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School of Psychology

A Study Exploring the Supervisory Relationship in the Context of Culturally Responsive Supervision: A Supervisee's Perspective

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by

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Abstract

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Clinical supervision is a form of relationship-based education facilitating the development of clinical competence and ethical therapeutic practice. Evidence suggests that clinical supervision is not immune to the social inequalities inherent in contemporary society. However, there appears to be a scarcity of empirical literature exploring the impact of these variables in supervision and the development of cultural competence in supervision.

Paper 1 presents a systematic review and thematic synthesis exploring the impact of racism experienced within cross-racial clinical supervision. Findings from 14 included studies highlighted the harmful effects of racism on practitioners from racially minoritised backgrounds. Themes were related to emotional distress, ruptures within the supervisory

relationship, power imbalances, a lack of cultural competence development and coping strategies. Further implications for clinical and research practice are discussed.

Paper 2 presents a quantitative study that aimed to investigate supervisee perceptions of cultural responsivity in supervision and the quality of the supervisory relationship. The study explored how perceptions may vary when supervisors and supervisees are racially/ethnically similar or different. Trainee and qualified supervisees (N = 222) completed an online survey exploring their perceptions of cultural discussions, supervisory relationships, and acculturation. Supervisees from Racial/Ethnic Minoritised groups in dyads with White supervisors perceived their supervision as the least culturally responsive, with lower quality supervisory relationships. Greater perceived cultural responsivity in supervision was found to significantly predict better supervisory relationships. However, this was not moderated by acculturation to mainstream British culture. Findings and essential recommendations for future research and current practice are discussed.

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Research Thesis: Declaration of Authorship

Print name: Bianca Vekaria

Title of thesis: A Study Exploring the Supervisory Relationship in the Context of Culturally Responsive Supervision: A Supervisee's Perspective

I declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
5. I have acknowledged all main sources of help;
6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
7. None of this work has been published before submission

Signature: .....Date: 3.6.21.....

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Chapter 1 Literature Review Paper

Title: The Impact of Experiences of Racism within Cross-Racial Clinical Supervision: a Systematic Review

Journal Specification: The journal '*Clinical Psychology and Psychotherapy*' has been chosen as a guide in determining the preparation of the paper. Articles providing comprehensive reviews have no word limit.

Word count (including tables/figures): 9373

Abstract

Clinical supervision is a major component of the development and maintenance of competent and ethical therapeutic practice. There is some evidence to suggest that supervision may not occur in isolation from an individual's lived experiences. However, little research considers the impact of social inequalities, such as racism, experienced within clinical supervision and how this impacts practitioners.

The current review aimed to explore the status and quality of the existing empirical literature related to racism experienced within cross-racial supervision and provide suggestions for future research. MEDLINE, CINAHL, ProQuest, Web of Science and PsycINFO were searched between November 2020 and February 2021, and the review was conducted according to current guidelines. 14 empirical studies were selected for further analysis, nine of which were unpublished doctoral theses.

Thematic synthesis was used to analyse 11 qualitative studies, revealing five analytical themes. These included: 'emotional distress evoked', 'rupture in the SR and mistrust', 'power imbalances and silencing', 'lack of cultural competence and self-reflection' and 'coping and validation'. The findings of three included quantitative studies were narratively summarised. Implications for improving cross-racial supervisory practices are considered, and the need for safety in supervision is highlighted. Further research would benefit from exploring the impact of racism on UK practitioners, where social and professional contexts differ from the USA. In conclusion, the current review supports the notion that clinical supervision is not immune from racism. When this is experienced in supervision, it can negatively impact practitioners and the supervisory relationship.

1.1 Introduction

1.1.1 Modern-Day Racism

Racism can be defined as an ideology of racial power and privilege based on physical characteristics (e.g., skin colour). It is rooted in the historical oppression of racial groups through prejudice and discrimination. It is based on the socially constructed belief that these groups are inferior to the dominant racial group. The dominant group then maintains a position of power, and racism is used to preserve a socially constructed racial hierarchy (Harrell, 2000). Therefore conceptualising 'race' can be a contentious issue as there is no biological basis to the term, yet it operates within a social-political context (Smedley & Smedley, 2005). In Britain today, racism remains a complex and multifaceted issue, deeply embedded in the fabric of contemporary society given Britain's racist, colonial and imperialist past (Patel & Keval, 2018).

The language used to describe racial inequalities, and the individuals they impact has evolved and continues to change. For the purposes of this paper, the term 'Racially/Ethnically Minoritised' (REM) is used, as it explains that people do not naturally exist as a racial/ethnic minority; instead, they are actively 'minoritised' by social processes (Gunaratnum, 2003).

Over time, racism has evolved from overt forms to more covert forms (Dovidio et al., 2002). Overt racism, in many contexts, is viewed as socially unacceptable and condemned. Experiences of overt racism are often associated with offensive/derogatory language and violence, with negative consequences on wellbeing. Subtler, covert forms of racism appear to be more socially palatable, better disguised, and often go unnoticed (Barnes, 2011; Essed, 1991).

Racism is often reproduced within institutions of practices of power. Individuals within these institutions may not necessarily hold overtly racist views; however, they may

engage in activities that maintain the 'status quo', thus disadvantaging some individuals over others (Patel et al., 2000).

Covert racism, often referred to as racial microaggressions, remain offensive and racially charged (Pierce, 1970; Sue et al., 2007). These commonplace actions can be verbal or non-verbal and may not be intentional, but they continue to communicate hostility or negative messages to minoritised individuals (Desai, 2018). Racial microaggressions can include negative stereotypes, 'colour-blind' approaches (e.g., treating everyone equally whilst failing to acknowledge the inequalities experienced by REM individuals), tokenisation (a symbolic effort to create the impression of inclusivity and equality), use of racial slurs, invalidation of racial concerns, and discrimination (Rollock, 2012). The impact of covert racism depends mainly on how it is perceived and understood by the recipient. For instance, some encounters of covert racism may be subtle and therefore not automatically perceived as offensive, harmful or threatening by those who do not have a lived experience of racism or to REM individuals with relatively low levels of racial awareness (Barnes, 2011; Desai, 2018). In contrast, a REM individual with a higher degree of racial awareness might be highly offended (Constantine & Sue, 2007). The subtle ways in which covert racism manifests itself means that it is much harder to evidence and challenge, which can be disempowering (Adetimole et al., 2005).

1.1.2 Clinical Supervision

Clinical supervision is an essential requirement within clinical practice (Roth & Fonagy, 1996). In mental healthcare, clinical supervision can be specific to an area of expertise such as cognitive behavioural therapy (Padesky, 1996) or clinical nursing (e.g., Proctor, 1986). It ultimately aims to promote ethical and high-quality care for clients (Patel, 2011). It is recommended that clinical supervision comprises developmental, normative and restorative functions (Proctor, 1986). Supervisors, therefore, have an important role in using their expertise to assist supervisees in learning and skills development. They are accountable for ensuring and evaluating safe and competent clinical

practice, which serves a normative function. Additionally, they encourage fidelity to therapeutic models and the adaptation of models where appropriate (Milne, 2009). Finally, supervisors provide supervisees with emotional support and encouragement concerning their clinical work, which serves a restorative function (Proctor, 1986). Although definitions and processes may vary slightly, clinical supervision is typically mandatory for trainee/qualified therapists; however, supervision literature remains scarce and under-researched (Wheeler & Richards, 2007).

An array of supervision-specific models exist (e.g., Hawkins & Shohet, 2006; Padesky, 1996; Proctor, 1986; Wasket, 2009); however, there remains a lack of consensus on a shared definition of clinical supervision between disciplines (Buss et al., 2011). Many models derive from the psychotherapy and counselling fields and remain primarily theoretically driven instead of relying on evidence-based supervision outcomes (Lewis, 2012). There is a paucity of research investigating the supervisory experiences of mental health professionals in the UK, with limited empirical support (Division of Clinical Psychology (DCP), 2014).

Existing empirical research consistently demonstrates the importance of the supervisory relationship (SR) to supervisory outcomes and success (Ellis & Ladany, 1997; Holloway, 1995; Kilminster & Jolly, 2000; Ladany et al., 1999). The SR is central to mutual learning in supervision; it also creates a holding environment for the supervisee's professional development (Holloway, 2016). Rapport and experiences of support are critical factors in forming and maintaining the SR (Beinart, 2014) and collaboration between supervisor and supervisee (Ratcliff et al., 2000). In instances where there is a poor supervisory alliance, supervisees tend to disclose less with their supervisor (Ladany et al., 1996).

General attachment patterns may also influence the SR (Mikulincer & Shaver, 2007). Driver (2005) suggests that attachment dynamics, based on attachment theories (e.g., Bowlby, 1983), may frequently play out in the SR, similarly to other relationships where

vulnerability plays a role. Therefore, understanding and attending to these processes may lead to containment and security within the SR, which may enable further exploration, development of professional skills and satisfaction in supervision (Hiebler-Ragger et al., 2021).

The Systems Approach to Supervision (SAS) is a supervision-specific model; it holds the SR as the container of a dynamic process in which a personal way of using a structure of power and involvement is negotiated to facilitate learning (Holloway, 1995). It is based on Leary's (1957) Theory of Interpersonal Relations that posits that individuals bring their interpersonal histories and experiences into the SR. According to the SAS model, cultural values (e.g., gender, race, sexual orientation, religious beliefs) are embedded in the supervisor and supervisee's attitudes and behaviours. Therefore, they are critical aspects of supervision (Holloway, 2016).

However, although referencing race, the SAS model (Holloway, 1995) does not explicitly reference how it may operate within the broader socio-political context and how it may impact power dynamics within the SR (Smedley & Smedley, 2005). Power dynamics are inherent in the SR due to the hierarchical structure of supervision, where supervisors often hold evaluative power and clinical expertise over supervisees (Porter & Vasquez, 1997). Failure to acknowledge power dynamics in the SR may result in ineffective supervision; hence supervisors are encouraged to attend to power imbalances from the beginning of the supervisory process (Cook et al., 2018, Ellis et al., 2014). This may include defining the supervisory process, roles, boundary issues, and collaboratively reflecting on privilege and power (Szymanski, 2003). Addressing power in the SR may facilitate supervisee autonomy and empowerment; however, central to this is creating an environment of safety, where supervisees feel heard and valued (Porter & Vasquez, 1997). Different racial identities and social norms may influence the SR due to differences in privilege and power (Hernández and McDowell, 2010).

1.1.3 Cross-Racial Clinical Supervision

Cross-racial supervision describes a SR where the supervisee and supervisor belong to different racial backgrounds (Duan & Roehlke, 2001). Cross-racial SRs may provide opportunities to engage in meaningful discussions about issues of race, ethnicity and culture. However, these conversations may not always have positive outcomes if individuals in the SR have not reflected on their own racial identity and cultural influences (Constantine & Sue, 2007).

Cross-racial supervision research is dominated by studies aiming to understand and improve cultural competence (Schroeder et al., 2009). Most of the work has focused on helping practitioners develop cultural awareness, knowledge and skills, to better serve diverse populations (Burkhard et al., 2006; Estrada et al., 2004). When REM supervisees perceive their supervisor to be culturally competent, they report greater satisfaction with the SR, more trust and willingness to self-disclose, and greater cultural sensitivity to their client's needs (Schroeder et al., 2009). This highlights the need for collaborative supervisory processes, where responsibility, power and accountability are more equally shared (Orlans & Edwards, 2001).

Furthermore, for the development of cultural competence to be effective, underpinning racial dynamics and racism in supervision must be addressed and explored safely (Constantine, 1997). However, in a field where practitioners are predominately 'White' (Turpin & Coleman, 2010), the manifestation and perpetuation of racist behaviours in supervision, whether unintentional or intentional, remains challenging to address and under-researched (Pieterse, 2018).

1.1.3.1 Barriers to Confronting Racism in Supervision

Racism can be a complex construct to discuss and confront; it can be uncomfortable and challenging for both the supervisor and supervisee (irrespective of race). For example, REM individuals often have a lived experience of racism, encountered in overt and covert forms in everyday life, which can be painful and difficult to talk about (Constantine & Sue,

2007). In contrast, for those who experience the privilege of not dealing with everyday racism, engaging in discussions around race or racism may result in discomfort and avoidance. For example, they may not understand or believe the magnitude and complexity of the issues, leading to invalidating responses. Discussions may also be avoided out of fear of appearing ignorant or incompetent due to a lack of awareness and insight (Burkard et al., 2006; Patel, 2004).

Although individuals may not intend to act in a deliberately racist manner, our society and, therefore, spaces such as clinical supervision are not immune from racism (Masatoras & Andrews, 2011). Many supervisors receive minimal training on issues of diversity or issues that may manifest in cross-racial SRs (Priest, 1994). Therefore, practitioners are often unaware of the negative biases and stereotypes they may hold and how they may have formed. However, microaggressions are more likely to occur in a supervisory climate where cultural concerns are not openly discussed, or REM individuals feel unsafe raising concerns (Constantine & Sue, 2007). The failure to appropriately discuss and explore these variables may adversely affect the SR and supervisory outcomes (Constantine, 1997; Daniels, D'Andrea & Kim, 1999). Thus, unconscious racism can manifest in the supervisory process with detrimental effects on REM supervisees and the clients they serve (Sue et al., 2010). There is limited research looking at the experiences of REM practitioners, how such instances impact them and how they navigate these complex professional spaces (Desai, 2018).

Psychological professions place considerable emphasis on processes of self-reflection and the integration of the personal and professional self (British Psychological Society, 2010; Hughes, 2009). It is recognised that supervision plays a vital role in facilitating these processes (Patel et al., 2000; Ryde, 2011). However, difficulties may be exacerbated here for REM individuals, who are often tasked with navigating 'White' spaces led by Eurocentric values and norms. This can often result in additional discomfort, isolation and frustration (Paulraj, 2016; Shah, 2010). Some studies have demonstrated that

individuals from REM backgrounds are more likely to encounter racism-related distress in cross-racial supervision, mainly when there is a failure to provide a safe space to attend to the unique experiences of REM individuals (Sehgal et al., 2011). As a result, many REM practitioners often report feeling marginalised and silenced (Aditemole et al., 2005; Shah, 2010).

Therefore, it is fair to argue that in consideration of cross-racial SRs, power imbalances may be amplified due to differing histories, experiences, privileges, and oppression experienced by both (Patel, 2011). Hence, it becomes vital to consider the impact of race and racism on supervisory processes and outcomes (Ancis & Ladany, 2010).

1.1.4 Aims of the Current Review

To date, no systematic reviews have explored the impact of racism in cross-racial supervision incorporating both REM supervisee and REM supervisor perspectives. Therefore, very little is known about how racism may manifest in the SR, how practitioners are affected, and supervisory outcomes. The current review aims to synthesise and critically appraise the existing empirical evidence to better understand the under-researched perspectives of REM practitioners who experience racism within cross-racial clinical supervision.

1.1.5 Research Question

What is the impact of experiences of racism encountered within cross-racial clinical supervision?

1.2 Method

A systematic methodology was developed to review the current evidence base. The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA; Moher et al., 2009) was used to report findings. In addition, the review protocol was registered

with the International Prospective Register of Systematic Reviews (PROSPERO; CRD42020224749).

1.2.1 Search Strategy

A systematic method was used to search MEDLINE, CINAHL, ProQuest, Web of Science and PsycINFO between November 2020 and February 2021. The Boolean search method was used, combining words with phrases such as (i) supervis*, (ii) racis* OR racial and (iii) microaggression*. All papers published in English were included and reviewed using EndNote.

1.2.2 Eligibility Criteria

The relevance of each study was assessed according to the inclusion and exclusion criteria (See Appendix A). Studies were included if they were empirical, concerned with clinical supervision for therapeutic practitioners, and referenced racism explicitly experienced within cross-racial clinical supervision. Both published and grey literature were included. Studies that did not meet the criteria were excluded, including reviews, reflective articles, commentaries and studies non-specific to clinical supervision in a therapeutic context. Studies where racism was encountered within supervision, but not specifically cross-racial supervision, were also excluded. As recommended by Boland et al. (2017), a second reviewer screened 10% of randomly selected studies at the title and abstract stage and all studies at the full-text stage (against the inclusion and exclusion criteria). No discrepancies were found between reviewers.

1.2.3 Study Selection

The database searches yielded 1981 papers initially. Of these, 579 duplicates were removed, followed by a review of the titles and abstracts. During the initial screening process, 77 studies were included. This was followed by the refinement process based on the research question and eligibility criteria. Finally, the references of full-text articles assessed for eligibility were hand-searched to identify any other relevant papers for

inclusion. Fifteen papers were systematically included, as demonstrated within the PRISMA tool (Figure 1).

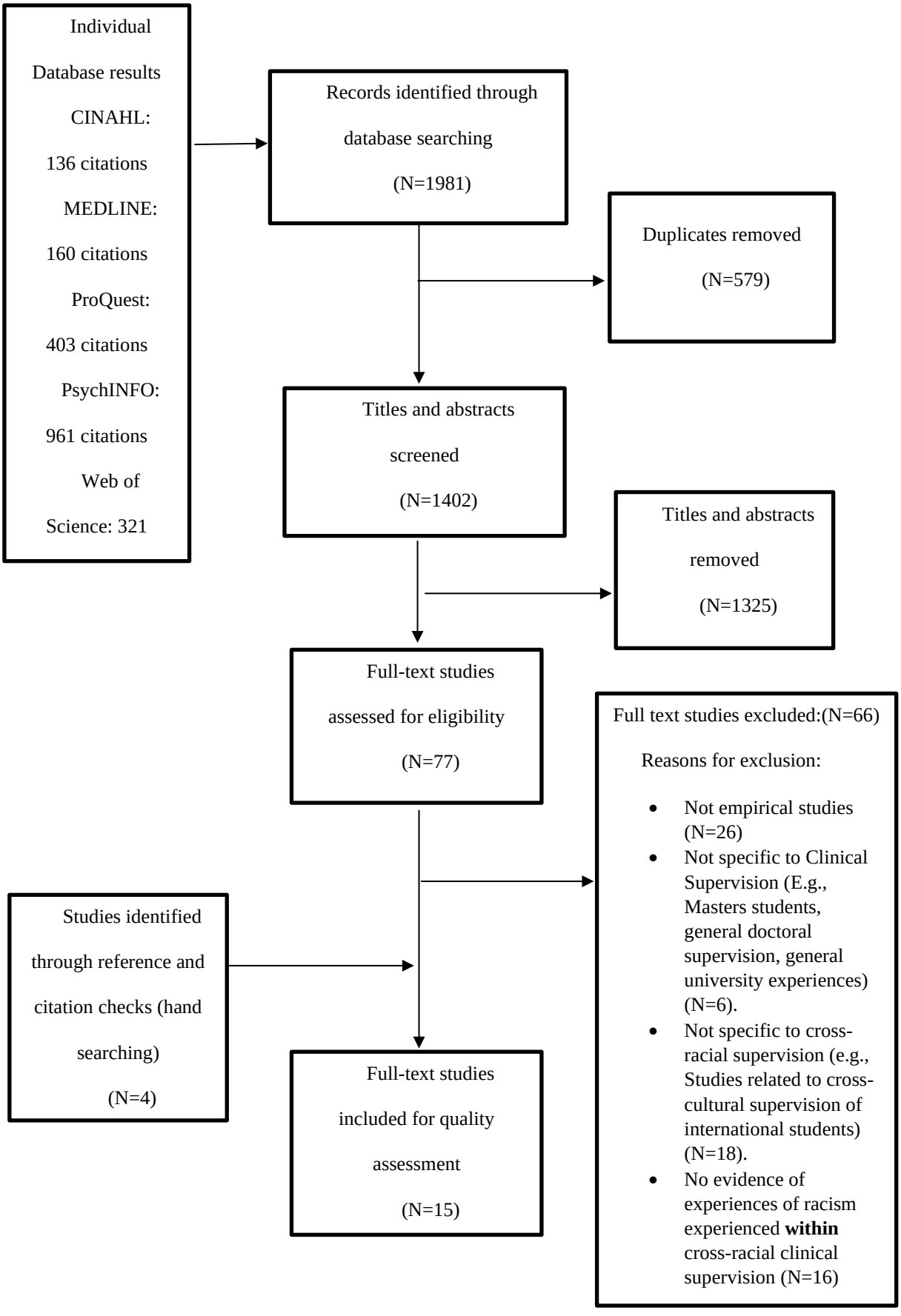

Figure 1.

PRISMA Flow diagram depicting details of the screening and selection process (Moher et al., 2009)

1.2.4 Quality Assessment

The methodological quality of the included papers was assessed using the QualSyst checklists (Kmet et al., 2004). This quality assessment tool was selected due to the range of quantitative and qualitative study designs reported in the included studies. It is a robust tool used in a similar systematic review exploring cultural factors in clinical supervision (Roche, 2017). Following the assessment guidelines, three quantitative studies were rated using 14 assessment criteria covering various areas. These included the quality of study design, selection bias, sample size, confounders, suitability of analyses conducted, reporting of significant and non-significant results, and the validity of conclusions made. Two points were allocated when the criteria were met fully, and one point for partially met criteria. If a criterion was not applicable, points for that item were omitted from the total 28 available points (reduced if specific questions do not apply to the study). The total number of points awarded was divided by the number of points available to calculate the quality rating. In addition, 12 qualitative studies were rated similarly, using 10 assessment criteria. These covered various areas, including quality of study design, context, connection to a theoretical framework, sampling, data collection, suitable analysis, verification to establish credibility, reflexivity and conclusions supported by findings. A quality score of $\geq .75$ indicated strong quality, a score between .55 and .75 demonstrated moderate quality, and a score $\leq .55$ indicated poor quality (Kmet et al., 2018).

Nine unpublished doctoral dissertations were additionally quality assessed using The AACODS checklist (Tyndall, 2010), which is specifically designed to appraise grey literature. Papers were scored according to six categories: authority, accuracy, coverage, objectivity, date and significance. One point was available for each fully met category, and papers were scored out of six.

A second reviewer independently rated all studies to verify the quality ratings. Although there was good agreement between reviewers, scores were compared and

discussed until a final agreement was reached due to the subjective nature of the assessment. After discussion, one paper was omitted from the review due to a low-quality rating (Lipscomb & Ashley, 2017). The details of all quality scores can be found in Tables 1 and 2.

Table 1.

Study Characteristics of Peer-Reviewed Studies

Author(s) (year), Country	Study Aims	Design and instruments	Sample size and participant characteristics (*N*)	Age & Mean	Race/Ethnicity of Supervisees	Race/Ethnicity of Supervisors	Key Findings	Quality Rating
Burkhard et al. (2006), USA	To explore cultural responsiveness and unresponsiveness in cross-cultural supervision	Qualitative design. Interviews	Clinical & counselling psychology doctoral students (*N*=26)	24-48yrs Mean: 30.15 SD=5.5	N=6: Black N=6: Asian N=1: Latina N=13: White	White and REM	Culturally unresponsive supervision negatively affected supervisees and the SR. REM supervisees experienced racism more frequently and with greater negative effects than White supervisees	0.90
Constantine & Sue (2007), USA	To explore Black trainees' perceptions of racial microaggressions, in cross-racial supervision with White supervisors	Qualitative design (IPA); semi-structured interviews	Counselling or Clinical Psychology Doctoral students (*N*=10)	25-38yrs	Black	White	7 microaggression themes were experienced by Black supervisees. The impact of these were found to be detrimental to Black trainees and the SR	0.95

Hall (2018), USA	To examine transference enactments in cross-racial supervision	Qualitative design; focus groups	Clinical social workers (*N*=57)	31-62yrs	White	Black	The cross-racial SR was impacted by social and racial identity factors, support, power struggle(s) and micro-aggressions/invalidations	0.80
Lipscomb & Ashley (2017), USA*	To explore the experiences of racialised therapists providing clinical services	Qualitative case study design; Interviews & own experiences	Clinical social workers (*N*=4)	-	N=2: Black N=1: Mexican N=1: Mixed	N=2: White N=1: Italian N=1: Latina	Reflections revealed that race, power and privilege impact the SR and recommendations were provided to cultivate the SR	**0.70***
Jang et al. (2019), USA	To explore the needs and challenges of REM supervisees in cross-cultural supervision	Qualitative design (CQR); semi-structured interviews	REM supervisees in counsellor education programmes. (*N*=10)	28-41yrs Mean age: 32.7 SD = 4.92	N=4: Black N=3: South Korean N=1: Colombian N=1: Ethiopian N=1: Turkish	White	All participants reported having trouble communicating with their White supervisors. Supervisors' cultural sensitivity facilitated participants' perceived level of satisfaction about the cross-racial supervision experience	0.95

Nilsson & Duan (2007), USA	To examine the relationships between role difficulties in supervision, counselling self-efficacy, and perceived prejudice in U.S. REM supervisees working with White supervisors	Correlational study design; COSE; MMRS; RCRAI	REM supervisees in accredited postgraduate psychology programmes (clinical, counselling, school and professional-scientific programs) (*N*=69)	22-47yrs Mean age: 29.26 SD=5.10	N=23: Hispanic, Latino or Latina N=16: Black N=13: Multiracial; N=11:Asian American or Pacific Islander N=4:Arab American N=2: American Indian or Alaska Native	White	Perceived prejudice was significantly correlated with role ambiguity (r = .24, p < .05, R^2 =.09) and role conflict (r = .27, p < .05, R^2 = .15) in supervision. Indicating that more experiences of prejudice were associated with more uncertainty regarding the supervisor's expectations and how to manage the sometimes-contradictory roles of being a student, supervisee, colleague, and counsellor simultaneously. All findings showed small to medium effect sizes.	0.88

Note. COSE = Counseling Self-Estimate Inventory (Larson et al., 1992); MMRS = Majority-Minority Relations Survey (Sodowsky, Lai, & Plake, 1991); RCRAI = Role Conflict and Role Ambiguity Inventory (Olk & Friedlander, 1992); REM = 'Racially/Ethnically Minoritised'; IPA = Interpretative Phenomenological Analysis; CQR = Consensual Qualitative Research

*One study (Lipscomb & Ashley, 2017) was removed from the review after quality assessment due to a low-quality score.

Table 2.

Study characteristics of Grey Literature

Authors (year), Country	Study Aims	Design and instruments	Sample size and participant characteristics (*N*)	Age Range & Mean	Race/Ethnicity of Supervisee	Race/Ethnicity of Supervisor	Key Findings	Quality Rating	AACODS Score
Barnes, (2011), USA	To investigate the relationship between racial microaggressions, racial identity, and supervisory working alliance in cross-racial SRs	Correlational study design WAI-S REMSS-SF (α=.93) CRIS	Counselling doctoral students and counsellor educators (*N*=34)	26-53yrs Mean: 35yrs	White	Black	No significant relationships found between supervisor racial identity attitudes and their perceptions of racial microaggressions. A negative relationship was found between perceptions of racial microaggressions and the supervisory working alliance, including tasks, bonds and goals with a large effect size (R^2 = .31).	0.9	6/6

Sukumaran, (2016), USA	To investigate the impact of experiences of racial microaggressions on the supervisory working alliance	Correlational study design SWAI RMA (α=.94) SMCI CCCI-R COSE	Supervisees in masters/doctoral programmes in counselling/family therapy/clinical psychology (*N*=175)	23-59yrs Mean: 29.38yrs *SD* = 5.15	N = 62: Asian N= 42: Hispanic N = 38 Black N = 21: Multiracial N= 12: International student.	White	Experiencing racial microaggressions in supervision negatively affects working alliance, and perceived supervisor multicultural competence. Supervisory working alliance (Adjusted R^2 = .21) and perceived supervisor cultural competence (Adjusted R^2 = .24) fully mediated the relationship between racial microaggressions experienced and supervisee's cultural counselling self-efficacy with medium-large effect sizes.	1	6/6
Crawford, (2020), USA	To explore experiences of Black supervisors working cross racially with White supervisees	Qualitative semi-structured interviews	Counsellor educators (*N*=12)	28-45yrs Mean: 35.7yrs	White	Black	Three major themes found concerning: i) The Salience of Racial Identity Amongst Black Supervisors ii) Methods and Precautions Taken to Maintain Safety in Supervision iii) Perceptions and Impact of Race and Racism.	1	4/6

Davis, (2017), USA	To explore the lived experiences of REM supervisees regarding racial bias within SRs.	Qualitative: IPA interviews and memoing	Doctorate- level supervisees in counsellor training programmes (*N*=10)	28-51 yrs Mean: 37.8yrs	N=1: Latina N=2: Japanese N=7: African American	N=9: White N=1: African American	The findings in this study revealed themes related to distress in the SR, disappointment, disengagement and the emotional reaction to experience	0.95	4/6
Dupiton, (2019), USA	To explore whether the Black female therapist can maintain congruence/ authenticity during cross-racial supervision.	Qualitative; semi-structured interviews	Therapists (*N*=15)	28- 45 yrs Mean 34.1yrs	Black	White	Six themes were reported in this study concerning: healing while wounded, experiencing racism, covering/masking, authenticity and strength of Black female therapists, lack of safety in the SR and willingness to do the work in cross-racial supervision	0.8	4/6
Hedin, (2018), USA	To examine the role of power and microaggressions, which manifest within cross-racial videoconferencing supervision	Qualitative: case study design; Interviews RMA	Trainee or qualified Mental health practitioners (*N*=3)	27-54yrs Mean: 38.6yrs	N=1: Hispanic N=1: Mixed N=1: Black	White	Results revealed individual and collective case themes that affected supervisees emotionally, physically, and behaviourally. In addition, themes indicated that experiencing racial microaggressions impacted the supervisor-supervisee and counsellor-client relationship.	1	5/6

Knight, (2017), USA	To investigate REM supervisor's experiences of microaggressions in cross-racial supervision and racially similar supervision	Qualitative:IPA Interviews	Counsellors (*N*=8)	34-65yrs Median age: 40yrs	Asked to reflect on microaggressions experienced in both cross-racial and racially similar dyads	N=6: Black N=2: Hispanic	This study reported four themes and five subthemes to describe participants' experiences: assumptions including negative reactions, relationships and coping (self-reflection, consultation and therapy, and other coping strategies).	1	4/6
Pichardo, (2017), USA	To explore Asian American supervisees' experiences of racial microaggressions in cross-racial supervision	Qualitative: IPA Interviews	Masters or doctoral level clinicians in a clinical psychology program (*N*=9)	26-53yrs Mean age: 35yrs	N=1: Asian Indian N=3: Korean N=3: Chinese N=1: Vietnamese N=1: Taiwanese	White	The seven domains explored in this study included: racial microaggressions experienced by Asian American supervisees, reactions/responses, and the negative impact on supervisees and the SR.	0.95	4/6

Powers, (2014), USA	To explore Black supervisees' perceptions of racial difference on the SR	Qualitative multiple case study design Interviews	Counsellors (*N*=8)	26-42yrs Mean age: 33.25yrs	Black	White	Themes found included: cultural idiosyncrasies, supervisees' ambivalence, cultural contact, microaggressions, power differential and healthy scepticism	1	6/6

Note. SR=Supervisory relationship; WAI-S= Working Alliance Inventory-Supervisor (Bahrick, 1989); REMSS-SF= Racial Microaggressions in Supervision Scale-Supervisor's Form (adapted from Constantine & Sue, 2007); CRIS=Cross Racial Identity Scale (Vandiver et al., 2000); SWAI=Supervisory Working Alliance Inventory– Trainee Form (Efstation et al.,1990); RMA= Racial Microaggressions in Supervision Checklist (Constantine & Sue, 2007); SMCI=Supervisor Multicultural Competency Inventory (Inman, 2006); CCCI-R= Cross Cultural Counselling Inventory—Revised (LaFromboise, et al., 1991); COSE=Counseling Self-Estimate Inventory (Larson et al., 1992); IPA = Interpretative Phenomenological Analysis

1.2.5 Data Extraction

Key information from each study was extracted and is outlined in Tables 1 and 2. The tables include each study's design, aims, sample size, demographic information and key findings relating to the research question. In addition, data extracted for quantitative studies was narratively summarised.

1.2.6 Thematic Synthesis

A thematic synthesis based on the method described by Thomas and Harden (2008) was used to analyse data from 11 qualitative studies. This method was developed specifically for systematic reviews considering individuals' perspectives and experiences to address questions about the suitability of interventions (Barnett-Page & Thomas, 2009). It also offers good transparency and accessible outcomes (Laparidou et al., 2021). The first author read and re-read studies to fully immerse in the data as recommended by Thomas and Harden (2008). All text within 'Results'/'Findings' sections of studies were exported into NVivo Software (Version 12) for analysis. The first stage of Thomas and Harden's method included line-by-line coding of findings to generate initial codes. Stage two included comparing and grouping initial codes based on similarities and differences across papers to develop descriptive themes. The final stage involved developing higher-order analytic themes by looking at the studies in relation to the review question. It was an inductive process of reflection and interpretation within and across studies. Thematic synthesis was carried out by the first author and verified by a second reviewer, disparities in coding were resolved through reflective discussion, and the coding frame was adjusted in accordance.

1.2.7 Reflexive Statement

The first author adopted a critical realist epistemological position throughout the thematic synthesis process (Cook & Campbell, 1979). Critical realism distinguishes between the 'real world' and 'observable world', constructed and interpreted through subjective perceptions and social constructions (Sayer, 2000). Therefore, reflexivity

enables the recognition of personal assumptions and preconceptions that may influence the research process (Palaganas et al., 2017). It should be noted that all members of the research team self-identified as belonging to a REM group. Three research team members, similarly to participants, were mental health practitioners with personal experiences of cross-racial clinical supervision. Efforts were made to minimise individual bias through reflection and discussion of prior knowledge and personal experiences with harmful encounters in cross-racial clinical supervision. It is recognised that subjective experiences may have contributed to the analysis and interpretations of data (Madill et al., 2000).

1.3 Results

1.3.1 Characteristics of Selected Studies

Across all 14 included studies, 278 participants took part in quantitative research, and 172 participants took part in qualitative research. All studies took place in the USA. The sample includes a variety of therapy practitioners in accredited training courses and qualified practitioners. Ten studies considered REM supervisee perspectives, whereas four considered REM supervisor perspectives (Barnes, 2011; Crawford, 2020; Hall, 2018; Knight, 2017). The papers were published across a fourteen-year period, between 2006 and 2020. The demographic and descriptive data are outlined for published studies in Table 1 and grey literature in Table 2.

1.3.2 Quantitative Studies

Three quantitative studies were included in this review. Two studies focused on the perspectives of REM supervisees (Nilsson & Duan, 2007; Sukumaran, 2016) and one study focused on the views of REM supervisors (Barnes, 2011). All studies used a correlational study design. Two quantitative studies were unpublished doctoral theses (Sukumaran, 2016; Barnes, 2011), and one study was published (Nilsson & Duan, 2007).

1.3.2.1 REM Supervisee Perspective

The two studies, ten years apart, both found that experiences of racism when present within cross-racial supervision negatively impacted the SR. Both studies were of high

quality and measured perceptions of racism and aspects of the SR using validated measures developed from previous research (Nilsson & Duan, 2007; Sukumaran, 2016).

Sukumaran (2017) found that the quality of the SR and perceived supervisor cultural competence influenced the relationship between racism experienced and REM supervisee cultural counselling self-efficacy, with medium-large effect sizes. Similarly, Nilsson and Duan (2007) reported that experiences of racism negatively affected REM supervisees' confidence by increasing levels of uncertainty in cross-racial supervision regarding their White supervisor's expectations and how to relate to them. Additionally, REM supervisees found it difficult to simultaneously manage multiple sometimes contradictory roles (e.g., supervisee, colleague, trainee) and inherent conflicts in the SR. These findings suggest that experiencing racism in supervision negatively influences supervisee's confidence and communication, which is further impacted if supervisors were perceived as less culturally competent.

In contrast, it was found that when racism is experienced in supervision, a good SR may be crucial in enabling repairs and cultural discussions to occur, which may positively influence the supervisee's cultural competence self-efficacy (Sukumaran, 2016). Therefore, both studies demonstrate the supervisor's critical role in creating an environment of safety in cross-racial supervision and promoting cultural discussions (Nilsson & Duan, 2007; Sukumaran, 2016).

1.3.2.2 REM Supervisor Perspective

From the REM supervisor perspective, one high quality unpublished study (Barnes, 2011) found compelling evidence suggesting that REM supervisors' perceptions of racism in cross-racial supervision negatively impacted their perceptions of the SR, including supervisory tasks, bonds, and goals. Experiences of racism and the working alliance were measured using validated measures used in previous research (Barnes, 2011). This study shows, that similar to REM supervisees (Nilsson & Duan, 2007; Sukumaran, 2016), REM

supervisors in cross-racial dyads may also experience racism. This may have detrimental effects on supervisory outcomes and indirectly impact clients (Burkhard et al., 2006).

1.3.3 Qualitative Studies

The qualitative studies used semi-structured interviews and focus groups to elicit descriptive data concerning the impact of racism within clinical supervision. Most studies considered perspectives from REM supervisees in cross-racial supervision, whilst three related to REM supervisor perspectives in cross-racial supervision (Crawford, 2020; Hall, 2018; Knight, 2017). Seven studies were unpublished doctoral theses (grey literature), whilst four were published studies (Burkhard et al., 2006; Constantine & Sue, 2007; Hall, 2018; Jang et al., 2019). Thematic synthesis was used to analyse findings and develop five overarching analytical themes: 'emotional distress evoked', 'rupture in the SR and mistrust', 'power imbalances and silencing', 'cultural competence and self-reflection' and 'coping and validation' (see Appendix B for themes and illustrative quotes).

1.3.3.1 Emotional Distress Evoked

1.3.3.1.1 REM Supervisee Perspective

From the REM supervisee perspective, feelings of anger, fear, anxiety, disappointment, pain, and shock were commonly evoked after experiencing racism in supervision (Burkhard et al., 2006; Constantine & Sue, 2007; Davis, 2017, Dupiton, 2019, Hedin, 2018, Jang et al., 2019; Pichardo, 2017, Powers, 2014). As a result, some avoided confronting supervisors as they feared negative supervisory consequences and evaluations (Burkhard et al., 2006; Constantine & Sue, 2007; Davis, 2017). Others feared experiencing further stereotypical racial judgement and disappointment if they did speak up (Davis, 2017; Hedin, 2018; Powers, 2014; Pichardo, 2017). For instance, being perceived as a 'characterisation of an angry Black woman' (Powers, 2014, p. 110).

Some REM supervisees described feeling confused about their supervisor's expectations after experiencing racism within supervision. As a result, they began to question themselves and doubt their experiences, which led to intense feelings of self-

blame, regret, and distress (Davis, 2017; Pichardo, 2017; Jang et al., 2020). Others felt they had 'overreacted' to racial microaggressions and reported feeling 'ashamed' and 'guilty' (Pichardo, 2017, p. 55). Some thought they had under-reacted and not spoken up enough, which led to feelings of guilt and regret (Davis, 2017, Dupiton, 2019).

REM supervisees across four studies described feeling exposed and humiliated, particularly when White supervisors tokenised them or positioned them as experts on all race-related matters. They felt their need to self-preserve and freedom not to provide a comment was ignored (Davis, 2017; Dupiton, 2019; Hedin, 2018; Pichardo, 2017).

1.3.3.1.2 REM Supervisor Perspective

REM supervisors similarly described experiences of racism within cross-racial supervision as frustrating, shocking, disappointing, painful, and wounding (Crawford, 2020; Hall, 2018; Knight, 2017). All three studies referred to experiences of vicarious racism through the supervisee's use of derogatory language when referring to clients, which caused further hurt and offence (Crawford, 2020; Hall, 2018; Knight, 2017). Some REM supervisors described questioning their experiences and feeling unsure about whether they were 'reacting to the wrong thing', which felt exhausting (Hall, 2018, p. 1028). Some supervisors described having to let things go, which resulted in regret and frustration (Crawford, 2020; Hall, 2018; Knight, 2017).

1.3.3.2 Rupture in the Supervisory Relationship and Mistrust

1.3.3.2.1 REM Supervisee Perspective

After experiencing racism in cross-racial supervision, REM supervisees felt 'guarded' (Burkhard et al., 2006, p. 20; Davis, 2017, p.84) and 'hesitated to invest more time and energy' into the relationship (Pichardo, 2017, p. 70). For many others, experiences of racism in supervision led to feeling unvalued and uncared for by their supervisors (Constantine & Sue, 2007; Davis, 2017; Hedin, 2018; Jang et al., 2019; Pichardo, 2017; Powers, 2014). Some REM supervisees began hiding emotions, withdrawing, and disclosing less in supervision as they felt 'unable to be themselves'

(Dupiton, 2019, p. 97). They described their engagement and the SR as becoming superficial as they felt anxious about raising cultural concerns, which led to overall dissatisfaction in supervision (Burkhard et al., 2006; Dupiton, 2019; Hedin, 2018; Pichardo, 2017; Powers, 2014).

REM supervisees across all eight studies described experiences of racism within cross-racial supervision leading to a rupture in the SR and an unsafe environment, which resulted in further dissatisfaction and mistrust (Burkhard et al., 2006; Constantine & Sue, 2007; Davis, 2017; Dupiton, 2019; Hedin, 2018; Jang et al., 2019; Pichardo, 2017; Powers, 2014). However, on a positive note, some REM supervisees reported that openly discussing their distress in supervision and addressing areas of concern made a significant difference in salvaging and repairing the SR after racism was experienced (Burkhard et al., 2006; Davis, 2017).

1.3.3.2.2 REM Supervisor Perspective

All three studies mentioned mistrust and emotional withdrawal from supervision, which negatively impacted the SR (Crawford, 2020; Hall, 2018; Knight, 2017). Some supervisors described emotionally compartmentalising experiences of racism and working harder to maintain professional boundaries to continue with cross-racial supervision and maintain the relationship. For some, the risk of complaint from the supervisee was perceived to be high if they were to confront them (Crawford, 2020; Hall, 2018; Knight, 2017). However, other REM supervisors described taking the responsibility to create a positive SR, encourage discussions and increase emotional safety in supervision (Crawford, 2020; Hall, 2018; Knight, 2017).

1.3.3.3 Power Imbalances and Silencing

1.3.3.3.1 REM Supervisee perspective

Power imbalances in cross-racial supervision were exacerbated after experiencing racism from supervisors. Supervisors in a position of authority had evaluative and knowledge power, which made it harder for supervisees to confront them (Burkhard et

al., 2006; Constantine & Sue, 2007; Davis, 2017, Dupiton, 2019, Hedin, 2018, Pichardo, 2017, Powers, 2014). When REM supervisees attempted to confront their supervisor regarding racism experienced, avoidance, dismissal, invalidation, and minimisation were shared experiences. Some supervisees were told they were 'thinking a little bit much into' things (Jang et al., 2019, p. 8).

REM supervisee's described feeling emotionally shut down and silenced by their supervisors, which contributed to avoiding further discussions (Burkhard et al., 2006; Constantine & Sue, 2007; Davis, 2017; Dupiton, 2019; Hedin, 2018; Jang et al., 2019). For others, confronting racism in supervision led to further disappointment, sadness, and hopelessness in affecting change (Power, 2014; Pichardo, 2017).

Some REM supervisees referred to issues of power that manifested in the evaluative feedback they received in supervision. For example, some REM supervisees felt their White supervisors had minimal expectations towards them due to their race or avoided providing constructive feedback due to fears of being perceived as racist, negatively impacting supervisee motivation and counselling self-efficacy (Constantine & Sue, 2007; Jang et al., 2019). Other REM supervisees described a layer of extra judgment and scrutiny by supervisors. For example, they felt their clinical work was harshly criticised due to their supervisor's underlying negative assumptions about their race (Dupiton, 2019; Hedin, 2018). Consequently, some supervisees reported exerting greater efforts, feeling extra pressure, and working harder than White supervisees to prove their competency in cross-racial relationships (Dupiton, 2019; Hedin, 2018).

1.3.3.3.2 REM Supervisor Perspective

Supervisors across all three studies appeared to be mindful of power differentials in cross-racial supervision and how they may manifest (Crawford, 2020; Knight, 2017; Hall, 2018). Some REM supervisors were aware that White supervisees might hold more power within the predominantly White institutions they worked in, particularly if they were to raise a complaint. This led to increased feelings of unsafety for REM supervisors

(Crawford, 2020). Other REM supervisors reported that their intersecting identities often left them vulnerable and unsafe in cross-racial supervision due to historical narratives and prejudice. Black male and female supervisors spoke about having to process and combat the stereotypes that existed for Black men and Black women and being mindful that supervisees may perceive them in this way (Crawford, 2020; Knight, 2017; Hall, 2018). In one study, a Black male supervisor referred to his hypervigilance when in a space with a White female supervisee due to his awareness of being perceived as a threat (Crawford, 2020).

REM supervisors across all three studies experienced White supervisees doubting or challenging their authority and expertise. REM supervisors received pushback or experienced supervisees seeking external validation from White supervisors (Crawford, 2020; Hall, 2018; Knight, 2017). For some REM supervisors, these pushbacks resembled experiences of microaggressions and microinsults, leading to them questioning whether they had the drive to continue to supervise in cross-racial settings (Crawford, 2020). Some supervisors felt obligated to work harder, prove their competence and expertise to White supervisees and ensure that their supervision approach was received positively (Crawford, 2020; Hall, 2018; Knight, 2017)

1.3.3.4 Cultural Competence and Self-Reflection

1.3.3.4.1 REM Supervisee Perspective

From the REM supervisee perspective, experiences of racism encountered within supervision led to supervisors being perceived as culturally incompetent. Especially when supervisors made insensitive and stereotypical comments about clients, resulting in cultural insensitive treatment recommendations (Burkhard et al., 2006; Constantine & Sue, 2007; Davis, 2017; Jang et al., 2019, Pichardo, 2017). Some REM supervisees noticed that their supervisors were often unaware of their own biases, prejudices, and offence they were causing in supervision and their clinical work (Burkhard et al., 2006; Constantine & Sue, 2007).

Some REM supervisees described their supervisors as attempting to broach racial issues in a 'superficial manner', where they often avoided going into depth (Powers, 2014, p. 79). Others felt that their supervisor's discomfort in addressing racial/cultural concerns was related to their supervisor's inability to admit their lack of knowledge and expertise (Constantine & Sue, 2007; Davis, 2017; Dupiton, 2019; Jang et al., 2019). Other REM supervisees were dissatisfied with cross-racial supervision. They felt they were 'robbed' of the opportunity to learn new skills and develop their cultural competence due to their supervisor's cultural incompetence (Pichardo, 2017, p. 71). This impacted the SR as REM supervisees reported withdrawing, disclosing less and in some instances ignoring supervisor recommendations (Constantine & Sue, 2007; Pichardo, 2017; Power, 2014).

1.3.3.4.2 REM Supervisor Perspective

In contrast, some REM supervisors learnt to embrace their discomfort and view experiences of racism encountered as learning opportunities for supervisees by directly addressing concerns as they arose. In this way, supervisees were helped to develop their cultural competence and establish safety in the SR (Crawford, 2020; Hall, 2018). Other REM supervisors noticed that White supervisees were often avoidant or apologetic when cultural discussions were introduced in cross-racial supervision (Knight, 2017). They noticed that White supervisees would often struggle to reflect on their privilege and how this might impact their clients. However, they would find it easier to reflect on and challenge other biases such as gender (Knight, 2017; Hall, 2018).

Some REM supervisors reflected on missing opportunities to address racism within cross-racial supervision (Knight, 2017; Crawford, 2020). Some reported feeling shocked and disappointed when supervisees made culturally insensitive comments, particularly when they had already broached cultural discussions in supervision (Knight, 2017). Others felt afraid to push White supervisees too hard as previous experiences led to supervisee's withdrawing from the process or lashing out with damaging consequences (Knight, 2017). One supervisor described avoiding discussions of race altogether as a way of protecting

himself. He feared that bringing the topic up could raise the risk of being perceived as threatening, making his supervisees feel uncomfortable (Crawford, 2020).

1.3.3.5 Coping and Validation

1.3.3.5.1 REM Supervisee Perspective

REM supervisees described the importance of seeking support from trusted individuals outside of cross-racial supervision to help them cope with the racism encountered within it (Burkhard et al., 2006; Constantine & Sue, 2007; Davis, 2017; Dupiton, 2019; Hedin, 2018; Jang et al., 2019; Pichardo, 2017; Powers, 2014). In addition, some REM supervisees emphasised their need for self-care, self-compassion, and self-preservation after experiencing racism in cross-racial spaces. This enabled them to feel more self-accepting and secure in themselves (Davis, 2017, Dupiton, 2019).

Supervisees sought comfort, emotional support, and reassurance by sharing their experiences with loved ones and REM colleagues who had similar experiences (Burkhard et al., 2006; Davis, 2017; Hedin, 2018; Pichardo, 2017). In addition, many supervisees sought out additional consultation for client treatment outside of supervision from trusted staff members in their programme or REM supervisors. However, this meant that supervisors were not always fully aware of clinical decisions made regarding clients they were clinically responsible for (Burkhard et al., 2006; Constantine & Sue, 2007, Davis, 2017).

Some REM supervisees developed strategies to safeguard themselves and avoid further judgment in cross-racial supervision. Others coped by working harder to combat stereotypes, often leading them to start questioning their professional identity and career choice (Dupiton, 2019; Powers, 2014).

The REM supervisees spoke about the validation experienced after sharing experiences of racism within cross-racial supervision in a safe and non-judgmental space. This was authenticating for many REM supervisees, as it was a crucial step in helping them externalise their experience, as opposed to internalising it (Burkhard et al., 2006; Davis,

2017; Hedin, 2018; Pichardo, 2017). Some supervisees sought personal counselling to process their experiences and navigate racism experienced within supervision (Davis, 2017, Pichardo, 2017). Some spoke about growing from experiences of racism by learning to skilfully advocate for themselves and their clients and challenge power dynamics. This contributed to a sense of identity and self-confidence (Davis, 2017; Dupiton, 2019; Hedin, 2018, Pichardo, 2017).

1.3.3.5.2 REM Supervisor Perspective

Seeking external support (e.g., peers, family, friends, mentors etc.) and developing various coping strategies to deal with racism experienced in supervision was crucial across studies (Crawford, 2020; Hall, 2018; Knight, 2017). Some discussed needing to 'realign' with their principles and sense of self, engaging in coping strategies such as self-reflection, therapy, and creative outlets (Hall, 2018; Knight, 2017, p. 81). Others described therapy and consultation as a way of managing their experiences and avoiding internalisation of negative feelings evoked by the racism encountered from supervisees (Hall, 2018; Knight, 2017).

REM supervisors in one study described challenging moments as 'teachable moments' and an opportunity to develop skills in confronting supervisee's biases and racism in supervision. Supervisors spoke about working collaboratively and intentionally with supervisees to create a sense of safety and alliance to navigate meaningful conversations about 'race' in supervision (Crawford, 2020, p. 91).

1.4 Discussion

This systematic literature review aimed to explore the impact of racism experienced within cross-racial clinical supervision. It incorporated the experiences of 446 participants across 11 qualitative and three quantitative studies. Five of these studies were published studies whilst nine were unpublished.

1.4.1 Summary of Main Findings

1.4.1.1 REM Supervisee Perspective

The review found relationships between experiences of racism in supervision and increased uncertainty and difficulties in the cross-racial SR (Nilsson & Duan, 2007; Sukumaran, 2016). Interestingly, the aforementioned findings were corroborated by eight qualitative studies: three of which were published studies (Burkhard et al., 2006; Constantine & Sue, 2007; Jang et al., 2019) and five of which were unpublished doctoral theses (Davis, 2017, Dupiton, 2019, Hedin, 2018, Pichardo, 2017, Powers, 2014). The findings from these studies add a valuable richness to compliment the quantitative research described within five key themes: 'emotional distress evoked', 'rupture in the SR and mistrust', 'power imbalances and silencing', 'cultural competence and self-reflection' and 'coping and validation'.

Sukumaran (2016) also suggested that if racism is addressed appropriately and responsively in supervision, the SR and supervisees' confidence in their cultural competence may be positively impacted. This notion was supported from a qualitative perspective by Burkhard et al. (2006) and Davis (2017) who noted that an openness from supervisors to address and discuss racism after it occurs helped salvage and repair the SR.

1.4.1.2 REM Supervisor Perspective

The one unpublished quantitative study considering the REM supervisor's perspective similarly demonstrated that experiencing racism in cross-racial supervision can negatively affect the SR (Barnes, 2011). In support, the qualitative research (Crawford, 2020; Hall, 2018; Knight, 2017) indicated that racism experienced in cross-racial supervision negatively impacted REM supervisors' well-being and confidence, with negative effects on the SR.

1.4.2 Critique of the Literature Reviewed

The findings of this review suggest that cross-racial supervision, like other social contexts, is not immune from racism and hierarchies of power and privilege. Racism can subtly enter the SR and clinical recommendations (Nilsson & Duan, 2007).

Experiences of racism can be difficult to evidence and challenge (Adetimole et al., 2005), a strength of this review is the inclusion of studies that highlight the covert and overt ways that racism manifests itself in cross-racial supervision. Clear examples and illustrative quotes from qualitative data provide an insight into the experiences, coping and resilience of REM practitioners in an under-researched area (Wong et al., 2014). The review is also the first to consider both REM supervisee and REM supervisor perspectives, highlighting poignant themes present for individuals in different positions of power in the SR. Studies include participants spanning a range of ages, therapy professions, and different qualification stages.

Whilst the studies offer an insight into cross-racial supervisory dynamics, the quantitative studies (Barnes, 2011; Nilsson & Duan, 2007; Sukumaran, 2016) utilised correlational designs, meaning that they cannot infer causation (Field, 2018). Additionally, although the qualitative studies (e.g., Hedin, 2018) provided rich information about the experiences of REM individuals, small sample sizes lead to questions around generalisability (Carminati, 2018). The majority of the qualitative research included researchers who identified as belonging to a REM group, with personal experiences of cross-racial supervision. Most reviewed studies provided reflexive accounts to account for how personal biases and personal experiences of racism may have influenced aspects of their research, which was a clear strength (Morse et al., 2002). However, it remains important to consider the findings within this potential bias (Madill et al., 2000).

There are also several factors that will impact upon the generalisability of the findings. It is fair to propose that sampling methods that utilised purposive or convenience sampling, particularly given the distressing and unjust nature of racism, may mean that the

participants comprise those who were motivated to respond and share their experiences. They may not be representative of the myriad of emotions, experiences and coping styles inherent when one experiences racism (Sue et al., 2007). A gender bias also exists as 86.8% of all participants were female. This makes it difficult to generalise findings to males from REM backgrounds, who tend to be underrepresented in psychology workforces (Clearing House for Postgraduate Courses in Clinical Psychology, 2019). Additionally, all studies were conducted in North America, where social histories and social contexts differ from other countries such as the UK (Desai, 2018). Consequently, results may not be generalisable to the differing training pathways, healthcare professionals, specialities or practitioner roles across the world. It has been found that UK based REM trainee psychologists experience racism within professional training (Paulraj, 2016; Shah, 2010; Adetimole et al., 2005), warranting further research in this area.

The fact that some of the research (Burkhard et al., 2006; Davis, 2017; Hedin, 2018; Jang et al., 2019; Knight, 2017; Nilsson & Duan, 2007; Pichardo, 2017; Sukumaran, 2016) grouped participants from different racial backgrounds into one REM group fails to acknowledge the nuances of different cultures. Furthermore, it has been shown that some cultural groups may experience racism in supervision more frequently than others (Constantine & Sue, 2007). This is an important consideration that needs to be explored further by the research.

1.4.3 Clinical Implications

The clinical implications highlighted by the current review include the importance of self-reflection on interpersonal behaviours, power differentials and emotional reactions to facilitate learning. Power differentials may be amplified in cross-racial SRs due to differing racial hierarchies (Wilson et al., 2016), making it challenging to initiate meaningful conversations about issues of race (Sue, 2010). Individuals in positions of normative power and privilege are often unable to see it for themselves without deliberate self-reflection (Patel, 2011). They may be minimally aware of their own cultural

influences, biases and potential role in denigrating REM groups which further impacts the cross-racial SR negatively (Wong et al., 2014). For instance, REM individuals may be evaluated against mainstream values without considering their cultural values and impact (Fong & Lease, 1997).

Therefore, power needs to be used constructively in supervision, where establishing plans for cultural discussions is a collaborative process (Porter & Vasquez, 1997). All supervisees and supervisors must take personal responsibility for self-examination, keeping issues of race on supervision agendas and continued learning to improve their practice. This process needs to be normalised (regardless of practitioner racial background) and prioritised as a key component of personal and professional development (Davidson & Patel, 2008).

An additional clinical implication is the responsibility of training programmes, professional bodies, and service leads to further consider protective and coping strategies for REM individuals. Most participants employed coping strategies to deal with the stress caused by experiencing racism in cross-racial supervision. Current research suggests that healthy coping strategies could moderate the effects of racial microaggression stress on psychological outcomes (Wong et al., 2014). This may involve mandatory anti-racism supervision training, embedding anti-racism practice within curriculums and safe spaces for REM practitioners where individuals could reflect on the experiences outside of formal supervision (Addai et al., 2019). Moreover, formal routes to voice concerns that arise in supervision could be beneficial. Including external mediation and support to help safeguard victims of racism and decide appropriate consequent actions.

1.4.4 Theoretical and Research Implications

The findings suggest that establishing safety within the SR may be an important variable in cross-racial supervision. It seems fair to propose that models of attachment (e.g., Bowlby, 1983) could be used to formulate and inform supervision experiences (Wilson et al., 2016). Supervisors can form a safe base, enabling supervisees to explore

and develop competence (Pistole & Watkins, 1995). Wilson and colleagues (2016) suggested that this safety may be facilitated by qualities such as consistency, empathy, and warmth. However, for individuals from REM backgrounds, as suggested from this review's findings, establishing safety may require the presence of additional qualities and actions. Such as attending to their racial identity and acknowledging differences in lived experiences of racism. Cultural humility, cultural responsivity, and openness to engage in challenging and uncomfortable conversations about race may be pivotal to establishing safety and developing the SR (Burkhard et al., 2006; Constantine & Sue, 2007).

This review provides support for the SAS model (Holloway, 1995), which holds the SR as the core dimension of supervision. The SAS model encourages supervisees and supervisors to recognise the importance of cultural factors and their interaction with contextual factors (Holloway, 2016). It draws on Leary's (1957) Theory of Interpersonal Relations that posits that individuals bring their interpersonal histories and experiences into the SR. In addition, the SAS model proposes that developing self-awareness should be a shared goal of supervision (Holloway, 2016), which again supports the review's findings that self-awareness of racial power, privilege and oppression should also be a shared goal of supervision.

Future research should consider examining the impact of racism experienced within cross-racial supervision in the UK, alongside current protective and coping strategies. It may be helpful for existing measures such as the RMA (Constantine & Sue, 2007) to be adapted and validated with a UK population or for new measures to be developed to aid data collection. Additionally, there is a distinct lack of research looking at the development of cultural competence within clinical supervision, cross-racial supervisory outcomes and how these practices may be improved (Desai, 2018).

Furthermore, the review highlighted the abundance of unpublished research in this area. Future research needs to prioritise peer-reviewed publication and broader dissemination of research related to issues of inequality and racism in supervision.

1.4.5 Critique of the Review Methodology

A strength of the current review is that it is the first systematic review and thematic synthesis to explore the impact of racism in cross-racial supervision to the author's knowledge. All studies were systematically identified and selected using a thorough search procedure, with findings highlighting the scarcity of research in this critical field. A pre-specified protocol (registered with PROSPERO) was followed, ensuring transparency and replicability.

An additional strength of the review methodology is its incorporation of quantitative and qualitative studies, which provides a well-rounded picture of the current evidence base (Pluye & Hong, 2014). The use of thematic synthesis also enabled rich qualitative data from different settings, using different data collection methods to be brought together to generate higher-order themes and demonstrate the commonality of experiences (Thomas & Harden, 2008).

Furthermore, the inclusion of grey literature is a strength of this review; studies were critiqued using a standardised quality assessment tool and an additional specific grey literature tool. There are conflicting views regarding whether unpublished grey literature should be included in systematic reviews (McAuley et al., 2000). Publication status and the process of peer review is often used as a gold standard for study quality. However, doctoral dissertations are subject to scrutiny by specialist examiners, and it is argued that they are credible sources (Golding et al., 2014). There is limited evidence to suggest that grey literature is of lower quality (Hopewell et al., 2007), and its inclusion also aims to reduce publication bias (Higgins & Green, 2011). The current review highlights the abundance of grey literature in this field with few published studies. Given the discomfort associated with racism and the strong emotions, it can evoke, a potential publication bias in this field may need further exploration. Interestingly unpublished studies in this review demonstrate similar findings to those outlined in peer-reviewed journals.

However, this review is not without its limitations. For example, the inclusion of exclusively English-language papers may have excluded necessary evidence. In addition, a small number of quantitative studies and heterogeneity in the designs and instruments impacted the quantitative summary of results by limiting the possibility to combine results and draw conclusions statistically.

The review and search strategy focused on experiences of racism within cross-racial supervision, which may have impacted findings. Racism can also be enacted between racially similar supervisory dyads and supervisory dyads where both practitioners are REM individuals, however there is limited research looking at these (Constantine & Sue, 2007). It would be helpful for some of these limitations to be considered further in future reviews.

1.4.6 Conclusion

The current review aimed to explore the impact of experiences of racism encountered within cross-racial clinical supervision. The findings suggested that their experiences emotionally and psychologically impacted REM supervisors and supervisees. The SR was negatively impacted, with power imbalances and cultural incompetence highlighted as problematic in cross-racial SRs. Strengths of the reviewed literature included an extension of our knowledge of how racism may manifest in supervisory spaces and an emphasis on the voices of both REM supervisees and REM supervisors. Limitations included issues of generalisability due to recruitment strategies, characteristics of the sample and all studies being conducted in North America. Clinical implications such as the importance of addressing power differentials and emphasising anti-racism training in supervision were suggested.

Additionally, theoretical implications were also considered concerning attachment theory. The review highlighted that safety might look different for REM practitioners, and other qualities such as attending to racial identities in supervision may be required to establish safety. The review supported the SAS model of supervision, which posits that cultural factors and contextual factors are key to SR, including experiences of racism and

an understanding of systemic racism. Strengths of the review methodology included the inclusion of grey literature, which formed the majority of included studies and qualitative and quantitative data. However, the review highlighted a gap in the existing literature, as no UK based studies were found in this field, suggesting that further exploration and publication is needed. Therefore, findings may need to be considered alongside outlined methodological limitations.

1.5 References

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Chapter 2 Empirical Paper

Title: A Study Exploring the Supervisory Relationship in the Context of Culturally Responsive Supervision: A Supervisee's Perspective

Journal Specification: The '*British Journal of Psychology*' has been chosen as a guide in determining the preparation of the paper. Research articles have a word limit of 8000 words (excluding the abstract, reference list, tables and figures)

Word count (including tables): 7722

Abstract

Supervisees' perceptions of culturally responsive supervision and supervisory relationships were explored between different supervisory dyads, comprising supervisees from Racial/Ethnic Minoritised (REM) and White backgrounds. Trainee and qualified clinical, counselling psychologists and CBT Therapists (N = 222) completed an online survey investigating supervisees' perceptions of their supervisory relationship, acculturation and race/ethnicity discussions in supervision.

Pairwise comparisons between White supervisees in dyads with White supervisors and REM supervisees in dyads with White supervisors revealed that REM supervisees perceived their supervision as less culturally responsive, with lower quality supervisory relationships. In pairwise comparisons between White supervisees in dyads with REM supervisors and REM supervisees in dyads with White supervisors, REM supervisees experienced the least culturally responsive supervision, with lower quality supervisory relationships. REM supervisees reported feeling less safety and more experiences of harmful culturally unresponsive supervision than White supervisees. Greater perceived cultural responsivity in supervision predicted better supervisory relationships; however, this was not moderated by acculturation to mainstream British culture. Limitations such as issues of generalisability, a need for additional measures and a lack of supervisor perspectives were considered. Findings suggest that culturally responsive discussions in supervision may develop cultural competence and strengthen the supervisory relationship, particularly in cross-cultural supervisory dyads.

2.1 Introduction

2.1.1 Clinical Supervision and the Supervisory Relationship

Clinical supervision is the formal provision of a relationship-based education between a supervisee and supervisor (Milne, 2009). It aims to help supervisees develop and integrate therapeutic and professional skills into clinical practice, to improve client outcomes (Fleming & Steen, 2012). Supervisors also play a critical evaluative role and ensure ethical therapeutic practice, alongside providing appropriate emotional support (British Psychological Society, 2013; Milne & James, 2000).

The existing clinical supervision literature repeatedly highlights the supervisory relationship (SR) as the most important factor for successful supervision, regardless of the supervision model adopted (Beinart, 2012; Inman & Ladany, 2008; Ladany et al., 1999; Milne, 2009). The quality of the SR is often used as the most significant predictor of supervisee satisfaction within supervision (Magnuson et al., 2000; Milne, 2009; Ramos-Sanchez et al., 2002). Once safety and trust are established, supervisors can support supervisees to 'explore' and develop therapeutic skills (Beinart, 2012; Cliffe et al., 2016; Watkins & Riggs, 2012). The underlying premise is that as supervisees feel more contained, competent and securely attached with the SR, they can more effectively offer this secure base to their clients (Kurtz, 2005; Milkulincer & Shaver, 2007). Studies indicate a strong relationship between supervisee attachment with the SR and supervision satisfaction (Gunn & Pistole, 2012; Marmarosh et al., 2013). There is also some evidence to suggest that the supervisee's interpersonal histories and experiences, such as race, ethnicity and cultural identity, can also influence the level of attachment within the SR (Beinart, 2004; Leary, 1957).

2.1.2 Defining Culture and Cultural Competence

Culture is a heterogeneous construct, often conceptualised by multiple contextual variables (Small et al., 2010). This paper focuses specifically on race and ethnicity when

referring to aspects of culture. Rapidly changing cultural demographics indicate that attention to cultural diversity is a necessity, as issues of difference and other social inequalities become increasingly more prevalent in the field of healthcare (Hird et al., 2001, Patel, 2011).

Culture influences individual worldviews, beliefs and values, shaping how problems are perceived and interpreted by clients, clinicians and services (Gainsbury, 2017). Hence, psychological services must offer culturally competent support consistent with the values and unique life experiences of Racially or Ethnically Minoritised (REM) individuals (Patel & Keval, 2018). The term 'minoritised' provides a social constructionist approach to understanding that social processes shaped by power are responsible for 'minoritisation' and that individuals do not naturally exist as racial or ethnic minorities (Gunaratnum, 2003; Predelli et al., 2012).

Cultural competence can be defined as a practitioner's acquisition of cultural awareness, knowledge, and skills needed to provide effective and responsive treatment for all cultural groups (Sue & Sue, 2008). Cultural competence begins with self-awareness, by understanding one's values, assumptions, and biases formed due to cultural influences. One can then begin to understand more about individuals from other cultural groups (Ancis, 2004).

2.1.3 Cultural Competence Development in Supervision

Clinical supervision is considered crucial in developing various skills, including cultural competency among mental health professionals (Falender & Shafranske, 2004). It can enable clinicians to understand culturally diverse clients better and establish effective therapeutic relationships, leading to better therapeutic outcomes (Gainsbury, 2017). Culturally responsive supervision assumes that the practitioner's cultural background/s and experiences permeate into their clinical practice and clinical supervision (Arthur & Collins, 2009). Culturally responsive supervisors promote cultural competence in supervision

through responsivity, reflective discussion and modelling their cultural competence (Ancis & Marshall, 2010; Burkhard et al., 2006; Sue & Sue, 2007).

However, existing developmental supervision models based on psychological theories may contain cultural biases or fail to mention the importance of cultural variables within the supervisory process (Banks, 2001; Patel, 2011). Hawkins and Shohet (2006) proposed 'The Seven-Eyed Model' of supervision, which integrates relational and systemic aspects of supervision into a model. While this is one of the few models to reference the importance of cultural variables on the SR, it does not explicitly focus on developing cultural responsivity and cultural competence in supervision.

The centrality of power relationships in the supervisory process needs a more detailed consideration in the literature (Patel, 2011). The supervisor's evaluative and individual power may be referred to; however, the addition of cultural power (power and privileges benefiting the dominant ethnic group over REM groups) may remain unmentioned (Ryde, 2000). Hence power relations may manifest in the SR in different ways, dependent on the cultural identity of any person in the supervisory triad. For instance, when a REM supervisee is supervised by a White supervisor who belongs to the 'dominant' culture, differing histories and experiences of privilege and oppression may amplify the power imbalance inherent within the SR. Other variables such as age, gender and class may also impact power relations, and intersecting identities should be considered (Patel, 2011). Therefore, supervisors must address power and privilege differentials in supervision and their impact on the SR (Cook et al., 2018).

According to Helm's (1990, 1995) Racial Identity Development theory, it is proposed that individuals must process and work through various stages, which begin with reflection and awareness of their race and stage of identity development (Jernigan et al., 2010). The theory's central premise is the evolution of an individual's racial/cultural identity on a continuum, ranging from no awareness of the impact of racial inequalities in society to a heightened awareness of its implications. In consideration of White groups,

racial identity development evolves from a lack of understanding of racism and White privilege known as the ‘contact' status. This then develops to confronting racism, oppression and forming alliances with REM individuals, known as the ‘autonomy’ stage. In contrast, the REM group’s racial identity development may begin with the idealisation of the dominant cultural group, known as the ‘conformity’ stage. Finally, evolving to a sense of belonging to one’s racial group and accepting others who are racially different, known as the ‘integrative awareness’ stage (Pillay, 2013).

Helms and Cook (1999) suggested that the supervisor’s racial identity played a primary role in shaping the SR. It was found that supervisees and supervisors at higher racial identity statuses (with similar worldviews) had the most robust agreements on goals, tasks and stronger emotional bonds. A higher racial identity status was also positively related to higher self-report cultural competence. Conversely, when supervisees had a more advanced racial identity status than their supervisors, the weakest SRs were reported, and cultural competence development was impacted (Ladany et al., 1997). Estrada and colleagues (2004) stated that supervisors must provide a safe environment and broach responsible discussions about culture and power. However, the empirical literature to date suggests many supervisors may lack awareness, cultural competence and access to appropriate training (D’Andrea & Daniels, 1997).

2.1.4 Challenges to Culturally Responsive Supervision

Mental health psychological therapists remain predominately from White backgrounds, and clinicians from REM backgrounds are under-represented (Kline, 2014; Turpin & Coleman, 2010). Consequently, REM supervisees are more likely to experience cross-cultural supervisory relationships with White supervisors and are potentially more at risk of experiencing culturally unresponsive supervision than White supervisees (Sukumaran, 2016).

To develop cultural competence, practitioners must reflect on and confront personal cultural norms, values, assumptions and biases in supervision (Patel, 2011). Higher

perceived levels of supervisor cultural competence have been shown to lead to more cultural discussion and self-disclosure by supervisees (Mori et al., 2009), better case conceptualisation and better treatment outcomes (Inman, 2006). However, it has been suggested that White supervisors may experience greater reluctance to bring up cultural issues due to their lack of awareness and cultural competence (Constantine, 1997; Ladany et al., 1997). This can lead to infrequent supervisory cultural discussions (Bond, 2010; Burkhard et al., 2006; Gatmon et al., 2001), potentially causing mistrust and deterioration in the SR (Constantine & Sue, 2007; Patel, 2011). In support, Burkhard et al. (2006) found that REM and White supervisees in culturally responsive supervision felt encouraged to further explore cultural issues, with positive effects on the SR and client outcomes.

Interestingly, REM supervisees reported more cultural unresponsiveness and adverse effects than White supervisees. Furthermore, Hird et al. (2004) found that White supervisors reported less cultural competence than REM supervisors. However, the latter group spent more time discussing cultural issues in supervision, regardless of their supervisee's race or ethnicity. Additionally, White supervisors reported discussing cultural issues more with REM supervisees than with White supervisees (Schroeder et al., 2009).

It appears that there may be discrepancies between supervisors' and supervisees' perceptions of cultural discussion in supervision. Duan and Roehlke (2001) found that supervisors reported making more efforts to address cultural issues than supervisees perceived. Whilst supervisees said that they had a greater sensitivity to cultural issues than their supervisors. These findings imply that there needs to be direct engagement in cultural competence development in supervision.

A further important factor is the supervisee's level of acculturation when considering the importance of cultural competence in supervision, as it may help explain some of the heterogeneity that exists within different cultural groups (Rivera, 2010). Acculturation occurs when individuals adapt and socialise to the mainstream cultural context of the country they live in, which is different to the heritage culture they have been socialised

within (Testa et al., 2019). For example, a supervisee from a REM background who was raised overseas and moved to the UK in their early adulthood may be less acculturated to the dominant British culture than REM supervisees born in the UK. This may mean that they experience poorer perceptions of the SR, greater difficulty in challenging supervisors and expressing opinions due to the lack of cultural competence in supervision (Nilsson & Anderson, 2004; Nilsson & Dodds, 2006; Nilsson & Duan 2007). To date, little is known about the impact of a supervisee's level of acculturation to mainstream British culture and how this might strengthen or weaken the SR.

2.1.5 Rationale

Despite the importance of this area, there is a distinct lack of UK research exploring supervisees' perspectives of culturally responsive supervision, acculturation and its impact on the SR (Patel, 2011). Many studies to date (e.g., Burkhard et al., 2006; Constantine & Sue, 2007) have originated in North America, making it difficult to generalise findings to the UK's differing demographics, social and cultural histories (Cherry et al., 2000). Furthermore, the limited cross-cultural supervision research has overwhelmingly focussed on supervisory dyads comprising a White supervisor and a REM supervisee from counselling backgrounds (Ladany et al., 1997). As a result, little is known about the impact of cultural similarity and dissimilarity in supervision, particularly across different supervisory dyads and professional contexts (Banks-Johnston, 2002).

The current study aims to explore supervisees' perspectives of culturally responsive supervision within the UK. It is the first to explore existing relationships between the supervisee's level of acculturation, perspectives of culturally responsive supervision and the perceived quality of the SR within cross-cultural and culturally similar supervisory dyads. Including supervisory dyads consisting of White supervisees (WSE) and White supervisors (WSR); REM supervisees (REMSE) and WSR; WSE and REM supervisors (REMSR); and REMSE and REMSR. This study will consider qualified clinicians and trainees from Clinical and Counselling Psychology and Cognitive Behavioural Therapy

(CBT) backgrounds. It is hoped that this research may provide a deeper insight into the current culturally responsive supervisory practices within the UK, informing future practice and training.

2.1.6 Research Questions and Hypotheses

1. Are there any existing differences between supervisory dyads (WSE-WSR; REMSE-WSR; WSE-REMSR; REMSE-REMSR) in relation to perceptions of culturally responsive supervision and the perceived quality of the SR within supervision?

2. Are there differences between REMSE and WSE perceptions of discussions of race and ethnicity in supervision?

3. It is predicted that higher levels of perceived supervisor cultural responsivity will be associated with higher levels of satisfaction with the supervisory relationship (irrespective of the supervisees' cultural background).

4. Is the relationship between perceived culturally responsive supervision and perceived quality of the SR moderated by how acculturated the supervisee is to mainstream British culture?

5. Further exploratory analysis will be conducted using a hierarchical multiple linear regression model to explore predictors of greater quality SRs for REMSE and WSE supervisees.

2.2 Method

2.2.1 Ethics Procedure

The current study was approved by the University of Southampton's Research Ethics Committee. It was also approved by the NHS Health Research Authority (HRA) and Health and Care Research Wales (HCRW) Ethics Committee (proportionate review). (Appendix C).

2.2.2 Design

The present study used a quantitative cross-sectional design incorporating a between-groups (WSE-REMSR, REMSE-REMSR, WSE-WSR, REMSE-WSR) comparison design and a correlation design.

2.2.3 Participants

Participants were recruited from across the UK, from NHS sites, professional training programmes, professional bodies and social media sites. The inclusion criteria were those who identified as either trainee or qualified: Clinical Psychologists, Counselling Psychologists, or CBT Therapists. Participants had to be over the age of 18 years, working in clinical practice and receiving clinical supervision from their current/most recent supervisor for longer than four months. Participants were excluded if they were not currently working in the UK and were not partaking in regular individual clinical supervision (minimum of once a month for qualified supervisors).

A total of 231 participants took part in the study; nine participants' data were removed as they did not select their job role (N = 6) or provide information about their ethnicity (N = 1), or only received group supervision (N = 2). Table 3 displays the included number of participants across professional roles, whilst Table 4 and 5 displays participant's demographic information.

Table 3.
Participant Characteristics across Professional Roles

	Professional Role						
	Trainee Clinical Psych.	Trainee Counselling Psych.	Trainee CBT T.	Clinical Psych.	Counselling Psych.	CBT T.	Total
N	110	21	12	64	5	10	222
Female *N*	99	20	11	54	4	9	197
Male *N*	11	0	1	10	1	1	24
Other *N*	0	1	0	0	0	0	1

Table 4.

Participant Ethnicity and Group Identity

Ethnic Group		REM	White
	n	*n*	*n*
White: British, White Irish, Any other White background	152	16	136
Asian or Asian British: Indian, Pakistani, Bangladeshi, Chinese, Any other Asian background	39	39	0
Black or Black British: African, Caribbean, Any other Black background	14	14	0
Mixed: Mixed Asian and White, Mixed Black African and White, Mixed Black Caribbean and White, Any other Mixed background	12	12	0
Arab	2	2	0
Other	3	3	0
Total *(n)*	222	86	136

Table 5.

Participant Demographic Characteristics by Supervisory Dyad

	WSE-WSR ***n*** **(%)**	**REMSE-WSR** ***n*** **(%)**	**WSE-REMSR** ***n*** **(%)**	**REMSE-REMSR** ***n*** **(%)**
Total *(n)*	126	75	11	10
Age				
21-24	1 (0.8%)	0	0	0
25-34	84 (66.7%)	47 (62.7%)	8(72.7%)	10(100%)
35-44	28 (22.2%)	22 (29.4%)	1(9.1%)	0
45-54	7 (5.6%)	5 (6.7%)	2(18.2%)	0
55-64	3 (2.4%)	1 (1.3%)	0	0
65 and over	3 (2.4%)	0	0	0
Gender				
Female	111 (88.1%)	66 (88%)	11(100%)	9(90%)
Male	14 (11.1%)	9 (12%)	0	1(10%)
Prefer not to say	1 (0.8%)	0	0	0
Qualification status				
Trainee	88 (69.8%)	41 (54.7%)	6 (54.5%)	8 (80%)
Qualified	38 (30.2%)	34 (45.3%)	5 (45.5%)	2 (20%)
Job Role				
Trainee Clinical P.	69 (54.8%)	32 (42.7%)	5 (45.5%)	4 (40%)
Trainee Counselling P.	11 (8.7%)	5 (6.7%)	1 (9.1%)	4 (40%)
Trainee CBT Therapist	8 (6.3%)	4 (5.3%)	0	0
Clinical P.	29 (23%)	30 (40%)	5 (45.5%)	0
Counselling P.	2 (1.6%)	3 (4%)	0	0
CBT Therapist	7 (5.6%)	1 (1.3%)	0	2 (20%)
Professional sector				
Local Authority	4 (3.2%)	0	0	0
NHS	108 (85.7%)	66 (88%)	10 (90.9%)	8 (80%)
Non-NHS Health	4 (3.2%)	3 (4%)	1 (9.1%)	0
Private	4 (3.2%)	3 (4%)	0	1 (10%)
Academia	4 (3.2%)	1 (1.3%)	0	1 (10%)
Social Care	1 (0.8%)	0	0	0
Other	1 (0.8%)	2 (2.7%)	0	0
Ethnicity				
White	126 (100%)	15 (20%)	11 (100%)	0
Asian or Asian British	-	34 (45.3%)	-	5 (50%)
Black or Black British	-	10 (13.3%)	-	4 (40%)
Mixed	-	12 (16%)	-	0
Arab	-	2 (2.7%)	-	0
Other	-	2 (2.7%)	-	1 (10%)

2.2.4 Measures

2.2.4.1 Demographic Data

Demographic data for participants' age, gender, ethnicity and information about their current supervisor's ethnicity was collected and based on self-report. If their supervisor's racial/ethnic identity was unknown, supervisees were asked to take the best guess (See Appendix D for Demographic questionnaire).

2.2.4.2 Culturally Responsive Supervision

The Race-Ethnicity Supervision Scale (RESS) (Burkard & Hartmann, 2012) is a 29 item self-report measure that examines supervisee perspectives of culturally responsive and unresponsive supervisory practices. It is based on supervisee ratings within four domains of culturally responsive supervision, on a seven-point Likert scale (1= Never; 4 = Neutral; 7 = Always). Domains include: 1) *promoting supervisee race-ethnicity cultural competence*, 2) *development and responsivity to cultural identity within supervision*, 3) *perceived supervisor cultural competence*, and 4) *harmful supervisory practices*. The RESS demonstrates good internal consistency and reliability; the total scale Cronbach's alpha coefficient was 0.97 (Bartell, 2016). In the current study, the scale was also found to have a strong internal consistency of $\alpha = 0.97$ (See Appendix E).

2.2.4.3 SR Quality

The Short Supervisory Relationship Scale (S-SRQ) (Cliffe, Beinart & Cooper, 2016) is an 18 item self-report scale that assesses supervisee's perspectives of their supervisor based on three sub-scales: *safe base, reflective education* and *structure*. Participants rate their agreement with statements on a seven-point Likert scale from '*Strongly Disagree*' to '*Strongly Agree'*. The scale has previously shown a strong internal consistency of $\alpha = 0.96$ and has been validated for use with UK trainee clinical psychologists. In the current study, the scale was found to have a strong internal consistency of $\alpha = 0.93$ (See Appendix F).

2.2.4.4 Supervisee's Level of Acculturation

The Vancouver Index of Acculturation (VIA) (Ryder, Alden & Paulhus, 2000) is a 20 item self-report scale. It measures orientations towards heritage and mainstream cultural groups. Item statements are general rather than formulated for specific target groups. The VIA includes 10 items assessing heritage acculturation and 10 items assessing mainstream acculturation. For example, item 1 reads, "I often participate in my heritage cultural traditions", and item 2 reads, "I often participate in mainstream British cultural traditions". Additional acculturation domains assessed include beliefs in values, preferences for entertainment, and maintenance of cultural practices. Items are rated on a nine-point scale ranging from 1 (strongly disagree) to 9 (strongly agree), with higher scores indicating greater acculturation to the referenced culture. In the current study, the scale was found to have a good internal consistency of $\alpha = 0.89$ (See Appendix G).

2.2.4.5 Race/Ethnicity Discussions in Supervision

Visual Analogue Scales (VAS) are one of the most simple and effective ways of measuring subjective experience (McCormack, Horne, & Sheather, 1988); they are reliable and valid (Ahearn, 1997). The VAS assessed the supervisee's views on the helpfulness, comfort, and importance of discussing race and ethnicity in supervision. Participants were asked to provide ratings on simple seven-point Likert scales ranging from 1 (Not comfortable at all) to 7 (This is extremely comfortable); 1 (Not at all helpful) to 7 (This is extremely helpful); 1 (Not at all important) to 7 (This is extremely important). In the current study, the scale was found to have a low internal consistency of $\alpha = 0.64$ (See Appendix H).

2.2.5 Procedure

A live link to the survey and the study advertisement was shared within recruiting emails (See Appendix I), inviting participants to complete an online survey (Qualtrics XM survey software). Initially, participants were directed to the online participant information page and consent statement via the link (See Appendix J).

Participants then completed the demographic questionnaire, followed by the VIA. Next, participants were asked to take part in a short visualisation exercise asking them to think about their current supervisor and current experience of supervision. It was hoped that bringing their supervisor to mind would encourage greater accuracy within self-reported measures (McAvinue & Robertson, 2007). The participants then completed measures in the following order: S-SRQ, RESS, followed by VAS questions. The next stage invited participants to opt into Part B of the study to answer five free-text questions[1]. Those that did not wish to participate in Part B and those that completed Part B were then directed to the online debriefing statement, ending their participation. At the end of the survey, participants were given the opportunity to be entered into a prize draw for a chance to win one of four £50 Amazon vouchers.

2.3 Results

The results will be discussed in the order of the research questions posed in the following sub-headed sections.

2.3.1 Are there any existing differences between supervisory dyads in relation to perceptions of culturally responsive supervision and the perceived quality of the SR within supervision?

Exploration of the data revealed the presence of significant outliers and non-normal distribution. Data was also unbalanced in each of the four supervisory dyads, with a smaller sample for 'WSE-REMSR' and 'REMSE-REMSR' supervisory dyads, as expected given the disproportionate underrepresentation of REM supervisors within the profession (Turpin & Coleman, 2010). For these reasons, a non-parametric, Kruskall-Wallis test was selected for analysis (Field, 2018).

[1] Qualitative Data was also collected in this study for participants that opted to answer five free text questions in Part B. These questions were concerned with participant's thoughts related to improving current culturally responsive supervisory practices. This data will be analysed and reported in a future paper.

2.3.1.1 Differences in the perceived quality of the SR within supervision (S-SRQ)

A Kruskall-Wallis test showed a significant difference in S-SRQ scores between the four supervisory dyads, $H(3) = 22.82$, $p = <0.001$. Pairwise comparisons of supervisory dyads suggested significant differences in S-SRQ scores (after Bonferroni adjustment) between REMSE-WSR and WSE-WSR supervisory dyads ($p = <0.001$) and WSE-REMSR and REMSE-WSR supervisory dyads ($p = <0.05$). The effect size was calculated as $d=Z\sqrt{N}$ (Pallant, 2007). None of the other comparisons were significant after Bonferroni adjustment (all *p*s > 0.12). Ranked S-SRQ scores can be found in Table 6.

Post-hoc Mann-Whitney tests were used to further explore differences in S-SRQ subscale scores between supervisory dyads. It found that supervisees in the WSE-WSR dyad scored significantly higher than supervisees in the REMSE-WSR dyad in the 'Safe Base' subscale, $U(N_{\text{WSE-WSR}} = 126, N_{\text{REMSE-WSR}} = 75) = 3005$, $z = -4.34$, P < .00, d=0.31; 'Reflective Education' subscale, $U(N_{\text{WSE-WSR}} = 126, N_{\text{REMSE-WSR}} = 75) = 3181$, $z = -3.88$, P < .001, d=0.27 and 'Structure' subscale of the S-SRQ, $U(N_{\text{WSE-WSR}} = 126, N_{\text{REMSE-WSR}} = 75) = 3913$, $z = -2.04$, P < .05; d=0.14.

The tests also revealed that supervisees in WSE-REMSR supervisory dyads, had significantly higher scores than REMSE-WSR supervisees, in the 'Safe Base' subscale, $U(N_{\text{WSE-REMSR}} = 11, N_{\text{REMSE-WSR}} = 75) = 252$, $z = -2.08$, P < .05, d=0.22 and 'Structure' subscale, $U(N_{\text{WSE-REMSR}} = 11, N_{\text{REMSE-WSR}} = 75) = 187.5$, $z = -2.92$, P < .01, d=0.31. However, there was not a significant difference between dyads in the 'Reflective Education' subscale, $U(N_{\text{WSE-REMSR}} = 11, N_{\text{REMSE-WSR}} = 75) = 262$, $z = -1.95$, P = .051).

2.3.1.2 Differences in the perceptions of culturally responsive supervision (RESS)

A Kruskall-Wallis test showed a significant difference in RESS scores between the four supervisory dyads, $H(3) = 24.76$, $p = <0.001$. Pairwise comparisons of supervisory dyads suggested significant differences in RESS scores (after Bonferroni adjustment)

between REMSE-WSR and WSE-WSR supervisory dyads (p = <0.001) and WSE-REMSR and REMSE-WSR supervisory dyads (p = <0.01). The effect size was calculated as $d=Z\sqrt{N}$ (Pallant, 2007). None of the other comparisons were significant after Bonferroni adjustment (all ps > 0.06). Ranked RESS scores can be found in Table 6.

Post-hoc Mann-Whitney tests were used to further explore differences in subscale scores between significantly different supervisory dyads. Supervisees in the WSE-WSR dyad scored significantly higher than supervisees in the REMSE-WSR dyad in the 'Promotion of Supervisee Cultural Competence' subscale, $U(N_{\text{WSE-WSR}} = 126, N_{\text{REMSE-WSR}} = 75) = 2786$, z = -4.86, P < .001, d=0.34; 'Perceived Supervisor Competence' subscale, $U(N_{\text{WSE-WSR}} = 126, N_{\text{REMSE-WSR}} = 75) = 3201$, z = -3.83, P < .001, d=0.27 and 'Harmful Supervision' subscale, $U(N_{\text{WSE-WSR}} = 126, N_{\text{REMSE-WSR}} = 75) = 3658.5$, z = -3.35, P= 0.01, d=0.24. However, there was no significant difference between dyads on the 'Development of Cultural Identity' subscale, $U(N_{\text{WSE-WSR}} = 126, N_{\text{REMSE-WSR}} = 75) = 4187$, z = -1.35, P = 0.176).

Supervisees in the WSE-REMSR dyad scored significantly higher than supervisees in the REMSE-WSR dyad in the 'Promotion of Supervisee Cultural Competence' subscale, $U(N_{\text{WSE-REMSR}} = 11, N_{\text{REMSE-WSR}} = 75) = 144.5$, z = -3.47, P =.001, d=0.37 and 'Perceived Supervisor Competence' subscale, $U(N_{\text{WSE-REMSR}} = 11, N_{\text{REMSE-WSR}} = 75) = 154$, z = -3.35, P =.001, d=0.36. However, there was no significant difference between dyads on the 'Development of Cultural Identity' subscale, $U(N_{\text{WSE-REMSR}} = 11, N_{\text{REMSE-WSR}} = 75) = 266$, z = -1.91, P = 0.56) and 'Harmful Supervision' subscale, $U(N_{\text{WSE-REMSR}} = 11, N_{\text{REMSE-WSR}} = 75) = 295$, z = -1.74, P= 0.082.

Table 6.

Mean Ranked S-SRQ and RESS Scores Across Supervisory Dyads

Supervisory Dyad	*N*	S-SRQ ranked score	RESS ranked score
WSE-REMSR	11	139.55	157.18
REMSE-REMSR	10	133.30	140.15
WSE-WSR	126	124.20	121.75
REMSE-WSR	75	83.14	83.75

2.3.2 Are there differences between REMSE and WSE perceptions of discussions of race and ethnicity in supervision?

Exploration of the data revealed the presence of significant outliers and non-normal distribution. For this reason, a non-parametric Mann-Whitney U test was selected for analysis to determine significant differences between REM and White supervisees on each of the VAS items (Field, 2018).

REMSE felt it was more important to talk about issues of race and ethnicity (concerning personal issues and cultural identity) than WSE. A significant difference was found between group ranked means on this VAS item; $U(N_W = 136, N_{REM} = 86) = 4924$, $z = -2.12$, $P < 0.05$, $d = .14$). REMSE were less comfortable with raising sensitive issues related to race and ethnicity in supervision than WSE. A significant difference was found between group ranked means on this VAS item; $U(N_W = 136, N_{REM} = 86) = 4669.5$, $z = -2.61$, $P < 0.05$, $d = .18$). There were no other significant differences between White and REM supervisees on the remaining VAS items (all ps > 0.139).

2.3.3 It is predicted that higher levels of perceived supervisor cultural responsivity will be associated with higher levels of satisfaction with the supervisory relationship (irrespective of the supervisees' cultural background).

Kendall's Tau correlation was used to calculate whether there was a correlation between RESS scores and SSRQ scores (Field, 2018). A significant correlation was found between perceptions of culturally responsive supervision and the quality of the SR; greater RESS scores were related to greater SR scores ($\tau b = .443$, $p < .001$).

2.3.4 Is the relationship between perceived culturally responsive supervision and perceived quality of the SR moderated by how acculturated the supervisee is to mainstream British culture?

A moderation analysis was used to explore if the relationship between perceptions of cultural responsivity in supervision (RESS scores) and greater SR quality (S-SRQ scores) was moderated by the supervisee's level of acculturation to mainstream British culture (VIA scores). The analysis indicated a significant regression equation, (F [3, 218] = 50.58, p <.001) with an R^2 of .41. However, the relationship between perceived cultural responsivity (X) and quality of in the supervisory relationship (Y) was not moderated by supervisee acculturation to mainstream British culture (W). This was carried out using PROCESS v.3.3 (Hayes, 2018). As seen in Table 6, a significant positive relationship was found for greater perceived cultural responsivity predicting greater quality of the supervisory relationship, irrespective of the supervisee's cultural background.

Table 7.

Results of Moderation Analysis Predicting Quality of the SR

	B	*SE*	*t*	*p*	*95%CI*
Perceived cultural responsivity	**.30**	**.02**	**12.25**	**<.000***	**[.25, .34]**
Supervisee level of acculturation to mainstream British culture	1.05	.79	1.33	.19	[-.51, 2.60]
Perceived cultural responsivity x Supervisee level of acculturation to mainstream British culture	-.02	.02	-.88	.38	[-.06, .02]

2.3.5 Further exploratory analysis will be conducted using a hierarchical multiple linear regression model to explore predictors of greater quality SRs for REMSE and WSE

Hierarchical multiple linear regressions were carried out among the REM supervisee and then the White supervisee samples separately to explore similarities and differences in the predictors of quality of the supervisory relationship (scores of VIA, length of time with supervisor, and RESS subscales). Two regressions were carried out for each supervisee group individually (REMSE and WSE). In the first block, age and gender were entered to control for demographics. The supervisee's level of acculturation to mainstream British culture (VIA score) and the length of time working with their current supervisor were entered in the second block to be controlled for. The final block consisted of all the controlled variables and the remaining RESS subscales ('Promotion of Supervisee cultural competence'; 'Development of supervisee cultural identity'; 'Perceived Supervisor cultural competence' and 'Harmful practice in supervision').

2.3.5.1 Predictors of quality of in the supervisory relationship for REM supervisees

Results are shown in Table 8 and indicate a significant regression equation for the final block, (F [6, 79] = 23.22, p <.001) with an R^2 of .64. Thus, three RESS subscale variables: development of supervisee cultural identity, perceived supervisor cultural competence and harmful practice (higher scores indicate less harmful practice experienced), were significantly positively associated with SR quality for REM supervisees.

Table 8.

Regression Results for Predictors of the Quality of the SR for REM Supervisees

Block 3	B	SEB	beta	t	Sig	r zero order	sr^2	95% CI
Level of acculturation to mainstream British culture	.63	1.27	.04	.49	.623	-.07	.001	[-1.91, 3.16]
Length of time with supervisor	1.62	1.25	.09	1.30	.197	.17	.008	[-.86, 4.11]
Promotion of supervisee cultural competence	-.10	.13	-.11	-.79	.430	.56	.29	[-.35, .15]
Development of supervisee cultural identity	**.52**	**.22**	**.27**	**2.35**	**.021**	**.60**	**.03**	**[.08, .96]**
Perceived supervisor cultural competence	**.90**	**.35**	**.37**	**2.55**	**.013**	**.67**	**.03**	**[.20, 1.60]**
Harmful practice	**2.21**	**.39**	**.43**	**5.68**	**.000**	**.64**	**.15**	**[1.43, 2.98]**

note. sr^2 small effect size = 0.02, medium effect size = 0.15, large effect size = 0.35

2.3.5.2 Predictors of quality of in the supervisory relationship for White supervisees

Results are shown in Table 9 and indicate a significant regression equation for the final block, (F [6, 128] = 9.287, p <.001) with an R^2 of .30. Thus, perceived supervisor cultural competence appeared to be significantly positively associated with the quality of the supervisory relationship for White supervisees, with a small effect size.

Table 9.

Regression Results for Predictors of the Quality of the SR for White Supervisees

Block 3	B	SEB	beta	t	Sig	r zero order	sr^2	95% CI
Level of acculturation to mainstream British culture	.36	.90	.03	.40	.692	-.02	.001	[-1.42, 2.14]
Length of time with supervisor	-.15	.79	-.01	-.19	.849	.06	.0002	[-1.72, 1.42]
Promotion of supervisee cultural competence	.15	.08	.24	1.84	.068	.51	.02	[-.01, .31]
Development of supervisee cultural identity	.03	.15	.02	.22	.824	.30	.0003	[-.26, .33]
Perceived supervisor cultural competence	**.57**	**.23**	**.31**	**2.45**	**.015**	**.52**	**.03**	**[.11, 1.02]**
Harmful practice	.73	.45	.13	1.61	.109	.12	.01	[-1.64, 1.62]

note. sr^2 small effect size = 0.02, medium effect size = 0.15, large effect size = 0.35

2.4 Discussion

2.4.1 Main Findings

The current study aimed to explore supervisees' perspectives of culturally responsive supervision within the context of the supervisory relationship and to explore existing differences between cross-cultural and culturally similar supervisory dyads. A further aim was to determine whether greater cultural responsivity in supervision predicted better SRs. The study also investigated whether the relationship between cultural responsivity in

supervision and SR quality was moderated by acculturation to mainstream British culture. Finally, predictors of SR quality for REMSE and WSE were further explored. The findings are discussed below in order of research questions and hypotheses.

2.4.1.1 Differences Between Supervisory Dyads

This study found that WSE-WSR dyads self-reported significantly higher quality SRs and cultural responsivity in supervision than REMSE-WSR dyads. Additionally, WSE-REMSR dyads self-reported significantly higher quality SRs and cultural responsivity in supervision than REMSE-WSR dyads. REMSE-WSR dyads self-reported significantly less safety and structure in supervision when compared with WSE-WSR and WSE-REMSR dyads.

Additionally, REMSE-WSR dyads perceived their supervisors as significantly less culturally competent and perceived them to be promoting supervisee cultural competence less than WSE-WSR and WSE-REMSR dyads did. REMSE-WSR dyads also reported experiencing significantly more harmful culturally unresponsive supervision than WSE-WSR dyads; however, no significant difference was found between REMSE-WSR and WSE-REMSR dyads. These findings are consistent with a previous study that found REMSE were more likely to experience culturally unresponsive supervision, less safety and difficulties within the SR than WSE (Burkhard et al., 2006).

Interestingly, no significant differences were found between dyads on their perceptions of cultural identity development. Due to the overall low self-reported scores across dyads, it appears that this infrequently occurred in supervision. This may, in part, be due to the Eurocentricity of traditional supervision models, which may fail to incorporate the importance of cultural identity as a variable impacting the SR (Daniels et al., 1999).

REMSE in the current study experienced their WSR as less culturally responsive, particularly if they did not engage in cultural discussions. This could be due to a lack of awareness, training, or fears of revealing incompetence (Constantine & Sue, 2007; Desai, 2018). However, if WSR appear less willing to engage in critical cultural discussions,

REMSE may potentially feel unsafe and disclose less, leading to less reflection, personal development and dissatisfaction (Patel, 2011).

2.4.1.2 Discussions of Race and Ethnicity in Supervision

The VAS items were used to explore the comfort, helpfulness and importance of race/ethnicity discussions in supervision. Small effect sizes were reported for significant VAS items, with a low internal consistency of $\alpha = 0.64$, suggesting that results should be cautiously interpreted. REMSE felt it was significantly more important to discuss race and ethnicity (concerning personal issues and cultural identity) than WSE. REMSE were also significantly less comfortable with raising personal cultural concerns in supervision than WSE. This may be due to lived experiences of minoritisation and increased cultural identity awareness than WSE (Burkhard et al., 2006; Constantine & Sue, 2007).

Traditionally, supervision skills are developed through the supervisee's own experiences and modelling from their supervisor (Wheeler, 2004). However, in this instance, if WSE learn that cultural discussions about their own cultural identity are less important in supervision, these practices could likely be perpetuated when they become supervisors, irrespective of the cultural identity of the supervisee.

2.4.1.3 Cultural Responsivity and SR Quality

This study found that higher RESS scores significantly predicted higher S-SRQ scores, irrespective of supervisee cultural background. This emphasises the importance of cultural responsivity in supervision and its potential role in positively impacting the SR. In support, Burkard et al. (2006) reported that greater cultural responsivity in supervision might be related to higher quality SRs.

2.4.1.4 Acculturation and the SR

The study found that supervisee acculturation to mainstream British culture was not a predictor of higher quality SRs, nor did it moderate the relationship between RESS and S-SRQ scores. This finding is different from a previous study in which Nilsson & Anderson (2004) reported a significant relationship between supervisee acculturation and satisfaction

in the SR. However, their sample consisted mainly of international supervisees, which differs from the sample in the current study, where most participants were British. REMSE may therefore feel the need to assimilate to mainstream British ways of relating and communicating to succeed within the profession (Tong et al., 2019). The phenomenon of acculturation is a complex process (Berry, 1997) and future studies need to consider a validated acculturation measure that accounts for this complexity with greater sensitivity and comparable population norms.

2.4.1.5 Predictors of Higher Quality SRs for REMSE and WSE

The regression analyses demonstrated that supervisors 'perceived cultural competence' was a predictor of SR quality for both WSE and REMSE. This suggests that the development of cultural competence in supervision, facilitated by a culturally competent supervisor, may lead to better quality SRs for supervisees, regardless of their cultural background. Additionally, for REMSE, 'development of cultural identity' in supervision and fewer experiences of 'harmful culturally unresponsive practices' were significant predictors of SR quality thus highlights the need for their cultural identity to be discussed. It is important to note that REMSE also seem more vulnerable to harmful culturally unresponsive supervision than WSEs.

Duan and Roehlke (2001) found that both WSE and REMSE in cross-racial supervisory dyads felt it was essential for their supervisors to express an interest in their cultural background. Conversely, the current study found that WSE may not perceive the development of cultural identity to be as crucial in the SR as REMSEs.

This could be partly explained by the perpetuation of 'Whiteness' within the profession, where 'culture' is sometimes regarded as a dimension reserved for REM groups only (Wood & Patel, 2017). WSE may naturally experience less dissonance and cultural issues than REM group in cross-racial SRs (Constantine & Sue, 2007). Therefore, they may require greater levels of introspection and awareness to understand the influence of their cultural identity on themselves and others (Prajapati et al., 2019). Within the

context of developing cultural competence, all practitioners must actively work towards developing their self-awareness, it can be harmful if this is not seen as a priority for all (Patel, 2011).

It is largely the supervisor's responsibility to ensure safety in supervision and promoting cultural discussions. In support, Gatmon et al. (2001) demonstrated that providing an atmosphere of safety and frequent opportunities for cultural discussions significantly increased supervisee satisfaction. However, it is important to note that 'safety' may hold different meanings for different individuals depending on personal experiences and social contexts (Addai et al., 2019). Thus, the notion of feeling safe in supervision may involve the ability of the supervisor to encourage and model openness, honesty and reflection. They may share their vulnerabilities and limitations in terms of personal knowledge and skills to build trust. To support this, both parties may need to reflect on and discuss their differing roles and identities, particularly concerning issues of power embedded in the SR, culture and racism (Patel, 2011).

2.4.2 Strengths and Limitations

This is the first UK study to explore supervisee perspectives of culturally responsive supervision to the author's knowledge. It incorporated the RESS, a validated quantitative measure with good psychometric properties, specifically exploring the constructs of race and ethnicity in supervision (Bartell, 2016). Previous UK studies have relied on qualitative data collection methods, making generalisability difficult (Desai, 2018). Furthermore, this study incorporated a range of professionals from clinical and counselling psychology and CBT therapists who were either in training or qualified practitioners to ensure the data reflects a range of therapy-related backgrounds. An additional strength was the number of participants (N=222) that took part with 39% self-identifying as belonging to a REM group.

In consideration of limitations, this study relied entirely on self-report data which can be subject to bias (Rosenman et al., 2011). Participants were asked to visualise their

current or most recent supervisor and an assumption was made that responses were honest and accurately recalled. However, some participants may have provided more socially desirable responses, in an attempt to 'look good' in the survey or not come across as too critical of their supervisor. Additionally, some responses may be based on inaccurate recall or interpretation of retrospective events (Buchanan, 2007). Furthermore, a selection bias may have been present, as participants who volunteered in the study may have had a personal interest in the study topic. Supervisory dyads also remained heavily unbalanced, with very few supervisees in REMSE-REMSR and WSE-REMSR dyads which reflects the underrepresentation of REM supervisors within the profession (Turpin & Coleman, 2010).

Supervisees were allocated to supervisory dyads based on the demographic information provided about their supervisor; if unknown, supervisees were asked to take a best guess. However, if the WSR self-identified as belonging to a REM group, the supervisee may be unaware of this. The study heavily relied on supervisee perspectives, with no clarification of supervisor perspectives to complement findings. Although there may be differences in perceptions between the two groups, differences in supervision styles and expectations across professions could also potentially impact the SR (Fleming, 2004). Further research may benefit from a greater WSE-REMSR and REMSE-REMSR sample size and additional measures (e.g., acculturation measure and a measure of cultural identity development status) to further determine what predicts SR quality.

2.4.3 Theoretical and Research Implications

Helm's (1990, 1995) Racial Identity Development theory proposed that racial identity is developed through processing and working through various stages which exist on a continuum. Cook (1994) expanded on this theory and described progressive, regressive and parallel dyads. In progressive dyads, the supervisor is further along in their cultural identity development than their supervisee. In regressive dyads, the supervisee is further along in their cultural identity development than their supervisor. Furthermore, in

parallel dyads, the supervisor and supervisee have similar cultural identity statuses; this could be a high or low development status (Pillay, 2013).

This theory may help to explain some of the findings in the current study. Due to the predominance of WSE within the profession (Turpin & Coleman, 2010), REMSE are more likely to be placed in cross-cultural dyads than WSE. If WSE and WSR are similarly at lower stages of cultural identity development, they may experience parallel dyads, where both may be unaware of deficits in cultural responsivity. This might negatively affect cultural competence development and treatment for REM clients (Ladany et al., 1997).

REMSE may be further along in their cultural identity development due to their own lived experiences of minoritisation and awareness of cultural differences within the UK (Constantine & Sue, 2007). If paired with a WSR at a lower cultural identity development stage, a regressive SR is likely to be experienced. Ladany et al. (1997) suggested that regressive SRs are often the most difficult to navigate due to inherent power dynamics in supervision. WSR may not be aware of the need to develop their racial/ethnic identity as their cultural identity is often seen as the 'norm' within the UK.

REMSE may be more sensitive to their lack of cultural and societal power, exacerbated by their WSR's evaluative role in their development and low cultural responsivity. This may lead to fear and discomfort in raising issues which may perpetuate silence and lead to negative consequences (Adetimole et al., 2005). Therefore, it becomes vital for power relations and their impact on all individuals within the supervisory triad to be addressed in supervision (Holloway, 1995; Patel, 2011). In addition, this may aid the development of trust and mutual empowerment, particularly in cross-cultural dyads (Martinez & Holloway, 1997).

In line with theories of attachment within the SR (Beinart, 2004; Leary, 1957), developing an understanding of supervisee and supervisor interpersonal histories, experiences, and cultural identity awareness may influence the level of security within the SR, particularly for REMSE. Regressive, parallel and progressive dyads (Cook, 1994) and

cultural identity development stages within the UK alongside their impact on the SR will require further investigation in future studies.

2.4.4 Clinical Implications

The results highlight the discrepancy in perceptions of culturally responsive supervision and the SR between REMSE and WSE. REMSE reported experiencing less cultural responsivity and satisfaction in the SR, which may lead to less reflection, personal development, and unmet supervisory needs (Patel, 2011). The results also suggest that the development of cultural competence in supervision remains limited.

This highlights the need for therapy training programmes, professional bodies, supervisors, and service leads to ensure culturally responsive supervision practice development. There is also a need for supervision models and protocols that aid the development of culturally responsive supervision and cultural competence. For instance, culturally responsive supervision training could become an expectation of continued professional development and course accreditation (Fleming, 2004).

For REMSE to feel greater safety and security in the SR, WSR may need to demonstrate greater cultural responsivity and model openness, honesty and reflection. They may do so by prioritising the development of their own cultural identity, which may require self-assessment and reflection. They may also indicate an interest in their supervisee's cultural identity and a willingness to help them develop this further in supervision by engaging in culturally responsive discussions. They may involve sharing their vulnerabilities and limitations in terms of personal knowledge and skills. To support this, both parties may need to reflect on and discuss their differing roles and identities, particularly concerning issues of power embedded in the SR, culture and racism (Patel, 2011). This could help to form, strengthen and maintain the SR (Kurtz, 2005). However, it is important to note that 'safety' may hold different meanings for different individuals depending on personal experiences and social contexts (Addai et al., 2019).

The concept of supervision of supervision has proven to help develop skills (Scaife, 2009), and this could be utilised to ensure the cultural competence development. Supervisors must reflect on their own cultural identity, power and privilege within their supervision so that they do not unintentionally perpetuate culturally unresponsive supervisory practices. Learning to discuss power, culture, ethnicity and racism in supervision may be difficult and distressing (Schroeder et al., 2009). Therefore, it is important that supervisors and supervisees develop a language and reflexivity to aid discussions in this area to enhance the SR. It may be helpful to collaboratively establish the parameters of how these issues can be discussed in the contracting process at the start of supervision, with a regular review (Patel, 2011; Scaife, 2009).

In addition, the predominance of WSR and 'Whiteness' within services and training courses must also be addressed (Wood & Patel, 2017). It is vital for training courses and services to increase REM group representation within the professions. However, this must be accompanied by improved support for REM groups, a reduction in tokenistic gestures and decolonisation of taught psychology models with inherent cultural biases.

2.4.5 Conclusion

In summary, the present study found differences between supervisory dyads on their perceptions of culturally responsive supervision and SR quality, with REMSE-WSR supervisees self-reporting the least culturally responsive supervision and lower quality SRs. The findings suggest that greater cultural responsivity in supervision and cultural identity development may strengthen the SR. Cultural identity development needs and further exploration within the SR were highlighted. The study's strengths included the use of a validated measure and the inclusion of trainee and qualified perspectives across three professions. The limitations related to issues of generalisability, a need for greater sensitivity of measures and a lack of supervisor perspectives. Overall, this study concludes that self-reflection of cultural identity, power and privilege are important prerequisites to providing culturally responsive supervision. Supervisors, services, training courses and

professional bodies are well placed to provide culturally responsive supervision training and prioritise the development of cultural competence in supervision. This may benefit the SR, supervisee well-being and supervision outcomes, ultimately improving the quality of culturally responsive care offered to clients.

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Appendix

Appendix A: Inclusion/exclusion criteria for systematic review

	Inclusion Criteria	Exclusion Criteria
Population(s)	Supervisees or supervisors working therapeutically in relation to practice based clinical work (i.e. with adults, children, families…etc.)	University students, doctoral students not in a clinical programme, research supervision, non-therapy related supervisees/supervisors
Intervention(s)	Cross-racial clinical supervision (The supervisee and supervisor are racially different to one another) and ethnicity information is provides	Cross-cultural supervision where race/ethnicity is not specifically mentioned
Comparators	Any	-
Outcomes	Any evidence of racism encountered **within** cross-racial clinical supervision	Racism not experienced specifically within cross-racial supervision or in non-empirical papers
Study design	Any **empirical** study, written in English	-
Setting	Any	

Appendix B: Analytical and descriptive themes with illustrative quotes

Analytical Themes	Descriptive Themes	Illustrative Quotes
Emotional distress evoked	Negative and psychologically painful emotions	"…described as painful in that they evoked strong feelings of shock, disbelief, anger, and disappointment." (Constantine & Sue, 2007, p. 148).
		"So initially, blood boiling and I was in shock as well because I couldn't believe she was saying that to me." (Knight, 2017, p. 84)
		"Participant 4 expressed her frustration when she perceived that her supervisor was treating her differently due to Asian stereotypes." (Pichardo, 2017, p. 52)
		"Um, so I think more often than not, I've let these things go when I've been in academic settings. Um, and that, that's discouraging to myself. It's unfortunate and eats at me in a certain way." (Crawford, 2020, p. 86)
	Strong physical/somatic sensations	"Immediately following the microaggressive comment from her supervisor, Adrian described a somatic response to the insult, "I just it was like… I didn't respond any way in my head it was that my body physically reacted to her." (Hedin, 2018, p. 81)
		"[My supervisor] used to say things about

		Black clients that would just make my skin crawl" (Constantine & Sue, 2007, p. 146)
		"Yeah, it's so weird; [dealing with racial microaggressions] impacted my fertility and my health. It was all sorts of stuff that came up. I saw all these doctors, I was constantly getting sick. It just ruined my body." (Pichardo, 2017, p. 66)
Rupture in the SR and mistrust	Withdrawing from SR	
		"The little processing, we were able to do between ourselves was so [laden] with her stereotypes about me that I was constantly offended and just tried to get through the rest of the supervision relationship without a major blow-up." (Constantine & Sue, 2007, p. 146)
		"It makes me put a wall up. I feel like I don't want to open up. I feel I have to walk on eggshells. I'm a little guarded." (Davis, 2017, p. 84)
		"I never saw my supervisor quite the same after that session…I didn't think I could ever trust him again and it turns out that I didn't" (Constantine & Sue, 2007, p. 147)
	Superficial relationship	
		"I also avoided her a lot and I think that what I did was I made a lot of our interactions very short …. Where I was very task-oriented when I started to talk to her, [rather] than being very free-spirited as I usually am. I found myself kind of switching the way that I wanted to interact with her as my supervisor."(Davis, 2017, p. 84)
		"It made me wonder if he had any real investment in me as a person." (Constantine & Sue, 2007, p. 147)
		"I began to talk on a superficial level, and I felt terrified to raise any issues, especially cultural concerns" (Burkhard et al., 2006, p. 20)
	Unsafety and masking	
		"The relationship was tense, and I did not particularly like my supervisor, and I believed

		that she felt the same way toward me." (Burkhard et al., 2006, p. 18)
		"Black supervisors discussed how they were aware of how their supervisees, particularly their White supervisees, might view them." (Crawford, 2020, p. 70)
		"I'm a Black man… and sometimes I have to really tread very lightly…I feel like I have to be very humble, very meek. I have to be on my best behavior. I have to talk a certain way." (Davis, 2017, p. 107)
		"It was Inez's definition of her supervisor that solidified her perception that supervision was not a safe place to discuss such complex topics as race and culture." (Powers, 2014, p. 114)
		"(The supervisee) expressed disappointment in a system that she presumed to be safe, only to discover the protected nature of this space did not include everyone" (Davis, 2017, p. 81)
Power imbalances and silencing	Minimisation of threat	'Inez expressed feeling "dismissed" by her supervisor and proclaimed, "if I can't get him to acknowledge an issue, I'm certainly not gonna bring up any racial or cultural differences."' (Powers, 2014, p. 100)
		"…How do I reduce as much risk as possible, that's on my radar. That was on my radar. Every time I worked with a White student, especially a White female because of at any point in time I could be considered a perpetrator. I could be considered a threat. I can be considered that. And that was really what I live with." (Crawford, 2020, 87).
	Harsh/unfair criticism	"[RM supervisees] typically indicated that European American supervisors criticized

		them and their approach to culture in client cases." (Burkhard et al., 2006, p. 19)
		"The participants also conveyed that they felt it was necessary to prove to their supervisors and peers that they are in fact "good enough" and capable of being in their position as therapists." (Dupiton, 2019, p. 67).
	Challenges of authority	
		"Carla has supervised more than 50+ students over the past 10 years, she stated that both males and females seem to challenge her intelligence when she provided feedback and/or recommendations." (Hall, 2018, p. 1025)
		"She often received pushback or challenges from her White supervisees, where her supervisees would ask other White professors/supervisors for validation instead of relying on what Virginia said in supervision." (Crawford, 2020, p. 76)
		"She feared if she brought up concerns, her supervisor may refuse to sign off on her client or supervision hours." (Hedin, 2018, p. 83)
Lack of cultural competence and self-reflection	Supervisor cultural ignorance and unawareness	"White supervisors' lack of understanding of supervisees' communication styles related to their lack of knowledge of supervisees' cultures." (Jang et al., 2020, p. 8)
		"The truth of the matter is they needed more information and experience in cross-cultural therapy." (Hall, 2018, p. 1028)
		'"We don't know if race is a factor, and probably will not know, so why don't you not worry about that and focus on treating the client." (Burkhard et al., 2006, p. 19).
		"Several Black supervisees in this study reported that their supervisors made treatment recommendations that did not appear to be culturally sensitive, and these trainees seemed to believe that the recommendations were tied to racism or unexamined cultural biases." (Constantine & Sue, 2007, p. 148)
		"He was so invested in trying to be the

		expert in everything that he didn't want to own up to the fact that he didn't have a clue about working with Black clients." (Constantine & Sue, 2007, p. 146)
	Discomfort of cultural discussions	"One participant shared that they avoid the conversation of race altogether as a way to protect themselves." (Crawford, 2020, p. 82)
		"I had the feeling that my White supervisor just didn't want to challenge some of my [areas for growth] because he didn't want to seem racist." (Constantine & Sue, 2007, p. 147)
		"Supervisors showed less sensitivity to cultural differences, which may lead to minimal effort to understand supervisees' counselling theoretical backgrounds." (Jang et al., 2020, p. 9)
		"Well, a lot of times supervisees minimize how privilege impacts clients, I noticed that female supervisees are especially quick to challenge gender biases, while overlooking the privilege of being 'White.'" (Hall, 2018, p. 1028).
	RM supervisors/supervisees as cultural experts	"Assumption from her supervisor was that if she shared a cultural background with a client, then Adrian did not need additional support" (Hedin, 2018, p. 79)
Coping and Validation	Need for support networks and connection	"Often, the act of racial microaggressions can be confusing to victims, and in many instances, participants cited that they reached out to their colleagues, friends, and family to process what happened." (Pichardo, 2017, p. 72)
	External help to externalise racism	"What helped me was always sharing my experience with other people that surrounded me. I wasn't able to process this by myself without sharing. I just wanted to have someone

to really be there and listen to me, what I have experienced…but it was helpful to externalize my experience" (Davis, 2017, p. 95)

"One participant stated that she "burdened other staff by consulting with them on cases when cultural issues were relevant to the client."' (Burkhard et al., 2006, p. 21)

Building resilience

"Black female therapists experience racism yet serve with purpose, with a focus on advocacy/representation, and the Black female therapist as powerful." (Dupiton, 2019, p. 62)

"I think a big piece of advice from me would be, if you're uncomfortable, do something…You deserve better supervision. Feeling like you're wasting your time the whole year is not fair to you, it's not fair to your clients." (Davis, 2017, p. 95)

Appendix C. HRA Ethical Approval

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Miss Bianca Vekaria
University of Southampton
Building 44/3089
Highfield Campus
SO17 1BJ

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

21 September 2020

Dear Miss Vekaria

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**A study exploring the supervisory relationship in the context of culturally responsive supervision: a supervisee's perspective**
IRAS project ID:	**284122**
Protocol number:	**N/A**
REC reference:	**20/EM/0221**
Sponsor	**University of Southampton**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The standard conditions document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **284122**. Please quote this on all correspondence.

Yours sincerely,
Alex Thorpe

Approvals Manager

Email: approvals@hra.nhs.uk

Copy to: *Dr Alison Knight, Sponsor's Representative*

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Copies of advertisement materials for research participants [Study Advertisement]	1.2	16 June 2020
Copies of advertisement materials for research participants [Social media adverts]	1	14 August 2020
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Insurance Evidence]	1	21 August 2020
IRAS Application Form [IRAS_Form_26082020]		26 August 2020
IRAS Application Form XML file [IRAS_Form_26082020]		26 August 2020
IRAS Checklist XML [Checklist_17092020]		17 September 2020
Letter from sponsor [Letter from sponsor]	1	21 August 2020
Letters of invitation to participant [Invitation Email]	1.2	16 June 2020
Non-validated questionnaire [Visual Analogue Scale Questions]	1.2	16 June 2020
Non-validated questionnaire [Qualitative Free-Text Questions]	1	16 June 2020
Non-validated questionnaire [Supervisor Visualisation Exercise]	1	16 June 2020
Non-validated questionnaire [Demographic Questionnaire with Tracked Changes]	2.2	16 September 2020
Non-validated questionnaire [Demographic Questionnaire (Clean version)]	2.2	16 September 2020
Organisation Information Document [Organisation Information Document (Template)]	1	14 August 2020
Other [Response to REC provisional opinion]	1	17 September 2020
Other [Survey Flow Document]	1	25 August 2020
Other [Part B invitation and consent]	1	14 August 2020
Participant information sheet (PIS) [Online PIS and Consent]	2.2	16 June 2020
Participant information sheet (PIS) [Debriefing Statement]	1	16 June 2020
Research protocol or project proposal [Project Proposal]	1.2	16 June 2020
Schedule of Events or SoECAT [SoE]	1	27 August 2020
Summary CV for Chief Investigator (CI) [Chief Investigator CV]	1	20 July 2020
Summary CV for student [Chief Investigator CV]	1	20 July 2020
Summary CV for supervisor (student research) [Academic supervisor CV]	1	20 July 2020
Summary CV for supervisor (student research) [Main Academic Supervisor CV]	1	20 July 2020
Summary of any applicable exclusions to sponsor insurance (non-NHS sponsors only) [Insurance letter]	1	21 August 2020
Validated questionnaire [Vancouver Index of Acculturation]	1	16 June 2020
Validated questionnaire [Race-Ethnicity Supervision Scale]	1	16 June 2020
Validated questionnaire [Short-Supervisory Relationship Questionnaire]	1	16 June 2020

IRAS project ID	284122

Information to support study set up

The below provides all parties with information to support the arranging and confirming of capacity and capability with participating NHS organisations in England and Wales. This is intended to be an accurate reflection of the study at the time of issue of this letter.

Types of participating NHS organisation	Expectations related to confirmation of capacity and capability	Agreement to be used	Funding arrangements	Oversight expectations	HR Good Practice Resource Pack expectations
All sites will perform the same research activities therefore there is only one site type.	Organisations will not be required to formally confirm capacity and capability, and research procedures may begin after provision of the local information pack, provided the following conditions are met. - You have contacted participating NHS organisations (see below for details)HRA and HCRW Approval has been issued. - The NHS organisation has not provided a reason as to why they cannot participate. - The NHS organisation has not requested additional time to confirm. You may start the research prior to the above deadline if HRA and HCRW Approval has been issued and the site positively confirms that the research may proceed.	An Organisation Information Document has been submitted and the sponsor is not requesting and does not expect any other site agreement to be used.	No study funding will be provided to sites as per the Organisational Information Document.	A Principal Investigator should be appointed at study sites of this type.	No Honorary Research Contracts, Letters of Access or pre-engagement checks are expected for local staff employed by the participating NHS organisations. Where arrangements are not already in place, research staff not employed by the NHS host organisation undertaking any of the research activities listed in the research application would be expected to obtain a Letter of Access based on standard DBS checks and occupational health clearance.
	You may now provide the local information pack for your study to your participating NHS organisations in England and/or Wales. If you have not already started to provide the local information packs to participating NHS organisations in Northern Ireland and/or Scotland please do so when you are ready. A current list of R&D contacts is accessible at the NHS RD Forum website and these contacts MUST be used for this purpose. The password to access the R&D contact list is Redhouse1.				

Other information to aid study set-up and delivery

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales in study set-up.
The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

Appendix D. Demographic form

1. Please state your age group.

Under 21	21-24	25 – 34	35 – 44	45 – 54	55 – 64	65 and over
☐	☐	☐	☐	☐	☐	☐

2. Please provide your gender

☐ Male

☐ Female

☐ Prefer not to say

☐ Other (please state)

3. What is your ethnic group?

☐ **White**: White British, White Irish, Any other White background (please specify below)

☐ **Asian or Asian British**: Indian, Pakistani, Bangladeshi, Chinese, Any other Asian background (please specify below)

☐ **Black or Black British**: African, Caribbean, Any other Black background (please specify below)

☐ **Mixed**: Mixed Asian and White, Mixed Black African and White, Mixed Black Caribbean and White, Any other Mixed background (please specify below)

☐ **Arab**: (please specify)

☐ **Other**: (please specify)

4. What is your religion?

☐ (Please specify)

☐ I do not follow a religion

☐ I'd prefer not to say

5. Do you self-identify as belonging to a Racial/Ethnic-Minority group?

☐ Yes

☐ No

☐ I'd prefer not to say

6. What is your country of birth?

☐ England

☐ Wales

☐ Scotland

☐ Northern Ireland

☐ Other (Please write the name of the country below)

[Add logic] (If 'Other' is selected)

a) How long have you lived in the UK?

☐ Less than a year

☐ 1-5 years

☐ 6-10 years

☐ 11- 19 years

☐ More than 20 years

7. Please provide your current job role

☐ Trainee Clinical Psychologist

☐ Trainee CBT Therapist

☐ Trainee Counselling Psychologist

☐ Clinical Psychologist

☐ Counselling Psychologist

☐ Cognitive Behaviour Therapist

☐ Other (please state)

7a. [Add logic] (If yes to Trainee clinical psychologist/Trainee counselling psychologist/Trainee CBT Therapist) Please state what year of training you are in?

☐ 1

☐ 2

☐ 3

☐ N/A (Please provide reason)

[Add logic] (If yes to Clinical Psychologist/Counselling Psychologist/CBT Therapist) Please state the number of years you have been qualified.

☐ Less than a year

☐ 1-5 years

☐ 6-10 years

☐ 11- 19 years

☐ More than 20 years

8. How frequently do you receive **individual** clinical supervision?

☐ Every week

☐ Every 2 weeks

☐ Every month

☐ Other (please specify)

b) What is the duration of your clinical supervision session?

(Please state)

c) Do you also receive group supervision?

☐ Yes

☐ No

[Add logic] (If yes): Please specify how often you receive group supervision and in which context.

9. What is the context of the professional sector in which you work?

- ☐ Local authority
- ☐ NHS
- ☐ Non-NHS health sector
- ☐ Private sector
- ☐ Academia
- ☐ Social care
- ☐ Other (please state)

10. In which geographical UK region are you currently working?

- ☐ East Midlands
- ☐ East of England
- ☐ London
- ☐ North East
- ☐ North West
- ☐ Northern Ireland
- ☐ Scotland
- ☐ South East
- ☐ South West
- ☐ Wales
- ☐ West Midlands)

11. How long have you been supervised by your current supervisor for?

- ☐ 4 months

☐ 5 months

☐ 6 months

☐ 7+ months

12. What is your current/most recent supervisor's racial/ethnic identity? If unknown, please provide an educated assumption.

☐ **White**: White British, White Irish, Any other White background (please specify)

☐ **Asian or Asian British**: Indian, Pakistani, Bangladeshi, Chinese, Any other Asian background (please specify)

☐ **Black or Black British**: African, Caribbean, Any other Black background (please specify)

☐ **Mixed**: Mixed Asian and White, Mixed Black African and White, Mixed Black Caribbean and White, Any other Mixed background (please specify)

☐ **Arab**: (please specify)

☐ **Other**: (please specify)

Appendix E. Race-Ethnicity Supervision Scale (RESS)

Race-Ethnicity Supervision Scale (Burkard & Hartmann, 2012)

If the statement in the following items describes the way your supervisor always select the number 7, if it never applies to how your supervisor behaves select the number 1. Use the numbers in between to describe the variations between these extremes, and if you have a neutral feeling about the question, select the number 4.

Finally, we consider the term *culture* or *cultural* to specifically refer to race or ethnicity.

Race: is defined as a category of humankind that shares certain distinctive physical traits (E.g. skin colour or hair texture)

Ethnicity: is linked with cultural expression and identification. It describes a group of people who share similar values, language, culture or behavioural patterns.

My Supervisor….	Never			Neutral			Always
	1	2	3	4	5	6	7
1. Helps me develop treatment plans that are sensitive to my clients' race/ethnicity	○	○	○	○	○	○	○
2. Teaches me how to attend to clients' race/ethnicity during therapy	○	○	○	○	○	○	○
3. Encourages me to integrate race/ethnicity in assessment	○	○	○	○	○	○	○
4. Offers me feedback on my level of competency in addressing racial/ethnic concerns in therapy	○	○	○	○	○	○	○
5. Helps me identify areas of growth with regard to how my race/ethnicity influences therapy	○	○	○	○	○	○	○
6. Helps me to be more sensitive to clients' race/ethnicity	○	○	○	○	○	○	○

7. Encourages me to examine how my racial/ethnic attitudes influence my clinical work	○	○	○	○	○	○	○
8. Helps me value addressing race/ethnicity in my clinical work	○	○	○	○	○	○	○
9. Asks if race/ethnicity is relevant when discussing client cases	○	○	○	○	○	○	○
10. Helps me to be more attentive to how race/ethnicity influence my work as a therapist	○	○	○	○	○	○	○
11. Provides feedback on my responsiveness to clients' racial/ethnic background	○	○	○	○	○	○	○
12. Challenges me to incorporate race/ethnicity when conceptualising a client case	○	○	○	○	○	○	○
13. Helps me to identify how my biases toward race/ethnicity affect my work with clients	○	○	○	○	○	○	○
14. Considers my client's race/ethnicity when reviewing treatment plans	○	○	○	○	○	○	○
15. Discusses how our racial/ethnic identities affect our supervision relationship	○	○	○	○	○	○	○
16. Shows interest in learning about my racial/ethnic identity	○	○	○	○	○	○	○
17. Is sensitive to how he/she and I are racially/ethnically different	○	○	○	○	○	○	○
18. Discusses how her/his racial/ethnic identity affects our supervision relationship	○	○	○	○	○	○	○
19. Asks about my racial/ethnic identity	○	○	○	○	○	○	○
20. Tries to understand my	○	○	○	○	○	○	○

racial/ethnic identity							
21. Believes it is important to understand how race/ethnicity influences clinical work	○	○	○	○	○	○	○
22. Is knowledgeable about various resources to develop competence with racial/ethnic diversity	○	○	○	○	○	○	○
23. Is knowledgeable about the role of race/ethnicity in treatment planning	○	○	○	○	○	○	○
24. Understands how a client's race/ethnicity may influence case conceptualisation	○	○	○	○	○	○	○
25. Understands the effect that race/ethnicity can have on therapy	○	○	○	○	○	○	○
26. Has made racially/ethnically insensitive comments	○	○	○	○	○	○	○
27. Makes stereotypic comments about some clients' race/ethnicity	○	○	○	○	○	○	○
28. Pathologizes the role of race/ethnicity in my clients' lives	○	○	○	○	○	○	○
29. Makes me feel unsafe when discussing racially/ethnically diverse clients	○	○	○	○	○	○	○

Appendix F. Short-Supervisory Relationship Questionnaire

The Short Supervisory Relationship Questionnaire (S-SRQ) (Cliffe, Beinart & Cooper, 2016)

The following statements describe some of the ways a person may feel about his/her supervisor.

To what extent do you agree or disagree with each of the following statements about your relationship with your supervisor? Please tick the column that matches your opinion most closely.

	Strongly Disagree	**Disagree**	**Slightly Disagree**	**Neither Agree nor Disagree**	**Slightly Agree**	**Agree**	**Strongly Agree**
1. My supervisor was approachable	○	○	○	○	○	○	○
2. My supervisor was respectful of my views and ideas	○	○	○	○	○	○	○
3. My supervisor gave me feedback in a way that felt safe	○	○	○	○	○	○	○
4. My supervisor was enthusiastic about supervising me	○	○	○	○	○	○	○
5. I felt able to openly discuss my concerns with my supervisor	○	○	○	○	○	○	○
6. My supervisor was non-judgemental in supervision	○	○	○	○	○	○	○
7. My supervisor was open-minded in supervision	○	○	○	○	○	○	○
8. My supervisor gave me positive feedback on my performance	○	○	○	○	○	○	○
9. My supervisor had a collaborative approach in supervision	○	○	○	○	○	○	○
10. My supervisor encouraged me to reflect on my practice	○	○	○	○	○	○	○
11. My supervisor paid attention to my unspoken feelings and anxieties	○	○	○	○	○	○	○
12. My supervisor drew flexibly from a number of theoretical models	○	○	○	○	○	○	○
13. My supervisor paid close attention to the process of supervision	○	○	○	○	○	○	○
14. My supervisor helped me identify my own learning/training needs	○	○	○	○	○	○	○
15. Supervision sessions were focussed	○	○	○	○	○	○	○

16. Supervision sessions were structured	○	○	○	○	○	○	○
17. My supervision sessions were disorganised	○	○	○	○	○	○	○
18. My supervisor made sure that our supervision sessions were kept free from interruptions	○	○	○	○	○	○	○

Appendix G. The Vancouver Index of Acculturation

Vancouver Index of Acculturation (Ryder, Alden & Paulhus, 2000)

Please select *one* of the numbers to the right of each question to indicate your degree of agreement or disagreement. Many of these questions will refer to your *heritage culture*, meaning the original culture of your family. It may be the culture of your birth, the culture in which you have been raised, or any culture in your family background. If there are several, pick the one that has influenced you *most.* If you do not feel that you have been influenced by any other culture, please name a culture that influenced previous generations of your family.

My heritage culture is: ……..

					Disagree				**Agree**
I often participate in my heritage cultural traditions.	1	2	3	4	5	6	7	8	9
I often participate in mainstream British cultural traditions	1	2	3	4	5	6	7	8	9
I would be willing to marry a person from my *heritage culture*	1	2	3	4	5	6	7	8	9
I would be willing to marry a White British person.	1	2	3	4	5	6	7	8	9
I enjoy social activities with people from the same *heritage culture* as myself	1	2	3	4	5	6	7	8	9
I enjoy social activities with White British people.	1	2	3	4	5	6	7	8	9

I am comfortable interacting with people of the same *heritage culture* as myself.	1	2	3	4	5	6	7	8	9
I am comfortable interacting with White British people.	1	2	3	4	5	6	7	8	9
I enjoy entertainment (e.g. movies, music) from my *heritage culture*.	1	2	3	4	5	6	7	8	9
I enjoy British entertainment (e.g. movies, music).	1	2	3	4	5	6	7	8	9
I often behave in ways that are typical of my *heritage culture*.	1	2	3	4	5	6	7	8	9
I often behave in ways that are typically British.	1	2	3	4	5	6	7	8	9
It is important for me to maintain or develop the practices of my *heritage culture*.	1	2	3	4	5	6	7	8	9
It is important for me to maintain or develop British cultural practices.	1	2	3	4	5	6	7	8	9
I believe in the values of my *heritage culture*.	1	2	3	4	5	6	7	8	9
I believe in mainstream British values	1	2	3	4	5	6	7	8	9
I enjoy the jokes and humour of my *heritage culture*.	1	2	3	4	5	6	7	8	9
I enjoy White British jokes and humour.	1	2	3	4	5	6	7	8	9
I am interested in having friends from my *heritage culture*.	1	2	3	4	5	6	7	8	9
I am interested in having White British friends.	1	2	3	4	5	6	7	8	9

Appendix H. VAS style questions

These questions are interested in your views on how important and helpful it is to discuss issues of Race and Ethnicity in supervision.

1. **How <u>important</u> do you think it is to talk about issues of race and ethnicity with your supervisor?**
   a) ***From the perspective of your clients? (In relation to your clinical practice and clients)***

Not at all important	This is unimportant	This is somewhat unimportant	Neither important or unimportant	This is somewhat important	This is important	This is extremely important
1	2	3	4	5	6	7

   b) ***From your own perspective as a supervisee? (In relation to your own personal issues and cultural identity)***

Not at all important	This is unimportant	This is somewhat unimportant	Neither important or unimportant	This is somewhat important	This is important	This is extremely important
1	2	3	4	5	6	7

2. **When relevant, how <u>comfortable</u> are you with <u>raising sensitive</u> issues related to race and ethnicity in supervision?**
   a) ***From your own perspective as a supervisee?***

Not at all comfortable	This is uncomfortable	This is somewhat uncomfortable	Neither comfortable or uncomfortable	This is somewhat comfortable	This is comfortable	This is extremely comfortable
1	2	3	4	5	6	7

b) From the perspective of your clients?

Not at all comfortable	This is uncomfortable	This is somewhat un comfortable	Neither comfortable or uncomfortable	This is somewhat comfortable	This is comfortable	This is extremely comfortable
1	2	3	4	5	6	7

3. How <u>comfortable</u> are you in discussing <u>other issues</u> of difference or inequality (not related to race/ethnicity) in supervision? (I.e. gender, sexuality, disability, religion…etc.)

Not at all comfortable	This is uncomfortable	This is somewhat un comfortable	Neither comfortable or uncomfortable	This is somewhat comfortable	This is comfortable	This is extremely comfortable
1	2	3	4	5	6	7

4. How <u>helpful</u> is it to talk about personal issues of race and ethnicity with your supervisor?

Not at all helpful	This is unhelpful	This is somewhat unhelpful	Neither helpful or unhelpful	This is somewhat helpful	This is helpful	This is extremely helpful
1	2	3	4	5	6	7

Appendix I. Study Advertisement

University of Southampton

PARTICIPANTS NEEDED FOR AN ONLINE STUDY LOOKING AT SUPERVISEE EXPERIENCES OF CULTURALLY RESPONSIVE CLINICAL SUPERVISION

PARTICIPATE AND GET THE CHANCE TO WIN 1 OF 4 £50 AMAZON VOUCHERS

What is this study about?

As part of my doctoral research project, I am looking to explore supervisee experiences of culturally responsive supervision. This includes how your supervisor helps to promote your cultural competence and cultural identity in supervision, and how culturally competent you perceive your supervisor to be. I am also interested on the impact of these experiences on the supervisory relationship. This study aims to gain a better understanding of how these processes work when the supervisee and supervisor are racially/ethnically similar or different to one another. I am hopeful that this study will contribute to improved understanding and practice of culturally responsive supervisory practices in the UK.

What will I be asked to do?

You will be asked to complete some questionnaires via an internet survey. After completion, you will then have the option to take part in the second part of the study which is interested in your recommendations on improving supervisory practices in the UK. The study should take approximately 15-20 minutes to complete if you decide to complete both parts of the study.

Can I participate?

- Are you a Trainee or Qualified: Clinical Psychologist, Counselling Psychologist or CBT Therapist working clinically in the UK?
- Do you receive regular individual clinical supervision? (minimum of once a month). Have you had clinical supervision with your current or most recent supervisor for longer than 4 months? (For first year Trainees, this would only include clinical supervision received whilst on training)

If the answer to all of these questions is yes and you would like to take part in the study, please follow the link below

https://sotonpsychology.eu.qualtrics.com/jfe/form/SV_5ciayWJJWmO2Y6N

If you have any more queries or would like to know more about this study, please do not hesitate to get in touch. Principal investigator: Bianca Vekaria (bv1u18@soton.ac.uk); Research supervisors: Dr. Margo Ononaiye (m.s.ononaiye@soton.ac.uk) & Dr. Peter Phiri (peter.phiri@southernhealth.nhs.uk)

ERGO No. 57540, Version 1.2, Dated: 16/06/20

Appendix J. Online consent form

Online Participant Information Sheet and Consent

Study Title: A study exploring the supervisory relationship in the context of culturally responsive supervision: a supervisee's perspective

Researcher: Bianca Vekaria

ERGO number: 57540
IRAS number: 284122

You are being invited to take part in the above research study. To help you decide whether you would like to take part or not, it is important that you understand why the research is being done and what it will involve. Please read the information below carefully and ask questions if anything is not clear or you would like more information before you decide to take part in this research. You may like to discuss it with others but it is up to you to decide whether or not to take part. If you are happy to participate you will be asked for your consent online.

What is the research about?

This research is being undertaken as part of a doctoral qualification in Clinical Psychology at The University of Southampton. Supervision plays an important role in ensuring safe therapeutic practice, supporting professional development, mutual learning of skills and providing a space for practitioners to reflect on the personal impact of their work (British Psychological Society (BPS), 2014).

However, little is known about culturally responsive supervision in the UK today, particularly about how multicultural elements of supervision such as discussions about race and ethnicity are perceived by supervisees.

The first part of this study aims to better understand supervisees' experiences and perceptions of culturally responsive supervision and how this in turn affects the supervisory relationship. We will also explore whether the supervisee's level of acculturation (how socialised an individual is to the mainstream culture of the country in which they reside), modifies the relationship between culturally responsive supervision and the supervisory relationship. This study is interested in exploring the differences between supervisee perceptions of culturally responsive supervision in racially/ethnically similar and different supervisory dyads.

The second part of the study will explore supervisee recommendations on how multicultural supervisory practices could be improved in the UK. It is hoped that the findings from this research will help shape future support, training and guidance for supervisees and supervisors in discussing these issues. It is hoped that this will in turn benefit their relationship and their clients.

This research is sponsored by the University of Southampton, details of the person acting on behalf of the research sponsor are included: Dr Alison Knight (Head of Research Integrity and Governance), 023 8059 5058, rgoinfo@soton.ac.uk.

Why have I been asked to participate?

We are inviting **Trainee or Qualified: Clinical Psychologists, Counselling Psychologists and CBT therapists** to take part in this online survey. To take part, you must work in the UK and should

have received clinical supervision from your current or most recent supervisor for a minimum of 4 months. Trainee clinical psychologists in their first year of training, must have completed their first clinical placement in order to take part in the study. If you are a Trainee counselling psychologist or Trainee CBT therapist, You must have worked with your most recent supervisor for a minimum of 4 months (whilst on training), in order to take part in the study.

What will happen to me if I take part?

If you decide to take part, you will be asked to complete an online survey. The first part is crucial for the study and will take approximately 10 minutes. This will include a demographic survey, questions about your level of acculturation to mainstream British culture, questions about your relationship with your supervisor and questions regarding issues of race/ethnicity and culturally responsivity in supervision.

If after this, you have another 10 minutes and would like to participate in the second part of the study, you will be asked to fill in five free-text qualitative questions about your recommendations on improving supervisory practices in the UK.

Are there any benefits in my taking part?

By taking part, you will have the opportunity to reflect on your experiences of discussing issues of race and ethnicity with your current or most recent supervisors and how this may have impacted your supervisory relationship. As a thank you for participating, there is also a chance of winning a £50 Amazon Voucher by entering a free prize draw at the end of the survey, where you will be asked for your name and email address.

Are there any risks involved?

Taking part in the survey might make you more aware of certain aspects of your identity, dissatisfaction with your supervisor or your supervisory relationship. You may not have typically thought about these aspects of supervision and this may evoke some negative feelings or discomfort. It is not anticipated that this discomfort will be higher than what you might normally expect in your role.

If you do encounter any discomfort during this study and would like some information on sources of emotional support please follow the link below.

https://www.northessexiapt.nhs.uk/west-essex/self-help

What data will be collected?

Electronic data (survey responses) will be collected online and will be kept strictly confidential. This will include collection and use of person data that is special category data according to Data Protection (this includes information on ethnicity; gender identity; religious beliefs and your job role from which you can be uniquely identified). This personal data will be handled securely during collection, analysis, storage and transfer using encryption and password protected access.

Will my participation be confidential?

Your participation and the information we collect about you during the course of the research will be kept strictly confidential.

Only members of the research team and responsible members of the University of Southampton may be given access to data about you for monitoring purposes and/or to carry out an audit of the study to ensure that the research is complying with applicable regulations. Individuals from regulatory authorities (people who check that we are carrying out the study correctly) may require access to your data. All of these people have a duty to keep your information, as a research participant, strictly confidential.

To protect your anonymity, if you do choose to enter the prize draw at the end of the study, your first name and email address will be removed and kept securely and separately from your survey responses. Electronic data will be encrypted and stored in a password-protected database only accessible to the research team. All data will be deleted according to the University of Southampton guidelines.

Do I have to take part?

No, it is entirely up to you to decide whether or not to take part. If you decide you want to take part, you will need to provide consent by ticking the checkboxes below to show you have agreed to take part.

What happens if I change my mind?

You have the right to change your mind and withdraw at any time without giving a reason and without your participant rights being affected. If you wish to withdraw at any point during the study, please do so by exiting the survey.

Please note that in anonymous surveys it is not possible for participants to withdraw their data retrospectively. If at any time during the study you decide to withdraw from the study, you can do so by simply exiting the survey. Responses will only be saved upon completion of Part A of the study. If you choose to opt into Part B of the study, your responses for this part of the study will only be saved upon completion of Part B.

What will happen to the results of the research?

Your personal details will remain strictly confidential if you wish to take part in the prize draw. The project will be written up as part of my doctoral thesis, disseminated at conferences and submitted for publication in a peer-reviewed journal. Research findings made available in any reports or publications will not include information that can directly identify you without your specific consent.

Where can I get more information?

If you have any more queries or would like to know more about this study, please do not hesitate to get in touch, details of members of the research team are provided below.

Chief Investigator: Bianca Vekaria (bv1u18@soton.ac.uk); Research supervisors: Dr. Margo Ononaiye (m.s.ononaiye@soton.ac.uk) & Dr. Peter Phiri (peter.phiri@southernhealth.nhs.uk)

What happens if there is a problem?

If you have a concern about any aspect of this study, you should speak to the researchers who will do their best to answer your questions.

If you remain unhappy or have a complaint about any aspect of this study, please contact the University of Southampton Research Integrity and Governance Manager (023 8059 5058, rgoinfo@soton.ac.uk).

Data Protection Privacy Notice

The University of Southampton conducts research to the highest standards of research integrity. As a publicly-funded organisation, the University has to ensure that it is in the public interest when we use personally-identifiable information about people who have agreed to take part in research. This means that when you agree to take part in a research study, we will use information about you in the ways needed, and for the purposes specified, to conduct and complete the research project. Under data protection law, 'Personal data' means any information that relates to and is capable of identifying a living individual. The University's data protection policy governing the use of personal data by the University can be found on its website (https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page).

This Participant Information Sheet tells you what data will be collected for this project and whether this includes any personal data. Please ask the research team if you have any questions or are unclear what data is being collected about you.

Our privacy notice for research participants provides more information on how the University of Southampton collects and uses your personal data when you take part in one of our research projects and can be found at http://www.southampton.ac.uk/assets/sharepoint/intranet/ls/Public/Research%20and%20Integrity%20Privacy%20Notice/Privacy%20Notice%20for%20Research%20Participants.pdf

Any personal data we collect in this study will be used only for the purposes of carrying out our research and will be handled according to the University's policies in line with data protection law. If any personal data is used from which you can be identified directly, it will not be disclosed to anyone else without your consent unless the University of Southampton is required by law to disclose it.

Data protection law requires us to have a valid legal reason ('lawful basis') to process and use your Personal data. The lawful basis for processing personal information in this research study is for the performance of a task carried out in the public interest. Personal data collected for research will not be used for any other purpose.

For the purposes of data protection law, the University of Southampton is the 'Data Controller' for this study, which means that we are responsible for looking after your information and using it properly. The University of Southampton will keep identifiable information about you for 10 years after the study has finished after which time any link between you and your information will be removed.

To safeguard your rights, we will use the minimum personal data necessary to achieve our research study objectives. Your data protection rights – such as to access, change, or transfer such information - may be limited, however, in order for the research output to be reliable and accurate. The University will not do anything with your personal data that you would not reasonably expect.

If you have any questions about how your personal data is used, or wish to exercise any of your rights, please consult the University's data protection webpage (https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page) where you can make a request using our online form. If you need further assistance, please contact the University's Data Protection Officer (data.protection@soton.ac.uk).

Thank you for taking the time to read the information about and considering participation in the research.

Please check the boxes below if you agree with the statements and wish to proceed to the study:

☐ I have read and understood the online consent and participation information sheet (Version 2.2, dated 16.6.20) and have had the opportunity to ask any questions (should I need to).

☐ I understand that my participation is voluntary and I may withdraw at any time during the online survey for any reason without my participation rights being affected.

☐ I understand that by checking this box in the information and consent form I am giving my consent to taking part in this survey and agree for my data to be used for the purpose of this study.