical training coordinator who was not a clinician. The coordinator called me and accused me of working outside my scope of practice. I explained to her what I was doing and why her accusations were not correct. She then said that I should have told the trainees what they would be doing and that I had mislead them and she was therefore pulling them out of their agreements. I was shocked that she had not considered that I was (1) competent and (2) that I would not mislead trainees. I did not feel that I had been given the benefit of a doubt and felt very strongly that it was the result of stereotypical worldview of African Americans that influenced the coordinator.

At first, it did not occur to me that culture and societal narratives about culture may have shaped these interactions. I was aware of power and privilege, but did not connect them to interactions with students. I felt that I had power and privilege in the relationships because of my experience in the field. Privilege in the reverse, where the trainee held the privilege in a supervisory relationship, had not been an experience that I was prepared for or initially recognized. As I had more and more experiences with dominant culture supervisees, I was forced to look at the supervisory relationship from a different perspective. I looked at the power distribution from the standpoint of differences in worldview. Many of my supervisees had never seen or been involved with an African American supervisor or professor. Their experiences with African Americans were influenced by unexplored biases, prejudices, and stereotypes. I believed that their responses to my supervision were largely from experiences that informed their worldview of African Americans. I invited supervisees to have open discussion about anything they felt comfortable discussing; I remained informative and compassionate with their anxieties and concerns about therapeutic work; and most of all I helped them discover their own potential to become excellent therapist, something that was always my goal for my supervisory journey.

Conclusion

The role of a supervisor is influenced by many factors. Minority supervisors have a worldview that influences their perspectives and informs the way in which they approach supervision. These experiences may differ from dominant culture supervisors and trainees, especially when working with minority populations with which they have shared experiences. Supervisees must challenge their own worldviews to

be able to accept different ways of seeing their minority clients' clinical dilemmas and to intervene effectively. Minority/ethnic supervisors may be instrumental in preparing students and interns to see the therapeutic world from a different worldview.

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