University of Southampton

Faculty of Environmental and Life Science

School of Psychology

Advancing Culturally Responsive Clinical Supervision: Exploring Supervisees' Perspectives and the Development of the Clinician Cultural Humility Scale

by

Paola De Luca

ORCID ID 0009-0000-3592-1924

Thesis for the degree of Doctorate in Clinical Psychology

[August 2025]

Word count: 23,189

Abstract

Clinical supervision is essential for providing ongoing support and development to supervisees, with significant implications to clinical practice. There has been a recent emphasis on ensuring that culture is considered and integrated into the supervision space. However, more insight is needed into how supervisees experience culturally responsive supervision and how can we assist clinicians to develop their cultural humility.

Chapter one aims to set the context of the two completed studies by expanding further on the process and rationale. Specifically, reflections of conducting the research from the author's personal cultural lens is considered. The chapter also addresses the shift of terminology from cultural competence to humility, and the use of incorporating the Delphi method within the empirical study.

The second chapter is a systematic review that aimed to further explore supervisees' perspectives of the impact of receiving culturally responsive clinical supervision. A total of 15 papers were included in the thematic synthesis which identified three main themes of 'strengthened the supervisory relationship', 'supported professional development and learning', and 'facilitated culturally responsive clinical work'. Further clinical and research implications are discussed.

The final chapter details a quantitative study that developed a cultural humility measure for clinical supervision and assessed its psychometric properties. The study used a three-part design with two samples; the first stage devised the initial scale (Clinician Cultural Humility Scale; CCHS), the second stage used the Delphi method to revise the scale, and the third stage used a cross-sectional survey to assess and further revise the scale. The factor analyses found a 10-item scale with three subfactors, namely: 'Awareness and Self-reflection', 'Openness in Clinical Practice', and 'Supportive Interactions'. The CCHS showed good internal reliability and, overall, the correlation analyses showed convergent relationships with existing scales. The results, implications and recommendations for future research are identified and discussed.

Keywords: clinical supervision, cultural responsivity, cultural humility.

Table of Contents

Abstract 2

Table of Contents 3

Table of Tables 8

Table of Figures 9

Research Thesis: Declaration of Authorship 11

Acknowledgements 12

Definitions and Abbreviations 13

Chapter 1 Setting the Context of Culture in Supervision 16

1.1 Locating 'me' in the Research 17

1.1.1 Systematic Review 19

1.2 The Shift from Cultural Competence to Cultural Humility 20

1.3 The Delphi Method 21

1.4 Dissemination Plan 24

1.5 References 25

Chapter 2 Supervisees' Perspectives of the Impact of Receiving Culturally Responsive Clinical Supervision: A Qualitative Review 33

2.1 Abstract 34

2.2 Introduction 36

2.2.1 Clinical Supervision 36

2.2.2 Culture in Clinical Supervision 37

2.2.3 Cultural Models of Clinical Supervision 39

2.2.4 Power, Culture and Clinical Supervision 42

2.2.5 Current Review 43

2.2.6 Research Question 44

2.3 Method 44

2.3.1 Search Strategy 44
2.3.2 Eligibility Criteria 44
2.3.3 Study Selection 45
2.3.4 Data Extraction 46
2.3.5 Quality Assessment 47
2.3.6 Thematic Synthesis 54
2.3.7 Reflective Statement 55
2.4 Results 56
2.4.1 Quality Assessments 56
2.4.2 Characteristics of Selected Studies 56
2.4.3 Synthesis 56
2.4.3.1 Main Theme - Strengthened the Supervisory Relationship 57
2.4.3.2 Main Theme - Supported Professional Development and Learning 60
2.4.3.3 Main Theme - Facilitated Culturally Responsive Clinical Work 63
2.5 Discussion 65
2.5.1 Summary of Findings 65
2.5.2 Theoretical Considerations 68
2.5.3 Strengths, Limitations and Future Research 69
2.5.4 Clinical Implications 72
2.5.5 Conclusion 73
2.6 References 75
Appendix A - Search Terms 93
Appendix B - Inclusion/Exclusion Criteria for Systematic Review 95
Appendix C – Quality Assessment Tables 97
Appendix D – Extract of Coding Manual 99
Appendix E – Thematic Map Developments 101

Chapter 3 The Development and Validation of the Clinician Cultural Humility Scale (CCHS) for Clinical Supervision 104

3.1 Abstract 105

3.2 Background 106

3.2.1 Clinical supervision and cultural responsivity 106

3.2.2 Cultural humility 107

3.2.3 Measuring cultural humility in clinical supervision 109

3.2.4 Current research 111

3.3 Methods 111

3.3.1 Ethics 111

3.3.2 Design 112

3.3.2.1 Item generation – Development of the Clinician Cultural Humility Scale (CCHS) 112

3.3.3 Sample 1 112

3.3.3.1 Participants - Experts 112

3.3.4 Measures and procedure 114

3.3.5 Data analysis 115

3.4 Results 115

3.4.1 Development of the CCHS 115

3.4.1.2 Delphi round one 115

3.4.1.3 Delphi round two 118

3.5 Methods 118

3.5.1 Sample 2 118

3.5.1.2 Participants – Clinicians 118

3.5.2 Measures 120

3.5.2.1 Demographic data 120

3.5.2.2 CCHS 120

3.5.3 Validation of measure 121

3.5.3.1 Multidimensional Cultural Humility Scale (MCHS) 121

3.5.3.2 Cultural Humility Scale for Supervision (CHS-S) 121

3.5.3.3 Marlowe-Crowne Social Desirability Scale-Short Form (MCSDS-SF) 122

3.5.4 Procedure 122

3.5.5 Data analysis 122

3.6 Results 123

3.6.1 Validation of the CCHS 123

3.6.2 Sample 2 analysis 123

3.6.2.2 Initial assumptions 124

3.6.2.3 Confirmatory factor analysis 124

3.6.2.4 Exploratory factor analysis 124

3.6.2.5 Reliability 128

3.6.2.6 Convergent and divergent validity 129

3.6.2.7 Discriminant validity 130

3.7 Discussion 131

3.7.1 The measurement of cultural humility 133

3.7.2 Strengths and limitations 135

3.7.3 Clinical implications 137

3.7.4 Future research 138

3.7.5 Conclusion 139

3.8 References 140

Appendix A- University of Southampton Research Ethics Approval.....154

Appendix B- HRA Ethics Approval.....156

Appendix C- Inclusion Criteria (Sample One).....158

Appendix D- Tables of Demographics for Sample One and Two 159

Appendix E- Recruitment Email to Experts (Sample One) 165

Appendix F- Reminder email to Experts (Sample One) 166

Appendix G- Online participant information sheet and consent form (Sample One).....167

Appendix H - Demographic Questionnaire (Sample One) 172

Appendix I- Online Debrief Form (Sample One) 174

Appendix J- Inclusion Criteria (Sample Two) 176

Appendix K- Study Poster (Sample Two).....177

Appendix L- Email Recruitment (Sample Two) 178

Appendix M- Online Demographic Questionnaire (Sample Two) 180

Appendix N - Questionnaires (Sample Two).....183

Appendix O- Online Participant Information Sheet and Consent Form (Sample Two) 189

Appendix P- Online Debriefing Form (Sample Two).....194

Appendix Q- Descriptive Statistics of CCHS and MCHS (Sample Two) 196

Supplementary Materials.....197

Table of Tables

Chapter 2

Table 1 *Study Characteristics of Published Literature*…….. 48

Table 2 *Study Characteristics of Grey Literature*…….. 51

Chapter 3

Table 1 *Expert Demographics*……... 113

Table 2 *Delphi Round One Item Descriptive Statistics and Consensus*……. 117

Table 3 *Delphi Round Two Descriptive Statistics and Consensus*…… 118

Table 4 *Clinicians - Participants Demographics*……... 119

Table 5 *EFA Factor Loadings*…… 127

Table 6 *Factor Correlation Matrix of CCHS*……. 128

Table 7 *Cronbach α for the CCHS Subscales*…… 129

Table 8 *Pearson's correlations between the CCHS subscales and MCHS subscales and the MCSDS-SF scale*…… 130

Table of Figures

Chapter 2

Figure 1 *PRISMA Flow Diagram for Screening and Selection Process of Review (Page et al.,2021)*……. 46

Figure 2 *Thematic Map of Themes and Subthemes*..... 57

Chapter 3

Figure 1 *Scree Plot*……. 126

Research Thesis: Declaration of Authorship

Print name: Paola De Luca

Title of thesis: Advancing Culturally Responsive Clinical Supervision: Exploring Supervisees' Perspectives and the Development of the Clinician Cultural Humility Scale

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: 15.08.2025.....

Acknowledgements

Firstly, I'm very grateful to all the individuals who participated in this research, as without them, this study would not have been possible. I would like to acknowledge and thank my supervisors, Professor Margo Ononaiye, Dr Bianca Vekaria and Dr Peter Phiri. Their unwavering support, guidance and expertise have been invaluable, and I feel grateful to have shared this research with people as passionate about this topic as myself.

I would also like to thank Dr Catherine Brignell and Dr Juliet Lowther for their support and knowledge during the analysis process.

To my cohort friends and colleagues, I'm very thankful to have navigated this journey together, especially the morale support and laughter we have shared.

Finally, to my compassionate family and friends, who have been understanding and patient with me during this time and have always given me support in the moments of self-doubt, thank you. A special thank you to my partner Alex, for his unconditional encouragement, kindness and wisdom throughout this process. I feel extremely grateful that he has always supported me and believed in my capabilities.

Definitions and Abbreviations

AACODS .....Authority, Accuracy, Coverage, Objectivity, Date, Significance Checklist

BPS.....British Psychological Society

CASP.....Critical Appraisal Skills Programme

CCHS .....Clinician Cultural Humility Scale

CHS .....Cultural Humility Scale

CHS-S.....The Cultural Humility Scale for Supervision

CFA .....Confirmatory Factor Analysis

CFI.....Comparative Fit Index

EDI .....Equality, Diversity and Inclusion

EFA .....Exploratory Factor Analysis

ERGO .....Ethics and Research Governance Online

HCPC .....Health and Care Professions Council

HRA .....Health Research Authority

KMO.....Kaiser-Meyer-Olkin

MCC .....Multicultural Counselling Competence Model

MCHS.....The Multidimensional Cultural Humility Scale

MCSDS-SF.....Marlowe-Crowne Social Desirability Scale- Short Form

MCO.....Multicultural Orientation Framework

MCO-S .....Multicultural Orientation Framework for psychotherapy Supervision

NHS.....National Health Service

NICE.....National Institute for Health and Care Excellence

PRISMA.....Preferred Reporting Items for Systematic Reviews and Meta-Analyses

PROSPERO.....International Prospective Register of Systematic Reviews

REM.....Racially/ethnically-minoritised

RMSEA.....Root Mean Squared Error of Approximation

SD.....Standard Deviation

SPSS.....Statistical Package for the Social Sciences

SRIS.....Self-Reflection and Insight Scale

SRMR.....Standardised Root Mean Square Residual

TIPI.....Ten-Item Personality Inventory

TLI.....Tucker-Lewis Index

Chapter 1 Setting the Context of Culture in Supervision

Word count (excluding references): 2319

1.1 Locating 'me' in the Research

Reflexivity in qualitative research, and arguably all research, is particularly important because it examines the influence and value of the author's subjectivity (Olmos-Vega et al., 2023). During the process of researching and exploring culture in clinical supervision, I reflected on my position as a female Trainee Clinical Psychologist with dual nationality, residing in the south of the UK. My awareness of my British and Latin American heritage, and how deeply my cultural lens informs me as a clinician, was significantly heightened, specifically how I relate to my colleagues, clients, supervisors and the services I work in. I thought about how the language I use, and my mannerisms are intrinsically shaped by my cultural upbringing. I also considered how these aspects feed into how I form connections with others and, importantly, how I connect with the literature in these studies. For example, I resonated from reading about supervisees' experiences of feeling misunderstood due to their cultural background, being labelled negatively, or needing to educate colleagues about cultural differences. It made me reflect on how our work context may or may not facilitate our cultural identities to be shared or, feel understood. Sadly, culture awareness within clinical psychology in the UK has been criticised, especially by ethnically minoritised communities, for being culturally blind and both "consciously and unconsciously racism blind" (Wood & Patel, 2017, p. 282). For me, this further highlights the importance of researching culture in clinical psychology and drives my commitment to be part of tackling inherent systemic issues within the profession.

Furthermore, conducting this research made me reflect on my experiences of supervision and how I have had first-hand experience of a range of both culturally responsive and culturally unresponsive supervision. This elicited some feelings of sadness in me, as I place great value on the role of supervision in supporting my clinical work and professional development, and I wondered how significantly those encounters may have impacted my

practice. The emphasis on integrating EDI into training programmes and the growing awareness of the racial/cultural barriers to entering the profession of clinical psychology (Ahsan, 2020; Bawa et al., 2021), has only been highlighted in recent years. Additionally, it has been argued that bias during the Doctorate selection process, at application screening and interview, has contributed to the lack of diversity on clinical psychology training courses (Francis, 2024).

I resonated with many of the studies' participants who described the importance to them of a supervisor's proactiveness when discussing culture and the quality of the supervisory relationship. This made me reflect further on my experiences, particularly those instances in which I had to be proactive in raising cultural discussions, which were often accompanied by feeling a sense of uncertainty as to how these would be received by my supervisors. I felt benefit from supervisors initiating cultural discussions, particularly at the start of our supervisory relationship. I recognised that this may also intersect with my position as a trainee, on a clinical training programme which requires me to pass placements, and my ethnic background, which typically differs from my supervisors. As such, I have felt more aware of the power dynamic between myself and the supervisor, as I have often felt that my position and 'social graces' can place me in a position of holding less power (Burnham, 1993; 2012). This made me think about the diverse experiences of the participants in both studies and the importance of capturing such experiences in research, especially for those that may feel worried or powerless to get their voices heard in the workplace (Bailey et al., 2024; Daloye, 2022; Ebubedike et al., 2024; Shah, 2010).

Considering the Ecological Systems Model (Bronfenbrenner, 1994), I thought about the wider systems around me and the systems and context I was located within. From a mesosystem perspective, I recognised that the research supervisory team were also from ethnically minoritised backgrounds and, together, we shared a passion for improving

culturally responsive clinical supervision in the field. This fostered a sense of safety with conducting my research, knowing that the research team was aligned in its aims. I was mindful that, given our backgrounds and intentions, our perspectives could also carry bias. Therefore, it was important to acknowledge our position, which we discussed in research supervision including the possible implications of this.

From a wider macrosystem perspective, the British Psychological Society's (BPS; 2017) has guidelines and an emphasis on developing services to be more culturally sensitive (Fung et al., 2012; Kirmayer & Jarvis, 2019). However, I was surprised by the limited number of published studies in this area, which may suggest a bias or barrier within the macrosystem, towards being able to publish findings aimed at influencing systemic change relating to race and culture in psychotherapy, services, clinical programmes, and supervision practices. Conducting these studies coupled with my awareness of these systemic challenges, highlights the importance of disseminating the findings to facilitate improving culturally responsive clinical supervision and hopefully the wider implications from receiving such supervision.

1.1.1 Systematic Review

During the process of reviewing and analysing the data in the systematic review, I acknowledged that my aforementioned perspective including my role and cultural background was inherently intertwined in the process, which is an important component of the critical realist approach (Barnett-Page & Thomas, 2009). For example, I thought about when I was coding the data, if my lens was focusing on specific participants more than others. Although I did not identify this to be the case, I felt it was highly valuable that throughout the process, I engaged in regular discussion with my second reviewer, who was from a different ethnic background to me, and my research team, ensuring openness around the values I held and systems of which I was part. It is important to note that this perspective

was not perceived as a limitation; rather, it was regarded a valuable factor and is important to acknowledge in qualitative studies (Braun & Clarke, 2019).

1.2 The Shift from Cultural Competence to Cultural Humility

The term cultural competence, originally developed in the 1980s within the social work and psychology field (Gallegos, 1982), refers to the ability to have an awareness of both one's own and other's cultures, alongside the acquisition of relevant cultural knowledge pertaining to beliefs, values and behaviours (Danso, 2018). It is often defined as a "set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations'' (Cross et al., 1989, p. 4).

The literature regarding multicultural supervision has typically focussed on the pillars of competence, knowledge and skills (Constantine, 2003; Falender et al., 2014). There is also an awareness of the attitudes, often linked with values, to develop multicultural competence (Falender, 2014; Falender et al., 2014; Falender, 2018). Constantine (2003) noted that multicultural supervision competence is a dynamic process. However, Beagan (2018) argued that cultural competence is often framed as a more rigid concept, which positions professionals as the benchmark standard, and assumes that competence can be fully achieved. Furthermore, it has been highlighted that competence can be perceived as a static phenomenon, which is at odds with the inherent dynamism and ever-changing nature of culture (Lekas et al., 2020).

In comparison, the term cultural humility is understood as an ongoing process of reflection, education and learning which differs from the term competence (Tervalon & Murray-Garcia, 1998; Upshaw et al., 2020; Yeager & Bauer-Wu, 2013). Conversely, Yancu and Farmer (2017) proposed that cultural competence and cultural humility complement and

overlap with each other, instead of being independent concepts. They proposed that cultural competence is viewed as a 'product', with an end goal such as proficiency in knowledge which can be taught and acquired, whereas cultural humility describes a 'process' of reflection and openness. However, importantly, the authors highlighted that a core component of cultural humility is the recognition that we are all cultural beings with multiple and intersecting identities.

Taking this into account, the empirical study, therefore, focused on the term cultural humility due to the emphasis of its position of openness to continuously learn and reflect, irrespective of years of clinical experience or levels of expertise in psychotherapy, and the recognition that we are all cultural beings (Hook et al., 2013; Tervalon & Murray-Garcia, 1998). The empirical paper positions itself as encouraging all clinicians to engage with cultural humility and take a compassionate reflective perspective during the ongoing learning process.

1.3 The Delphi Method

In devising the questionnaire, it was important to have a methodological procedure which allowed for meaningful findings to be attained (Boynton & Greenhalgh, 2004; DeVellis, 2017). Therefore, the Delphi method was chosen to appropriately incorporate expert opinions and previous relevant literature to form part of devising this scale. Furthermore, the Delphi method has been recommended for scale development to enable the active involvement from experts in the field in contributing towards its development, without the risk of biasing responses (Dragostinov et al., 2022). Thus, an array of expertise and opinions are able to be captured.

The empirical study included experts from the field of psychological therapies and/or EDI to directly provide a valuable input into the development of the scale. During the

recruitment of these experts for the Delphi study, I had apprehension about whether experts would take interest in the research. I was aware that sometimes Delphi studies suffer from high drop-out rates (Schifano & Niederberger, 2025), and therefore, I was worried that the same could occur in the current study. Whilst there were procedures in the methodology which increased the likelihood for engagement, such as reminder emails, I felt uncertain as to whether we would have sufficient engagement across the two Delphi rounds. However, I was surprised to discover that the study had low drop-out rates, which suggested engagement with the study topic area. It is important to note that three rounds typically tend to be sufficient for a consensus to be reached, and for an adequate response rate (Stone & Busby, 2005), however the total number of rounds depend on when a consensus is reached by experts (Giannarou & Zervas, 2014). This research used a predefined definition of consensus, an important consideration of conducting a Delphi study (Barrett & Heale, 2020) and needed only two rounds to reach consensus. I wondered if the study had required more Delphi rounds, whether the attrition rates would have become an issue, a challenge which is noted in the literature (Flanagan et al., 2016; Keeney et al., 2001; Schifano & Niederberger, 2025).

The Delphi method is a technique which was devised with the purpose to reach a reliable consensus among a panel of experts (Dalkey & Helmer, 1963). There have been variations to the methodology (Sumsion, 1998; Jorm, 2015), however, there is common agreement that the method entails a structured process of communication to allow for a problem or question to be considered, with opportunity for information and knowledge to be shared or expressed (Linstone & Turnoff, 1975), which was the emphasis of this current research.

It has been argued that the method must contain these three components: ‘expert anonymity’, ‘controlled feedback’ and ‘group responses analysis’ (Adler & Ziglio, 1996) which was once again included in this research design. ‘Expert anonymity’ refers to experts being unaware of each other’s identity during the research process to support honest

responses and feedback. The term ‘controlled feedback’ is a common characteristic of Delphi studies, which describes how feedback on experts’ responses is relayed in between response rounds (Nasa et al., 2021). ‘Group response analysis’ serves to ensure that each response from experts is representative to the final consensus (a measure and indication of whether agreement has been reached between experts). Furthermore, other key features include: a facilitator/researcher who organises the study, identifies the question and determines the expert criteria, determines consensus criteria, undertakes recruiting of experts, ensures anonymous rounds for experts, gathers responses and analyses responses, and conducts potential multiple rounds with feedback until consensus is reached (Jorm, 2015). Consistent with this research, multiple rounds may also occur if some items on the questionnaire reach consensus, but other items need to be re-rated or there are new items that are included (Chalmers et al., 2014).

In mental health research, the Delphi method has been used broadly for a variety of purposes (Jorm, 2015), including developing guidelines for trial protocols (Tetzlaff et al., 2012), developing a mental health concept (San et al., 2015), and developing questionnaires (Xie et al., 2015). Furthermore, Delphi methods can incorporate both a qualitative and quantitative approaches (Trevelyan & Robinson, 2015), such as open-ended questions and Likert-scale questionnaires. For example, for guidelines studies, it is typical for focus groups to be used with expert panels to then inform subsequent questionnaire items for further rounds (Jorm, 2015). Within scale development studies, it is more common to use quantitative questionnaires within the Delphi methodology (Lee et al., 2020; Mengual-Andrés et al., 2016; Neupane & Bhattarai, 2024). Notably, it has been argued that the Delphi method should not be used to ask factual questions; rather, opinion-based questions are more suitable (Gordon, 1994). Therefore, the Delphi method represents an adaptable and pragmatic technique to enable answers to appropriate research questions (Boynton & Greenhalgh, 2004;

DeVellis 2017; Dragostinov et al., 2022), which is why it was chosen for this questionnaire development study.

1.4 Dissemination Plan

The systematic review paper will be submitted to the 'Clinical Psychology and Psychotherapy' journal because of its international reach, and its focus on novel findings within the mental health and clinical psychology field. This journal is appropriate because the review is current and novel. The empirical paper will be submitted to the 'British Journal of Psychology' due to its interest in studies that offer new implications for practice using a broad range of methodological approaches. It is hoped that publishing in these journals will allow for the important findings and implications to be disseminated widely across the field.

1.5 References

Adler, M., & Ziglio, E. (1996). *Gazing into the oracle: The delphi method and its application to social policy and public health*. Jessica Kingsley Publishers.

Ahsan, S. (2020). Holding up the mirror: Deconstructing whiteness in clinical psychology. *Journal of Critical Psychology, Counselling and Psychotherapy, 20*(3), 45–55.

Bailey, A., Tickle, A., & Sabin-Farrell, R. (2024). 'Isn't it mad that we're all psychologists and we can't talk about our feelings?': A mixed-methods study exploring trainee clinical psychologists' experience of (non) disclosure of psychological distress during training. *Clinical Psychology & Psychotherapy*, *31*(1), e2941, 1-20. https://doi.org/10.1002/cpp.2941

Barnett-Page, E., & Thomas, J. (2009). Methods for the synthesis of qualitative research: A critical review. *BMC Medical Research Methodology*, *9*(59), 1-11. https://doi.org/10.1186/1471-2288-9-59

Barrett, D., & Heale, R. (2020). What are Delphi studies?. *Evidence-based nursing*, *23*(3), 68-69. https://doi.org/10.1136/ebnurs-2020-103303

Bawa, H., Cudmore, K., Ong, L., & Knott, K. (2021). Barriers and improvements to the clinical psychology doctorate selection process. *Clinical Psychology Forum, 339*, 16-20. https://doi.org/10.53841/bpscpf.2021.1.339.16

Beagan, B.L. (2018). A critique of cultural competence: Assumptions, limitations, and alternatives. In C. Frisby, & W. O'Donohue (Eds.), *Cultural competence in applied psychology* (pp. 123-138). Springer. https://doi.org/10.1007/978-3-319-78997-2_

Boynton, P. M., & Greenhalgh, T. (2004). Selecting, designing, and developing your questionnaire. *BMJ, 328*(7451), 1312–1315. https://doi.org/10.1136/bmj.328.7451.1312

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health*, *11*(4), 589-597. https://doi.org/10.1080/2159676X.2019.1628806

British Psychological Society. (2017). *Practice Guidelines Third edition.* https://doi.org/10.53841/bpsrep.2017.inf115

Bronfenbrenner, U. (1994). Ecological models of human development. In T. Husen & T. N. Postlethwaite (Eds.), *International encyclopedia of education* (2nd ed., pp. 1643–1647). Pergamon/Elsevier.

Burnham, J. (1993). Systemic supervision: The evolution of reflexivity in the context of the supervisory relationship. *Human Systems: The Journal of Systemic Consultation and Management, 4,* 349- 381.

Burnham, J. (2012). Developments in social GRRRAAACCEEESSS: Visible-invisible and voiced unvoiced. In I. B. Krause (Ed.), *Culture and reflexivity in systemic psychotherapy: Mutual perspectives* (1st ed., pp. 139–160). Karnac Books.

Chalmers, K. J., Bond, K. S., Jorm, A. F., Kelly, C. M., Kitchener, B. A., & Williams-Tchen, A. J. (2014). Providing culturally appropriate mental health first aid to an Aboriginal or Torres Strait Islander adolescent: development of expert consensus guidelines. *International Journal of Mental Health Systems*, *8*, 1-10. https://doi.org/10.1186/1752-4458-8-6

Constantine, M. G. (2003). Multicultural competence in supervision. In D. B., Pope-Davis, H. L. K., Coleman, W. Ming Liu, & R. L., Toporek (Eds.), *Handbook of multicultural competencies in counseling and psychology* (pp. 83-39)1. Sage Publications.

Cross, T. L., Bazron, B. J., Dennis, K. W., & Isaacs, M. R. (1989). *Towards a culturally competent system of care: A monograph on effective services for minority children who are severely emotionally disturbed.* CASSP Technical Assistance Center. https://files.eric.ed.gov/fulltext/ED330171.pdf

Dalkey, N., & Helmer, O. (1963). An experimental application of the delphi method to the use of experts. *Management Science*, *9*(3), 458-467. https://doi.org/10.1287/mnsc.9.3.458

Daloye, D. (2022). The experiences of black and minority ethnic trainee counselling psychologists: An interpretative phenomenological analysis. *Counselling Psychology Review*, *37*(1), 31-40. https://doi.org/10.53841/bpscpr.2022.37.1.31

Danso, R. (2018). Cultural competence and cultural humility: A critical reflection on key cultural diversity concepts. *Journal of Social Work, 18*, 410-430. https://doi.org/10.1177/1468017316654341

DeVellis, R. F. (2017). *Scale development: Theory and applications* (4th ed.). Sage Publications.

Dragostinov, Y., Harðardóttir, D., McKenna, P. E., Robb, D. A., Nesset, B., Ahmad, M. I., ... & Rajendran, G. (2022). Preliminary psychometric scale development using the mixed methods Delphi technique. *Methods in Psychology*, *7*(100103), 1-10. https://doi.org/10.1016/j.metip.2022.100103

Ebubedike, N., Callanan, M., & Oldershaw, A. (2024). 'The relentless nature of whiteness': Black psychologists' experiences of racial microaggressions in cross-cultural

supervision. *Clinical Psychology and Psychotherapy, 31*(3), 1-14. https://doi.org/10.1002/cpp.3011

Falender, C. A. (2014). Clinical supervision in a competency-based era. *South African Journal of Psychology*, *44*(1), 6-17. https://doi.org/10.1177/0081246313516260

Falender, C. A. (2018). Clinical supervision—the missing ingredient. *American Psychologist*, *73*(9), 1240-1250. https://psycnet.apa.org/doi/10.1037/amp0000385

Falender C. A., Shafranske E. P., Falicov C. (Eds.). (2014). *Multiculturalism and diversity in clinical supervision: A competency-based approach*. American Psychological Association.

Flanagan, T., Ashmore, R., Banks, D., & MacInnes, D. (2016). The Delphi method: Methodological issues arising from a study examining factors influencing the publication or non-publication of mental health nursing research. *Mental Health Review Journal*, *21*(2), 85-94. https://doi.org/10.1108/mhrj-07-2015-0020

Francis, S. (2024). Exploring considerations of equality, diversity and inclusion in selection for a doctorate in clinical psychology programme: A qualitative study. *Stolen Tools*, *2*(1), 17-29. https://doi.org/10.59745/st.v2i1.36

Fung, K., Lo, H. T., Srivastava, R., & Andermann, L. (2012). Organizational cultural competence consultation to a mental health institution. *Transcultural Psychiatry*, *49*(2), 165-184. https://doi.org/10.1177/1363461512439740

Gallegos, J. S. (1982). The ethnic competence model for social work education. In B. W. White (Ed.), *Color in a white society* (pp. 1-9). National Association of Social Workers.

Giannarou, L., & Zervas, E. (2014). Using delphi technique to build consensus in practice. *International Journal of Business Science & Applied Management*, *9*(2), 65-82. https://hdl.handle.net/10419/190657

Gordon, T. J. (1994). The delphi method. *Futures Research Methodology*, *2*(3), 1-30.

Hook, J. N., Davis, D. E., Owen, J., Worthington, E. L., Jr., & Utsey, S. O. (2013). Cultural humility: Measuring openness to culturally diverse clients. *Journal of Counseling Psychology, 60*(3), 353–366. https://doi.org/10.1037/a0032595

Jorm, A. F. (2015). Using the Delphi expert consensus method in mental health research. *Australian & New Zealand Journal of Psychiatry*, *49*(10), 887-897. https://doi.org/10.1177/0004867415600891

Keeney, S., Hasson, F., & McKenna, H. P. (2001). A critical review of the delphi technique as a research methodology for nursing. *International Journal of Nursing Studies*, *38*(2), 195-200. https://doi.org/10.1016/S0020-7489(00)00044-4

Kirmayer, L. J., & Jarvis, G. E. (2019). Culturally responsive services as a path to equity in mental healthcare. *Healthcare Papers*, *18*(2), 11-23.

Lee, J., Lee, S. H., & Chang, G. T. (2020). Expert consensus on the development of a health-related questionnaire for the pediatric field of korean medicine: A delphi study. *BMC Complementary Medicine and Therapies*, *20*(10), 1-13. https://doi.org/10.1186/s12906-019-2796-x

Lekas, H.-M., Pahl, K., & Fuller Lewis, C. (2020). Rethinking cultural competence: Shifting to cultural humility. *Health Services Insights*, *13,* 1-4. https://doi.org/10.1177/1178632920970580

Linstone, H. A., & Turoff, M. (Eds.). (1975). *The delphi method*. Addison-Wesley.

Mengual-Andrés, S., Roig-Vila, R., & Mira, J. B. (2016). Delphi study for the design and validation of a questionnaire about digital competences in higher education. *International Journal of Educational Technology in Higher Education*, *13*, 1-11. https://doi.org/10.1186/s41239-016-0009-y

Nasa, P., Jain, R., & Juneja, D. (2021). Delphi methodology in healthcare research: How to decide its appropriateness. *World Journal of Methodology*, *11*(4), 116-129. https://doi.org/10.5662/wjm.v11.i4.116

Neupane, S. M., & Bhattarai, P. C. (2024). Constructing the scale to measure entrepreneurial traits by using the modified delphi method. *Heliyon*, *10*(7), e28410. https://doi.org/10.1016/j.heliyon.2024.e28410

Olmos-Vega, F. M., Stalmeijer, R. E., Varpio, L., & Kahlke, R. (2023). A practical guide to reflexivity in qualitative research: Amee guide no. 149. *Medical Teacher*, *45*(3), 241-251. https://doi.org/10.1080/0142159X.2022.2057287

San, L., Serrano, M., Cañas, F., Romero, S. L., Sánchez-Cabezudo, Á., & Villar, M. (2015). Towards a pragmatic and operational definition of relapse in schizophrenia: A Delphi consensus approach. *International Journal of Psychiatry in Clinical Practice*, *19*(2), 90-98. https://doi.org/10.3109/13651501.2014.1002501

Schifano, J., & Niederberger, M. (2025). How Delphi studies in the health sciences find consensus: A scoping review. *Systematic Reviews*, *14*(14), 1-21. https://doi.org/10.1186/s13643-024-02738-3

Shah, S. (2010). *The experience of being a trainee clinical psychologist from a black and minority ethnic group: A qualitative study* [Doctoral dissertation, University of Hertfordshire). University of Hertfordshire Research Archive. http://hdl.handle.net/2299/5088

Stone F. L., & Busby, D. (2005). The Delphi method. In D. Sprenkle & F. Piercy (Eds.), *Research methods in family therapy* (2nd ed., pp.238–253). Guilford Press.

Sumsion, T. (1998). The Delphi technique: An adaptive research tool. *British Journal of Occupational Therapy, 61*(10), 403–406. https://doi.org/10.1177/030802269806100403

Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved*, *9*(2), 117-125. https://doi.org/10.1353/hpu.2010.0233

Tetzlaff, J. M., Moher, D., & Chan, A. W. (2012). Developing a guideline for clinical trial protocol content: Delphi consensus survey. *Trials*, *13*(176), 1-10. https://doi.org/10.1186/1745-6215-13-176

Trevelyan, E. G., & Robinson, N. (2015). Delphi methodology in health research: How to do it?. *European Journal of Integrative Medicine*, *7*(4), 423-428. https://doi.org/10.1016/j.eujim.2015.07.002

Upshaw, N. C., Lewis Jr, D. E., & Nelson, A. L. (2020). Cultural humility in action: Reflective and process-oriented supervision with black trainees. *Training and Education in Professional Psychology*, *14*(4), 277-284. http://dx.doi.org/10.1037/tep0000284

Wood, N., & Patel, N. (2017). On addressing 'Whiteness' during clinical psychology training. *South African Journal of Psychology*, *47*(3), 280-291. https://doi.org/10.1177/0081246317722099

Xie, Z., Lv, X., Hu, Y., Ma, W., Xie, H., Lin, K., ... & Wang, H. (2015). Development and validation of the geriatric depression inventory in chinese culture. *International Psychogeriatrics*, *27*(9), 1505-1511. https://doi.org/10.1017/S1041610215000162

Yancu, C., & Farmer, D. (2017). Product or process: Cultural competence or cultural humility. *Palliative Medicine and Hospice Care Open Journal*, *3*(1),1-4. http://dx.doi.org/10.17140/PMHCOJ-3-e005

Yeager, K. A., & Bauer-Wu, S. (2013). Cultural humility: Essential foundation for clinical researchers. *Applied Nursing Research*, *26*(4), 251-256. https://doi.org/10.1016/j.apnr.2013.06.008

Chapter 2 Supervisees' Perspectives of the Impact of Receiving Culturally Responsive Clinical Supervision: A Qualitative 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. Authors guidelines can be found: https://onlinelibrary.wiley.com/page/journal/10990879/homepage/forauthors.html

Word count (excluding abstract, tables, figures, references and appendices): 8,756

2.1 Abstract

Objective: Clinical practice guidelines currently emphasise the importance of delivering culturally responsive care to diverse populations. There are also recommendations for services to be culturally aware to ensure that appropriate support is being provided for all communities. Quantitative studies and reviews identified the positive implications of adopting a culturally responsive approach in supervision. However, it is unclear what the impact of receiving such supervision is from supervisees' perspectives. The current review aimed to be the first to focus on the impact of receiving culturally responsive clinical supervision as a supervisee adopting a qualitative approach.

Method: A systematic search of five databases (MEDLINE, PsycINFO, CINAHL, Web of Science and ProQuest) identified 15 studies which were included in the final review. A thematic synthesis was conducted to identify the final themes and produce a thematic map.

Results: Three main themes were found relating to the impact of receiving culturally responsive clinical supervision: 'strengthened the supervisory relationship', 'supported professional development and learning', and 'facilitated culturally responsive clinical work'. Nine subthemes were also discovered.

Conclusions: Overall, it was found that culturally responsive supervision positively impacted supervisees, from reinforcing the supervisory relationship to developing their clinical skills. The findings provide support for the value of culturally responsive supervision due to the broad implications on clinical practice. The review highlighted the need for further research to be conducted across more countries to capture diverse cultures and perspectives. Implications and recommendations for clinicians, training programmes and services are discussed.

Key Practitioner Message:

- Supervisees found culturally responsive supervision impacts positively on their development, supervisory relationship and their clinical skills.
- Culturally responsive clinical supervision can benefit supervisees, supervisors and clinical practice.
- It is important that supervisors take a proactive role in facilitating culturally responsive supervision.

Keywords: *Cultural responsivity, clinical supervision, supervisee, thematic synthesis*

2.2 Introduction

Within the context of a culturally and ethnically diverse United Kingdom (UK; Hussain et al., 2020; Vertovec, 2007), there have been initiatives aimed at increasing diversity within the psychological professions' workforce (Cape et al., 2008; Ononaiye, 2024; Turpin & Fensom, 2004). The initiatives aim to develop a culturally diverse workforce that support the needs of diverse client groups with an attuned understanding of culture and diversity, which in turn informs service accessibility and treatment (Edwards et al., 2022). Although there is a long way to go within all professions including clinical psychology (Ahsan, 2020; Wood & Patel, 2017), progress has been made in how services have started to recognise a need for representation and cultural awareness within their workforce (Ononaiye, 2024; Turpin & Coleman, 2010). Therefore, it is important that clinicians are supported to build their skills in effectively responding to the needs of culturally diverse populations (Edwards et al., 2022).

2.2.1 Clinical Supervision

Clinical supervision is an essential requirement of professional practice for clinicians, integral to both clinical training programs and the standards of proficiency established by the Health and Care Professions Council (HCPC) for practitioner psychologists (HCPC, 2023a). It has been proposed that clinical supervision is a space to develop safety for the supervisee, with protective boundaries such as confidentiality, facilitating the discussion of personal and professional reflections (Care Quality Commission, 2013). The key aims of clinical supervision are to provide a regular process that facilitates learning, supports the professional development of the supervisee, and ensures the ongoing consideration of client wellbeing, safety, and welfare (Bernard & Goodyear, 2013; Falender & Shafranske, 2004). In support, Proctor (1988) conceptualised clinical supervision as serving three main functions, including 'formative' that supports supervisees' development, 'normative' involving conducting a

review of supervisees' clinical work in adherence to the relevant guidelines, and 'restorative' that supports supervisees' wellbeing and resilience. Furthermore, Falender and Shafranske (2004) defined clinical supervision as a collaborative process in which various techniques are employed, including modelling and problem-solving as well as maintaining legal and ethical requirements, in keeping with the standards of the relevant psychological professional bodies governing the clinician's practice.

Importantly, DePue et al. (2022) established a connection between clinical supervision, the supervisory working alliance (SWA), and the client therapeutic alliance. The SWA has also been shown to be positively associated with supervision outcome, and the supervisees' perception of the supervisory relationship had a positive correlation with the relationship to the client (Park et al., 2019). Furthermore, attending to cultural factors can serve to develop a strong working alliance between supervisor and supervisee (Crockett & Hays, 2015; Vekaria et al., 2023a).

2.2.2 Culture in Clinical Supervision

Although culture has been defined in different ways, it is commonly defined as "a group with shared behaviours, values, and beliefs that are passed from generation to generation" (Keith, 2011, p.4). Importantly, culture can be dynamic and complex encompassing various subcultures (Keith, 2011; Miller, 2008). Culture is also influential in shaping values and beliefs, as well as how services and clinicians understand their clinical work (Gainsbury, 2017).

Recommendations support the need for mental health services to be more culturally aware in order to appropriately and equitably support clients from diverse backgrounds (Fung et al., 2012; Kirmayer & Jarvis, 2019). This is vital considering that ethnically minoritised populations often report having more negative experiences in their engagement with mental

health services, as is evident in the higher treatment dropout rates (de Haan et al., 2018; Dixon et al., 2016; Maura et al., 2017) and an increased use of crisis services (Delphin-Rittmon et al., 2015). Such conditions accentuate the disparity and inequality in both access to care and treatment outcomes (Suresh & Bhui, 2006). Furthermore, there are potential risks associated with clinicians' lack of consciousness to their own beliefs, stereotypes and biases, among which include negatively impacting their clients' therapeutic experiences (Hook et al., 2016). Additionally, it has been suggested that such unawareness on the clinician's part may create barriers for clients from ethnic minoritised communities and give rise to feelings of being misunderstood, mistrust and microaggressions (Williams & Halstead, 2019). Consequently, the evidence emphasises the detrimental effects of being culturally unaware and unresponsive, which reinforces the central importance of embedding an appreciation of culture within clinical supervision.

The British Psychological Society's (BPS, 2017) practice guidelines state the importance of practitioners developing both their cultural awareness and cultural responsivity, as both can impact the care people receive. In particular, the guidelines emphasise that "all psychologists will have the necessary skills and abilities to work with all sections of the community" (BPS, 2017, p. 32). Clinical supervision offers an opportunity to consider cultural issues within both clinical practice and within the supervisory relationship (Scaife, 2019). Furthermore, it has been argued that cultural responsivity expresses the understanding that a clinician's cultural background is intrinsically entwined within their clinical work and supervision (Arthur & Collins, 2009). Cultural humility is regarded as a critical facilitator of cultural responsivity and is conceptualised as an approach whereby practitioners, while engaging in interpersonal interactions, demonstrate an appreciation for the values, beliefs, and cultural contexts of others (Lekas et al., 2020; Stubbe, 2020). In turn reflecting an open commitment to continuous learning and development. Within clinical

practice, it has also been conceptualised as the "ability to maintain an interpersonal stance that is other-oriented in relation to aspects of cultural identity that are most important to the client" (Hook et al., 2013, p. 354). It is argued that supervisors who demonstrate cultural humility enhance positive interactions with their supervisees from diverse backgrounds and naturally promote their development (Watkins et al., 2019a). Therefore, culturally responsive supervision is important for both clinicians and client care, as they are often intertwined.

2.2.3 Cultural Models of Clinical Supervision

Traditional models of supervision do not consider the role of culture (e.g. Liese & Beck, 1997; Wetchler, 1990), however, some consideration has been given in more recent models. For example, the Seven-Eyed model (Hawkins & Shohet, 2012; Hawkins & McMahon, 2020) is a relational systemic model which draws on numerous psychological theories and comprises two primary processes, namely the clinical work with the client (the client, the supervisee's intervention, and the supervisee-client relationship) and the supervisory process (the supervisee, the supervisor, and the supervisory relationship).The seventh eye of the model contemplates the wider context of these two processes. While this model details seven lenses of the supervisory process, to support in reflecting upon both practitioner and client identities (Buxton & Scudder, 2022), it is important to note that it does not explicitly assert culture to be a central component.

One model, however, that does attribute culture as a fundamental pillar is the Multicultural Counselling Competence model (MCC; Sue et al., 1982; Sue, 1990). While it was not originally developed as a supervision model, it has since been heavily utilised over the years in developing measures (e.g. LaFromboise et al., 1991; Sodowsky et al., 1994) and as the basis of ethical practice (Arredondo & Toporek, 2004; Constantine & Ladany, 2001). The MCC model specifies three components that can be adopted during clinical supervision

to support reflection. This includes an 'awareness' of one's own assumptions and biases, 'knowledge' by attempting to understand the client's world view, and 'skills' to enable the development of strategies and interventions which meet the needs of the client). There has been a subsequent development to the model with the proposed Multiple Dimensions of Cultural Competence model (MDCC; Sue, 2001), however, the literature regarding these models is not without critique. There are concerns as to how the models would practically support clinicians when working with clients from a different ethnic background (Mollen et al., 2003) and in instances of cultural conflicts (Beaulieu, 2011). A content analysis raised questions regarding the quality of the research into the MCC, noting that it predominantly comprised of descriptive survey findings and use of convenience sampling techniques (Worthington et al., 2007). Furthermore, the tenuous link between scales (e.g. the Multicultural Counseling Inventory; Sodowsky et al., 1994) and the model's framework calls into question the model's practical utility. Worthington and colleagues (2007) recommended that further process and outcome research is conducted to bridge the gap between theory and practice.

The Multicultural Orientation Framework (MCO; Owen, 2013) has been proposed as a valuable perspective to adopt within the clinical supervision process to ensure culture is effectively embedded (Watkins et al., 2019b). Specifically, the MCO framework for psychotherapy supervision (MCO-S; Watkins et al., 2019b) outlines the three main pillars of cultural humility, cultural comfort and cultural opportunities. In consideration of cultural humility, supervisors take an open stance, recognising themselves as cultural beings, with a willingness to learn and understand the backgrounds of their supervisees and clients. The pillar of cultural comfort refers to the emotional responses experienced while engaging in discussions around culture that may include discomfort. Supervisors endeavour to convey a non-defensive and open attitude, allowing them to work through any cultural discomfort to,

in turn, facilitate the meaningful exploration of cultural issues. Finally, within the scope of the cultural opportunities pillar are the opportune moments, both pursued and missed, that arise during supervision for engaging in cultural discussions with supervisees. This often requires supervisors to take a proactive approach to discuss cultural topics safely within supervision.

As a new addition to the existing body of literature, research examining the impact of MCO-S remains limited (Watkins et al., 2019b). However, there has been a recent quantitative study which found the more supervisees perceived their supervisors to demonstrate cultural humility, the greater satisfaction they felt with their supervision experience (Wilcox et al., 2022a). While these findings go some way in substantiating the model, a notable critique is that participants were predominantly from a White American background, thus questioning the generalisability of the results to all heritages, cultures and ethnicities. Wilcox and colleagues (2023) attempted to address this limitation by exploring cultural humility, comfort and supervision processes for psychotherapist trainees from an ethnically minoritised background. Their findings largely supported those of their previous study, revealing that supervisees who rated White supervisors as demonstrating higher levels of cultural humility and comfort also reported stronger working alliances and greater satisfaction within clinical supervision compared to lower reported levels of cultural humility (Wilcox et al., 2023). Additionally, a recent scoping review reaffirmed the importance of MCO/MCO-S as key conceptualisations in the clinical supervisory process and in supporting positive outcomes of supervision (Mahon, 2024) however, as this was not a systematic review, it did not provide a synthesis, but rather, used content analysis and frequency count to ascertain the report's findings. It also did not explore or synthesise the possible rich in-depth experiences that qualitative studies can offer (Creswell & Poth, 2018).

Nevertheless, the findings complement the existing quantitative literature that acknowledges culturally responsive supervision does incorporate humility and competence through cultural discussions and reflections (Burkard et al., 2006; Sue & Sue, 2013; Vekaria et al., 2023b). Supervisees' perspectives of supervisors' cultural humility predicted whether supervisory concerns were raised and, therefore, the likelihood of them being addressed (Cook et al., 2020). Specifically, supervisees who perceived their supervisors as more culturally humble predicted fewer nondisclosures of supervision feedback and concerns in general, including but not limited to cultural issues (Cook et al., 2020), thus further consolidating the importance of cultural humility within culturally responsive supervision, from supervisees perspectives. It would, however, be valuable to further understand supervisees' experiences of cultural responsivity in supervision interactions, specifically from a qualitative perspective.

2.2.4 Power, Culture and Clinical Supervision

It is pertinent to consider that within the supervisory relationship there is often a power hierarchy, with supervisees typically experiencing less power within this dynamic (Stefano et al., 2017). Nevertheless, the relationship is capable of being deeply layered with complexities and nuances (Cook et al., 2018; Patel, 2011). When considering the intersectionality of cultural discussions within the supervisory dynamic, it is probable that supervisees and supervisors experience these discussions differently. Ryde (2000) identifies three primary forms of power present in cross-cultural supervision: role power, individual power, and cultural power. Role power is typically held by the supervisor, who possesses the most power, while cultural power pertains to the individual belonging to the dominant ethnic group. Individual power has its origin in the individual personality traits of either the supervisor or supervisee, which may transcend both their professional role and culture (Ryde,

2000). Also, it has been argued that not acknowledging the role of power in the supervision process can be potentially detrimental and lead to unsafe practices (Patel, 2011). Consequently, this multifaceted dynamic within clinical supervision creates difference in how supervision is experienced. Currently within the UK, 84% of psychological practitioners, and therefore supervisors, are predominately from White backgrounds (HCPC, 2023b) and, by virtue, will hold considerable cultural and role power, which may be problematic if not addressed.

2.2.5 Current Review

Quantitative research suggests the importance of culturally responsive clinical supervision and its implications (Wilcox et al., 2022; 2023; Zhang et al., 2021). To date, there has not been a qualitative systematic review exploring experiences of culturally responsive clinical supervision. There is a need for the literature to provide more clarity on the impact of cultural responsivity in clinical supervision particularly from supervisees' perspectives due to the concept of power (Patel, 2011; Ryde, 2000) and the potential harm that can be caused in supervision if not appropriately discussed (Vekaria et al., 2023a). Qualitative research is often well-suited to generating deeper insights into such experiences (Akyıldız & Ahmed, 2021; Tavallaei & Talib, 2010) and building knowledge of complex issues through different lenses (Gough & Lyons, 2016), such as the complex processes inherent to the culturally responsive supervisory relationship. This review will, therefore, conduct systematic qualitative synthesis to gain a deeper understanding of supervisees' experiences of receiving culturally responsive clinical supervision. Additionally, this review aims to explore supervisees' perspectives of the impact of experiences, emotionally, behaviourally, and/or on their clinical practice. Specifically, this review aims to facilitate the development of culturally

responsive clinical supervision and uncover its potential beneficial impacts for both the supervisor, supervisee and for clinical practice.

2.2.6 Research Question

What are supervisees' perspectives of the impact of receiving culturally responsive clinical supervision?

2.3 Method

As part of the systematic methodology, the review protocol was registered with the International Prospective Register of Systematic Reviews (PROSPERO; CRD42024561053). This study used the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA; Page et al., 2021) to report the study's findings.

2.3.1 Search Strategy

A systematic search method was utilised in the following databases: MEDLINE, PsycINFO, CINAHL, Web of Science and ProQuest during late October and early November 2024, with a final search run in early February 2025 to ensure that any new relevant papers were also captured. Regarding the search strategy, the Boolean method was used which used a combination of relevant keywords and phrases such as (i) clinical supervis* OR supervis*, (ii) perspective* OR attitude*, (iii) cultural N1(responsive* OR humility). For the complete search strategy, please refer to Appendix A. Moreover, all included papers were published in English and were reviewed using Rayyan.

2.3.2 Eligibility Criteria

The studies were screened against the inclusion and exclusion criteria (refer to Appendix B for full criteria) by the main researcher. Only studies that were empirical, concerned with supervisees receiving clinical supervision by a qualified therapist, and explicitly focusing on

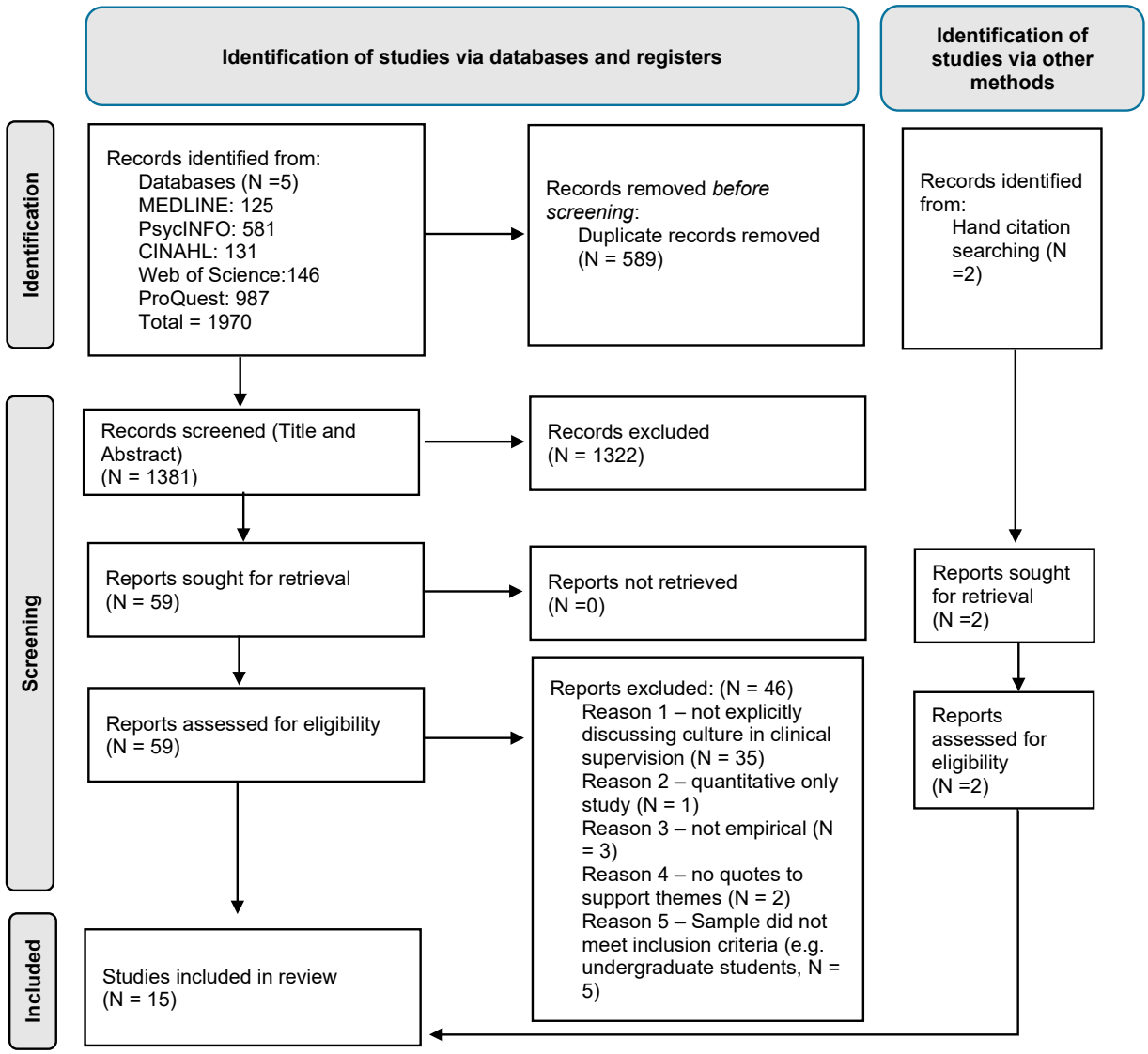
discussions of culture (responsivity/ humility or competence) in the context of clinical practice within clinical supervision were included. Published studies and grey literature were included. Mixed-methods studies were considered if eligible only from the qualitative section of study. Studies that did not meet the inclusion criteria, such as non-empirical papers, solely quantitative papers, studies which only concerned research supervision, undergraduate students and those that did not explicitly discuss culture within clinical supervision were excluded. Studies that only focused on group supervision were also excluded. In line with Cherry et al.'s (2024) recommendations, 10% of randomly selected studies at the title and abstract stage were reviewed by a second reviewer, and all studies at the full text stage comparing against the eligibility criteria. There were no discrepancies between reviewers at both stages.

2.3.3 Study Selection

The database searches initially found 1970 papers (when filtered for English studies only) and from these initial finds, 589 duplicates were removed. An initial screening of titles and abstracts followed, and 59 studies were included. These studies were then full-text reviewed against the eligibility criteria to determine their inclusion. The reference lists of full-text papers and relevant systematic reviews were also used to hand-search and identify any further relevant papers for inclusion. As shown in the PRISMA tool (Page et al., 2021; Figure 1), 15 papers were included in the systematic synthesis.

Figure 1

PRISMA Flow Diagram for Screening and Selection Process of Review (Page et al., 2021)



2.3.4 Data Extraction

The following key characteristics from each study were extracted and are outlined in Tables 1 and 2: study's year, country origin, aims, design, sample size, participant demographics (including age, profession, gender and ethnicity), and key study findings. All main qualitative findings, including quotes, were extracted for the synthesis analysis.

2.3.5 Quality Assessment

The quality assessment of the included published papers was conducted using the Critical Appraisal Skills Programme (CASP, 2024). This tool was used because it is a specific checklist for qualitative studies and is commonly utilised as an appraisal tool which enables insight into its critiques (Dixon-Woods et al., 2007; Long et al., 2020). It also offers a structured approach for researchers to follow (Soilemezi & Linceviciute, 2018). The CASP (2024) checklist assesses the validity of results, what the results are, and how valuable the results are. The maximum score across the factors was 10, with higher scores indicating higher quality studies (see Appendix C for detailed table).

Five unpublished papers, doctoral dissertation papers, were quality assessed using the AACODS Checklist (Tyndall, 2010), which is a specific quality assessment tool for grey literature. The checklist comprises of six categories against which papers are scored: authority, accuracy, coverage, objectivity, date and significance (AACODS, 2010). A maximum score of six could be obtained across the six categories, with higher scores indicating higher quality studies (see Appendix C for detailed table).

A second reviewer independently rated five of the included studies. Scores were compared and discussed, and reviewers discussed if there were any discrepancies with scores, which were all resolved through discussions. No studies were omitted due to quality assessment.

Table 1

Study Characteristics of Published Literature

Authors (Years), Country	Study Aims	Design and Instruments	Sample Size & Participant Characteristics (N)	Age Range & Mean	Gender	Ethnicity/Race	Key Findings
Ancis & Marshall, (2010), USA	To explore trainee counsellor's experiences of culturally competent CS using the multicultural framework.	Qualitative design (constant comparative), Semi-structured interviews.	Counselling psychology doctorate students. *(N=4)*	27-41	Woman = 1 Man = 2 Unknown = 1	European American = 3 Asian American = 1	Aspects across the five domains of the multiculturally competent supervision framework (Ancis & Ladany, 2001) were described by the trainees. Impact of receiving this type of supervision was also discussed.
Burkard et al., (2006), USA	To explore supervisees experiences of culturally responsive and unresponsive cross-cultural CS.	Qualitative design (consensual qualitative research; CQR), Semi-structured interviews.	Doctoral professional psychology students, either counselling or clinical psychology *(N = 26*)	24-48, Mean =30.15 (SD= 5.47)	Women = 26	European American = 13 African American = 6 Asian American = 6 Latina = 1	Culturally responsive CS had positive implications for both the supervisory relationship and client outcomes. Culturally un-responsive CS had negative implications, with ethnically minoritised supervisees experiencing more unresponsive CS.
Jin et al., (2022), USA	To explore international supervisees' experiences of CS, including supervisors'	Qualitative design (phenomenological approach), open-ended	Doctoral professional psychology students, either counselling or clinical psychology	28-36, Mean = 31.60 (SD = 2.80)	Women = 5 Men = 5	Asian = 8 (80%) Latinx = 2 (20%)	Four main themes (& five sub-themes) were found which included experiences of supervisors' multicultural competence and lack of, and challenges associated with

	multicultural competency.	questionnaire via an online study	(*N = 10*)				this. Implications for supervisors and training programmes are discussed.
Kuznietsova et al., (2025), Ireland	To explore psychotherapists supervisees' experiences of multicultural supervision in Ireland.	Qualitative design (descriptive-interpretive), semi-structured interviews	Trainee/qualified clinicians in psychological therapy. 10 qualified clinicians and five counselling psychology doctoral trainees. (*N = 15)*	20-59	Male = 7 Female = 8	Irish = 11 Irish-English = 1 Australian = 1 Southern European = 1 Eastern European = 1	Five domains were found from supervisees' perception of helpful and unhelpful cultural CS and its impact in the context of working in Ireland. Specific supervisors' behaviours are discussed and implications for practice.
Soheilian et al., (2014) USA	To explore supervisees' perspectives of their supervisor's cultural competence in CS and the clinical implications.	Qualitative design (discovery-oriented), open-ended questions via an online survey.	Psychotherapy students enrolled to either a master's – or doctoral-level training programme. *(N = 102)*	22-67 Mean = 29.34 (SD = 6.71)	Woman = 79 (78%) Man = 22 (22%) Unknown =1	European American = 69 (68%) Other participant data not reported.	Trainees found that supervisors educated and explored cultural issues, therapeutic intervention and skills and encouraged self-awareness and openness within supervision. The impact of this on client work was explored.
Vekaria et al., (2023b), UK	To explore supervisee's perspectives of how culturally responsive CS could be enhanced.	Qualitative design (thematic analysis), free text questions in online questionnaire.	Trainee/qualified clinicians in psychological therapy – CBT, Clinical or Counselling Psychology (*N = 131*)	25- 65+	Female = 116 Male = 14 Prefer not to state = 1	White = 86 (66%) Racially/Ethnically Minoritised (REM) = 45 (34%)	Five main themes were found including increasing cultural competence and humility to improve cultural responsivity. The importance of safety in CS and supervisor responsibility was discussed. Implications for professional bodies.

Wilcox et al., (2022b), USA	To gain insight of supervisees' experiences of helpful and unhelpful CS, and their expectations of culturally responsive (CS).	Qualitative design (thematic analysis; TA), open-ended questions.	Psychotherapy psychology students enrolled to either a master's- or doctoral- level therapy training programme. (*N = 102*)	Mean = 30.22 (SD = 6.67)	Women = 84 Man = 16 Genderqueer/ gender non-conforming = 2	White Non-Hispanic/Latinx = 77 Biracial/Multiracial = 8 Hispanic/ Latinx = 7 Asian/Pacific Islander = 7 Different Identity = 3	Three main categories were found: helpful cultural supervisory experiences; unhelpful cultural supervisory experiences. 12 sub-themes within the categories. Consistent to some elements of the MCO and MCC models.

Note. CS = Clinical supervision.

Table 2

Study Characteristics of Grey Literature

Authors (Years), Country	Study Aims	Design & Instruments	Sample Size & Participant Characteristics (N)	Age Range & Mean	Gender	Ethnicity/Race	Key Findings
Becerra, (2018), USA	To explore supervisees' perspectives of specific supervisor behaviours/interventions of effective and ineffective multicultural supervision	Qualitative design (grounded theory), open-ended questions via an online survey	Counselling psychology students enrolled in an APA accredited programme or internship site. *(N= 59)*	20-61+	Cisgender woman = 66% Cisgender man = 30.5% Genderqueer/ Gender fluid = 1.7% Other = 1.7%	White = 69% Asian = 11.9% Black or African American = 10.2% Latina/o or Hispanic = 3.4% Other = 5.1%	Positive experiences of multicultural experiences promoted positive supervisory relationship and growth for the supervisee. Negative experiences of multicultural supervision had detrimental impact for the supervisee including distress and self-doubt. Specifics of behaviours and implications discussed.
Byrd, (2022), USA	To explore trainee counsellors' experiences of effective CS and the impact of their supervisor's multicultural competence.	Qualitative design (interpretive phenomenological analysis; IPA) semi-structured interviews.	Master's level counselling students (either attending or graduated from accredited psychotherapy programmes) (*N = 4)*	Not reported	Woman = 1 Man = 1 Trans masculine = 1 Non-binary = 1	White = 4	Four primary themes about effective CS were described by supervisees including considering multicultural factors and supervisory alliance. Supervisor's humility and commitment to learning was important to supervisee's CS experience.

Darby (2014), USA	To explore supervision experiences of mono-racial and cross-racial counselling supervision from supervisee and supervisor perspectives.	Qualitative design, (descriptive phenomenological method), individual semi-structured interviews.	Counsellor trainees enrolled in a MFT* programme and one school counselling student (*N = 9*)	23-49 years old (average = 34 years).	Female = 8 Male = 1	Black = 3 Black & Asian = 2 Black & Hispanic = 2 Black, Amish & Latino = 1 Chinese = 1	Five main categories were found including how awareness and discussion of culture can impact needs being identified and met, with clinical implications. Implications for clinical practice and future research raised.
Del Re, (2022), USA	To gain further insight of supervisees' experiences of multicultural competence and cultural humility in CS and the clinical implications.	Qualitative design (consensual qualitative research; CQR), semi-structured interviews	Licensed (dependent or independently) counsellors. *(N = 10)*	Not reported	Women = 9 Men = 1	White = 7 Black = 2 Other/Not identified = 1	Supervisees perception of supervisor's cultural competence was experienced with rapport, intention and action which had implications to client work.
McLeod (2009), USA	Exploring supervisors and supervisees experiences of multicultural CS (how cultural issues are discussed).	Qualitative design, (phenomenological framework), individual, semi-structured interviews.	Supervisees working in different settings and either enrolled into master's level or doctoral counselling programmes or certification program (*N = 9*)	24-40 years old (*M* = 28 years)	Female = 8 Male = 1	Caucasian = 5 African American = 3 Multiracial = 1	Positive and negative themes were found, including safety and awareness and facilitating development of cultural competence.
Townsend, (1996), USA	Exploring African American supervisees perspectives of	Qualitative design, semi-structured	Trainee counsellors enrolled in a counselling	Not reported	Not reported	African American = 10	Two main categories of emotional bond and supervisor competence were found to understand

	effective cross-cultural CS..	open-ended interviews.	programme. (*N = 10*).				supervisees experiences. Conceptualisation and implications of these findings were discussed.
Williams (2020), USA	Exploring African American supervisees experiences of cross-cultural CS (including cultural competence)	Qualitative design (phenomenological reduction), semi structured open- ended interviews.	Mental health clinicians/ trainees (supervisees). Mental health counselling master's students = 5 Qualified therapist = 1 Counselling doctorate student =1 *(N = 7*)	23-35 years old	Women = 6 Men = 1	Black = 3 African American = 4	12 main themes emerged from the data of supervisees experiences including positive experiences who addressed cultural difference (responsiveness) and negative experiences included not attending to cultural issues.
Zapata (2010), USA	To explore how supervisees and supervisors experience having multicultural discussions in CS.	Qualitative design, (grounded theory), supervision session and follow-up interviews.	Clinical or Counselling doctoral trainees/interns (*N = 5*)	27-32 years old (*M* = 30.00, *SD* = 1.87)	Female = 5	Euro-American/White = 4 Asian/Asian-America = 1	Four main domains were found from the data including cultural lens and the characteristics of the discussions. The importance of supervisory relationship and intentionality of discussing cultural issues were highlighted. Implications for clinical practice and a theoretical model was proposed.

Note. CS = Clinical supervision. MFT = Marriage and Family Therapy.

2.3.6 Thematic Synthesis

Findings were analysed using a thematic synthesis approach, based on the Thomas and Harden (2008) method. This method was employed as it uses the structured framework of thematic analysis techniques as a foundation, together with grounded theory and meta-ethnography (Cahill et al., 2018; Paterson, 2011). In contrast, a purely meta-ethnography method is an interpretive approach (Noblit & Hare, 1988), which can focus on high level interpretation such as exploring how studies are related through creation of metaphors, concepts or theory (Atkins et al., 2008). As thematic synthesis focuses on synthesising data of a range of studies (Thomas & Harden, 2008) and has been positively critiqued for its practicality of findings (Paterson, 2011), it was chosen for this review as a more inclusive and suitable methodological approach.

As recommended by Thomas & Harden (2008), the first author read through each study several times to fully familiarise themselves with the data. Next, all text contained within 'Results/Findings' sections of studies were extracted and exported into NVivo Software (Version 14) to proceed to analysis if all results sections were relevant/met the inclusion criteria for the research question. If it was clear that only specific sections of results met the inclusion criteria, only those sections were extracted into NVivo for coding. Firstly, in line with the methodology (Thomas & Harden, 2008), initial codes were generated through line-by-line coding. Secondly, initial codes were reviewed to distinguish similarities and differences between them and to group these together to begin developing initial themes. Thirdly, through reviewing this review's specific question and aiming to go beyond the original content of the studies, higher-order analytical themes were developed. This final stage was an inductive approach, which involved the interpretation and consideration of all studies. The first author conducted the thematic synthesis, and the initial and final themes were discussed with the research team. The coding manual was also appraised by a second

reviewer; discrepancies in any coding were resolved through discussions and amendments to the coding manual (see Appendix D).

2.3.7 Reflective Statement

When using a qualitative approach, it is imperative to reflect and explore one's own position, lens and biases (Bowleg, 2017; Dodgson, 2019; Willig, 2012). Reflexivity is a key practice in qualitative research to facilitate recognising possible implications of one's position, beliefs and experiences within the study (Dodgson, 2019). The first author took a critical realist epistemological approach to this thematic synthesis (Barnett-Page & Thomas, 2009). This perspective recognises that there is a 'real' world and a 'measurable' world, and that it is important to also acknowledge the power and impact of the unobservable systems *(*Gorski, 2013; Koopmans & Schiller, 2022). Therefore, the data was explored through the critical realist lens which considers the influences of beliefs, values, societal structures and systems which affect the generation of meaning and data (Koopmans & Schiller, 2022).

Furthermore, the first author is a Trainee Clinical Psychologist with mixed experiences of culturally responsive and unresponsive clinical supervision. The first author is of dual nationality with British and Latin American heritage, a heterosexual ciswoman residing in the UK. The research team members are all mental health practitioners, from REM backgrounds, with experience of culturally responsive and unresponsive clinical supervision. The research team also acknowledged that they had an interest in enhancing experiences of cultural responsivity in clinical supervision. As is common with qualitative analysis, it is acknowledged that subjective experiences could have influenced the interpretation of the data and results (Madhill et al., 2000). To minimise bias, discussions and reflections were had among the research team to recognise prior experiences and knowledge held between us.

2.4 Results

2.4.1 Quality Assessments

In regard to quality ratings, all studies used in this thematic synthesis appeared to have scored appropriate ratings on the CASP and AACODS tools accordingly. Within the published literature, all studies stated their aims, had suitable methodology and appropriate designs and data collection. There were four studies which appeared to only partly discuss ethical considerations (Ancis & Marshall, 2010; Burkard et al., 2006; Soheilian et al., 2014; Wilcox et al., 2022b), which is important to consider. Within the grey literature, the majority of studies scored highly on the AACODS. In Townsend (1996), there was ambiguity over discussing potential biases, methodology and coverage, which questions the robustness and transparency of their findings.

2.4.2 Characteristics of Selected Studies

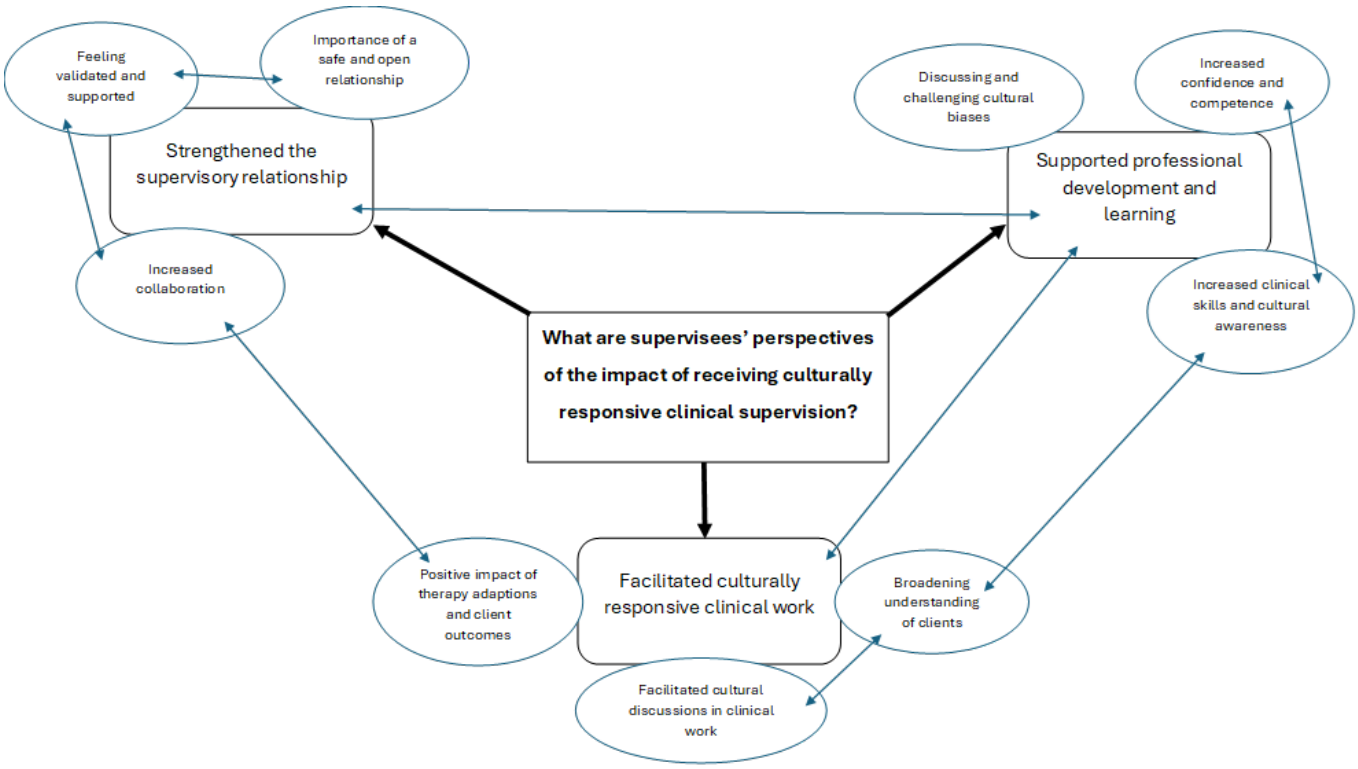
Across all 15 included studies, 503 participants took part in qualitative research. Most studies took place in the USA (13), with one study based in Ireland (Kuznietsova et al., 2025) and one in the UK (Vekaria et al., 2023b). The sample included a variety of clinicians from either accredited training courses or qualified practitioners. The papers' dates ranged across a 29-year period, between 1996 and 2025. The studies used a mixture of semi-structured interviews and open-ended questionnaire questions to capture participants' perspectives. Seven studies were published (Ancis & Marshall, 2010; Burkard et al., 2006; Kuznietsova et al., 2025; Jin et al., 2022; Soheilian et al., 2014; Vekaria et al., 2023b; Wilcox et al., 2022b) whilst eight were unpublished doctoral theses (grey literature). The demographic and descriptive data are outlined in Tables 1 and 2.

2.4.3 Synthesis

The thematic synthesis analysis (Thomas & Harden, 2008) developed three overarching analytical themes: ‘strengthened the supervisory relationship’; ‘supported professional development and learning’; and ‘facilitated culturally responsive clinical work’. Within themes, nine subthemes also emerged, see Figure 2 for the thematic map (see Appendix E for thematic map developments).

Figure 2

Thematic Map of Themes and Subthemes



2.4.3.1 Main Theme - Strengthened the Supervisory Relationship

There was a strong theme of supervisees’ noticing that culturally responsive clinical supervision strengthened the supervisory working relationship. Supervisors were described as taking a proactive position in supervision, often by initiating cultural discussions, acknowledging and respecting differences, and attending to supervisees’ specific needs (Ancis & Marshall, 2010; Becerra, 2018; Burkard et al., 2006; Byrd, 2022; Jin et al., 2022;

Vekaria et al., 2023b; Wilcox et al., 2022b; Willliams, 2020). Overall, there was an enhanced sense of connection and richer discussion in supervision (Burkard et al., 2006; Del Re, 2022; Zapata, 2010). Within this theme there were three key subthemes of 'importance of a safe and open relationship', 'feeling validated and supported', and 'increased collaboration'.

2.4.3.1.1 Importance of a Safe and Open Relationship

A safe and open relationship was described as essential for supervisees to feel able to then be open about their cultural experiences (Becerra, 2018; Wilcox et al., 2022b). The creation of an open and respectful space was highlighted by supervisees, specifically one based on mutual understanding, cultural sensitivity and building trust (Ancis & Marshall, 2010; Jin et al., 2022; Townsend, 1996; Wilcox et al., 2022b). It was also noted by authors that supervisors were actively interested and engaged in supervision, being curious about the supervisees' cultural identities contributed towards the establishment of a safe and open relationship (Becerra, 2018; Burkard et al., 2006; Zapata, 210).

Supervisees described safety needing to be created by the supervisor (Vekaria et al., 2023b), with supervisor's own openness and self-disclosure supporting this process in supervision: "*'safety' was created by the supervisor in her openness about her own ethnicity and her curiosity about my own*" (Vekaria et al., 2023b: *supervisee*). It is important to note that although this did not form part of a final subtheme, some supervisees and authors discussed the time and sensitivity needed to build the safety and comfort with a supervisor, especially with cross-racial supervisory dyads (Jin et al., 2022; Williams, 2020): "*So, it took me a little while to be comfortable enough to look at this white person and be like, 'hey, White people are frustrating today.' And to really feel comfortable talking about my experiences as a Black woman*." (Williams, 2020: *supervisee*).

2.4.3.1.2 Feeling Validated and Supported

Supervisees described that having culturally responsive clinical supervision validated their specific experiences and identities, which in turn, meant that supervisees felt more heard and understood by their supervisor (Burkard et al., 2006; Townsend, 1996). This validation also increased a sense of safety in the supervision space: "*she validated my concerns and made [supervision] feel a lot safer"* (Becerra, 2018: *supervisee*). Additionally, supervisors were described as providing guidance and support which made supervisees feel closer to supervisors (Becerra, 2018; Jin et al., 2022; Zapata, 2010).

It should be acknowledged that some of the supervisees felt a sense of discomfort when discussing cultural differences in supervision (Burkard et al., 2006; Zapata, 2010). Specifically, Burkard et al. (2006) noted that this discomfort was only reported in supervisees from an ethnic minoritised background and not from the European American supervisees (Burkard et al., 2006). In addition, Zapata (2010) described that some supervisees felt a sense of discomfort in discussing cultural differences due to them being new conversations in supervision and the possible unexcepted shifts in power dynamics during the discussions: "*Kayla may be expressing an implicit fear of discussing difference with her supervisor, which could contribute to her level of discomfort*" (Zapata, 2010: *author*).

2.4.3.1.3 Increased Collaboration

Culturally informed supervision also leads to more joint-working and collaboration with the supervisor (Becerra, 2018; Burkard et al., 2006; Darby, 2014), which also advanced their learning: *"…we are going to have to learn this together so we approached that together and came up with resources for her…"* (Darby, 2014: *supervisee*). Moreover, collaboration in supervision was described as supporting a more thoughtful and culturally responsive approach in clinical work too: *"…the supervisor continually collaborated with me to ensure*

that we were being culturally mindful" (Becerra, 2018: *supervisee*). This assisted supervisees' ongoing development and positively influenced the supervisory relationship.

2.4.3.2 Main Theme - Supported Professional Development and Learning

The theme of supporting professional development and learning was perceived by supervisees and authors (Ancis & Marshall, 2010; Becerra, 2018; Byrd, 2022; Darby, 2014; Del Re, 2022; Jin et al., 2022; Kuznietsova et al., 2025; Soheilian et al., 2014; Vekaria et al., 2023b; Wilcox et al., 2022b). This was defined by supervisors providing feedback which developed learning and identified supervisees' strength and weakness, with an acknowledgment that evaluation was part of the supervisory process (Ancis & Marshall, 2010; Byrd, 2022; Wilcox et al., 2022b). Moreover, growth as a clinician was reflected upon as a positive outcome (Byrd, 2022; Del Re, 2022). Supervisees noted that, with the strengthened supervisory relationship, they felt more able to be vulnerable, take positive risks and learn from experiences (Ancis & Marshall, 2010; Becerra, 2018; Jin et al., 2022; McLeod, 2009). This theme encompassed the three subthemes of 'discussing and challenging cultural biases', 'increased confidence and competence', and 'increased cultural awareness and clinical skills'.

2.4.3.2.1 Discussing and Challenging Cultural Biases

It was noted that being active in discussing biases and assumptions in supervision supported the supervisees' development and awareness of biases they have not been previously recognised (Ancis & Marshall, 2010; Becerra, 2018; Del Re, 2022; McLeod, 2009; Townsend, 1996; Zapata, 2010):

"*Sometimes it is something that I'm not even clocking. He'll say, 'this is a big reaction from you; what's coming up?' This acknowledgment and challenge helped me pause for a*

second and recognize that perhaps, a client is getting more under my skin than I thought." (Del Re, 2022: *supervisee*).

These discussions and learnings were further supported by supervisors being open about their own biases with clients (Ancis & Marshall, 2010; Wilcox et al., 2022b) and encouraging supervisees to learn from clients (Soheilian et al., 2014). Furthermore, through discussing cultural biases, it was felt that there was then space to challenge and reflect on assumptions that arose within clinical supervision (Ancis & Marshall, 2010; Burkard et al., 2006; Del Re, 2022; Townsend, 1996): "*One participant pointed out that his supervisor helped him by attending to his blind spots and challenging them*" (Ancis & Marshall, 2010: *authors*).

2.4.3.2.2 Increased Confidence and Competence

The research described an increased confidence and empowerment in relation to discussing cultural topics in supervision and expressing how they feel (Becerra, 2018; Darby, 2014; Del Re, 2022; Kuznietsova et al., 2025; McLeod, 2009; Zapata, 2010): "*empowered to have more of a voice, to state how I was feeling, and not necessarily just follow his lead or to continue in the more traditional hierarchy that supervision has*." (Zapata, 2010: *supervisee*). This quote refers to the felt sense of confidence to discuss their opinion despite the power dynamic of the supervisory relationship, with one study describing a supervisee feeling able to teach their supervisor about their culture (Jin et al., 2022). Furthermore, there was recognition that learning was part of the supervisory process, and one supervisee described it as "*freeing*" (Del Re, 2022: *supervisee*) when they knew they would make mistakes along the way and could ask their supervisor for support.

Furthermore, with increased confidence came progression in terms of supervisees' competency when working with culturally diverse clients: "*I think the main thing is being*

competent in working with a certain population." (McLeod, 2009: *supervisee*), and provided a "*cultural comfort*" with their clinical work (Kuznietsova et al., 2025: *authors*). The increase in confidence and competence was often described as being intertwined with each other: "*her guidance has helped me to develop confidence and competence while also growing in my professional identity.*" (Becerra, 2018: *supervisee*). There was a link between the perceived growth in confidence and competence and supporting development in clinical skills (Burkard et al., 2006; Del Re, 2022).

2.4.3.2.3 Increased Cultural Awareness and Clinical Skills

Culturally responsive clinical supervision gave supervisees the opportunity to broaden and increase their cultural awareness about clinical work (Becerra, 2018; Burkard et al., 2006; Jin et al., 2022; Kuznietsova et al., 2025; Soheilian et al., 2014; Wilcox et al., 2022b; Williams, 2020). Supervisors played a significant role in proactively discussing culture in supervision and asking supervisees to think about how culture intersected with their clinical work (Ancis & Marshall, 2010; Byrd, 2022; Williams, 2020) and modelling an openness to be informed by both supervisees and clients (Townsend, 1996). Typically, supervisors would advance this learning of broadening cultural awareness through giving advice, having discussions, sharing resources or demonstrating their clinical expertise. There was an enhanced awareness and sensitivity to cultural issues that were present in therapy. Consequently, an increase in cultural awareness also broadened supervisees' understanding of clients. Supervisors would also demonstrate cultural awareness through their own ability to self-reflect, share knowledge of cultural issues and think together with supervisees, which, in turn, increased supervisees own cultural awareness.

"*I think the effective supervisors have had an awareness of who they are and the ability to reflect on that identity and how it shapes their own counseling practice and how my*

own identity could shape my own practice differently than it would, theirs." (Byrd, 2022: *supervisee*).

The enhanced cultural awareness also increased supervisees' clinical skills, such as knowing how to approach clinical work in a more culturally sensitive way (Becerra, 2018; Soheilian et al., 2014). Discussions in supervision subsequently informed how supervisees approached their clinical work and their thinking when working with clients. There was a relationship between supervisees' experiences of professional development and the third theme of 'facilitating their culturally responsive clinical work'. One supervisee described how their increased awareness directly impacted their clinical skills: *"...made me more aware of how I should behave and interact with my patients to ensure that they feel welcomed and respected*" (Becerra, 2018: *supervisee*).

2.4.3.3 Main Theme - Facilitated Culturally Responsive Clinical Work

This theme describes how culturally responsive clinical supervision had a positive impact on supervisees' clinical work (Becerra, 2018; Burkard et al., 2006; Soheilian et al., 2014; Zapata, 2010). There was consideration for how cultural factors had been impacting clinical work and clinical thinking when adapting therapy to be culturally sensitive, such as incorporating the client's values or language into therapy (Burkard et al., 2006; Soheilian et al., 2014; Wilcox et al., 2022b). It was described how supervision informed the treatment approach they took, often involving tailored approaches with clients to meet the needs of clients. This theme comprised the three subthemes of 'broadening understanding of clients', 'facilitated cultural discussions in clinical work', and 'positive impact of therapy adaptions and client outcomes'.

2.4.3.3.1 Broadening Understanding of Clients

Supervision provided a space to reflect on clients' cultural identities and widen supervisees perspectives on their understanding of their clinical work (Ancis & Marshall, 2010; Becerra, 2018; Del Re, 2022; Kuznietsova et al., 2025; Soheilian et al., 2014). This information informed the development of more culturally sensitive case conceptualisations, "*Cultural variables were incorporated into the conceptualisation as well as into interventions"* (Soheilian et al., 2014: *supervisee*). Supervisors supported this process and would often be proactive in raising cultural considerations when formulating and conceptualising cases. One supervisee expresses the emphasis and intention to understand clients through a cultural lens: "*These issues were never on the back burner or a second thought, but rather, they were the primary lens through which we understood clients*." (Becerra, 2018: *supervisee*). Through a broadened understanding of clients, supervisees had further opportunities to consider their own similarities and differences in relation to clients, which provided new perspectives to be developed.

2.4.3.3.2 Facilitated Cultural Discussions in Clinical Work

It was highlighted that engaging in cultural discussions and addressing cultural issues in clinical supervision also, by extension, facilitated these same discussions in clinical practice (Ancis & Marshall, 2010; Burkard et al., 2006; Byrd, 2022; Darby, 2014).

"So pointing out the differences in the beginning would be definitely helpful…it was kind of a scary thing to do especially in the information gathering process…but when I tried it with another client he…responded well to it…it wasn't as scary as I thought it would be." (Darby, 2014: *supervisee*).

Again, supervisors played an important role in encouraging supervisees to address cultural topics and differences within clinical work and to be curious with clients about the

possible impact (Ancis & Marshall, 2010; Becerra, 2018; Burkard et al., 2006; Darby, 2014; Towsend, 1996). One study noted how the supervisor showed "*efforts to help the supervisee consider the importance of multicultural elements*" (Becerra, 2018: *author*).

2.4.3.3.3 Positive Impact of Therapy Adaptions and Client Outcomes

The clinical impact of the increase consideration and discussions of cultural adaptions in therapy and conceptualisations was proposed (Ancis & Marshall, 2010; Burkard et al., 2006; Del Re, 2022; McLeod, 2009). The integration of cultural discussions and adaptions facilitated the therapeutic relationship and increased therapists' empathy towards the client's context (Burkard et al., 2006; Del Re, 2022; Kuznietsova et al., 2025; McLeod, 2009; Soheilian et al., 2014). It was noted how there was a perceived positive effect from clients in relation to therapy and outcomes; "*all four of the supervisees in this study indicated that they believed that multicultural discussions in supervision positively affected their outcomes with clients"* (Ancis & Marshall, 2010: *authors*). These authors proposed that the joint effort between supervisors and supervisees in clinical supervision was an integral catalyst to these changes.

Furthermore, supervisees noted the positive response in therapy, with clients having either an increased cultural awareness, understanding, enhanced engagement or collaboration in session, and supported them feeling able to progress in therapy (Ancis & Marshall, 2010; Becerra, 2018; Burkard et al., 2006; Darby, 2014; Del Re, 2022). One supervisee described how they were aware of client response when adopting a culturally responsive therapy approach: *"I gauge it if I can see them leave with something, or if they say they learned something, or if they say, Oh, that made a lot of sense to me."* (McLeod, 2009: *supervisee*).

2.5 Discussion

2.5.1 Summary of Findings

This systematic review aimed to explore supervisees' perspectives of the impact of receiving culturally responsive clinical supervision. Three overarching analytical themes were identified: 'strengthened the supervisory relationship'; 'supported professional development and learning'; and 'facilitated culturally responsive clinical work'. Overall, the review found there to be a positive impact of receiving culturally responsive clinical supervision in a range of areas, from their supervisory relationship to professional development and clinical work. There were relationships between themes and subthemes, which suggests how centrally influential cultural responsivity in supervision is for supervisees. For example, supervisees feeling secure in their supervisory relationship enabled a greater opportunity for reflection, learning and development in supervision. In turn, this supported cultural responsivity in supervisees' own clinical work, which was positive in relation to client outcomes and the therapeutic relationship. This supports the work of DePue et al. (2022) which promotes the link between the SWA and client therapeutic alliance in clinical supervision. It also reinforces Kangos and Pieterse's (2021) mediation study which found that the SWA mediated the relationship between clinicians' cultural humility and client's treatment outcomes.

The role of the supervisor was focal throughout this review, with supervisees expressing desire for, and expressing their appreciation when, supervisors take a proactive role in discussing culture in supervision. In consideration of the role of power dynamics within the supervisory relationship, this finding feels important as supervisees often report feeling they hold less power (De Stefano et al., 2017; Ryde, 2000) and therefore may need the supervisor to be active in initiating cultural discussions.

Importantly, the theme of 'strengthened supervisory relationship' described supervisees' reported sense of a stronger connection and greater safety with their supervisor during culturally responsive supervision. This theme had three subthemes, 'increased collaboration', 'feeling validated and supported', and 'importance of a safe and open

relationship'. In support, previous quantitative research suggested that the incorporation of cultural aspects can support the SWA (Crockett & Hays, 2015; Vandament et al., 2022). Reinforcing the notion that supervisees derive greater supervision satisfaction when supervisors were perceived as showing more cultural humility and comfort (Wilcox et al., 2023). It also supports Rothwell et al. (2021) who noted how trust and support are enablers of effective clinical supervision in healthcare. Specifically, supervisees reported that supervisors' openness to cultural discussions strengthened the connection with their supervisor, bringing them closer, and enhancing mutual understanding (Becerra, 2018; Burkard et al., 2006; Zapata, 2010). Similarly, Mahon's (2024) quantitative review found that the application of the MCO-S framework with its three pillars, within supervision, was correlated with a stronger supervisory working alliance and greater satisfaction.

The main theme of 'supported professional development and learning' encompassed supervisees' feeling a growth in their professional confidence, ability and clinical skills. Supervisees stated that the subtheme of 'discussing and challenging cultural biases' was an important component of their supervision, as a chance to further their learning about any assumptions they hold, and allowing space to reflect upon and challenge these biases. Specifically, there was a connection between the 'strengthened supervisory relationship' and 'supported professional development and learning' themes as feeling safe and secure in the supervisory relationship supported feeling able to raise sensitive discussions regarding cultural biases. In support, Cook et al. (2020) revealed that the supervisors' degree of cultural humility predicted supervisees' willingness to raise concerns and, therefore, address any issues in supervision. Furthermore, the 'supported professional development and learning' theme is in line with Watkins et al.'s (2019a) argument that supervisors who demonstrate cultural humility also promote the development of supervisees. This theme's two other subthemes were connected, 'increased confidence and competence' and 'increased clinical

skills and cultural awareness', as there was growth in one area it complemented the growth and development in the other (e.g. clinical skills).

The 'facilitated culturally responsive clinical work' main theme, provides support for the suggestion that a clinician's lack of awareness to their own beliefs and biases can create barriers for clients from ethnic minoritised communities in feeling understood (Williams & Halstead, 2019). Furthermore, this theme reinforces the quantitative literature reporting that higher ratings of therapists' cultural humility leads to improved therapy outcomes from a client's perspective (Kivlighan et al., 2019; Owen et al., 2014; 2016). The associated subthemes were the 'positive impact of therapy adaptions and client outcomes', 'broadening understanding of clients', and 'facilitated cultural discussions in clinical work'. Taken together, it feels fair to propose that culturally responsive supervision increases cultural awareness and contributes to supervisees' broadening of clinical thinking relating to their cultural understanding of clients. This is in part due to supervisees having the space to reflect on their own identities and how they intersect with client work, allowing for broadened case conceptualisation and cultural understanding of clients (Becerra, 2018; Soheilian et al., 2014).

2.5.2 Theoretical Considerations

This review's findings provide support for the MCC and MCO-S frameworks. Specifically, the MCC's three components of cultural awareness, knowledge and development of skills (Sue et al., 1982; Sue, 1990; Sue & Sue, 2013) map onto supervisees' experiences whilst receiving culturally responsive supervision in this review. For example, supervisees acknowledged and described that through their supervision they developed cultural awareness and clinical skills during culturally responsive supervision (Becerra, 2018; Burkard et al., 2006; Jin et al., 2022; Kuznietsova et al., 2025; Soheilian et al., 2014; Wilcox et al., 2022b;

Williams, 2020). Furthermore, through this learning and development, supervisees felt better able to understand their client's perspectives, which maps onto the 'knowledge' pillar of the MCC framework. The MCC has been critiqued for its transferable applicability into clinical practice, for example, in how clinicians can apply the framework to foster cultural awareness and recognise areas of development (Mollen et al., 2003). This review enhances the MCC's clinical applicability, as it highlights the impact that culturally responsive supervision can have on not only supervisees but also clinical work.

Similarly, the MCO-S's three pillars of cultural humility, cultural comfort and cultural opportunities (Watkins et al., 2019b), are arguably present in this review's findings. Insofar as, supervisees expressed that from the safety of their supervisory relationship, developed in culturally responsive supervision, they felt more confident and comfortable to discuss culture and to incorporate a cultural narrative into their clinical work (Ancis & Marshall, 2010; Becerra, 2018; Burkard et al., 2006; Byrd, 2022; Darby, 2014; Del Re, 2022; Kunietsova et al., 2025; Soheilian et al., 2024; Zapata, 2010). Furthermore, this review found that supervisees felt that the supervisors' curiosity of wanting to understand multiple perspectives strengthened the supervisory relationship (Becerra, 2018; Burkard et al., 2006; Zapata, 2010). This finding is in line with Watkins et al.'s (2019b) definition of cultural humility in supervision, which emphasises supervisors having an openness to learn and understand the diverse cultural backgrounds of supervisees and clients. Similarly, the supervisors' commitment to discuss culture, even when potentially a sensitive and difficult conversation, conceptualised as cultural comfort in the MCO-S framework (Watkins et al., 2019b), was also shown in the subtheme 'discussing and challenging cultural biases' (Ancis & Marshall, 2010; Burkard et al., 2006; Del Re, 2022; Soheilian et al., 2014; Wilcox et al., 2022b).

2.5.3 Strengths, Limitations and Future Research

This systematic review, utilising a systematic methodology (Thomas & Harden, 2008), is the first to explore the impact of culturally responsive clinical supervision from supervisees' perspectives adopting a qualitative analysis. Although there have been recent reviews exploring multicultural orientation (Mahon, 2024), cultural humility in supervision (Zhang et al., 2021) and more broadly on supervisees experiences of supervision (Chircop Coleiro et al., 2023), there was a gap in the research reviewing the qualitative literature exploring supervisees' perspectives of culturally responsive clinical supervision.

The inclusion of both published and grey literature, which were critiqued using specific quality assessment tools (AACODS; Tyndal, 2010; CASP, 2024) is a further strength. Whilst there are notable challenges with including grey literature in systematic reviews (Hoffecker, 2020; Mahood et al., 2014), it is proposed that the benefits can outweigh them (Paez, 2017). It is argued that grey literature can be invaluable at increasing comprehensiveness in reviews and reducing issues surrounding publication bias (Higgins et al., 2024; Hopewell et al., 2005; Paez, 2017). Furthermore, all unpublished studies in this review were doctoral theses, which go through formal viva examinations and review (Dobson, 2018) and arguably increases the credibility of their publications. Importantly, given that this is historically an under researched area, and a potentially sensitive topic, it felt important to incorporate findings from grey literature in this review (Hoffecker, 2020). There is however a need for peer-reviewed research in this area to further disseminate the important issues and implications of cultural responsivity in supervision.

This review included studies that focused on semi-structured interviews (Ancis & Marshall, 2010; Burkard et al., 2006; Byrd, 2022; Darby, 2014; Del Re, 2022; Kuznietsova et al., 2025; McLeod, 2009; Townsend, 1996; Williams, 2020; Zapata, 2010), and open-ended questions (Becerra, 2018; Jin et al., 2022; Soheilian et al., 2024; Vekaria et al., 2023b; Wilcox et al., 2022b), predominantly through virtual study design such as telephone or online

methods (Ancis & Marshall, 2010; Becerra, 2018 and McLeod, 2009 were conducted in person and Kuznietsova et al., 2025, did not state). It is important to note that LaDonna et al. (2018) stated a preference for interviews when conducting qualitative research in order to collect richer data, whereas it has also been argued that online surveys provide a flexible method for collecting data and better facilitate analysis across the entire dataset (e.g., Braun et al., 2021). As this review comprised a combination of research designs and methodologies which could be considered a strength, it also raises the question as to whether richer data would have been generate if more studies had used an interview design.

In consideration of the generalisability of the findings, it is reasonable to suggest that the majority of the sampling methods were purposive and snowballing techniques (87%), which questions the representation of the sample possible bias (Parker et al., 2019). Specifically, as the research is exploring considerations around culture, it can be highly emotive for participants and may resurface past experiences of racial trauma (Pieterse, 2020), which could be a factor influencing whether individuals will want to share their experiences. Also, of the reported gender demographic data, excluding Townsend (1998) who did not report this data, it showed that the sample included predominantly female participants (80.1%) from a White ethnic background (64.4%). Furthermore, with the exception of Kuznietsova et al. (2025) and Vekaria et al. (2023b), all studies were conducted in the USA, this further limits the generalisability of the results from a cultural perspective. This review as also recommended by Mahon (2024), highlights the need for more research from different countries, cultures and other Equality Act (2010) characteristics, to expand on the findings which predominately originate from the USA.

As this review was specifically focused on supervisees' perspectives, future research could consider examining the impact of supervisors' views and experiences to provide further insights into the supervisory dyad and culturally responsive supervision.

2.5.4 Clinical Implications

The review further emphasises the need for, and importance of, adopting culturally responsive clinical supervision, which has significant implications for not only the supervisor, supervisees and the supervisory relationship, but also clients and clinical work. In line with the BPS (2017) practice guidelines, this review reinforces how vital it is to develop one's own cultural awareness and cultural responsivity within clinical practice, and more specifically in supervision. Notably, this study found that supervisees perceived their supervisory and therapeutic relationships, as well as therapy outcomes, to improve when experiencing culturally responsive clinical supervision. Thus, the findings of this review could have meaningful implications on how clients experience mental health support, and advancements to how services may be able to offer more equitable support to clients from culturally diverse backgrounds (Fung et al., 2012; Kirmayer & Jarvis, 2019).

This review has shown that it is important for the supervisor to initiate cultural discussions, share cultural experiences, knowledge and resources, encourage development through cultural case conceptualisation and provide feedback, especially when considering the layers of power within the supervisory relationship (Cook et al., 2018; Patel, 2011; Ryde, 2000). It is important to note that failing to acknowledge the role of power in supervision can potentially be damaging to the supervisory relationship (Patel, 2011), thus providing further evidence for the supervisor to address and be constantly mindful of cultural power as an inherent requisite of culturally responsive supervision.

This research provides evidence on how culturally responsive supervision can foster safety and openness for supervisees, with the subtheme of 'importance of safe and open relationship'. This aligns with safety and power in supervisory relationships, and the importance of supervisees feeling trust in the SWA (Hernández & McDowell, 2010; Lee et al., 2022). This review suggests a need for the supervisor to create a safe learning

environment to support supervisees to learn and feel able to voice their opinions and thoughts (Lee et al., 2022). The findings have identified that supervisors can do this is by modelling culturally responsive practice, empathy, openness, disclose their own identities from a cultural perspective (Ancis & Mardhall, 2010; Townsend, 1996; Vekaria et al., 2023b; Wilcox et al., 2022b) and through validation of supervisees' experiences (Becerra, 2018). It is also important to be particularly mindful of cross-cultural supervisory dyads, where there are possible elevated feelings of discomfort (Burkard et al., 2006; Zapata, 2010), and the time and sensitivity required to build trust, comfort and attend to cultural discussions (Williams, 2020).

In consideration of the supervisor, this review identifies the need for effective, culturally responsive, evidence-based, clinical supervision workshops to support the supervisor's continuous development and learning in this area (Goodyear et al., 2014). In support, supervisors have acknowledged that cultural discussions and the supervisory relationship are important factors to be able to provide culturally responsive and socially just supervision, to which end, they also emphasised a need for more guidance and training to be able to provide such supervision (Spowart et al., 2024). Therefore, training providers and clinical services should support supervisors by providing culturally informed supervision, through ensuring protected supervision time to reflect on their culture as supervisors, incorporating existing cultural supervision models (e.g. MCO-S) and current research into their practice, and by attending supervision training that aims to develop skills in this area.

2.5.5 Conclusion

The current review aimed to explore the impact of receiving culturally responsive clinical supervision from supervisees' perspectives. Three main themes were found from the thematic synthesis: 'strengthened the supervisory relationship', 'supported professional development

and learning', and 'facilitated culturally responsive clinical work'. Supervisees found that receiving culturally responsive supervision facilitated the supervisory relationship to feel stronger and allowed for more learning opportunities, which also supported their confidence and clinical practice. Overall, the findings provided support for the MCC and MCO-S frameworks, and the current literature. The review also highlighted the importance of the supervisor's role in facilitating culturally responsive supervision and, therefore, reinforcing the need for appropriate support and training for supervisors. The review suggests that through adopting culturally responsive supervision, there are meaningful positive implications to the supervisor, supervisee, the supervisory relationship and clinical practice.

2.6 References

Ahsan, S. (2020). Holding up the mirror: Deconstructing whiteness in clinical psychology. *Journal of Critical Psychology, Counselling and Psychotherapy*, *20*(3), 45-55.

Akyıldız, S. T., & Ahmed, K. H. (2021). An overview of qualitative research and focus group discussion. *International Journal of Academic Research in Education*, *7*(1), 1-15. https://doi.org/10.17985/ijare.866762

Ancis, J. R., & Marshall, D. S. (2010). Using a multicultural framework to assess supervisees' perceptions of culturally competent supervision. *Journal of Counseling & Development*, *88*(3), 277-284. https://doi.org/10.1002/j.1556-6678.2010.tb00023.x

Arredondo, P., & Toporek, R. (2004). Multicultural counseling competencies ethical practice. *Journal of Mental Health Counseling*, 26, 44–55. https://doi.org/10.17744/mehc.26.1.hw2enjqve2p2tj6q

Arthur N., & Collins, S. (2009). Culture-infused counselling supervision. In Pelling, N., Barletta, J., & Armstrong, P. (eds), *The Practice of Clinical Supervision* (pp. 267–295). Australian Academic Press.

Atkins, S., Lewin, S., Smith, H., Engel, M., Fretheim, A., & Volmink, J. (2008). Conducting a meta-ethnography of qualitative literature: Lessons learnt. *BMC Medical Research Methodology*, *8*(1), 21-31. https://doi.org/10.1186/1471-2288-8-21

Barnett-Page, E., & Thomas, J. (2009). Methods for the synthesis of qualitative research: A critical review. *BMC Medical Research Methodology*, *9*(59), 1-11. https://doi.org/10.1186/1471-2288-9-59

Beaulieu, G. R. (2011). *Towards a psychology of recognition: A critical analysis of contemporary multicultural counseling competency models* [Doctoral dissertation, The University of Texas at Austin]. University of Texas Libraries Repository. http://hdl.handle.net/2152/ETD-UT-2011-08-3988

Becerra, M. (2018). *Critical incidents in multicultural supervision and their impacts on supervisees and the supervision relationship* (Publication No. 10977270) [Doctoral dissertation, Southern Illinois University at Carbondale]. ProQuest Dissertations and Theses.

Bernard, J. M., & Goodyear, R. K. (2013). *Fundamentals of clinical supervision* (5th ed). Pearson Education Limited.

Bowleg, L. (2017). Towards a critical health equity research stance: Why epistemology and methodology matter more than qualitative methods. *Health Education & Behavior*, *44*(5), 677-684. https://doi.org/10.1177/1090198117728760

Braun, V., Clarke, V., Boulton, E., Davey, L., & McEvoy, C. (2021). The online survey as a qualitative research tool. *International Journal of Social Research Methodology*, *24*(6), 641-654. https://doi.org/10.1080/13645579.2020.1805550

British Psychological Society. (2017). *Practice Guidelines Third edition.* https://doi.org/10.53841/bpsrep.2017.inf115

Burkard, A. W., Johnson, A. J., Madson, M. B., Pruitt, N. T., Contreras-Tadych, D. A., Kozlowski, J. M., ... & Knox, S. (2006). Supervisor cultural responsiveness and unresponsiveness in cross-cultural supervision. *Journal of Counseling Psychology*, *53*(3), 288-301. https://psycnet.apa.org/doi/10.1037/0022-0167.53.3.288

Buxton, S., & Scudder, R. (2022). The importance of the supervisory relationship during adverse and unprecedented times. *Dramatherapy*, *43*(1-3), 16-32. https://doi.org/10.1177/02630672231158560

Byrd, M. (2022). *Pre-licensed counselor experiences of effective and multiculturally competent clinical supervision* (Publication No. 30164354) [Doctoral dissertation, Antioch University]. ProQuest Dissertations and Theses.

Cahill, M., Robinson, K., Pettigrew, J., Galvin, R., & Stanley, M. (2018). Qualitative synthesis: A guide to conducting a meta-ethnography. *British Journal of Occupational Therapy*, *81*(3), 129-137.https://doi.org/10.1177/0308022617745016

Cape, J., Roth, A., Scior, K., Thompson, M., Heneage, C., & Du Plessis, P. (2008). Increasing diversity within clinical psychology: The London initiative. In *Clinical Psychology Forum* (Vol. 190, pp. 7-10). British Psychological Society.

Care Quality Commission (2013). *Supporting information and guidance: Supporting effective clinical supervision*. https://work-learn-live-blmk.co.uk/wp-content/uploads/2018/04/CQC-Supporting-information-and-guidance.pdf

Cherry, G., Boland, A., & Dickson, R. (2024). *Doing a systematic review: A student's guide*. (3rd ed.). Sage Publications.

Chircop Coleiro, A., Creaner, M., & Timulak, L. (2023). The good, the bad, and the less than ideal in clinical supervision: A qualitative meta-analysis of supervisee experiences. *Counselling Psychology Quarterly*, *36*(2), 189-210. https://doi.org/10.1080/09515070.2021.2023098

Constantine, M. G., & Ladany, N. (2001). New visions for defining and assessing multicultural counseling competence. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki,

& C. M. Alexander (Eds.), *Handbook of multicultural counseling* (2nd ed., pp. 482–498). Sage Publications.

Cook, R. M., Jones, C. T., & Welfare, L. E. (2020). Supervisor cultural humility predicts intentional nondisclosure by post-master's counselors. *Counselor Education and Supervision*, *59*(2), 160-167. https://doi.org/10.1002/ceas.12173

Cook, R. M., McKibben, W. B., & Wind, S. A. (2018). Supervisee perception of power in clinical supervision: The power dynamics in supervision scale. *Training and Education in Professional Psychology*, *12*(3), 188-195. https://psycnet.apa.org/doi/10.1037/tep0000201

Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry and research design: Choosing among five approaches* (4th ed.). Sage Publications.

Critical Appraisal Skills Programme (2024). *CASP Qualitative Checklist.* https://casp-uk.net/casp-tools-checklists/qualitative-studies-checklist/

Crockett, S., & Hays, D. G. (2015). The influence of supervisor multicultural competence on the supervisory working alliance, supervisee counseling self-efficacy, and supervisee satisfaction with supervision: A mediation model. *Counselor Education and Supervision*, *54*(4), 258-273. https://doi.org/10.1002/ceas.12025

Darby, T. M. (2014). *White counsellor trainees' and white supervisors' experiences of cross-racial/ethnic counselling supervision* (Publication No. kent1416044269) [Doctoral dissertation, Kent State University]. OhioLINK. http://rave.ohiolink.edu/etdc/view?acc_num=kent1416044269

de Haan, A. M., Boon, A. E., de Jong, J. T., & Vermeiren, R. R. (2018). A review of mental health treatment dropout by ethnic minority youth. *Transcultural Psychiatry*, *55*(1), 3-30. https://doi.org/10.1177/1363461517731702

Delphin-Rittmon, M. E., Flanagan, E. H., Andres-Hyman, R., Ortiz, J., Amer, M. M., & Davidson, L. (2015). Racial-ethnic differences in access, diagnosis, and outcomes in public-sector inpatient mental health treatment. *Psychological Services*, *12*(2), 158-166. https://doi.org/10.1037/a0038858

Del Re, J. M. (2022). *Understanding post-graduate supervisees' experiences and perceptions of multicultural competence and cultural humility: A consensual qualitative study* (Publication No. 30164393) [Doctoral dissertation, The University of Toledo]. ProQuest Dissertations and Theses.

DePue, M. K., Liu, R., Lambie, G. W., & Gonzalez, J. (2022). Examining the effects of the supervisory relationship and therapeutic alliance on client outcomes in novice therapists. *Training and Education in Professional Psychology*, *16*(3), 253-263. http://dx.doi.org/10.1037/tep0000320

De Stefano, J., Hutman, H., & Gazzola, N. (2017). Putting on the face: A qualitative study of power dynamics in clinical supervision. *The Clinical Supervisor*, *36*(2), 223-240. https://doi.org/10.1080/07325223.2017.1295893

Dixon, L. B., Holoshitz, Y., & Nossel, I. (2016). Treatment engagement of individuals experiencing mental illness: Review and update. *World Psychiatry*, *15*(1), 13-20. https://doi.org/10.1002/wps.20306

Dixon-Woods, M., Sutton, A., Shaw, R., Miller, T., Smith, J., Young, B., . . . Jones, D. (2007). Appraising qualitative research for inclusion in systematic reviews: A

quantitative and qualitative comparison of three methods. *Journal of Health Services Research & Policy, 12*(1), 42–47. https://doi:10.1258/135581907779497486

Dobson, S. (2018). (Re-) Theorising the Viva. In S. Dobson (Ed.), *Assessing the Viva in Higher Education: Chasing Moments of Truth*, (1st ed, pp. 155-180). Springer, Cham. https://doi.org/10.1007/978-3-319-64016-7_8

Dodgson, J. E. (2019). Reflexivity in qualitative research. *Journal of Human Lactation*, *35*(2), 220-222. https://doi.org/10.1177/0890334419830990

Edwards, A., Santhosh, S., & Kunorubwe, T. (2022). Cultural change in IAPT - a work in progress. *CBT Today*, *50*(2), 24-28.

Equality Act, 2010, c. 15. https://www.legislation.gov.uk/ukpga/2010/15/contents/enacted

Falender, C. A., & Shafranske, E. P. (2004). *Clinical supervision: A competency-based approach*. American Psychological Association. https://doi.org/10.1037/10806-000

Fung, K., Lo, H. T., Srivastava, R., & Andermann, L. (2012). Organizational cultural competence consultation to a mental health institution. *Transcultural Psychiatry*, *49*(2), 165-184. https://doi.org/10.1177/1363461512439740

Gainsbury, S. M. (2017). Cultural competence in the treatment of addictions: Theory, practice and evidence. *Clinical Psychology and Psychotherapy, 24*, 987–1001. http://dx.doi.org/10.1002/cpp.206

Goodyear, R., Lichtenberg, J. W., Bang, K., & Gragg, J. B. (2014). Ten changes psychotherapists typically make as they mature into the role of supervisor. *Journal of Clinical Psychology*, *70*(11), 1042–1050. https://doi.org/10.1002/jclp.22125

Gorski, P. S. (2013). What is critical realism? And why should you care?. *Contemporary Sociology*, *42*(5), 658-670. https://doi.org/10.1177/0094306113499533

Gough, B., & Lyons, A. (2016). The future of qualitative research in psychology: Accentuating the positive. *Integrative Psychological and Behavioral Science*, *50*, 234-243. https://doi.org/10.1007/s12124-015-9320-8

Hawkins, P., & McMahon, A. (2020). *Supervision in the helping professions* (5th ed.). McGraw-Hill Open University Press.

Hawkins, P. & Shohet., R. (2012). *Supervision in the helping professions: An individual, group and organizational approach* (4th ed.). Open University Press.

Health & Care Professions Council. (2023a). *Standards of proficiency – Practitioner psychologists*. https://www.hcpc-uk.org/globalassets/resources/standards/standards-of-proficiency---practitioner-psychologists.pdf

Health & Care Professions Council. (2023b). *Diversity data: practitioner psychologists - July 2023*. https://www.hcpc-uk.org/resources/data/2023/diversity-data-practitioner-psychologists-2023/

Hernández, P., & McDowell, T. (2010). Intersectionality, power, and relational safety in context: Key concepts in clinical supervision. *Training and Education in Professional Psychology*, *4*(1), 29-35. https://psycnet.apa.org/doi/10.1037/a0017064

Higgins, J.P.T., Thomas, J., Chandler, J., Cumpston, M., Li, T., Page, M. J., & Welch, V. A. (Eds.). (2024). *Cochrane handbook for systematic reviews of interventions* (Version 6.5) [updated August 2024]. The Cochrane Collaboration. https://training.cochrane.org/handbook/current

Hoffecker, L. (2020). Grey literature searching for systematic reviews in the health sciences. *The Serials Librarian*, *79*(3-4), 252-260. https://doi.org/10.1080/0361526X.2020.1847745

Hook, J. N., Davis, D. E., Owen, J., Worthington Jr, E. L., & Utsey, S. O. (2013). Cultural humility: Measuring openness to culturally diverse clients. *Journal of Counseling psychology*, *60*(3), 353-366. https://doi.org/10.1037/a0032595

Hook, J. N., Watkins Jr, C. E., Davis, D. E., Owen, J., Van Tongeren, D. R., & Marciana, J. R. (2016). Cultural humility in psychotherapy supervision. *American Journal of Psychotherapy*, *70*(2), 149-166. https://doi.org/10.1176/appi.psychotherapy.2016.70.2.149

Hopewell, S., Clarke, M., & Mallett, S. (2005). Grey literature and systematic reviews. In H. Rothstein, A. Sutton, & M. Borenstein (Eds.), *Publication bias in meta-analysis: Prevention, assessment and adjustments* (pp. 49-72). John Wiley & Sons, Ltd.

Hussain, B., Sheikh, A., Timmons, S., Stickley, T., & Repper, J. (2020). Workforce diversity, diversity training and ethnic minorities: The case of the UK national health service. *International Journal of Cross Cultural Management*, *20*(2), 201-221. https://doi.org/10.1177/1470595820938412

Jin, L., Wang, C. D., Watkins Jr, C. E., Zhu, W., Zamudio, G., & Li, S. (2022). Cross-cultural clinical supervision: The voices of international doctoral trainees. *International Journal of Supervision in Psychotherapy*, *4*, 7-28. https://doi.org/10.47409/ijsp.2022.4.1

Kangos, K. A., & Pieterse, A. L. (2021). Examining how lesbian, gay, and bisexual Christian clients' perceptions of therapists' cultural humility contribute to psychotherapy outcomes. *Psychotherapy, 58*(2), 254–262. https://doi.org/10.1037/pst0000375

Keith, K. D. (Ed.). (2011). *Cross-cultural psychology: Contemporary themes and perspectives* (1st ed.). Wiley-Blackwell.

Kirmayer, L. J., & Jarvis, G. E. (2019). Culturally responsive services as a path to equity in mental healthcare. *HealthcarePapers*, *18*(2), 11-23.

Kivlighan, D. M. III, Adams, M. C., Drinane, J. M., Tao, K. W., & Owen, J. (2019). Construction and validation of the Multicultural Orientation Inventory—Group Version. *Journal of Counseling Psychology*, 66(1), 45–55. https://doi.org/10.1037/cou0000294

Koopmans, E., & Schiller, D. C. (2022). Understanding causation in healthcare: An introduction to critical realism. *Qualitative Health Research*, *32*(8-9), 1207-1214. https://doi.org/10.1177/10497323221105737

Kuznietsova, E., McMahon, A., & O'Neill, R. (2025). Supervisees' perceptions of multicultural supervision in a historically monocultural context. *The Clinical Supervisor*, *44*(1), 26-46. https://doi.org/10.1080/07325223.2024.2448954

LaDonna, K. A., Taylor, T., & Lingard, L. (2018). Why open-ended survey questions are unlikely to support rigorous qualitative insights. *Academic Medicine*, *93*(3), 347-349.

LaFromboise, T. D., Coleman, H. L., & Hernandez, A. (1991). Development and factor structure of the cross-cultural counseling inventory-revised. *Professional Psychology: Research and Practice*, *22*(5), 380-388.

Lee, E. H., Pitts, S., Pignataro, S., Newman, L. R., & D'Angelo, E. J. (2022). Establishing psychological safety in clinical supervision: Multi-professional perspectives. *The Clinical Teacher*, *19*(2), 71-78. https://doi.org/10.1111/tct.13451

Lekas, H. M., Pahl, K., & Fuller Lewis, C. (2020). Rethinking cultural competence: Shifting to cultural humility. *Health Services Insights, 13*, 1-4. https://doi.org/10.1177/1178632920970580

Liese, B. S., & Beck, J. S. (1997). Cognitive therapy supervision. In C. E. Watkins, Jr. (Ed.), *Handbook of psychotherapy supervision* (pp. 114–133). John Wiley & Sons, Inc.

Long, H. A., French, D. P., & Brooks, J. M. (2020). Optimising the value of the critical appraisal skills programme (CASP) tool for quality appraisal in qualitative evidence synthesis. *Research Methods in Medicine & Health Sciences*, *1*(1), 31-42. https://doi.org/10.1177/2632084320947559

Madill, A., Jordan, A., & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies. *British Journal of Psychology*, *91*(1), 1-20. https://doi.org/10.1348/000712600161646

Mahon, D. (2024). Beyond multicultural competency: A scoping review of multicultural orientation in psychotherapy and clinical supervision. *Mental Health and Social Inclusion*, *28*(6), 1095-1119. https://doi.org/10.1108/MHSI-01-2024-0012

Mahood, Q., Van Eerd, D., & Irvin, E. (2014). Searching for grey literature for systematic reviews: Challenges and benefits. *Research Synthesis Methods*, *5*(3), 221-234. https://doi.org/10.1002/jrsm.1106

Maura, J., & Weisman de Mamani, A. (2017). Mental health disparities, treatment engagement, and attrition among racial/ethnic minorities with severe mental illness: A review. *Journal of Clinical Psychology in Medical Settings*, *24*, 187-210. https://doi.org/10.1007/s10880-017-9510-2

McLeod, A. L. (2009). *A phenomenological investigation of supervisors' and supervisees' experiences with attention to cultural issues in multicultural supervision* [Doctoral dissertation, Georgia State University]. Scholar Works Georgia State University.

Miller, R. L., (2008). Community psychology. In S. F. Davis & W. Buskist (Eds.), *21st century psychology: A reference handbook* (pp. 395–405). Sage Publications.

Mollen, D., Ridley, C. R., & Hill, C. L. (2003). Models of multicultural competence: A critical evaluation. In D. B. Pope-Davis, H. L. K. Coleman, W. M. Liu & R. L. Toporek (Eds.), *Handbook of multicultural competencies: In counseling & psychology*. (pp. 21-37). Sage Publications, Inc. https://psycnet.apa.org/doi/10.4135/9781452231693.n2

Noblit, G. W., & Hare, R. D. (1988). *Meta-ethnography: Synthesizing qualitative studies*. Sage publications.

Ononaiye. M. (2024). The development of the PPN equality, diversity, and inclusion audit tool: What is and how to use it? *Clinical Psychology Forum,* 375, 48-52, https://doi.org/10.53841/bpscpf.2024.1.375.48

Owen, J. (2013). Early career perspectives on psychotherapy research and practice: Psychotherapist effects, multicultural orientation, and couple interventions. *Psychotherapy, 50*(4), 496–502. https://psycnet.apa.org/doi/10.1037/a0034617

Owen, J., Jordan Ii, T. A., Turner, D., Davis, D. E., Hook, J. N., & Leach, M. M. (2014). Therapists' multicultural orientation: Client perceptions of cultural humility, spiritual/ religious commitment, and therapy outcomes. *Journal of Psychology and Theology*, 42(1), 91–98. https://doi.org/10.1177/009164711404200110

Owen, J., Tao, K. W., Drinane, J. M., Hook, J., Davis, D. E., & Kune, N. F. (2016). Client perceptions of therapists' multicultural orientation: Cultural (missed) opportunities and cultural humility. *Professional Psychology: Research and Practice*, 47(1), 30–37. https://doi.org/10.1037/pro0000046

Paez, A. (2017). Gray literature: An important resource in systematic reviews. *Journal of Evidence-Based Medicine*, *10*(3), 233-240. https://doi.org/10.1111/jebm.12266

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., ... & Moher, D. (2021). The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. *BMJ*, *372*(71), 1-9. https://doi.org/10.1136/bmj.n71

Park, E. H., Ha, G., Lee, S., Lee, Y. Y., & Lee, S. M. (2019). Relationship between the supervisory working alliance and outcomes: A meta-analysis. *Journal of Counseling & Development, 97*(4), 437–446. https://doi.org/10 .1002/jcad.12292

Parker, C., Scott, S., & Geddes, A., (2019). Snowball Sampling, In P. Atkinson, S. Delamont, A. Cernat, J.W. Sakshaug, & R.A. Williams (Eds.), *SAGE research methods foundations.* Sage Publications. https://doi.org/10.4135/9781526421036831710

Patel, N. (2011). Difference and power in supervision: The case of culture and racism. In I. Fleming, & L. Steen (Eds.), *Supervision and clinical psychology* (2nd ed., pp. 96-117). Routledge. https://doi.org/10.4324/9780203805817

Paterson, B. L. (2011). "It looks great but how do I know if it fits?": An introduction to meta-synthesis research. In K. Hannes, & C. Lockwood (Eds.), *Synthesizing qualitative research: Choosing the right approach* (1st ed., pp. 1-20). John Wiley & Sons. Ltd.https://doi.org/10.1002/9781119959847.ch1

Pieterse, A. L. (2020). Attending to racial trauma in clinical supervision: Enhancing client and supervisee outcomes. In C. Knight, & L. D. Borders (Eds.), *Trauma-informed supervision* (1st ed., pp. 202-220). Routledge.

Proctor, B. (1988). Supervision: a co-operative exercise in accountability. In M. Marken and M. Payne (Eds.), *Enabling and ensuring: Supervision in practice* (pp. 21-23). National Youth Bureau.

Rothwell, C., Kehoe, A., Farook, S. F., & Illing, J. (2021). Enablers and barriers to effective clinical supervision in the workplace: A rapid evidence review. *BMJ Open*, *11*(9), 1-10. https://doi.org/10.1136/bmjopen-2021-052929

Ryde, J. (2000). Supervising across difference. *International Journal of Psychotherapy*, *5*(1), 37-48. https://doi.org/10.1080/13569080050020254

Scaife, J. (2019). *Supervision in clinical practice: A practitioner's guide* (3rd ed.). Routledge.

Spowart, J. K., & Robertson, S. E. (2024). Becoming a culturally responsive and socially just clinical supervisor. *Canadian Psychology, 65*(4), 257-269. https://doi.org.10.1037/cap0000388

Sodowsky, G. R., Taffe, R. C., Gutkin, T., & Wise, S. L. (1994). Development of the Multicultural Counseling Inventory: A self-report measure of multicultural competencies. *Journal of Counseling Psychology, 41*(2), 137–148. https://psycnet.apa.org/doi/10.1037/0022-0167.41.2.137

Soheilian, S. S., Inman, A. G., Klinger, R. S., Isenberg, D. S., & Kulp, L. E. (2014). Multicultural supervision: Supervisees' reflections on culturally competent supervision. *Counselling Psychology Quarterly*, *27*(4), 379-392. https://doi.org/10.1080/09515070.2014.961408

Soilemezi, D., & Linceviciute, S. (2018). Synthesizing qualitative research: reflections and lessons learnt by two new reviewers. *International Journal of Qualitative Methods*, *17*(1), 1-14. https://doi.org/10.1177/1609406918768014

Stubbe, D. E. (2020). Practicing cultural competence and cultural humility in the care of diverse patients. *Focus, 18*(1), 49-51. https://doi.org/10.1176/appi.focus.20190041

Sue, D. W. (l990). Culture specific techniques in counseling: A conceptual framework. *Professional Psychology: Research and Practice, 21*(6), 424-433. https://psycnet.apa.org/doi/10.1037/0735-7028.21.6.424

Sue, D. W. (2001). Multidimensional facets of cultural competence. *The Counseling Psychologist*, *29*(6), 790-821. https://doi.org/10.1177/0011000001296002

Sue, D. W., Bernier, J. E., Durran, A., Feinberg, L., Pedersen, P., Smith, E. J., & Vasquez-Nuttall, E. (1982). Position paper: Cross-cultural counseling competencies. *The Counseling Psychologist, 10*(2), 45–52. https://doi.org/10.1177/0011000082102008

Sue, D.W. & Sue, D. (2013), *Counseling the culturally diverse: Theory & practice* (6th ed.), John Wiley.

Suresh, K., & Bhui, K. (2006). Ethnic minority patients' access to mental health services. *Psychiatry*, *5*(11), 413-416. https://doi.org/10.1053/j.mppsy.2006.08.005

Tavallaei, M., & Talib, M. A. (2010). A general perspective on role of theory in qualitative research. *Journal of International Social Research*, *3*(11), 570-577.

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology*, *8*(45), 1-10. https://doi.org/10.1186/1471-2288-8-45

Towsend, I. R. (1996). *An examination of african-american supervisees' perceptions of white supervisors' cross-cultural competence* (Publication no. 9709149) [Doctoral dissertation, Auburn University]. ProQuest Dissertations & Theses.

Turpin, G., & Coleman, G. (2010). Clinical psychology and diversity: Progress and continuing challenges. *Psychology Learning & Teaching*, *9*(2), 17-27. https://doi.org/10.2304/plat.2010.9.2.17

Turpin, G., & Fensom, P. (2004). *Widening access within undergraduate psychology education and its implications for professional psychology: Gender, disability and ethnic diversity.* The British Psychological Society.

Tyndall, J. (2010). *AACODS Checklist*, Flinders University. https://fac.flinders.edu.au/dspace/api/core/bitstreams/e94a96eb-0334-4300-8880-c836d4d9a676/content

Vandament, M. L., Duan, C., & Li, S. (2022). Relationships among supervisee perceived supervisor cultural humility, working alliance, and supervisee self-efficacy among white supervisor and supervisee of color dyads. *Training and Education in Professional Psychology*, *16*(3), 244-252. https://doi.org/10.1037/tep000370

Vekaria, B., Thomas, T., Phiri, P., & Ononaiye, M. (2023a). Exploring the supervisory relationship in the context of culturally responsive supervision: A supervisee's perspective. *The Cognitive Behaviour Therapist*, *16*(22), 1-14. https://doi:10.1017/S1754470X23000168

Vekaria, B., Harrydwar, L., Thomas, T., & Ononaiye, M. (2023b). Supervisee perspectives on improving cultural responsivity in clinical supervision. *Clinical Psychology Forum*, *1* (371), 66-76. http://dx.doi.org/10.53841/bpscpf.2023.1.371.66

Vertovec S. (2007). Super-diversity and its implications. *Ethnic and Racial Studies, 30*(6), 1024–1054. https://doi.org/10.1080/01419870701599465

Watkins, C. E., Hook, J. N., Mosher, D. K., & Callahan, J. L. (2019a). Humility in clinical supervision: Fundamental, foundational, and transformational. *The Clinical Supervisor*, *38*(1), 58-78. https://doi.org/10.1080/07325223.2018.1487355

Watkins Jr, C. E., Hook, J. N., Owen, J., DeBlaere, C., Davis, D. E., & Van Tongeren, D. R. (2019b). Multicultural orientation in psychotherapy supervision: Cultural humility, cultural comfort, and cultural opportunities. *American Journal of Psychotherapy*, *72*(2), 38-46. https://doi.org/10.1176/appi.psychotherapy.20180040

Wetchler, J. L. (1990). Solution-focused supervision. *Family Therapy, 17*(2), 129–138.

Wilcox, M. M., Drinane, J. M., Black, S. W., Cabrera, L., DeBlaere, C., Tao, K. W., ... & Owen, J. (2022a). Layered cultural processes: The relationship between multicultural orientation and satisfaction with supervision. *Training and Education in Professional Psychology*, *16*(3), 235-243. https://psycnet.apa.org/doi/10.1037/tep0000366

Wilcox, M. M., Winkeljohn Black, S., Drinane, J. M., Morales-Ramirez, I., Akef, Z., Tao, K. W., ... & Owen, J. (2022b). A brief qualitative examination of multicultural orientation in clinical supervision. *Professional Psychology: Research and Practice*, *53*(6), 585-595. https://psycnet.apa.org/doi/10.1037/pro0000477

Wilcox, M. M., Winkeljohn Black, S., Farra, A., Zimmerman, D., Drinane, J. M., Tao, K. W., ... & Owen, J. (2023). Cultural humility, cultural comfort, and supervision processes and outcomes for BIPOC supervisees. *The Counseling Psychologist*, *51*(7), 1037-1058. https://doi.org/10.1177/00110000231188337

Williams, B. A. (2020). *The space between black & white: Examining the lived experiences of african american supervisees in cross-racial supervisory relationships* (Publication No. 27961242 [Doctoral dissertation, James Madison University]. ProQuest Dissertations & Theses.

Williams, M., & Halstead, M. (2019). Racial microaggressions as barriers to treatment in clinical care. *Directions in Psychiatry*, *39*(4), 265-280. https://doi.org/10.1080/13569080050020254

Willig, C. (2012). Perspectives on the epistemological bases for qualitative research. In H. Cooper, P. M. Camic, D. L. Long, A. T. Panter, D. Rindskopf, & K. J. Sher (Eds.), *APA handbook of research methods in psychology, Vol. 1. Foundations, planning, measures, and psychometrics* (pp. 5–21). American Psychological Association. https://doi.org/10.1037/13619-002

Wood, N., & Patel, N. (2017). On addressing 'Whiteness' during clinical psychology training. *South African Journal of Psychology*, *47*(3), 280-291. https://doi.org/10.1177/0081246317722099

Worthington, R. L., Soth-McNett, A. M., & Moreno, M. V. (2007). Multicultural counseling competencies research: A 20-year content analysis. *Journal of Counseling Psychology*, *54*(4), 351. https://doi.org/10.1037/0022-0167.54.4.351

Zapata, A. L. (2010). *A qualitative study examining discussions of multicultural perspectives in clinical supervision* (Publication No. 3428287) [Doctoral dissertation, Arizona State University] ProQuest Dissertations & Theses.

Zhang, H., Watkins Jr, C. E., Hook, J. N., Hodge, A. S., Davis, C. W., Norton, J., ... & Owen, J. (2021). Cultural humility in psychotherapy and clinical supervision: A research

review. *Counselling and Psychotherapy Research*, *22*(3), 548-557. https://doi.org/10.1002/capr.12481

Appendix A - Search Terms

All searches filtered for English language papers only.

MEDLINE, PsychInfo and CINAHL search terms:

S1	AB (supervi* OR clinical supervi*)	**Expanders** - Apply equivalent subjects **Search modes** - Boolean/Phrase
S2	AB (cultural N1(competenc* OR responsiv* OR awareness OR sensitiv* OR orientation OR humility) OR multicultural OR humility)	**Expanders** - Apply equivalent subjects **Search modes** - Boolean/Phrase
S3	AB (perspective* OR view* OR perception* OR attitude* OR opinion OR focus group* OR qualitative OR interview* OR phenomenology*)	**Expanders** - Apply equivalent subjects **Search modes** - Find all my search term
S4	S1 AND S2 AND S3	**Expanders** - Apply equivalent subjects **Search modes** - Find all my search term

Web of Science search terms:

supervi* OR clinical supervisi* (Abstract) and cultural N1(competenc* OR responsiv* OR awareness OR sensitiv* OR orientation OR humility) OR multicultural (Abstract) and perspective* OR view* OR perception* OR attitude* OR opinion OR focus group* OR qualitative OR interview* OR phenomenology* (Abstract)

ProQuest search terms:

noft(supervi* OR clinical supervi*) AND noft(cultural NEAR/1 (competenc* OR responsiv* OR awareness OR sensitiv* OR orientation OR humility) OR multicultural OR humility) AND noft(perspective* OR view* OR perception* OR attitude* OR opinion OR focus group* OR qualitative OR interview* OR phenomenology*) AND stype.exact(("Dissertations & Theses" OR "Scholarly Journals") NOT ("Newspapers" OR "Books" OR "Reports" OR "Magazines" OR "Speeches & Presentations" OR "Encyclopedias & Reference Works" OR "Wire Feeds" OR "Audio & Video Works" OR "Blogs, Podcasts, & Websites"))

Appendix B - Inclusion/Exclusion Criteria for Systematic Review

	Inclusion Criteria	Exclusion Criteria
Population	Supervisees providing psychological therapy (clinical based work with adults, children's families, etc) and receiving or has received clinical supervision by a qualified therapist. Over 18 years old.	Undergraduate students. Master's or Doctoral students who are not enrolled a clinical programme. Research supervision, and non-psychological therapy related. Under 18 years old.
Intervention (s)	Studies explicitly focusing on discussions of culture in the context of clinical practice within clinical supervision. Regarding 1:1 supervision	Studies which do not explicitly focus on exploring perspectives of culturally responsive clinical supervision. Studies which do not explicitly discuss culture in the context of clinical practice within clinical supervision. Regarding group supervision.
Comparators	Not applicable, it is not a requirement for included studies to have a comparator.	Not applicable, it is not a requirement for included studies to have a comparator.
Outcomes	Exploring supervisees' perspectives of receiving culturally responsive clinical supervision. How receiving culturally responsive clinical supervision has impacted supervisees.	Not exploring supervisees' perspectives of receiving culturally responsive/competent/ humble clinical supervision. Exploring supervisors' perspectives
Study Design	Qualitative empirical studies. Written in English. Any qualitative perspectives of discussing cultural responsivity, humility, or competence in the context of clinical 1:1 supervision.	Quantitative only studies. Non-empirical literature (e.g., book chapters or reflective articles). Not written in English. If there are no direct quotes provided to support the findings.
Setting	Supervisees' perspectives of culturally responsive clinical supervision in any setting (online/in person interviews/focus groups).	Not related to clinical supervision in the field of professional psychology, counselling, or mental health.

	Related to clinical supervision in the field of professional psychology, counselling, or mental health. Adult based research.	Not adult based research.

Appendix C – Quality Assessment Tables

Qualitative Risk of Bias Scores for Published Papers (CASP; 2024)

	Section A: are the results valid						**Section B: what are the results?**			**Section C: will the results help locally?**	
Study ID	**Statement of aims**	**Suitable methodology**	**Appropriate Design**	**Appropriate recruitment strategy**	**Data collection**	**Relationship between researchers and participants**	**Ethical Issues**	**Data analysis**	**Statement of findings**	**How valuable is the research**	**Summary score**
Ancis & Marshall, 2010	Y	Y	Y	Somewhat/ Can't Tell/	Y	Y	Somewhat/ Can't Tell	Y	Y	Y	8
Burkard et al., 2006	Y	Y	Y	Y	Y	Y- in supplementary material	Somewhat	Y	Y	Y	9
Kuznietsova et al., 2025 Ireland	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Ling et al., 2022	Y	Y	Y	Y	Y	Y	Y	Somewhat/ Can't Tell	Y	Y	9
Soheilian et al., 2014	Y	Y	Y	Y	Y	Y	Somewhat	Y	Y	Y	9

Vekaria et al., 2023	Y	Y	Y	Y	Y	Somewhat	Y	Y	Y	Y	9
Wilcox et al., 2022	Y	Y	Y	Y	Y	Y	Somewhat/ Can't Tell	Y	Y	Y	9

Note. Y = present

Qualitative Risk of Bias for Grey Literature (AACODS; Tyndall, 2010)

Study ID	**Authority**	**Accuracy**	**Coverage**	**Objectivity**	**Date**	**Significance**	**Summary Score**
Becerra, 2016	Y	Y	Y	Y	Y	Y	6
Byrd, 2022	Y	Y	Y	Y	Y	Y	6
Darby, 2014	Y	Y	Y	Y	Y	Y	6
Del Re, 2022	Y	Y	Y	Y	Y	Y	6
McLeod, 2008	Y	Y	Y	Y	Y	Y	6
Towsend, 1996	Y	Somewhat/ Can't Tell	Y	Can't Tell	Y	Y	4
Williams, 2020	Y	Y	Y	Y	Y	Y	6
Zapata, 2010	Y	Y	Y	Y	Y	Y	6

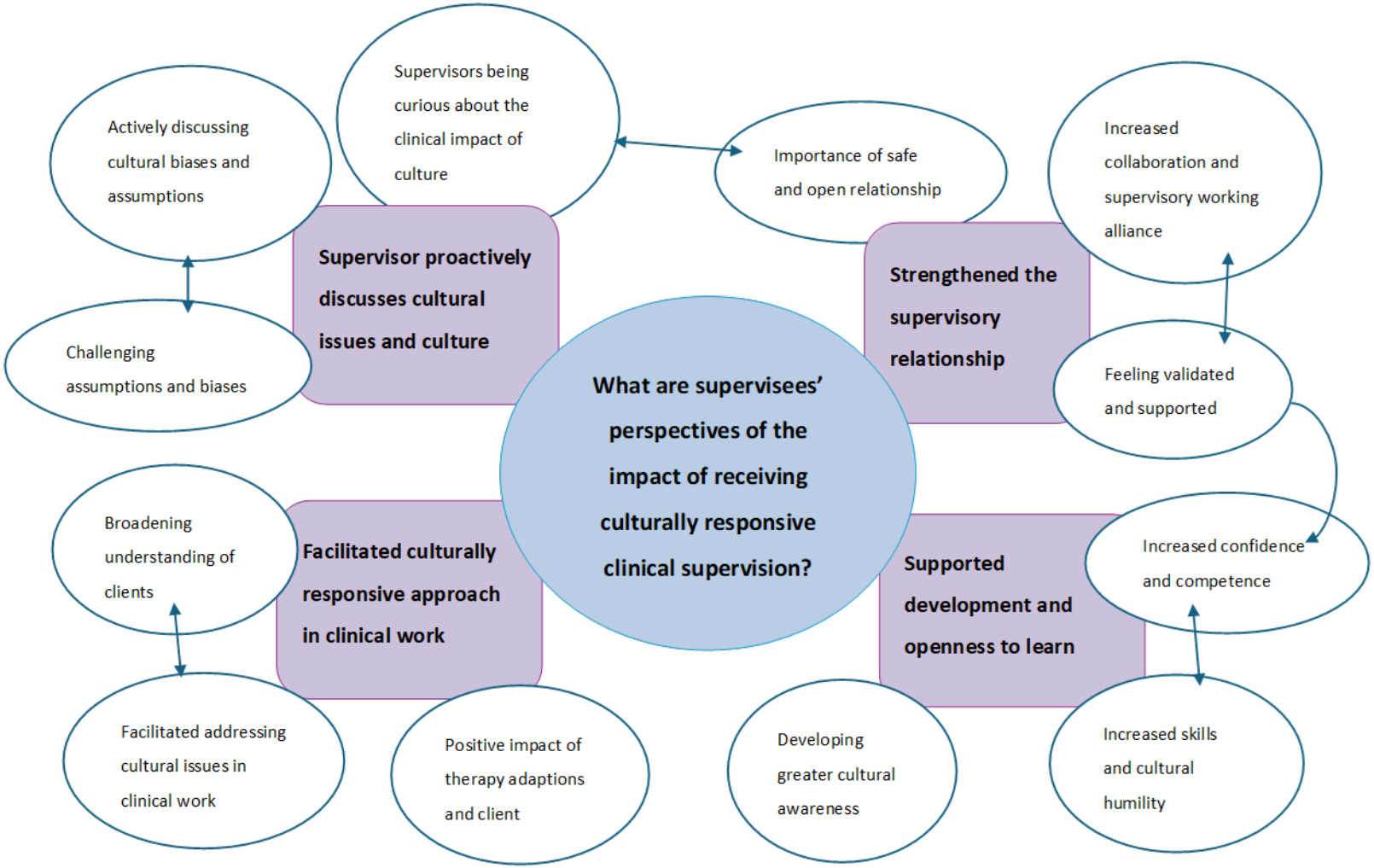
Note. Y = present

Appendix D – Extract of Coding Manual

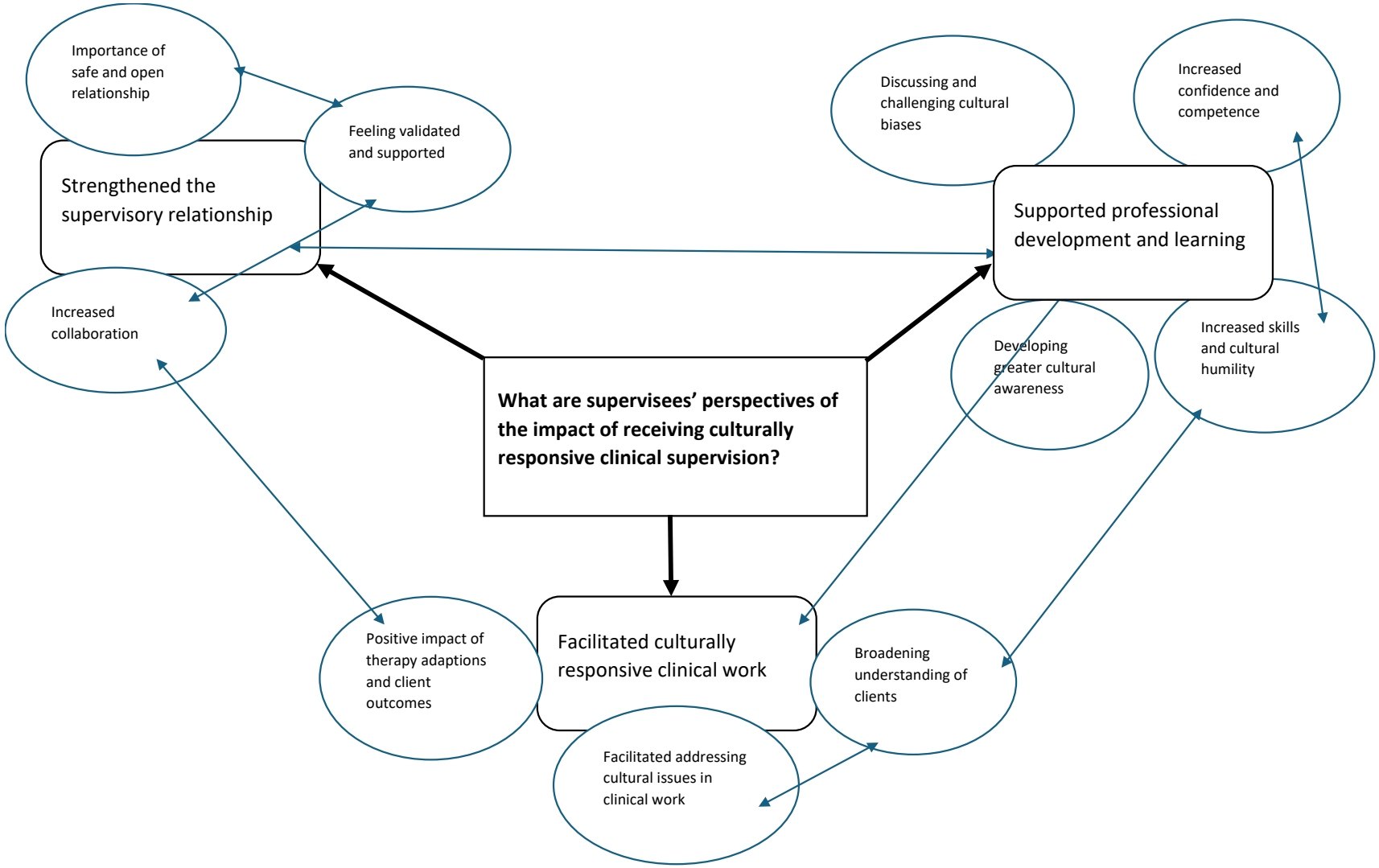
Main Theme	Subtheme	Illustrative Codes	Definition	Illustrative Quote/s
Strengthened the supervisory relationship	Feeling validated and supported	Supervisees feeling validated and supported Empathy and validation towards Supervisors providing guidance and support	A feeling that supervisees described of feeling understood and respected. Supervisors provided guidance and empathy to supervisees experiences.	*"This participant indicated feeling a "personal sense of validation*"" (Vekaria et al., 2023b: authors). "*she validated my concerns and made [supervision] feel a lot safer"* (Becerra, 2018: supervisee)
	Importance of a safe and open relationship	Safe supervision Safety created from openness of supervisors' curiosity about supervisees identity Secure and honest relationship Open and supportive supervisors	The significance of having a supervisory relationship that felt secure, based on trust, understanding, and cultural sensitivity and curiosity.	*"the importance of having a safe or open relationship"* (Wilcox et al., 2022b: author) *"having trust and good rapport so that I am comfortable asking questions"* (Wilcox et al., 2022: supervisee)

Increased collaboration	Increased collaboration in supervisory relationship Learning together Discussing cultural conceptualisation together	The supervisees' feeling of more joint-working, decision making in supervision about clinical work and noticing that they were both learning together to be culturally responsive.	*"…we are going to have to learn this together so we approached that together and came up with resources for her…"* (Darby, 2014: *supervisee)* *"I had one Japanese client. . . . I think through supervision [my supervisor] kept asking me how I conceptualized her"* (Ancis & Marshall, 2010: supervisee

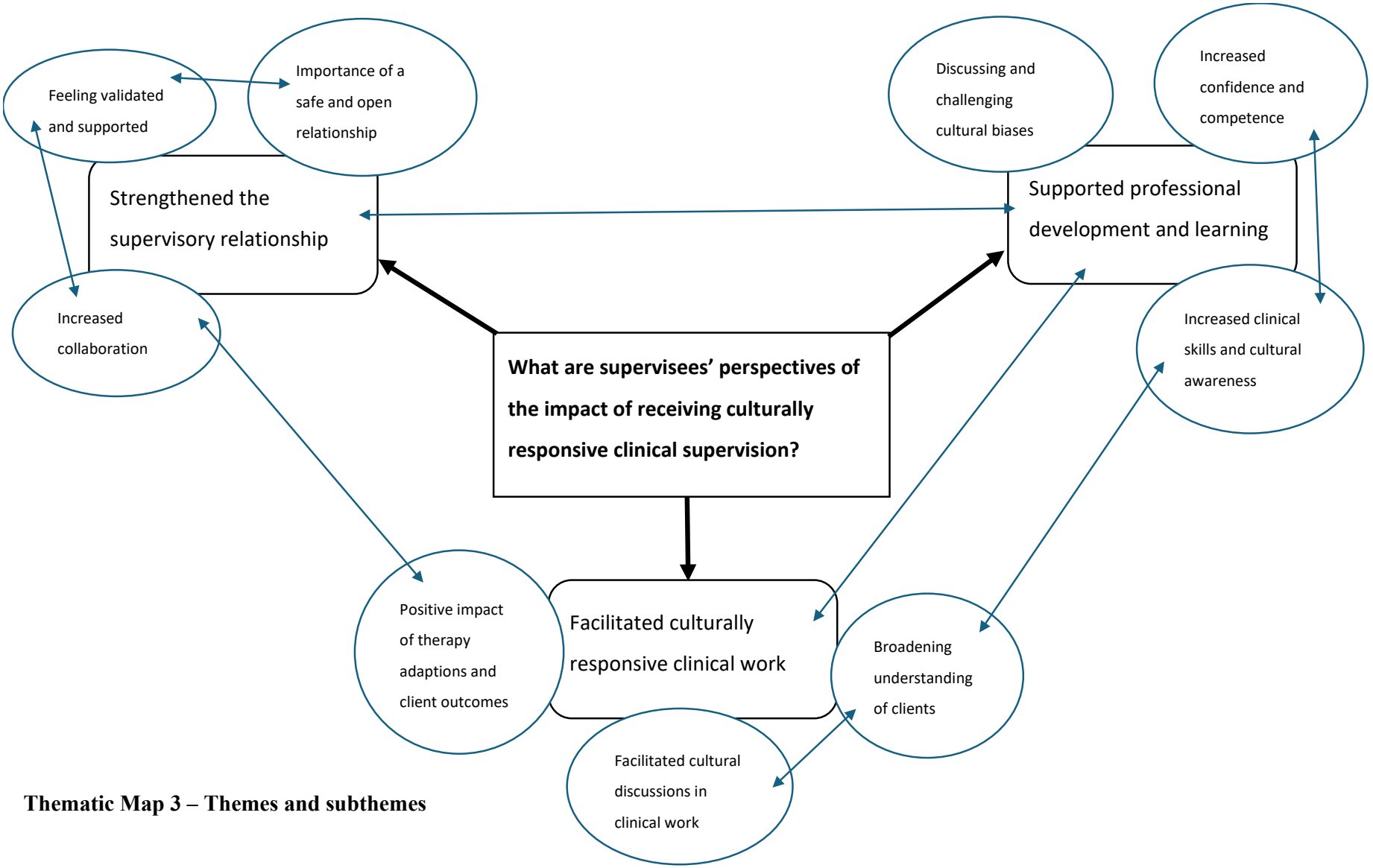
Appendix E – Thematic Map Developments



Thematic Map 1 – Themes and subthemes



Thematic Map 2 – Themes and subthemes



Thematic Map 3 – Themes and subthemes

Chapter 3 The Development and Validation of the Clinician Cultural Humility Scale (CCHS) for Clinical Supervision

Journal Specification: The following paper was written to follow the British Journal of Psychology. Papers have a maximum word limit of 8,000 (excluding the abstract, reference list, tables and figures). Authors guidelines can be found: https://bpspsychub.onlinelibrary.wiley.com/hub/journal/20448295/homepage/forauthors.html

Word count (excluding abstract, reference list, tables and figures): 7796

3.1 Abstract

Research has highlighted the importance of adopting a culturally responsive approach to clinical supervision. The current cultural humility measures designed for use in a clinical setting have been validated in the USA or been developed solely for clients. There is not a current validated cultural humility measure for UK clinicians to utilise within clinical supervision. The purpose of this study was to develop a scale to measure cultural humility in clinical supervision and assess its properties within a UK sample. A three-part phase design was used to develop the Clinician Cultural Humility Scale (CCHS). The initial scale items were developed based on the current cultural humility literature. Next, the Delphi method was utilised to gain expert opinion regarding the appropriateness of the scale items and consensus was reached after two Delphi rounds. Following consensus, confirmatory and then exploratory factor analyses were both employed to assess the CCHS's psychometric properties. The final version of the CCHS comprised 10-items with a three-factor structure and demonstrates good psychometric properties. It is suggested that the CCHS is an important and practical tool to support clinicians' development of cultural humility. Recommendations for future research and further implications are also discussed.

3.2 Background

3.2.1 Clinical supervision and cultural responsivity

Clinical supervision provides a formal space that allows supervisee and supervisor to reflect and consider new learnings (Milne, 2009), with the intent of further developing one's skills, knowledge (Bernard & Goodyear, 2013; Proctor, 1988), and enhance client outcomes (Fleming & Steen, 2012). It is well researched that the relationship between a supervisor and supervisee has shown to be crucial for supporting effective clinical supervision (Kilminster & Jolly, 2000; Sloan, 2005; Vandament et al., 2022). Specifically, the supervisory working alliance is a key factor for effecting positive change (Vandament et al., 2022). The importance of effective supervision has been highlighted in research (e.g., Chircop Coleiro et al., 2023) and shown to have an association with better client outcomes (e.g., Snowdon et al., 2017; Wheeler & Richards, 2007), such as fewer psychological symptoms of people with a mental health diagnosis (Snowdon et al., 2017). Similarly, effective clinical supervision has been shown to support supervisees' emotional wellbeing (Amery et al., 2020; Wilson et al., 2016).

It is important to acknowledge that culture is integral to clinicians' personal belief systems, which are inherently intertwined within their clinical practice (Gainsbury, 2017). A culturally responsive stance has been argued as an approach to reduce health disparities and enhance equity (Kibakaya & Oyeku, 2022). Cultural responsivity in clinical supervision therefore, pertains to the breadth of diversity and influencing factors within the supervisory relationship (Silva, 2018), by embracing diversity and the richness that difference can offer (Miller et al., 2019). It has been argued that a positive supervisory relationship includes the need for promoting awareness of diversity and the inclusion of culturally responsive clinical supervision (Patel, 2004; Vekaria et al., 2023a). Moreover, it was found that the absence of culturally responsive clinical supervision can be detrimental to the supervisory relationship. For example, Vekaria et al. (2023a) found that racially/ethnically-minoritised (REM)

supervisees with White supervisors, perceived their supervision as less culturally responsive compared to White supervisees. They also reported a lower quality supervisory relationship and more instances of culturally harmful supervision. These findings highlight the critical importance of ensuring that cultural responsivity is a routine part of the supervisory experience.

3.2.2 Cultural humility

The term cultural competence has moved on from a term which risks being viewed as a binary fixed outlook (Agner, 2020), towards a more fluid perspective, termed cultural humility. Cultural humility refers to an open and curious approach which encapsulates intrapersonal and interpersonal components (Davis et al., 2010; Zhang et al., 2021), in order to build awareness of one's own culture, biases and beliefs, and hold a humble approach and respect when interacting with others about cultural identities (Zhang et al., 2021). Within psychology, clinicians who embrace cultural humility with a genuine curiosity and collaboration, to understand and support clients' experiences and cultural context, inherently promote a non-expert position (Hook et al., 2013). Furthermore, a cultural humility stance enables a longstanding commitment to learning reflection, to support individuals and communities in a more responsive way (Upshaw et al., 2020; Yeager & Bauger-Wu, 2013). Cultural humility has also been promoted within leadership and at organisational levels, with the aim to increase inclusion and health equality (Robinson et al., 2021).

The concept of cultural humility was further explored by Foronda et al. (2016) across diverse contexts and five main attributes were identified. The authors proposed that 'openness' refers to an attitude that has a willingness to be able to explore and invite new ideas about cultural diversity. In contrast, they proposed that 'self-awareness' involves recognising one's own cultural values and beliefs and understanding how these influence interactions with others, including an awareness of both strengths and limitations.

Furthermore, they used the term ‘egoless’ to emphasise humility, rejecting notions of superiority, and treating others as equals, aligning with the principle of equality in human rights. Whereas Foronda and colleagues noted that ‘supportive interactions’ highlight the interpersonal aspect of cultural humility, characterised by active, engaging and supportive exchanges where responsibility is shared, fostering mutual respect and promotes humility. Finally, ‘self-reflection and critique’ is the continuous introspective reflective process of evaluating one’s thoughts, feelings and behaviours. They also put forward that this reflective stance promotes ongoing learning and discovery, with no definitive endpoint and that these five dimensions conceptualise cultural humility as a compassionate journey.

The literature on incorporating cultural humility within clinical supervision, though still novel, has revealed promising findings (e.g., Mahon, 2024; Zhang et al., 2021). It is argued that culturally humble supervisors are more likely to address and reduce biases and blind spots, as they adopt a learning-oriented, culturally reflective approach (Hawkins & Shohet, 2012; Hook et al., 2016). This approach fosters cultural conversations in supervision, recognising the importance of diversity, with the clinician, supervisor and clients (Hook et al., 2016). Zhang et al.’s (2021) systematic review of embedding cultural humility in psychotherapy and clinical supervision found improved outcomes in therapy, such as greater working alliances and treatment effectiveness. Similarly, the review noted that supervisors’ cultural humility, as perceived by the supervisees, predicted supervisee’s willingness to be open and disclose in supervision. Furthermore, Zhang and colleagues (2021) reported higher perceptions of a supervisor’s cultural humility were positively associated with working alliance, self-efficacy and satisfaction with supervision. However, it is important to note that most studies included in the review were correlational and cross-sectional and, therefore, findings should be interpreted tentatively and appropriately rather than implying causality (Becker et al., 2016). Nevertheless, it seems fair to propose that this review emphasises the potential importance of embedding cultural humility within supervision.

In consideration of theory, the Multicultural Orientation Framework (MCO; Owen et al., 2011; Owen, 2013) places culture at the centre of psychotherapy processes. The MCO, framework was applied directly to psychotherapy supervision (MCO-S; Watkins et al., 2019), with the addition of three key components, namely cultural humility, cultural comfort and cultural opportunities. Within this supervision model, cultural humility refers to supervisors adopting an open stance towards recognising and reflecting that they are cultural beings, as well as taking the lead in modelling cultural humility and curiosity. Of central importance is the attitude that cultural humility is a never-ending learning process. The model predominantly places the responsibility on the supervisor, and, although research is currently limited, there is evidence to support the model (Vekaria et al., 2023b; Wilcox et al., 2022; 2023). For example, supervisees who perceived their supervisors as demonstrating cultural humility reported greater satisfaction in supervision (Wilcox et al., 2022). Furthermore, a recent scoping review found the MCO/MCO-S to be particularly promising in supporting the supervisory working alliance and satisfaction and is associated with clients' outcomes in therapy (Mahon, 2024). Such findings further highlight the need for developing cultural humility in clinical supervision.

3.2.3 Measuring cultural humility in clinical supervision

Historically, measurement in psychology has been utilised to quantify and conceptualise proposed concepts and constructs, striving to offer meaningful utility (Michell, 1997). Specifically in the context of cultural discussions in supervision, understanding how these discussions are being held is crucial in the process of operationalising constructs (Bartell, 2016). Measurement can serve as a shared reference point for clinicians and researchers to facilitate advancement of understanding of how to assess and further explore constructs of culture in supervision (Bartell, 2016). To enable valid and meaningful conclusions and implications from research, scientific rigour and transparency are imperative throughout the measurement development process (Flake & Fried, 2020).

There are limited number of measures developed to specifically capture clinician's cultural humility (e.g., Gonzalez et al., 2021; Hook et al., 2013; Zhu et al., 2022). The Multidimensional Cultural Humility Scale (MCHS; Gonzalez et al., 2021), informed by Foronda et al.'s (2016) five pillars of cultural humility, is validated on a population of counsellors. It is a self-assessment measure that enables clinicians to assess their own cultural humility, with the aim of fostering one's cultural responsivity and sensitivity. This measure has been critiqued because it may not accurately represent the cultural humility domains as it is primarily based on one definition by Tervalon and Murray-Gracia (1988) and does not consider situational 'in the moment' facets of cultural humility, thus potentially inferring limitations to the content validity of the scale (Zhu et al., 2022).

In contrast, the Cultural Humility Scale (CHS; Hook et al., 2013), which is a widely used and validated measure in research (Zhang et al., 2021), was developed for clients to measure their therapist's cultural humility responsiveness. This measure was later adapted, but not formally validated, to be used within supervision termed the Supervision Cultural Humility Scale (CHS-S; Wilcox et al., 2022). Similarly to the MCHS, the CHS has been critiqued for not assessing the intrapersonal aspects of cultural humility, rather items are designed to measure the interpersonal dimension, which does not fully align with the MCO framework (Davis et al., 2018). It should be noted that both these measures are from the United States of America (USA), thus limiting their generalisability to wider populations (Zhang et al., 2021; Zhu et al., 2022). Furthermore, there isn't a cultural humility measure for clinicians to use within clinical supervision, using the five-factor structure as proposed by the literature (Foronda et al.; Gonzalez et al., 2021), that has been validated within a UK sample. It seems fair to argue that the development of such a scale is crucial to support the clinical development of cultural humility within supervision. This tool is developed therefore with the intention of ensuring a clinician can measure the inclusion of a cultural humility narrative within supervision. In addition, a scale validated within the UK, may bring a meaningful

impact for both clients and clinicians, while also representing a valuable contribution to research in the field. Furthermore, the measure hopes to support the strengthening of the supervisory relationship and the improvement of clinical outcomes (Zhang et al., 2021).

3.2.4 Current research

To address this gap, this study aims to develop a scale to measure cultural humility in clinical supervision using a five-factor structure and to assess its psychometric properties with a UK sample with the following hypotheses:

1) Scale Development - Experts will reach consensus on scale items in Delphi rounds to demonstrate the scale is appropriate for measuring cultural humility in clinical supervision.
2) Factor Structure - A confirmatory factor analysis (CFA) will confirm the scale has a good fit to the five-factor structure.
3) Reliability - The scale will have good internal reliability.
4) Validity -
    a. The scale will show convergent relationships with existing cultural humility scales (MCHS and CHS-S).
    b. The scale's subscales will show convergent relationships with the MCHS's subscales.
    c. The scale will show divergent validity against negative scale items on the CHS-S.
    d. The scale will show discriminant validity against the social desirability scale (MCSDS-SF).

3.3 Methods

3.3.1 Ethics

The study was approved by the University of Southampton's Research Ethics Committee (Appendix A) and by the NHS Health Research Authority (HRA; Appendix B).

3.3.2 Design

3.3.2.1 Item generation – Development of the Clinician Cultural Humility Scale (CCHS)

A three-part phase design was employed for this study. Firstly, the research team generated items that led to the development of a preliminary scale of cultural humility for clinical supervision, comprising 15 items (Clinician Cultural Humility Scale; CCHS; see Supplementary Materials p. 195). The research team devised the scale based on the relevant literature (Vekaria et al., 2023a; 2023b), previously validated cultural humility measures (e.g. Gonzalez et al., 2021; Hook et al., 2013) and the five dimensions of cultural humility model (Foronda et al., 2016), whilst also adapting the language for a UK population.

3.3.3 Sample 1

3.3.3.1 Participants - Experts

In the second phase of this study, the Delphi technique (Iqbal & Pipon-Young, 2009; Keeney et al., 2011; Linstone & Turoff, 1975) was used to identify which of the generated scale items would be appropriate to include in the measure. This method was chosen in line with previous research that has utilised the Delphi technique for scale development (e.g., Lee et al., 2020; Neupane & Bhattarai; 2024). The Delphi technique recommends a sample size of 30 experts to be optimal for analysis (Chuenjitwongsa, 2017), with larger panel sizes argued not to impact the quality of the findings (de Villiers et al., 2005). Experts in the field of equality, diversity and inclusion (EDI), and/or clinicians in the field of psychological therapies, were approached to participate in the validation of the items. For experts to be eligible to take part, they had to have a minimum of five years' post-qualified experience in the field of

psychological therapies; and/or direct experience of conducting research in the field of EDI; and/or an active interest in EDI related work, with experience of being supervised in a clinical or research role and delivering supervision (see Appendix C for full inclusion criteria). Table 1 shows demographics of experts who participated in round one of study, including gender, age and ethnicity (see Appendix D for further detailed tables). All participants were in either a clinical, academic or EDI professional role, and held a post-graduate qualification for over 5 years (see Appendix D).

Table 1

Expert Demographics

Characteristics	*N* (34)	%
Gender		
Female	24	70.6
Male	10	29.4
Age (years)		
25-34	4	11.8
35-44	18	52.9
45-54	9	26.5
55-64	3	8.8
Ethnicity		
†White: White British, White Irish, Any other White background	19	55.9

Asian or Asian British: Indian, Pakistani, Bangladeshi, Chinese, Any other Asian background	9	26.5
Black or Black British: African, Caribbean, Any other Black background	4	11.8
Mixed: Mixed Asian and White, Mixed Black African and White, Mixed Black Caribbean and White, Any other Mixed background	2	5.9

†*Note.* In the 'white' grouping 2 participants self-reported that they identified as belonging to an ethnic minority group.

3.3.4 Measures and procedure

The research team identified prospective participants to invite them to take part in the study. Purposive sampling was used to recruit experts through emails (Appendix E), inserted into which was the link to the study should they wish to participate. One follow-up reminder email was sent after the initial recruitment email to experts (Appendix F). Interested participants accessed the online study through Qualtrics XM survey software. Firstly, participants were directed to the online participant information sheet and consent form through the online link (Appendix G). They then completed a demographic questionnaire (Appendix H). Next, experts independently rated the 15 items in the CCHS by scoring how important each item was for developing cultural humility in clinical supervision using a 6-point Likert-type scale (*from 1- Strongly Disagree to 6 – Strongly Agree)*, to facilitate a clear position of agreement or disagreement from experts (de Villiers et al., 2005; Polit & Beck 2006).

This study had a total of two Delphi rounds because round one did not reach the predetermined criteria for consensus on all scale items. Therefore, for the second round of the Delphi, the same participants were sent a further email inviting them to take part to rate the one item which had not reached consensus in the first round. Participants were not required to

complete the demographic questionnaire again in round two. Round one took approximately 10-15 minutes and round two took approximately five minutes. All participants were emailed a debrief form (Appendix I) and thanked for taking part.

3.3.5 Data analysis

Data analysis was conducted using SPSS Statistics for Windows, Version 28.1.1.0. The mean, median, and standard deviation (SD) were calculated and reviewed against a twofold criterion to establish if consensus had been reached for each item on the measure. For each scale item, the first criterion to achieve consensus between experts was defined by at least 75% of participants scoring 1.5 SD from the mean or below for the given item (Chang et al., 2010; Christie & Barela, 2005). If consensus of this first criteria was not reached, the researcher would seek feedback from at least two participants about their response, one who scored above and one who scored below the threshold (Christie & Barela, 2005). Following feedback, the research team would decide to modify the item(s) for a subsequent Delphi round or remove the item from the scale. Additionally, the second criterion in determining an item's inclusion in the scale was for it to obtain a consensual rating of 5 '*Agree*' or 6 '*Strongly Agree*' would need to be obtained *(*de Villiers et al., 2005). If a consensus was reached at a score below 5 was reached, the research team would decide to either modify the item for a subsequent Delphi round or remove the item from the scale. The refinement of the scale and the final items are detailed in the results section.

3.4 Results

3.4.1 Development of the CCHS

3.4.1.2 Delphi round one

Of the 91 emails that were sent directly to experts, one email address bounced back, and 34 participants completed the first round of the Delphi (37.4% response rate). All items reached

consensus in relation to the set criteria of at least 75% of experts scoring 1.5 SD from the mean or below, following the first round of the Delphi (Table 2). With regards to the second criteria, except for item 3, all other items scored a mean rating of 5 (agree) or 6 (strongly agree) in the consensus and therefore did not need to be modified or removed. Since item 3 scored below a mean of 5, the research team decided to amend this item from: '*Cultural discussions play a central role in supervision'* to '*In supervision, I am open to discussing the role of culture in my clinical work'.* This amendment was made after the research team reviewed any discrepancies against the other items and identified that other items' language was more personalised and active for the clinician. This amended item was sent to experts in round two of the Delphi to determine whether consensus could be achieved.

Table 2

Delphi Round One Item Descriptive Statistics and Consensus

Item	*M*	*Md.*	*SD*	Consensus (*N*)	Consensus (%)
1	5.12	5.00	1.22	31	91.2
2	5.09	5.00	0.93	32	94.1
3	4.91	5.00	1.38	30	88.2
4	5.24	5.50	0.92	32	94.1
5	5.12	5.00	0.95	33	97.1
6	5.21	5.00	0.91	33	97.1
7	5.03	5.00	0.80	33	97.1
8	5.12	5.00	0.91	32	94.1
9	5.53	6.00	0.66	31	91.2
10	5.32	5.50	0.88	33	97.1
11	5.29	5.00	0.76	28	82.4
12	5.62	6.00	0.65	33	97.1
13	5.18	5.00	0.76	33	97.1
14	5.26	5.00	0.71	29	85.3
15	5.44	6.00	0.75	31	91.2

3.4.1.3 Delphi round two

The 34 participants that took part in round one of the Delphi were emailed directly to take part in the second round of the Delphi study to rate the amended item 3 only. Of the 34 participants which were contacted, 28 completed the second round (82.4% response rate). As seen from Table 3, the amended item 3 reached consensus after 96.4% of participants rated the item within the pre-determined SD range and the mean was above a rating of 5. Therefore, the 15 items were taken to the validation phase of the study.

Table 3

Delphi Round Two Descriptive Statistics and Consensus

Item	*M*	*Md.*	*SD*	Consensus *(N)*	Consensus *(%)*
3	5.36	6.00	.83	27	96.4

3.5 Methods

3.5.1 Sample 2

3.5.1.2 Participants – Clinicians

The third phase of the study utilised a cross-sectional survey-based design. Trainee and qualified clinicians in psychological therapies, working clinically in the UK (e.g., Clinical and Counselling Psychologists), who were receiving regular individual clinical supervision (minimum once a month) were targeted for this phase of the study. The decision was made to include both trainee and qualified clinicians as the measure was designed to be used by all professionals, no matter what their level of expertise. Participants also had to be aged at least

18 years old (see Appendix J for full inclusion criteria). Participants were recruited using purposive and snowballing techniques through social media platforms, University professional training programmes, professional bodies, and NHS trusts, through distribution of the study's poster (Appendix K) and emails (Appendix L). Table 4 shows participants demographic information, including gender, age and ethnicity (see Appendix D for detailed tables). There were 101 trainee clinicians (40.6%) and 148 qualified clinicians (59.4%) who took part in the study.

Table 4

Clinicians - Participants Demographics

Characteristics	*N* (249)	%
Gender		
Female	216	86.7
Male	33	13.3
Age (years)		
22-24	2	.8
25-34	134	53.8
35-44	63	25.3
45-54	34	13.7
55-64	15	6.0
65+	1	.4
Ethnicity		

†White: White British, White Irish, Any other White background	204	81.9
Asian or Asian British: Indian, Pakistani, Bangladeshi, Chinese, Any other Asian background	20	8.0
Black or Black British: African, Caribbean, Any other Black background	14	5.6
Mixed: Mixed Asian and White, Mixed Black African and White, Mixed Black Caribbean and White, Any other Mixed background	8	3.2
Other	3	1.2

†*Note*. In the 'white' grouping 14 participants self-reported that they identified as belonging to an ethnic minority group**.**

3.5.2 Measures

3.5.2.1 Demographic data

Participants completed a demographic questionnaire including age, gender, ethnicity, profession, and supervision frequency (Appendix M for questionnaire).

3.5.2.2 CCHS

The CCHS consisted 15 items, which were agreed upon during the second phase of the study through the Delphi rounds (See Supplementary Materials, p. 199), rated on the aforementioned six-point Likert scale. The CCHS asks participants to reflect upon statements and rate each item in consideration of their clinical work (Supplementary Materials, p.199). An example of an item scale: '*In clinical practice, I feel confident to ask culturally sensitive questions'.*

3.5.3 Validation of measure

Existing cultural humility measures were included to explore convergent and discriminant validity. To assess for potential biases of response, a social desirability measure was included, which has been used in similar scale validation research (Gonzalez et al., 2021). The internal consistency of all measures was explored to support with the interpretation of the results (Ahmed & Ishtiaq, 2021; Salmond, 2008). The measures are:

3.5.3.1 Multidimensional Cultural Humility Scale (MCHS)

The MCHS is a 15-item scale (Gonzalez et al., 2021) which is a validated self-assessment tool, within a USA sample, for clinicians aiming to develop their cultural humility (Appendix N). The measure directly maps onto Foronda and colleagues (2016) five dimension of cultural humility and asks participants to rate their level of agreement with each statement on a six-point Likert scale (1 = *Strongly Disagree* to 6 = *Strongly Agree*). The scale comprises of five subscales, each with three items: Openness, Self-awareness, Ego-less, Self-reflection and critique and Supportive interactions. The MCHS has shown satisfactory internal consistency and reliability with the total scale Cronbach's alpha coefficient, from the initial development of the scale, of .78 and .79 (Gonzalez et al., 2021). In the current study, the scale was found to have satisfactory internal consistency ($\alpha = .73$).

3.5.3.2 Cultural Humility Scale for Supervision (CHS-S)

The CHS is a 12-item scale, originally developed to enable clients to measure their therapist's cultural humility responsiveness (Hook et al., 2013). It was further adapted to be used in supervision (CHS-S; Wilcox et al., 2022), and although the scale items remained unchanged, the instructions were modified to make it relevant for supervisees to rate their supervisors. For the context of this study, the adapted version was utilised (Appendix N). The scale consists of two subfactors: positive characteristics (seven items) and negative characteristics (five items). The CHS-S version was found to have excellent internal consistency and reliability ($\alpha = .92$;

Wilcox et al., 2022). In the current study, the scale was found to have excellent internal consistency (α = .91).

3.5.3.3 Marlowe-Crowne Social Desirability Scale-Short Form (MCSDS-SF)

The MCSDS-SF measure (Crowne & Marlowe, 1960; Reynolds, 1982; Appendix N) consists of a 13-item scale which measures social desirability, with responses given in a true-false format. The short form version was found to have better reliability and fit compared to the original 33-item scale (Crowne & Marlowe, 1960) and continued to be highly correlated with the original version (Reynolds, 1982). The maximum score is 26, with higher scores indicating a higher tendency to respond in a social desirability way. The internal consistency for the total scale was α = .66 in the current study.

3.5.4 Procedure

A link to the survey and the study advertisement was shared through emails, social media platforms and in the University of Southampton Psychology building. Interested participants accessed the study online through the Qualtrics XM Survey platform to complete the self-report questionnaires which took approximately 15 minutes. Firstly, participants were directed to the online Participant Information Sheet and consent form (Appendix O). Following consent, participants then completed the demographic questionnaire, followed by the CCHS, MCHS, CHS-S and MCSDS-SF measures. They were then directed to the online debriefing statement (Appendix P). At the end of the study, participants were given the option to be entered into a prize draw for a chance to win one of four £50 Amazon vouchers. If they wished to enter, they clicked ‘yes’ and were taken to another online Qualtrics XM Survey page to ensure that their email addresses were not linked to their responses.

3.5.5 Data analysis

Data analysis was also conducted using SPSS AMOS Statistics for Windows, Version 28.0 for the validation of the measure. Due to the existing literature on the measurement of cultural humility (Foronda et al., 2016; Gonzalez et al., 2021), a confirmatory factor analysis (CFA) was conducted to explore if the proposed five-factor structure was of good fit in this study. To conduct a CFA, a minimum sample size of 150-315 participants is required (Muthén & Muthén, 2022). Using Hu & Bentler's (1999) cut-off values for a good model fit, the comparative fit index (CFI), Tucker-Lewis index (TLI), the root-mean-squared error of approximation (RMSEA), and the standardised root-mean-square residual (SRMR), were used to interpret the factor model. A good model fit was indicated by CFI ≥ .90, TLI ≥ .90, RMSEA ≤ .06, and SRMR ≤ .08 (Hu & Bentler, 1999). Reliability analysis was conducted to measure internal reliability of the scale. Correlation analyses were conducted between the CCHS, MCHS and CHS-S and their subscales to explore convergent and concurrent relationships. Further correlation analyses were run between the MCSDS-SF scale and CCHS to explore discriminate validity, with interpretation of effect size guided by Cohen's (1988) recommendations.

3.6 Results

3.6.1 Validation of the CCHS

3.6.2 Sample 2 analysis

320 participants accessed the study, however, 64 withdrew from the study, resulting in insufficient datasets for analysis. In total, 256 participants completed the online study; however, seven participants did not meet the inclusion criteria (e.g. less than monthly supervision; only group supervision) and, therefore, were removed from the dataset. The remaining 249 participants included four participants with single datapoints of missing at random data on the MCHS scale. Following the Newman (2014) missing data guidance,

multiple imputation analysis was used for those missing values and data was reported from the pooled values.

3.6.2.2 Initial assumptions

Histograms of the measures were reviewed to assess the distribution of data (Wilkinson & APA Task Force, 1999). Except for one, which showed a slight negative skew, all other histograms showed normal distribution. There is an increased likelihood of skewness due to the large sample size of this study and, therefore, the central limit theorem allows for partial deviation (Field, 2018). Histograms and boxplots of the scales were reviewed to identify any potential outliers. Only one outlier on the CHS-S scale was identified, in response to which winsorizing was used to transform the outlier to be within 3.SD from the mean (Erceg-Hurn et al., 2008; Price et al., 2015). Furthermore, a spot check of scatterplots showed linear relationships between all scales.

3.6.2.3 Confirmatory factor analysis

The initial model showed an overall poor fit, $\chi^2 = 263.54$ with 80 degrees of freedom, $p < .001$ (CFI = .855, TLI = .810, RMSEA = .096, SRMR = .085). As shown, all overall model indices did not meet the standard criteria for a good fit model (Bentler, 1990; Hu & Bentler, 1999). Possible model modifications were explored, however, this would have involved removing key items of subfactors and merging subfactors, thereby raising questions as to the construct validity of the subscales. Therefore, it was decided this was not justifiable on a theoretical basis. Consequently, an exploratory factor analysis (EFA) was conducted to explore the possibility of an alternative model with a different factor structure (Oliver et al., 2006; Schmitt, 2011).

3.6.2.4 Exploratory factor analysis

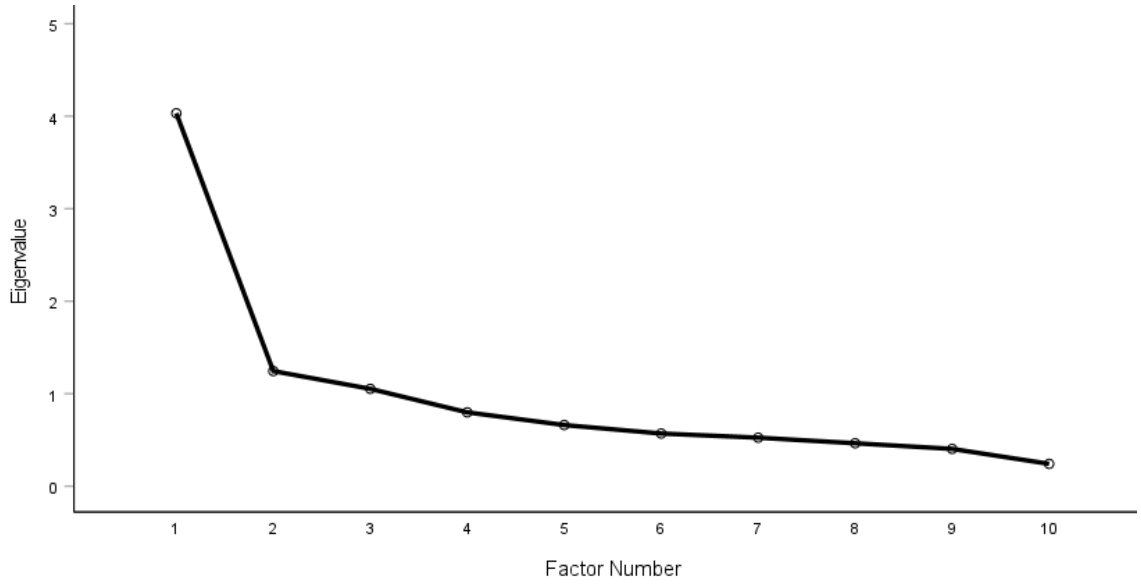
The Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy was .880, which is deemed as a ‘meritorious’ classification (Hutcheson & Sofroniou, 1999). The Bartlett’s test of

sphericity was significant (χ^2 (105) = 1338.09, p <.001; Field, 2018). The determinant value was acceptable due to it being above the recommended .00001 (.004), indicating that there is no multi-collinearity or singularity. Furthermore, scanning the correlation matrix did not also identify any correlational pairs greater than 0.8. Additionally, the anti-image matrices did not indicate any problematic variables. The reproduced matrix did not indicate issues with the residuals for items. In line with the recommended 0.3 cut off for communalities (Field, 2018), two items (five and 15) were removed from the analysis.

The first EFA, using principal axis factoring with direct oblimin rotation, was conducted with the remaining 13 items. After three factors, the scree plot showed that there was a levelling off, explaining 59.16% of the total variance. Item four was removed due to a low loading (<.40; Stevens, 1992), and item eight was removed due to cross-loadings (>.2). The factor analysis was re-run with the remaining 11 items, and it was decided that item 12 was to be removed due to its low loading and not appearing to meaningfully add to the subfactor from a theoretical basis. The factor correlation matrix showed that factors were correlated (above 0.3) and did not need to be re-run with an orthogonal rotation. Therefore, the final EFA, comprising a total of 10 items, had a scree plot with three factors after levelling off which explained 63.31% of the total variance (see Figure 1). A three-factor structure was also in line with Kaiser's criterion (1960), as only the first three factors had eigenvalues greater than one.

Figure 1

Scree Plot



Note. Scree plot shows the potential factor structures and their eigenvalues values.

The final model contained a total 10 items with three factors consisting of five, two and three items accordingly (see Table 5; see Appendix Q for descriptive statistics of full scale and subscales). The first factor was labelled ‘Awareness and Self-reflection’, the second factor ‘Openness in Clinical Practice’ and the third factor ‘Supportive Interactions’ (see Supplementary Material for final CCHS scale, p. 201). The factor correlation matrix can be seen in Table 6.

Table 5

EFA Factor Loadings

Items	Factor		
	1	2	3
I prioritise being able to seek support when I am unsure about how to work with cultural diversity.	.76		
I feel confident identifying and discussing my own cultural values and beliefs in supervision.	.60		
In supervision, I am open to discussing the role of culture in my clinical work.	.54		
I take time to reflect with openness and curiosity when my belief system is being challenged.	.51		
When I notice a cultural difference that is impacting clinical work, I feel it is important to discuss in supervision.	.48		
In clinical practice, I feel confident to ask culturally sensitive questions.		-.90	
I don’t let the fear of getting it wrong interfere with being culturally curious within my clinical work.		-.74	
Educating myself about different cultures is an important part of my values as a clinician			-.76
I seek opportunities to learn more about different cultures to help shape my clinical practice.			-.61

I take an active approach in creating a safe space to discuss culture and diversity within my clinical setting.	-.48

Note. N = 249. The extraction method was principal axis factoring with direct oblimin rotation.

Table 6

Factor Correlation Matrix of CCHS

Factor	1 (Awareness & Self-reflection)	2 (Openness in Clinical Practice)	3 (Supportive Interactions)
1	1	-.42	-.59
2	-	1	.35
3	-	-	1

Note. N = 249[1]

3.6.2.5 Reliability

The full CCHS scale showed good reliability (Cronbach's α = .83) with all subscales showing satisfactory to good reliability (George & Mallery, 2003; Tavakol & Dennick, 2011; see Table 7 for subscales). The Openness in Clinical Practice subscale showed a high correlation in the inter-item correlation matrix (.75). For all other subscales and full scale, the inter-item correlation matrix were associations mostly above .3, with a minority showing below .3. Item-total correlations were all in the acceptable range (r > .3), and Cronbach α if item deleted did not improve any subscales or the full scale, therefore all items were retained.

[1] Please note that the direction of the correlation does not influence the validity of the overall factor solution in exploratory factor analysis (Fabrigar & Wegener, 2012).

Table 7

Cronbach α for the CCHS Subscales

CCHS Subscales	Cronbach Alpha
Awareness and Self-Reflection	.74
Openness in Clinical Practice	.86
Supportive Interactions	.72

Note. N = 249

3.6.2.6 Convergent and divergent validity

Pearson correlation coefficient was used to establish convergent and divergent validity. The new CCHS scale (M = 49.98, SD = 5.93) correlated significantly with the CHS-S scale (M = 49.18, SD = 8.54) with a medium effect size (r (247) = .33, $p < .001$, 95% C.I [0.21, 0.43]), and the MCHS (M = 69.87, SD = 7.78) with a very large effect size (r (247) = .73, $p < .000$, 95% C.I [0.68, 0.79]). The majority of MCHS subscales were all significantly correlated with the CCHS subscales, ranging from small to large effect sizes (see Table 8; Appendix Q for descriptive statistics of MCHS). The Openness in Clinical Practice (CCHS) subscale did not significantly correlate with Supportive Interactions subscale (MCHS; Table 8). The CCHS scale showed a significant negative correlation against the negative subscale on the CHS-S (M = 11.02, SD = 4.64), with a small effect size (r (247) = -24, p < .001, 95% C.I [-0.35, -0.12]).

Table 8

Pearson's correlations between the CCHS subscales and MCHS subscales and the MCSDS-SF scale

		MCHS Subscales					MCSDS-SF Full Scale
		Openness	Self-awareness	Ego-less	Supportive Interactions	Self-reflection and Critique	
CCHS Subscales	Awareness and Self-reflection	.47**	.56**	.38**	.23**	.45**	.14*
	Openness in Clinical Practice	.61**	.33**	.53**	.09	.25**	.23**
	Supportive Interactions	.61**	.57**	.48**	.17**	.46**	.14*

Note. * significant correlation at the 0.05 level, **significant correlation at the 0.01 level.

3.6.2.7 Discriminant validity

The mean total scale score for the sample was 20.00 (*SD* = 2.63). The MCSDS-SF showed a significant correlation against the CCHS scale (r (247) = .21, p <.001, 95% C.I [0.09, 0.33]), with a small effect size. Subscales also showed a significant correlation, however, all with small effect sizes (see Table 8).

3.7 Discussion

This study developed the CCHS to measure cultural humility within clinical supervision and assessed its psychometric properties within a UK population. Overall, the findings indicate that the scale demonstrates good psychometric properties when conceptualised as a three-factor measure, 'Awareness and Self-reflection', 'Openness in Clinical Practice', and 'Supportive Interactions'. The results are discussed in the order of the hypotheses.

It was initially proposed that, by following the Delphi method, experts would reach consensus on scale items, thereby demonstrating the appropriateness of the measure. The first Delphi round resulted in the amendment of one item that initially failed to meet the consensus threshold. It is important to note that this item differed from most of the other scale items, and cultural humility measures such as the MCHS (Gonzalez et al., 2021), in that it did not distinctly employ a personal, active "I" statement. Following this amendment, and after the second Delphi round, the experts reached consensus on all the scale items. This aligns with the suggestion that two or three Delphi rounds are typically sufficient in this type of research (Delbeq et al., 1975; Stone & Busby, 2005), and with Petry et al.'s (2007) study which used two rounds for assessing a measure that has been established, similar to the CCHS, from relevant literature.

Next, it was hypothesised that the CFA would confirm a five-factor structure (Openness, Self-awareness, Ego-less, Supportive Interactions, Self-reflection and Critique; Foronda et al., 2016) as a good fit for the scale. The results did not support this hypothesis as the model showed a poor fit, and potential model modifications would have involved moving items to different subfactors or removing key items from subfactors, which would have potentially weakened the construct validity of those subfactors, and therefore, the significant modifications were not deemed justifiable on a theoretical basis (Flora & Flake, 2017; Foronda et al., 2016). It has, however, been suggested that it is common practice to run an EFA to explore an alternative model structure under these circumstances (Oliver et al., 2006;

Schmitt, 2011). Following the EFA analysis, the results showed a three-factor scale (Awareness and Self-reflection, Openness in Clinical Practice and Supportive Interactions), thus providing potential further support for not using the original five-factor model (Foronda et al., 2016).

It was stated that the CCHS scale would have good internal reliability. This hypothesis was supported as the Cronbach alpha showed that the revised three-factor CCHS scale had good overall internal reliability (Cronbach's $\alpha = .83$), and subscales showed satisfactory to good internal reliability. Reliability has been argued as one of the fundamental conditions for validity research (Mohajan, 2017), with alpha value estimates from 0.7 to 0.8 considered in the acceptable range (Nunnally & Bernstein, 1994).

It was anticipated that the CCHS would show convergent relationships with existing cultural humility scales (MCHS and CHS) and the MCHS subscales. Overall, the results partially supported this hypothesis, as the CCHS showed significant bivariate correlations with the CHS-S and the MCHS, with medium to large effect sizes. Higher correlation coefficients indicate stronger support for convergent validity (Boateng et al., 2018). In contrast, the negative scale on the CHS-S showed the expected significant negative correlation with the CCHS, but with a small effect size, indicating a weak relationship. The subscales of the MCHS also demonstrated varying effect sizes, ranging from small to large, showing variance in the strength of the convergence among subfactors. Additionally, the Openness in Clinical Practice (CCHS) subscale did not significantly correlate with the Supportive Interactions (MCHS) subscale. As the final revised CCHS, was a three-factor structure, compared to the MCHS five-factor structure, it is therefore not surprising that all subfactors did not significantly correlate with each other as they are not directly mapping onto the same original constructs (Foronda et al., 2016).

Finally, it was asserted that the CCHS would show discriminate validity against the social desirability measure. Although correlations between the CCHS and MCSDS-SF were

significant, the small effect sizes means once again that this result needs to be considered with caution (Cohen, 1988; Funder & Ozer, 2019). Therefore, the extent to which socially desirability influenced responses remains uncertain. Furthermore, the internal reliability of the MCSDS-SF in this study was poor, raising questions about the construct reliability of the measure in this study. It has been argued that due to the nature of the measure, internal reliability may be within the low .70 to .80 range (Reynolds, 1982), however, this study falls below this threshold. It is, therefore, difficult to establish whether responses on CCHS, and other cultural humility measures, are affected by social desirability. A common critique of self-reported culture-based measures is that, due to the socially sensitive topic area, they are more prone to eliciting socially desirable responses (Betancourt, 2003; Burkard et al., 2011; Constaine & Ladany, 2001; Larson & Bradshaw, 2017; Stanhope et al., 2005). For example, in Banaji and Greenwald's (2013) implicit bias study that explored race identified that associations of positive and negative assumptions of characteristics are made based on solely a person's racial identity. Therefore, it could be argued that with the current social desirability measures, it is difficult to establish the extent to which responses in self-reported culturally humility measures are affected by this phenomenon because of the inherently sensitive and complex topic that it is exploring (Larson & Bradshaw, 2017). Thus, this may suggest a need for a more sensitive social desirability measure, or the use of implicit bias tests, for this specific area.

3.7.1 The measurement of cultural humility

Interestingly, the final version of the CCHS did not fully align with previous research attesting to a five-factor structure for measuring clinician's cultural humility (MCHS; Gonzalez et al., 2021) and the five pillars of cultural humility: Openness, Self-Awareness, Ego-less, Supportive Interactions, Self-Reflection and Critique (Foronda et al., 2016). The CCHS found a three-factor model with 'Awareness and Self-reflection', 'Openness in Clinical Practice', and 'Supportive Interactions'.

The CCHS's 'Openness in Clinical Practice' and 'Supportive Interactions' subfactors both mapped onto the MCHS's corresponding subfactors (Gonzalez et al., 2021). These findings support recent qualitative research that found that supervisees perceived an "openness in the supervisory relationship" was important to improve culturally responsive clinical supervision (Vekaria et al., 2023b, p.70). Specifically, this finding related to the theme that in order to meaningfully attend to the supervisory relationship, having open discussions, whereby cultural biases, assumptions and information is shared within supervision, is key to strengthening the relationship. As previously highlighted, the supervisory relationship plays an important role in the effectiveness of supervision (Vandament et al., 2022), and this study's finding perhaps further emphasises the integral need for openness and support to be part of the relationship. Furthermore, the 'Openness in Clinical Practice' and 'Supportive Interactions' also arguably map onto the cultural comfort and cultural opportunities components of the MCO-S framework (Watkins et al., 2019). Specifically, cultural comfort, which refers to the emotional experience of engaging in cultural discussions, which can include discomfort and promotes an open stance, aligns with the 'Openness in Clinical Practice' subfactor. Similarly, the cultural opportunities pillar, which refers to the moments that arise within supervision to discuss culture and promotes a proactiveness, aligns with 'Supportive Interactions' subfactor. Thus, it could be suggested that the CCHS provides support to operationalise the MCO-S framework.

It seems fair to propose that, theoretically, the CCHS's 'Awareness and Self-reflection' maps onto both the MCHS's 'Self-Awareness' and the 'Self-reflection and Critique' subfactors (Gonzalez et al., 2021). In consideration of the latter subfactors, Foronda et al. (2016) proposed them as separate constituent pillars of cultural humility, but it could be inferred from this study that they are not fully discrete from each other and that, perhaps, clinicians need to first be aware of their values and beliefs before being able to fully self-reflect on the clinical implications (Roysircar, 2004; Woodward et al., 2015). Arguably, this

stance lends itself to the flexible and life-long learning process of developing cultural humility (Upshaw et al., 2020; Yeager & Bauger-Wu, 2013).

One possible explanation for the lack of the five-factor structure may be that the subfactor structure from the MCHS, devised using a USA sample (Gonzalez et al., 2021), was not directly applicable in an UK sample due to inherent cultural differences. This explanation is consistent with current critiques of the MCHS, that it is not generalisable to other populations (Zhang et al., 2021; Zhu et al., 2022), as the existing body of research has been conducted in the USA (Hook et al., 2013; Gonzalez et al., 2021; Wilcox et al., 2022). Furthermore, the concept of 'Egoless', which is a subfactor of the MCHS (Gonzalez et al., 2021), may have been incorporated within the other three subfactors on the CCHS, rather than a distinct subfactor. As defined by Foronda and colleagues (2016), egoless embodies humility and equality which is intrinsic to cultural humility and arguably embedded within the CCHS items. Therefore, this could provide an explanation as to why this study found an alternative factor structure.

3.7.2 Strengths and limitations

The measure's development was grounded in the existing literature on cultural humility (Foronda et al., 2016; Gonzalez et al., 2021; Hook et al., 2013), and this study utilised a robust experiment method including the views of experts in the field to design of the scale, utilising the Delphi method to assess the items and factor analysis to determine the final measure which demonstrated good reliability and acceptable validity. The CCHS is designed as a concise and practical tool for clinicians to use in supervision when working in typically busy clinical settings (Kemper et al., 2019; Ziegler et al., 2014).

It is important to note that despite being a recommended procedure (Jorn, 2015; Keeney et al., 2011; Linstone & Turoff, 1975), and used for the development of questionnaires (Lee et al., 2020; Mengual-Andrés et al., 2016; Neupane & Bhattari, 2024), the use and adaptation of

the Delphi method has been debated (Giannarou & Zervas, 2014; Nasa et al., 2021; Trevelyan & Robinson, 2015). The optimal number of rounds can depend on whether there is a criterion that consensus needs to reach, or whether it has been set 'a priori' (Trevelyan & Robinson, 2015). Although this study completed two rounds, with a low dropout rate of experts, to reach consensus criterion, it has been argued that when studies only have two rounds it may limit the ability to establish stability and consistency of the results, which could be explored in further multiple rounds (Trevelyan & Robinson, 2015).

The factor analysis included a good sample size from a range of professionals (e.g. Trainee and qualified Clinical Psychologists, Cognitive Behavioural Therapists and Systemic Therapist from public and private sectors) and other demographics (e.g. age ranged from 22 to 65+ years). Importantly, this measure is designed for all clinicians irrespective of how they identify from a cultural perspective; however, it would be fair to propose a potential limitation in that the measure was analysed with 82% of the participants identifying from a White ethnic background. Factor analysis can be valuable when investigating scale development and its validation (Flora & Flake, 2017), with previous studies developing cultural humility and supervision measures also using factor analysis (Gonzalez et al., 2021; Hook et al., 2023). Moreover, the sample for the validation analyses consisted entirely of UK clinicians (both trainees and qualified) practicing in a range of psychological therapies (e.g. Systemic Therapist, Counselling Psychologist and Cognitive Behavioural Therapists), which enhances the generalisability of the results. The lack of a test-retest methodological design however, to further strengthen the reliability of the results (Aldridge et al., 2017; Leppink & Pérez-Fuster, 2017), is a potential limitation of this study. It is unclear therefore whether the same consistency in the results would be replicated in a different sample.

Furthermore, the use of the MCSDS-SF measure (Reynolds, 1982) did not prove to be useful within this study as a measure of social desirability because of its poor internal reliability and, therefore, the impact of socially desirable responses could not be conclusively

determined. The MCSDS and its short form version have been found to be one of the most widely used tools to detect social desirability bias (Perinelli & Gremigini, 2016; Tan et al., 2021), however, a recent review highlighted that the measure should be used with caution due to validity concerns (Tan et al., 2021). Specifically, the MCSDS-SF was developed as a unidimensional scale, but research has questioned whether it is a two-factor structure measuring self-deception and impression management (Loo & Thorpe, 2000). Furthermore, as previously mentioned, the measure was perhaps not sensitive enough to capture social desirability responses in a study exploring culture and cultural humility (Larson & Bradshaw, 2017).

3.7.3 Clinical implications

The CCHS is developed by clinicians, for clinicians, to identify their areas of strengths and development in relation to ensuring cultural humility within supervision (see Supplementary Materials for full questionnaire, p. 201). Furthermore, with the growing interest in, and the demonstrated importance of developing cultural humility within clinical interactions (e.g., Mahon, 2024; Vekaria et al., 2023a; Zhang et al., 2021), this measure represents a valuable tool to enable not only the measurement of, but also the development of, cultural humility. For example, clinicians could utilise the tool to support having cultural conversations in supervision, with the CCHS items providing an anchor and starting point for discussing how cultural humility is embedded in their clinical practice and thinking about the ongoing process of development.

Importantly, the scale contributes to operationalising the existing cultural supervision frameworks such as the MCO-S (Watkins et al., 2019), which attributes cultural humility as a key component to the framework for psychotherapy supervision. While the MCO-S places greater emphasis on the supervisor initiating cultural discussions in supervision, the CCHS allows opportunity for both supervisee and supervisor to measure their own cultural humility

and facilitate discussions within supervision. Therefore, it is hoped that the CCHS may support culturally responsive clinical supervision (Hook et al., 2016; Patel, 2004; Silva, 2018), which has been shown to be associated with impacting the perception of the supervisory relationship and its effectiveness (Vekaria et al., 2023a).

3.7.4 Future research

It has been proposed that there is a potential positive impact of the development of cultural humility within supervision expanding to other areas of clinical practice and need, such as contributing to improving client outcomes (Zhang et al., 2021), increasing organisational health equality (Kibakava & Oveku, 2022; Robinson et al., 2021), and addressing and reducing cultural blind spots (Hawkins & Shobet, 2012; Hook et al., 2016). Therefore, it would be beneficial for future research to explore these potential clinical and organisational implications further using the CCHS.

To build upon the robustness of the measure further, a further CFA of the new three-factor structure using a new sample would be helpful. Kline (2014) recommends such an approach to validate new scales and confirm the factor structures. Also, it may be beneficial to include further measures to test the concurrent and construct validity of the new three-factor structure of the CCHS, for example the Self-Reflection and Insight Scale (SRIS; Grant et al., 2002) could be used to explore if there is an association with the 'Awareness and Self-reflection' subfactor. Furthermore, future research would benefit from incorporating a test-retest methodology to further test the reliability of the CCHS (Boateng et al., 2018).

In consideration of social desirability, there have been suggestions to consider using a brief personality measure alongside social desirability measures in clinical psychology (e.g. the Ten-Item Personality Inventory; TIPI; Gosling et al., 2003), as controlling for particular personality variables (e.g. the Big-Five traits such as 'agreeableness') can limit the influence of socially desirable responses (Perinelli & Gremigini, 2016). Alternatively, there is

potentially the need to explore the most appropriate way to measure social desirability in culture based research and consider whether a new specific measure needs to be developed.

3.7.5 Conclusion

This study has shown that the CCHS demonstrates good psychometric properties such as internal reliability and correlates significantly with the existing scales. However, while it did not entirely support previous literature on cultural humility in terms of factor structures (Foronda et al., 2016; Gonzalez et al., 2021), there were theoretical overlaps with the subfactors, that ultimately suggested a three-factor structure for the measurement of cultural humility. This scale provides a practical tool for clinicians and offers scope for further research into the implications of developing cultural humility within clinical practice. It is recommended that future research focuses on validating the measure with a new sample to confirm the factor structure and incorporates a test-rest method for further reliability analyses. Overall, the CCHS provides a useful tool to potentially support the development and measurement of clinicians' cultural humility in the UK.

3.8 References

Agner, J. (2020). Moving from cultural competence to cultural humility in occupational therapy: A paradigm shift. *The American Journal of Occupational Therapy, 74*(4), 1-7. https://doi.org/10.5014/ajot.2020.03806

Ahmed, I., & Ishtiaq, S. (2021). Reliability and validity: Importance in medical research. *Methods*, *12*(1), 2401-2406.

Aldridge, V. K., Dovey, T. M., & Wade, A. (2017). Assessing test-retest reliability of psychological measures. *European Psychologist*, 22(4), 207-218. https://doi.org/10.1027/1016-9040/a000298

Amery, K. K., Diaz-Caceres, Z., & Paris, B. M. (2020). The role of intercultural competence on graduate supervisor-supervisee relationship and well-being. *The Journal of Education Thought, 53*(2), 125-154. https://www.jstor.org/stable/27128300

Banaji, M. R., & Greenwald, A. G. (2013). *Blindspot: Hidden biases of good people*. Bantam.

Bartell, S. (2016). *Initial validation of the race-ethnicity supervision scale (RESS)* (Publication No. 1934) [Doctoral dissertation, Marquette University]. Marquette University e-Publications. https://epublications.marquette.edu/dissertations_mu/674/

Becker, T. E., Atinc, G., Breaugh, J. A., Carlson, K. D., Edwards, J. R., & Spector, P. E. (2016). Statistical control in correlational studies: 10 essential recommendations for organizational researchers. *Journal of Organizational Behavior*, *37*(2), 157-167. https://doi.org/10.1002/job.2053

Bentler, P. M. (1990). Comparative fit indexes in structural models. *Psychological Bulletin, 107*(2), 238–246. https://doi.org/10.1037/0033-2909.107.2.238

Bernard, J. M., & Goodyear, R. K. (2013). *Fundamentals of clinical supervision* (5th ed). Pearson Education Limited. https://public.ebookcentral.proquest.com/choice/publicfullrecord.aspx?p=5176134

Betancourt, J. R. (2003). Cross-cultural medical education: Conceptual approaches and frameworks for evaluation. *Academic Medicine*, *78*(6), 560-569.

Boateng, G. O., Neilands, T. B., Frongillo, E. A., Melgar-Quiñonez, H. R., & Young, S. L. (2018). Best practices for developing and validating scales for health, social, and behavioral research: A primer. *Frontiers in Public Health*, *6*(149), 1-18. https://doi.org/10.3389/fpubh.2018.00149

British Psychological Society. (2017). *Practice Guidelines Third edition.* https://doi.org/10.53841/bpsrep.2017.inf115

Burkard, A. W., Medler, B. R., & Boticki, M. A. (2001). Prejudice and racism: Challenges and progress in measurement. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (2nd ed., pp. 457– 481). Sage Publications.

Chang, A. M., Gardner, G. E., Duffield, C., & Ramis, M. A. (2010). A delphi study to validate an advanced practice nursing tool. *Journal of Advanced Nursing*, *66*(10), 2320-2330. https://doi.org/10.1111/j.1365-2648.2010.05367.x

Chircop Coleiro, A., Creaner, M., & Timulak, L. (2023). The good, the bad, and the less than ideal in clinical supervision: A qualitative meta-analysis of supervisee experiences. *Counselling Psychology Quarterly*, *36*(2), 189-210. https://doi.org/10.1080/09515070.2021.2023098

Christie, C. A., & Barela, E. (2005). The Delphi technique as a method for increasing inclusion in the evaluation process. *Canadian Journal of Program Evaluation, 20*(1), 105-122. https://doi.org/10.3138/cjpe.020.005

Chuenjitwongsa, S. (2017). *How to conduct a Delphi study*. Medical Education, Wales Deanery Cardiff University.

https://www.cardiff.ac.uk/__data/assets/pdf_file/0010/1164961/how_to_conduct_a_delphistudy.pdf

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Routledge.

Constantine, M. G., & Ladany, N. (2001). New visions for defining and assessing multicultural counseling competence. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (2nd ed., pp. 482–498). Sage Publications.

Crowne, D. P., & Marlowe, D. (1960). A new scale of social desirability independent of psychopathology. *Journal of Consulting Psychology*, *24*(4), 349-354. https://doi.org/10.1037/h0047358

Davis, D. E., DeBlaere, C., Owen, J., Hook, J. N., Rivera, D. P., Choe, E., ... & Placeres, V. (2018). The multicultural orientation framework: A narrative review. *Psychotherapy*, *55*(1), 89-100. https://psycnet.apa.org/doi/10.1037/pst0000160

Davis, D. E., Worthington Jr, E. L., & Hook, J. N. (2010). Humility: Review of measurement strategies and conceptualization as personality judgment. *The Journal of Positive Psychology*, *5*(4), 243-252. https://doi.org/10.1080/17439761003791672

Delbeq, A., Van de Ven, A., & Gustafson, D. H. (1975). *Group techniques for program planning: A guide to nominal group and Delphi processes*. Scott, Foresman and Company.

de Villiers, M. R., De Villiers, P. J., & Kent, A. P. (2005). The delphi technique in health sciences education research. *Medical Teacher, 27*(7), 639-643. https://doi.org/10.1080/13611260500069947

Erceg-Hurn, D. M., & Mirosevich, V. M. (2008). Modern robust statistical methods: An easy way to maximize the accuracy and power of your research. *American Psychologist*, *63*(7), 591 - 601. https://doi.org/10.1037/0003-066X.63.7.591

Fabrigar, L. R., & Wegener, D. T. (2012). *Exploratory factor analysis*. Oxford University Press.

Field, A. (2018). *Discovering statistics using IBM SPSS statistics* (5th ed.). Sage Publications Ltd.

Flake, J. K., & Fried, E. I. (2020). Measurement schmeasurement: Questionable measurement practices and how to avoid them. *Advances in Methods and Practices in Psychological Science*, *3*(4), 456-465. https://doi.org/10.1177/2515245920952393

Fleming, I., & Steen, L. (2012). *Supervision and clinical psychology: Theory, practice and perspectives*. Routledge

Flora, D. B., & Flake, J. K. (2017). The purpose and practice of exploratory and confirmatory factor analysis in psychological research: Decisions for scale development and validation. *Canadian Journal of Behavioural Science*, *49*(2), 78-88. http://dx.doi.org/10.1037/cbs0000069

Foronda, C., Baptiste, D. L., Reinholdt, M. M., & Ousman, K. (2016). Cultural humility: A concept analysis. *Journal of Transcultural Nursing*, *27*(3), 210-217. https://doi.org/10.1177/1043659615592677

Funder, D. C., & Ozer, D. J. (2019). Evaluating effect size in psychological research: Sense and nonsense. *Advances in Methods and Practices in Psychological Science*, *2*(2), 156-168. https://doi.org/10.1177/2515245919847202

Gainsbury, S. M. (2017). Cultural competence in the treatment of addictions: Theory, practice and evidence. *Clinical Psychology and Psychotherapy, 24*, 987–1001. http://dx.doi.org/10.1002/cpp.206

George, D., & Mallery, P. (2003). *SPSS for windows step by step: A simple guide and reference. 11.0 update* (4th ed.). Allyn & Bacon.

Giannarou, L., & Zervas, E. (2014). Using delphi technique to build consensus in practice. *International Journal of Business Science & Applied Management, 9*(2), 65-82. https://hdl.handle.net/10419/190657

Gonzalez, E., Sperandio, K. R., Mullen, P. R., & Tuazon, V. E. (2021). Development and initial testing of the multidimensional cultural humility scale. *Measurement and Evaluation in Counseling and Development, 54*(1), 56-70. https://doi.org/10.1080/07481756.2020.1745648

Gosling, S. D., Rentfrow, P. J., & Swann, W. B. (2003). A very brief measure of the Big-Five personality domains. *Journal of Research in Personality, 37*(6), 504–528. https://doi.org/10.1016/S0092-6566(03)00046-1

Grant, A. M., Franklin, J., & Langford, P. (2002). The self-reflection and insight scale: A new measure of private self-consciousness. *Social Behavior and Personality: An International Journal*, *30*(8), 821-835. https://doi.org/10.2224/sbp.2002.30.8.821

Hawkins, P. & Shohet., R. (2012). *Supervision in the helping professions: An individual, group and organizational approach* (4th ed.). Open University Press.

Hook, J. N., Davis, D. E., Owen, J., Worthington Jr, E. L., & Utsey, S. O. (2013). Cultural humility: Measuring openness to culturally diverse clients. *Journal of Counseling Psychology*, *60*(3), 353- 366. https://doi.org/10.1037/a0032595

Hook, J. N., Watkins Jr, C. E., Davis, D. E., Owen, J., Van Tongeren, D. R., & Marciana, J. R. (2016). Cultural humility in psychotherapy supervision. *American Journal of Psychotherapy*, *70*(2), 149-166. https://doi.org/10.1176/appi.psychotherapy.2016.70.2.149

Hu, L. T., & Bentler, P. M. (1999). Cutoff criteria for fit indexes in covariance structure analysis: Conventional criteria versus new alternatives. *Structural Equation Modeling: A Multidisciplinary Journal*, *6*(1), 1-55. https://doi.org/10.1080/10705519909540118

Hutcheson, G. D., & Sofroniou, N. (1999). *The multivariate social scientist: Introductory statistics using generalized linear models*. Sage Publications.

Iqbal, S., & Pipon-Young, L. (2009). The delphi method. *The Psychologist, 22*(7), 598-600.

Jorm, A. F. (2015). Using the Delphi expert consensus method in mental health research. *Australian & New Zealand Journal of Psychiatry*, *49*(10), 887-897. https://doi.org/10.1177/0004867415600891

Kaiser, H. F. (1960). The application of electronic computers to factor analysis. *Educational and Psychological Measurement, 20*(1), 141-151. https://doi.org/10.1177/001316446002000116

Keeney, S., Hasson, F. and McKenna, H. (2011). How to get started with the delphi technique. In S. Keeney, F., Hasson & H. McKenna (Eds.), *The delphi technique in nursing and health research* (pp. 43-68). John Wiley & Sons. https://doi.org/10.1002/9781444392029.ch

Kemper, C. J., Trapp, S., Kathmann, N., Samuel, D. B., & Ziegler, M. (2019). Short versus long scales in clinical assessment: Exploring the trade-off between resources saved and psychometric quality lost using two measures of obsessive–compulsive symptoms. *Assessment*, *26*(5), 767-782. https://doi.org/10.1177/1073191118810057

Kibakaya, E. C., & Oyeku, S. O. (2022). Cultural humility: A critical step in achieving health equity. *Pediatrics*, *149*(2), 1-2. https://doi.org/10.1542/peds.2021-052883

Kilminster, S. M., & Jolly, B. C. (2000). Effective supervision in clinical practice settings: A literature review. *Medical Education, 34*(10), 827-840. https://doi.org/10.1046/j.1365-2923.2000.00758.x

Kline, P. (2014). *The new psychometrics: science, psychology and measurement*. Routledge.

Larson, K. E., & Bradshaw, C. P. (2017). Cultural competence and social desirability among practitioners: A systematic review of the literature. *Children and Youth Services Review*, *76*, 100-111. https://doi.org/10.1016/j.childyouth.2017.02.034

Lee, J., Lee, S. H., & Chang, G. T. (2020). Expert consensus on the development of a health-related questionnaire for the pediatric field of Korean medicine: A delphi study. *BMC Complementary Medicine and Therapies*, *20*, 1-13. https://doi.org/10.1186/s12906-019-2796-x

Leppink, J., & Pérez-Fuster, P. (2017). We need more replication research–A case for test-retest reliability. *Perspectives on Medical Education*, *6*, 158-164. https://doi.org/10.1007/s40037-017-0347-z

Linstone, H. A., & Turoff, M. (Eds.). (1975). *The delphi method*. Addison-Wesley.

Loo, R., & Thorpe, K. (2000). Confirmatory factor analyses of the full and short versions of the Marlowe-Crowne Social Desirability Scale. *The Journal of Social Psychology, 140*(5), 628–635. https://doi.org/10. 1080/00224540009600503

Mahon, D. (2024). Beyond multicultural competency: A scoping review of multicultural orientation in psychotherapy and clinical supervision. *Mental Health and Social Inclusion*, *28*(6), 1095-1119. https://doi.org/10.1108/MHSI-01-2024-0012

Mengual-Andrés, S., Roig-Vila, R., & Mira, J. B. (2016). Delphi study for the design and validation of a questionnaire about digital competences in higher education. *International Journal of Educational Technology in Higher Education*, 13, 1-11. https://doi.org/10.1186/s41239-016-0009-y

Michell, J. (1997). Quantitative science and the definition of measurement in psychology. *British Journal of Psychology*, *88*(3), 355-383. https://doi.org/10.1111/j.2044-8295.1997.tb02641.x

Miller, K. L., Re Cruz, A., & Ala'i-Rosales, S. (2019). Inherent tensions and possibilities: Behavior analysis and cultural responsiveness. *Behavior and Social Issues, 28*(1), 16–36. https://doi.org/10. 1007/s42822-019-00010-1

Milne, D. L. (2009). *Evidence-based clinical supervision: Principles and practice*. John Wiley & Sons.

Mohajan, H. K. (2017). Two criteria for good measurements in research: Validity and reliability. *Annals of Spiru Haret University. Economic Series*, *17*(4), 59-82.

Muthén, L. K., & Muthén, B. O. (2002). How to use a Monte Carlo study to decide on sample size and determine power. *Structural Equation Modeling, 9*(4), 599– 620. https://doi.org/10.1207/S15328007SEM0904_

Nasa, P., Jain, R., & Juneja, D. (2021). Delphi methodology in healthcare research: How to decide its appropriateness. *World Journal of Methodology*, *11*(4), 116-129. https://doi.org/10.5662/wjm.v11.i4.116

Neupane, S. M., & Bhattarai, P. C. (2024). Constructing the scale to measure entrepreneurial traits by using the modified delphi method. *Heliyon*, *10*(7), e28410. https://doi.org/10.1016/j.heliyon.2024.e28410

Newman, D. A. (2014). Missing data: Five practical guidelines. *Organizational Research Methods*, *17*(4), 372-411. https://doi.org/10.1177/1094428114548590

Nunnally, J. C., & Bernstein, I. H. (1994). *Psychometric theory* (3rd ed.). Mcgraw-Hill.

Oliver, J. E., Jose, P. E., & Brough, P. (2006). Confirmatory factor analysis of the work locus of control scale. *Educational and Psychological Measurement*, *66*(5), 835-851. https://doi.org/10.1177/0013164405285544

Owen, J. (2013). Early career perspectives on psychotherapy research and practice: Psychotherapist effects, multicultural orientation, and couple interventions. *Psychotherapy, 50*(4), 496 –502. https://dx.doi.org/10.1037/a0034617

Owen, J., Leach, M. M., Wampold, B., & Rodolfa, E. (2011). Client and therapist variability in clients' perceptions of their therapists' multicultural competencies. *Journal of Counseling Psychology*, *58*(1), 1-9. https://doi,org/10.1037/a0021496

Patel, N. (2004). Power and difference in clinical psychology supervision: The case of 'race' and culture. In I. Fleming & L. Steen (Eds.), S*upervision and clinical psychology: Theory, practice and perspectives.* (pp. 108 - 135). Brunner-Routledge

Perinelli, E., & Gremigni, P. (2016). Use of social desirability scales in clinical psychology: A systematic review. *Journal of Clinical Psychology*, *72*(6), 534-551. https://doi.org/10.1002/jclp.22284

Petry, K., Maes, B. & Vlaskamp, C. (2007). Operationalizing quality of life for people with profound multiple disabilities: A delphi study. *Journal of Intellectual Disability Research, 51*(1), 334–349. https://doi.org/10.1111/j.1365-2788.2006.00882.x

Polit, D. F., & Beck, C. T. (2006). The content validity index: Are you sure you know what's being reported? Critique and recommendations. *Research in Nursing & Health*, *29*(5), 489-497. https://doi.org/10.1002/nur.20147

Price, R. B., Kuckertz, J. M., Siegle, G. J., Ladouceur, C. D., Silk, J. S., Ryan, N. D., ... & Amir, N. (2015). Empirical recommendations for improving the stability of the dot-probe task in clinical research. *Psychological Assessment*, *27*(2), 365-376. https://doi.org/10.1037/pas0000036.

Proctor, B. (1988). Supervision: a co-operative exercise in accountability. In M. Marken and M. Payne (Eds.), *Enabling and ensuring: Supervision in practice* (pp. 21-23). National Youth Bureau.

Reynolds, W. M. (1982). Development of reliable and valid short forms of the Marlowe-Crowne Social Desirability Scale. *Journal of Clinical Psychology*, *38*(1), 119-125. https://doi.org/10.1002/1097-4679(198201)38:1<119::AID-JCLP2270380118>3.0.CO;2-I

Robinson, D., Masters, C., & Ansari, A. (2021). The 5 Rs of cultural humility: A conceptual model for health care leaders. *The American Journal of Medicine*, *134*(2), 161-163. https://doi.org/10.1016/j.amjmed.2020.09.029

Roysircar, G. (2004). Cultural self-awareness assessment: Practice examples from psychology training. *Professional Psychology: Research and Practice*, *35*(6), 658-666. https://doi.org/10.1037/0735-7028.35.6.658

Salmond, S. S. (2008). Evaluating the reliability and validity of measurement instruments. *Orthopaedic Nursing*, *27*(1), 28-30. https://doi.org/10.1097/01.NOR.0000310608.00743.54

Schmitt, T. A. (2011). Current methodological considerations in exploratory and confirmatory factor analysis. *Journal of Psychoeducational Assessment*, *29*(4), 304-321. https://doi.org/10.1177/0734282911406653

Silva, A. (2018). Providing culturally responsive supervision. In M. C. Guiney (Ed.), *The school psychology supervisor's toolkit* (pp. 102-110). Routledge.

Sloan, G. (2005). Clinical supervision: Beginning the supervisory relationship. *British Journal of Nursing*, *14*(17), 918-923. https://doi.org/10.12968/bjon.2005.14.17.19756

Snowdon, D. A., Leggat, S. G., & Taylor, N. F. (2017). Does clinical supervision of healthcare professionals improve effectiveness of care and patient experience? A systematic review. *BMC Health Services Research*, *17*, 1-11. https://doi.org/10.1186/s12913-017-2739-5

Stanhope, V., Solomon, P., Pernell-Arnold, A., Sands, R. G., & Bourjolly, J. N. (2005). Evaluating cultural competence among behavioral health professionals. *Psychiatric Rehabilitation Journal*, *28*(3), 225-233 https://psycnet.apa.org/doi/10.2975/28.2005.225.233

Stevens, J. (1992). *Applied multivariate statistics for the social sciences*. (2nd ed.). Lawrence Erlbaum Associates.

Stone F. L., & Busby, D. (2005). The Delphi method. In D. Sprenkle & F. Piercy (Eds.), *Research methods in family therapy* (2nd ed., pp.238–253). Guilford Press.

Tan, H. C., Ho, J. A., Teoh, G. C., & Ng, S. I. (2021). Is social desirability bias important for effective ethics research? A review of literature. *Asian Journal of Business Ethics*, *10*(2), 205-243. https://doi.org/10.1007/s13520-021-00128-9

Tavakol, M., & Dennick, R. (2011). Making sense of cronbach's alpha. *International Journal of Medical Education*, *2*, 53-55. https://doi.org/10.5116/ijme.4dfb.8dfd

Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved*, *9*(2), 117-125. https://doi.org/10.1353/hpu.2010.0233

Trevelyan, E. G., & Robinson, N. (2015). Delphi methodology in health research: How to do it?. *European Journal of Integrative Medicine*, *7*(4), 423-428. https://doi.org/10.1016/j.eujim.2015.07.002

Upshaw, N. C., Lewis Jr, D. E., & Nelson, A. L. (2020). Cultural humility in action: Reflective and process-oriented supervision with black trainees. *Training and Education in Professional Psychology*, *14*(4), 277-284. http://dx.doi.org/10.1037/tep0000284

Vandament, M. L., Duan, C., & Li, S. (2022). Relationships among supervisee perceived supervisor cultural humility, working alliance, and supervisee self-efficacy among white supervisor and supervisee of color dyads. *Training and Education in Professional Psychology, 16*(3), 244-252. https://doi.org/10.1037/tep000037

Vekaria, B., Thomas, T., Phiri, P., & Ononaiye, M. (2023a). Exploring the supervisory relationship in the context of culturally responsive supervision: A supervisee's perspective. *The Cognitive Behaviour Therapist*, *16*(22), 1-14. https://doi:10.1017/S1754470X23000168

Vekaria, B., Harrydwar, L., Thomas, T., & Ononaiye, M. (2023b). Supervisee perspectives on improving cultural responsivity in clinical supervision. *Clinical Psychology Forum*, *1* (371), 66-76. http://dx.doi.org/10.53841/bpscpf.2023.1.371.66

Watkins Jr, C. E., Hook, J. N., Owen, J., DeBlaere, C., Davis, D. E., & Van Tongeren, D. R. (2019). Multicultural orientation in psychotherapy supervision: Cultural humility, cultural comfort, and cultural opportunities. *American Journal of Psychotherapy*, *72*(2), 38-46. https://doi.org/10.1176/appi.psychotherapy.20180040

Wheeler, S., & Richards, K. (2007). The impact of clinical supervision on counsellors and therapists, their practice and their clients. A systematic review of the literature. *Counselling and Psychotherapy Research, 7(*1), 54-65. https://doi.org/10.1080/14733140601185274

Wilcox, M. M., Drinane, J. M., Black, S. W., Cabrera, L., DeBlaere, C., Tao, K. W., Hook, J. N., Davis, D. E., Watkins, C. E., & Owen, J. (2022). Layered cultural processes: The relationship between multicultural orientation and satisfaction with supervision. *Training and Education in Professional Psychology, 16*(3), 235-243. https://doi.org/10.1037/tep00 00366

Wilcox, M. M., Winkeljohn Black, S., Farra, A., Zimmerman, D., Drinane, J. M., Tao, K. W., ... & Owen, J. (2023). Cultural humility, cultural comfort, and supervision processes and outcomes for BIPOC supervisees. *The Counseling Psychologist*, *51*(7), 1037-1058. https://doi.org/10.1177/00110000231188337

Wilkinson, L., & Task Force on Statistical Inference, American Psychological Association, Science Directorate. (1999). Statistical methods in psychology journals: Guidelines and explanations. *American Psychologist, 54*(8), 594–604. https://doi.org/10.1037/0003- 066X.54.8.594

Wilson, H. M., Davies, J. S., & Weatherhead, S. (2016). Trainee therapists' experiences of supervision during training: A meta-synthesis. *Clinical Psychology & Psychotherapy*, *23*(4), 340-351. https://doi.org/10.1002/cpp.1957

Woodward, N. S., Keville, S., & Conlan, L. M. (2015). The buds and shoots of what I've grown to become: The development of reflective practice in trainee clinical psychologists. *Reflective Practice*, *16*(6), 777-789. https://doi.org/10.1080/14623943.2015.1095728

Yeager, K. A., & Bauer-Wu, S. (2013). Cultural humility: Essential foundation for clinical researchers. *Applied Nursing Research*, *26*(4), 251-256. https://doi.org/10.1016/j.apnr.2013.06.008

Zhang, H., Watkins Jr, C. E., Hook, J. N., Hodge, A. S., Davis, C. W., Norton, J., ... & Owen, J. (2021). Cultural humility in psychotherapy and clinical supervision: A research review. *Counselling and Psychotherapy Research*, *22*(3), 548-557. https://doi.org/10.1002/capr.12481

Zhu, P., Liu, Y., Luke, M. M., & Wang, Q. (2022). The development and initial validation of the cultural humility and enactment scale in counseling. *Measurement and*

Evaluation in Counseling and Development, *55*(2), 98-115. https://doi.org/10.1080/07481756.2021.1955215

Ziegler, M., Kemper, C. J., & Kruyen, P. (2014). Short scales– five misunderstandings and ways to overcome them. *Journal of Individual Differences, 35*(4), 185-189. https://doi.org/10.1027/1614-0001/a000148

Appendix A- University of Southampton Research Ethics Approval

Approved by Research Integrity and Governance team - ERGO II 89941

ERGO II – Ethics and Research Governance Online https://www.ergo2.soton.ac.uk

Submission ID: 89941
Submission Title: Devising a new questionnaire which measures cultural humility in clinical supervision
Submitter Name: Paola De Luca

The Research Integrity and Governance team have reviewed and approved your submission.

You may only begin your research once you have received all external approvals (e.g. NRES/HRA/MHRA/HMPPS/MoDREC etc or Health and Safety approval e.g. for a Genetic or Biological Materials Risk Assessment).

The following comments have been made:

-
- Thank you for making the suggested changes

Once external approvals are received you must upload your final document set and approval letters to ERGO using the *Upload External Approvals* button if your project is sponsored by University of Southampton.
If your project is sponsored by another institution, please ignore this request as you will already have provided these documents.

ERGO II – Ethics and Research Governance Online https://www.ergo2.soton.ac.uk

Submission ID:89941
Submission Title: Devising a new questionnaire which measures cultural humility in clinical supervision
Submitter Name: Paola De Luca

This email is confirm that external approval documents have been successfully uploaded to this submission.

Click here to view this submission

TId: 23136_Email_To_Submitter__coordinator_has_confirmed_all_external_approvals_uploaded Id: 814711

pdl1e20@soton.ac.uk coordinator

Please do not reply to this message as it has been automatically generated by the system. This email address is not monitored.

Appendix B- HRA Ethics Approval

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Miss Paola De Luca
Trainee Clinical Psychologist
Somerset NHS Foundation Trust
University of Southampton
Building 44/3089, Highfield Campus
England
SO17 1BJ

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

21 June 2024

Dear Miss De Luca

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

Study title:	**Devising a new questionnaire which measures cultural humility in clinical supervision**
IRAS project ID:	**337750**
Protocol number:	**N.A**
REC reference:	**24/HRA/2154**
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 *"After HRA Approval – guidance for sponsors and investigators"* document on the HRA website gives detailed guidance on reporting expectations for studies with HRA and HCRW Approval, including:

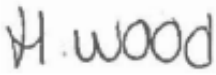
- Registration of Research
- Notifying amendments
- Notifying the end of the study

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 **337750**. Please quote this on all correspondence.

Yours sincerely,



Harriet Wood
Approvals Specialist
Email: approvals@hra.nhs.uk

Copy to: *Mrs Linda Hammond*

Appendix C- Inclusion Criteria (Sample One)

- **A minimum of 5 years' post-qualified experience** in the field of psychological therapies.

AND/OR

- Direct experience of **conducting research in the field of EDI.**

AND/OR

- An active interest in **EDI related work** as part of your clinical/academic role (such as a BAME advisory network /reflective groups/ steering groups).
- Experience of being supervised in a clinical or research role **and** delivered clinical or research supervision.
- Have a **post-graduate qualification** in their relevant field of expertise (such as Post Graduate Diploma or Doctorate level qualification).
- Participants must have sufficient level of English proficiency to participate in the study. The study rounds and materials will be in English, and the translation or use of interpreters will not be possible.
- Participants must have access to the internet such as through a computer or smartphone to access the study online.

Appendix D- Tables of Demographics for Sample One and Two

Expert Demographics

Characteristics	**N (*n* =34)**	**%**
Gender		
Female	24	70.6
Male	10	29.4
Current Professional Role*		
Clinical	17	50.0
Academic	7	20.6
Clinical & Academic	5	14.7
Clinical & EDI	2	5.9
Clinical, Academic & EDI	1	2.9
Research	1	2.9
EDI	1	2.9
Age (years)		
25-34	4	11.8
35-44	18	52.9
45-54	9	26.5
55-64	3	8.8
Highest Post-Graduate Qualification*		
Cognitive Behavioural Therapy Post-Graduate Diploma	1	2.9
Masters (including Clinical Psychology/ Forensic Psychology/ Systemic and Family Psychotherapy)	5	14.7

Doctorate (including Clinical Psychology/ Forensic Psychology)	28	82.4
Years of having Post-Graduate Qualification		
5-10	10	29.4
11-15	12	35.3
16+	12	35.3

Note. Some demographics were collapsed and merged into categories (e.g. specific professional job roles and specific post-graduate qualifications) to protect participants identity.

Experts - Participant Ethnicity and Group Identity

Ethnic Group	**N (%)**	**Ethnic Minority* (%)**	**Do not identify as Ethnic Minority (%)**
White: White British, White Irish, Any other White background	19 (55.9)	2 (5.9)	17 (50)
Asian or Asian British: Indian, Pakistani, Bangladeshi, Chinese, Any other Asian background	9 (26.5)	9 (26.5)	0 (0)
Black or Black British: African, Caribbean, Any other Black background	4 (11.8)	4 (11.8)	0 (0)
Mixed: Mixed Asian and White, Mixed Black African and White, Mixed Black Caribbean and White, Any other Mixed background	2 (5.9)	2 (5.9)	0 (0)
Total	34 (100)	17 (50)	17 (50)

Note. Participants self-reported whether they identified as belonging to an ethnic minority group.

Clinicians - Participants Demographics

Characteristics	**N (*n* = 249)**	**%**
Gender		
Female	216	86.7
Male	33	13.3
Age (years)		
22-24	2	.8
25-34	134	53.8
35-44	63	25.3
45-54	34	13.7
55-64	15	6.0
65+	1	.4
Current Professional Role *		
Trainee Clinical/ Forensic/Counselling Psychologist	87	34.9
Clinical Psychologist	51	20.5
Counselling Psychologist	6	2.4
Forensic Psychologist	5	2.0
Trainee Cognitive Behavioural Therapist	12	4.8
Cognitive Behavioural Therapist	49	19.7
Psychological Wellbeing Practitioner	11	4.4
Systemic Therapist	4	1.6
Other (including dual qualified roles)	24	9.6
Qualification Status		
Trainee	101	40.6

Qualified	148	59.4
Professional Sector		
NHS	224	90.0
Non-NHS health sector	6	2.4
Private Sector	8	3.2
Academia	1	.4
NHS & Private Sector	5	2.0
Other (including Prison & School)	5	2.0

Note. Some job roles collapsed/ merged into existing categories.

Clinicians - Participant Ethnicity and Group Identity

Ethnic Group	**N (%)**	**Ethnic Minority * (%)**	**Do not identify as an Ethnic Minority (%)**	**Prefer not to disclose (%)**
White: White British, White Irish, Any other White background	204 (81.9)	14 (5.6)	187 (75.1)	3 (1.2)
Asian or Asian British: Indian, Pakistani, Bangladeshi, Chinese, Any other Asian background	20 (8.0)	19 (7.6)	1 (.4)	0 (0)
Black or Black British: African, Caribbean, Any other Black background	14 (5.6)	14 (5.6)	0 (0)	0 (0)
Mixed: Mixed Asian and White, Mixed Black African and White, Mixed Black Caribbean and White, Any other Mixed background	8 (3.2)	8 (3.2)	0 (0)	0 (0)
Other	3 (1.2)	2 (.8)	0 (0)	1 (.4)
Total	249 (100)	57 (22.9)	188 (75.5)	4 (1.6)

Note. Participants self-reported whether they identified as belonging to an ethnic minority group.

Appendix E- Recruitment Email to Experts (Sample One)

Dear [insert name]

As you are known to Professor Margo Ononaiye who is part of the study team, we are contacting you as we would value your **participation in our study.** We are hoping to develop and validate a new measure to develop clinicians' cultural humility within clinical supervision, specifically within the UK. Current supervision measures have not been validated within a UK sample, so we hope our research can be applicable to clinicians working within the UK. As such, we are firstly approaching experts in the field of equality, diversity and inclusion, and experienced clinicians to take part in the developing phase of the measure.

As part of this research, will be using the Delphi technique which will consist of at **least one round** and may consist of a **series of 2-3 rounds** (using questionnaires) to collate your ratings on items of a new measure, and to achieve consensus.

The amount of time necessary for completion of each questionnaire (or rounds) will vary with each expert but should take approximately 10-15 minutes. There are no right or wrong answers to the questions. This study is seeking your expert opinion. We hope you will the process interesting, and results will be made available at you at the conclusion of this study.

Participation in this study is entirely **voluntary.** In addition, any information that you provide will be confidential and when the results of the study are reported, you will not be identifiable in the findings. We will need to collect your email address with your response for the rounds as the research team may need to contact you in-between the rounds. You will remain anonymous to other participants throughout this Delphi study and only the researchers will be able to identify your specific answers. If you decide to participate, you can also choose to enter a prize draw to win **one of four £50 Amazon vouchers**.

If you do agree to participant in this research, **please click on the link which will take you to the study information page (INSERT LINK).** If you have any questions, please, email myself or Professor Margo Ononaiye (cc'd in).

Thank you.

Kind regards,

Paola De Luca

University of Southampton

ERGO: 89941/ IRAS: 337750

Version 2, 03.04.24

Appendix F- Reminder email to Experts (Sample One)

Subject: Reminder – Delphi Study

Dear [insert name],

We are contacting you as a gentle reminder if you still wish to participate in the (insert round) of the Delphi study to please **complete the questionnaire through the link below by [insert date] at the latest.** We would appreciate that you could complete the questionnaire as soon as possible.

If you do not complete the questionnaire by **[insert date],** we will assume you no longer wish to participate in the study.

INSERT LINK TO STUDY

Please do not hesitate to contact us if you have any questions.

Thank you.

Kind regards,

Paola De Luca

University of Southampton

ERGO: 89941/ IRAS: 337750

Version 2, 03.04.24

Appendix G- Online participant information sheet and consent form (Sample One)

Online Participant Information Sheet and Consent

University of Southampton

Study Title: Devising a new questionnaire which measures cultural humility in clinical supervision.

Researcher: Paola De Luca
ERGO number: 89941
IRAS number: 337750

Thank you for taking the time to read this. 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 by checking the boxes at the end of this form.

What is the research about?

This research is being conducted by Paola De Luca for her thesis project which contributes towards her Doctorate in Clinical Psychology at The University of Southampton. Professor Margo Ononaiye is the Primary Supervisor for this project. This research is sponsored by University of Southampton, details of the person acting on behalf of the research sponsor are included: Linda Hammond, 023 8059 5058, rgoingo@soton.ac.uk

This research devises and assesses the psychometric properties of a new cultural humility measure intended for use in clinical supervision. The aim is that this measure will help clinicians to understand, measure, and further develop their skills in cultural humility. The data collected enables you to provide valuable feedback on the applicability and utility of the questionnaire items to inform the development of this scale as a valid measure for use in clinical supervision in the UK.

Why have I been asked to participate?

We are inviting experts within the field of equality, diversity, and inclusion (EDI), academics involved in the delivery of therapy training, and experienced clinicians within the field of psychological therapies to take part in this online study. To take part, experts are defined as having:

- **A minimum of 5 years' post-qualified experience** in the field of psychological therapies.

AND/OR

- Direct experience of **conducting research in the field of EDI**

AND/OR

- An active interest in **EDI related work** as part of your clinical/academic role.
- Experience of being supervised in a clinical or research role **and** delivered clinical or research supervision.
- Have a **post-graduate qualification** in their relevant field of expertise.

What will happen to me if I take part?

If you decide, you will agree to take part in online Delphi rounds. A Delphi round is a method of consultation whereby experts in a particular field are asked for their

opinion on a topic. From this expert opinion, the aim is that a consensus is achieved. Your expert opinion will be captured through an online survey (a Delphi round), and to reach consensus this may take one, two or a maximum of three rounds.
You will be asked to complete an online survey which will take approximately 10-15 minutes. The first online survey will consist of a demographic survey which includes questions asking you to indicate your race/ethnicity and occupation, followed by a series of items which will ask you to rate how important you think they are to be included in a cultural humility measure. After responses are collected, the research team may then contact you to ask you some further follow up questions. Also, after the first survey (the first Delphi round), the research team may also send out another online survey which will ask you to consider the items again and rate how important you think they are to be included in the measure, this would be a second Delphi round. If a third round is needed, it will be the same format as the second round. Most Delphi studies have two to three rounds of consultation.

Are there any benefits in my taking part?

If you complete any of the study rounds, you will have the option to enter into a raffle with the chance to win one of four £50 Amazon vouchers. You will also be contributing to the development and improvement of our understanding of exploring culture within clinical supervision, as well as creating a new measure that can be used to promote cultural humility in clinical practice.

Are there any risks involved?

As the survey is centred around questions about culture, cultural experiences, ethnicity and values, there is a possibility that it could cause some psychological discomfort or distress. It is not anticipated that this discomfort will be higher than what you might normally expect in your clinical role. You are free to discontinue the survey at any time by closing down the browser if you are finding that the study is triggering distress for you.
If after the survey, you are feeling discomfort and would like some information and/or resources on emotional support please follow the links below:

https://talkingtherapies.rdash.nhs.uk/self-help/
https://overcoming.co.uk/14/Help-for-Mental-Health

What data will be collected?

The electronic data (survey responses) will be collected online and will be kept confidential. This will include the collection and use of personal data that is special category data according to General Data Protection Regulation (2018); this includes information on ethnicity; gender identity; religious beliefs and your job role from which you can be uniquely identified. We will ask for your email address with your survey responses as the research team may need to contact you in-between the Delphi rounds. Your email addresses will also be used if you wish to be entered into the free prize draw. 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.

The 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 to take part, please 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.

What will happen to the results of the research?
The project will be written up as part of a 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. This study will also aim to publish the research findings with the new developed measure. It is hoped that clinicians can use the measure in clinical practice.

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: Paola De Luca (pdl1e20@soton.ac.uk); Research supervisors: Prof. Margo Ononaiye (m.s.ononaiye@soton.ac.uk); Dr Bianca Vekaria; & Dr. Peter Phiri.

What happens if there is a problem?
If you have any concerns about any aspect of this study whatsoever, you can email the Chief Investigator Paola De Luca (pdl1e20@soton.ac.uk) or the Primary Research Supervisor Professor Margo Ononaiye (m.s.ononaiye@soton.ac.uk) 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 Head of Research Ethics and Clinical Governance (023 8059 5058, rgoinfo@soton.ac.uk).

Data Protection Privacy Notice

How will we use information about you?
For the purposes of data protection law, the University of Southampton is the 'Data Controller' for this study, we will need to use information from you for this research project.

This information will include your email address and demographic information. People will use this information to do the research or to check your records to make sure that the research is being done properly.

We will keep all information about you safe and secure.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

What are your choices about how your information is used?

- You can stop being part of the study at any time, without giving a reason, but we will keep all identifiable information about you that we already have.
- We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

Where can you find out more about how your information is used?

You can find out more about how we use your information:

- the Human Regulatory Authority (HRA) protects and promotes the interests of patients and the public in health and social care research, More information can be found at www.hra.nhs.uk/information-about-patients/
- the leaflet available from www.hra.nhs.uk/patientdataandresearch
- by sending an email to University's Data Protection Officer (data.protection@soton.ac.uk).
- by asking one of the research team or from our general privacy policy.
- by sending an email to rgoinfo@soton.ac.uk, or by ringing us on 023 8059 5058.

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.

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

Please check the boxes below (by clicking on them) 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 and have had the opportunity to ask any

☐ I understand that my participation is voluntary, and I may withdraw at any time during the study for any reason without my

☐ 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.

☐ I consent to take part in the first Delphi round.

☐ I consent to take part if there are further rounds (2 to 3 rounds maximum)

Appendix H - Demographic Questionnaire (Sample One)

University of Southampton

Version 2 – 03.04.24

Experts Demographic Questionnaire Part B

1. Please state your email address:
2. Please state your age group

18-21	21-24	25-34	35-44	45-54	55-64	65+

3. Please provide your gender

- ❑ Male
- ❑ Female
- ❑ Non-Binary
- ❑ Prefer not to say
- ❑ Other (please state) ……

4. 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)

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

- ❑ Yes
- ❑ No
- ❑ Prefer not to say

6. Please provide your current job role:……
7. Which post graduate training qualification do you hold?

- ❑ Doctorate
- ❑ Masters
- ❑ Post graduate Diploma
- ❑ Other

Please specify the specific post graduate qualification……

8. How long have you held this qualification for?
    - ❑ 0- 4 years
    - ❑ 5-10 years
    - ❑ 11-15 years
    - ❑ 16 + years

9. Are you involved currently in any direct experience in participating in EDI projects (such as BAME advisory network / reflective groups/ steering groups)

❑ Yes
❑ No
❑ If yes, please state:

10. Do you have experience of being supervised in your clinical/research role?

❑ Yes
❑ No
❑ If yes, please state how long have you had experience:

11. Do you have experience of delivering clinical/ research supervision?

❑ Yes
❑ No
❑ If yes, please state how long have you had experience:

Appendix I- Online Debrief Form (Sample One)

Debriefing Form

Study Title: Devising a new questionnaire which measures cultural humility in clinical supervision.

Ethics/ERGO number: 89941 / **IRAS number:** 337750

Researcher(s): Paola De Luca, Professor Margo Ononaiye, Dr Bianca Vekaria & Dr Peter Phiri

University email(s): pdl1e20@soton.ac.uk

Version and date: Version 2, 03.04.2024

Thank you for taking part in our research project. Your contribution is very valuable and greatly appreciated.

Purpose of the study

The aim of this part of the research was to develop a new measure of cultural humility to use in clinical supervision. We were particularly interested in creating a measure that is appropriate for clinicians to use in clinical supervision.

In the next stage of the study, we will be looking to formally assess the psychometric properties of the new scale that was created in this part of the study. It is expected that by creating and assessing the new scale, it can help support clinicians in the field to continue to develop their cultural humility and have implications for the diverse population that clinicians work with in the UK. Your data and participation in the Delphi rounds will help our understanding of developing an appropriate cultural humility measure for clinicians in the UK.

Confidentiality

Results of this study will not include your name or any other identifying characteristics.

Study results

You may have a copy of the final research paper once the project is completed, you can let us know by using the contact details provided on this form.

Further support

If taking part in this study has caused you discomfort or distress, you can contact the following organisations (listed below) for support. As the survey could be a sensitive or emotive topic due to it centring around culture, ethnicity and values, we would guide you to the below is information and resources on emotional support if you feel like it would be useful for you:

https://talkingtherapies.rdash.nhs.uk/self-help/

https://www.mind.org.uk/

https://overcoming.co.uk/14/Help-for-Mental-Health

Further reading

If you would like to learn more about this area of research, you can refer to the following resources:

- Gonzalez, E., Sperandio, K. R., Mullen, P. R., & Tuazon, V. E. (2021). Development and initial testing of the multidimensional cultural humility scale. *Measurement and Evaluation in Counseling and Development*, *54*(1), 56-70. https://doi.org/10.1080/07481756.2020.1745648
- Hook, J. N., Davis, D. E., Owen, J., Worthington Jr, E. L., & Utsey, S. O. (2013). Cultural humility: Measuring openness to culturally diverse clients. *Journal of Counseling Psychology*, *60*(3), 353-366. https://doi.org/10.1037/a0032595

Further information

If you have any concerns or questions about this study, please contact Paola De Luca at pdl1e20@soton.ac.uk who will do their best to help.

If you remain unhappy or would like to make a formal complaint, please contact the Head of Research Integrity and Governance, University of Southampton, by emailing: rgoinfo@soton.ac.uk, or calling: + 44 2380 595058. Please quote the Ethics/ERGO number which can be found at the top of this form.

Thank you again for your participation in this research.

Appendix J- Inclusion Criteria (Sample Two)

- Participants must be either a Trainee or Qualified Clinician in a particular model of psychological therapy (e.g., Cognitive Behavioural Therapy / Counselling/ Systemic / Clinical Psychology).
- Participants must be working in the UK.
- Participants must be over the age of 18 (there is no upper age limit for this study).
- Participants must currently work in clinical practice.
- Participants will have received supervision from their current / most recent supervisor for a minimum of four months to allow for sufficient exposure to clinical work and supervision.
- Participants must be receiving regular clinical supervision (minimum of once a month).
- Participants will require access to the internet such as on a computer or smartphone to access the online survey.
- Participants must have sufficient level of English proficiency to participate in the study. The study materials will be in English, and the translation or use of interpreters will not be possible.

Appendix K- Study Poster (Sample Two)

University of Southampton

CLINICIANS NEEDED

For an online study looking at experiences of cultural humility in clinical supervision

PARTICIPATE AND BE IN WITH THE CHANCE OF WINNING 1 OF 4 £50 AMAZON VOUCHERS

WHAT IS THIS STUDY ABOUT?

- This research aims to create a new, and much needed, UK validated measure exploring the concept of cultural humility in clinical supervision. The measure will support both supervisors and supervisees to develop skills in the exploration of one's own culture, identity, and values within supervision to enable a more effective and supportive supervisory relationship and promote culturally informed client care.

WHAT WILL I BE ASKED TO DO?

- This study should take approximately 10-15 minutes to complete. You will be asked to provide demographic information and then to complete questionnaires to enable the research to validate the UK measure against other similar overseas measures.

WHO CAN PARTICIPATE?

- ☑ Are you a Trainee or Qualified Clinician in psychological therapies, such as: a Clinical Psychologist, Counselling Psychologist, Systemic Therapist 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?

IF THE ANSWER TO ALL THESE QUESTIONS IS YES AND YOU WOULD LIKE TO TAKE PART IN THE STUDY, PLEASE FOLLOW THE LINK BELOW:

https://southampton.qualtrics.com/jfe/form/SV_b2aXV6DQNNP NxBA

If you have any more queries or would like to know more about this study, please do not hesitate to get in touch! Email: pdl1e20@soton.ac.uk or m.s.ononaiye@soton.ac.uk (supervisor)

ERGO: 89941/ IRAS: 337750 Version 2 - 03.04.24

Appendix L- Email Recruitment (Sample Two)

Hello {insert name},

My name is Paola and I'm a second year Trainee Clinical Psychologist at the University of Southampton DClinPsych course. I'm emailing to ask if you would be happy to share my recruitment poster (attached) with your network [insert specifics].

My thesis study is interested in creating a new UK validated measure exploring the concept of cultural humility in clinical supervision. My project has received ethical approval from the University of Southampton and NHS (ERGO: 89941/ IRAS: 337750). It is an online survey which will take approximately 10-15 minutes. If anyone would like further information, they can contact me via email: pdl1e20@soton.ac.uk.

Thank you so much for your help and support.

Kind regards,

Paola De Luca

University of Southampton

ERGO: 89941/ IRAS: 337750

Version 2, 03.04.24

Dear all,

We hope you are well.

Thank you for taking part in my research that is supervised by Professor Margo Ononaiye, your expertise was truly valued in the development stage of the Cultural Humility Scale to use in clinical supervision. We are now moving onto the next phase of study which aims to validate the scale.

As you participated in the first phase, you will not be able to participate in this next phase. However, we would welcome your ongoing support with the study and ask if you are if you are able to share the attached study poster widely via your networks and to colleagues who may be able to take part. It is an online survey which will take approximately 10-15 minutes, which can be accessed either through scanning the QR on the poster or, clicking on the link: (INSERT LINK)

Thank you once again and please do not hesitate to contact me or Margo if you have any questions.

Kind regards,

Paola De Luca (she/her)

University of Southampton

Trainee Clinical Psychologist

University of Southampton

Version 1, 11.10.24

Appendix M- Online Demographic Questionnaire (Sample Two)

University of Southampton

Version 2 – 03.04.24

Clinicians Demographic Questionnaire Part C

12. Please state your age group

18-21	21-24	25-34	35-44	45-54	55-64	65+

13. Please provide your gender

- ❑ Male
- ❑ Female
- ❑ Non-Binary
- ❑ Prefer not to say
- ❑ Other (please state) .....

14. 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)

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

- ❑ Yes
- ❑ No
- ❑ Prefer not to say

16. 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

17. Please provide your current job role

- ❑ Trainee Clinical Psychologist
- ❑ Trainee Cognitive Behavioural Therapist

- ❑ Trainee Psychological Wellbeing Practitioners
- ❑ Trainee Counselling Psychologist
- ❑ Trainee Forensic Psychologist
- ❑ Trainee Systemic Therapist
- ❑ Clinical Psychologist
- ❑ Cognitive Behavioural Therapist
- ❑ Psychological Wellbeing Practitioners
- ❑ Counselling Psychologist
- ❑ Forensic Psychologist
- ❑ Systemic Therapist
- ❑ Other – please state

18. If yes to Trainee job role, please state what year of training you are in?
    - ❑ 1
    - ❑ 2
    - ❑ 3
    - ❑ N/A (please provide reason)

19. If yes to a qualified job role, please state what year of training you are in?
    - ❑ Less than a year
    - ❑ 1-5 years
    - ❑ 6-10 years
    - ❑ 11-19 years
    - ❑ More than 20 years

20. How frequently do you receive individual clinical supervision?
    - ❑ Every week
    - ❑ Every 2 weeks
    - ❑ Every month
    - ❑ Other (please specific)

21. What is the duration of your clinical supervision session?
    - ❑ Please state:

22. Do you also receive group supervision?
    - ❑ Yes
    - ❑ No
    - ❑ If yes – please specify how often you receive group supervision and in which context.

23. What is the context of the professional sector in which you work?
    - ❑ NHS
    - ❑ Local authority

- ❑ Non- NHS health sector
- ❑ Private sector
- ❑ Academia
- ❑ Social care
- ❑ Other (please state)

24. 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

25. How long have you been supervised by your current supervisor for?
    - ❑ 4 months
    - ❑ 5 months
    - ❑ 6 months
    - ❑ 7+ months

Appendix N - Questionnaires (Sample Two)

Multidimensional Cultural Humility Scale

Instructions: Please take a moment and read each of the following statements. Then, rate the level of agreement for which each statement best reflects your work with clients from diverse cultural backgrounds.

Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1	2	3	4	5	6

Openness

1. I am comfortable asking my clients questions about their cultural experience.	1	2	3	4	5	6
2. I seek to learn more about my clients' cultural background.	1	2	3	4	5	6
3. I believe that learning about my clients' cultural background will allow me to better help my clients.	1	2	3	4	5	6

Self-Awareness

4. I seek feedback from my supervisors when working with diverse clients.	1	2	3	4	5	6
5. I incorporate feedback I receive from colleagues and supervisors when I am faced with problems regarding cultural interactions with clients.	1	2	3	4	5	6
6. I am known by colleagues to seek consultation when working with diverse clients.	1	2	3	4	5	6

Ego-less

7. I ask my clients about their cultural perspective on topics discussed in session.	1	2	3	4	5	6
8. I ask my clients to describe the problem based on their cultural background.	1	2	3	4	5	6
9. I ask my clients how they cope with problems in their culture.	1	2	3	4	5	6

Supportive Interactions

10. I wait for others to ask about my biases for me to discuss them.	1	2	3	4	5	6
11. I do not necessarily need to resolve cultural conflicts with my client in counseling.	1	2	3	4	5	6
12. I believe the resolution of cultural conflict in counseling is the clients' responsibility.	1	2	3	4	5	6

Self-Reflection and Critique

13. I enjoy learning from my weaknesses.	**1**	**2**	**3**	**4**	**5**	**6**
14. I value feedback that improves my clinical skills.	**1**	**2**	**3**	**4**	**5**	**6**
15. I evaluate my biases.	**1**	**2**	**3**	**4**	**5**	**6**

Cultural Humility Scale (CHS)

DIRECTIONS: There are several different aspects of one's cultural background that may be important to a person, including (but not limited to) race, ethnicity, nationality, gender, age, sexual orientation, religion, disability, socioeconomic status, and size. Some things may be more central or important to one's identity as a person, whereas other things may be less central or important.

Please identify the aspect of your cultural background that is most central or important to you: ……

How important is this aspect of your cultural background?

Not at all important		Somewhat important		Very important
1	2	3	4	5

If there is a 2nd aspect of your cultural background that is important to you, please list: ……..

How important is this aspect of your cultural background?

Not at all important		Somewhat important		Very important
1	2	3	4	5

If there is a 3rd aspect of your cultural background that is important to you, please list: ……

How important is this aspect of your cultural background?

Not at all important		Somewhat important		Very important
1	2	3	4	5

Please think about your **supervisor**. Using the scale below, please indicate the extent to **which you agree or disagree** with the following statements about your **supervisor.**

Regarding the core aspect (s) of my cultural background, my supervisor……	**Strongly Disagree (1)**	**Mildly Disagree (2)**	**Neutral (3)**	**Mildly Agree (4)**	**Strongly Agree (5)**
1. Is respectful	1	2	3	4	5
2. Is open to explore	1	2	3	4	5
3. Assumes he/she/they already knows a lot	1	2	3	4	5
4. Is considerate	1	2	3	4	5
5. Is genuinely interested in learning more.	1	2	3	4	5
6. Acts superior	1	2	3	4	5
7. Is open to seeing things from my perspective	1	2	3	4	5
8. Makes assumptions about me.	1	2	3	4	5
9. Is open-minded.	1	2	3	4	5
10. Is a know-it-all.	1	2	3	4	5

11. Thinks he/she/they understands more than he/she/they does.	1	2	3	4	5
12. Asks questions when he/she/they is uncertain.	1	2	3	4	5

Personal Reaction Inventory

Listed below are a number of statements concerning personal attitudes and traits.

Read each item and decide how it pertains to you. Please respond either TRUE (T) or FALSE (F) to each item. Indicate your response by circling the appropriate letter next to the item. Be sure to answer all items.

1	It is sometimes hard for me to go on with work if I am not encouraged.	T	F
2	I sometimes feel resentful when I don't get my way.	T	F
3	On a few occasions, I have given up doing something because I thought too little of my ability.	T	F
4	There have been times when I felt like rebelling against people in authority even though I knew they were right.	T	F
5	No matter who I'm talking to, I'm always a good listener.	T	F
6	There have been occasions when I took advantage of someone.	T	F
7	I'm always willing to admit to it when I make a mistake.	T	F
8	I sometimes try to get even rather than forgive and forget.	T	F
9	I am always courteous, even to people who are disagreeable.	T	F
10	I have never been irked when people expressed ideas very different from my own.	T	F
11	There have been times when I was quire jealous of the good fortune of others.	T	F
12	I am sometimes irritated by people who ask favours of me.	T	F
13	I have never deliberately said something that hurt someone's feelings.	T	F

Appendix O- Online Participant Information Sheet and Consent Form (Sample Two)

Online Participant Information Sheet and Consent

Study Title: Devising a new questionnaire which measures cultural humility in clinical supervision

Researcher: Paola De Luca

ERGO number: 89941

IRAS number: 337750

Thank you for taking the time to read this. 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 by checking the boxes at the end of this form.

What is the research about?

This research is being conducted by Paola De Luca for her thesis project which contributes towards her Doctorate in Clinical Psychology at The University of Southampton. Professor Margo Ononaiye is the Primary Supervisor for this project. This research is sponsored by University of Southampton, details of the person acting on behalf of the research sponsor are included: Linda Hammond (Head of Research Integrity and Governance), 023 8059 5058, rgoingo@soton.ac.uk

This research devises and assesses the psychometric properties of a new cultural humility measure intended for use in clinical supervision. The aim is that this measure will help clinicians to understand, measure, and further develop their skills in cultural humility. The data collected enables you to provide valuable feedback on the applicability and utility of the questionnaire items to inform the development of this scale as a valid measure for use in clinical supervision in the UK.

Why have I been asked to participate?

We are inviting **Trainee or Qualified Therapists** (e.g., Cognitive Behavioural Therapist/ Counselling Psychologist/ Systemic Therapist/ Clinical Psychologist) to take part in this online survey. To take part, you must:

- Be currently working in **clinical practice in the UK** and have received supervision from your current or most recent supervisor for a **minimum of 4 months**.
- You also must be receiving clinical supervision at least once a month.

What will happen to me if I take part?

If you decide to take part, you will complete an online survey which will take approximately 10-15 minutes. The online survey will consist of a demographic

survey which includes questions asking you to indicate your race / ethnicity, followed by several different questionnaires which aim to explore the concept of incorporating cultural humility into clinical supervision.

At the end of the questionnaire, you can opt into whether you want to put your email address into the raffle to be in with a chance of winning a voucher.

Are there any benefits in my taking part?

If you complete the study, you will have the option to register your email address into a raffle with the chance to win one of four £50 Amazon vouchers. You will also be contributing to the development and improvement of our understanding of exploring culture within clinical supervision, as well as assessing a new potential measure that can be used to promote cultural humility in clinical practice.

Are there any risks involved?

As the survey is centred around questions about culture, cultural experiences, ethnicity and values, there is a possibility that it could cause some psychological discomfort or distress. It is not anticipated that this discomfort will be higher than what you might normally expect in your clinical role. You are free to discontinue the survey at any time by closing down the browser if you are finding that the study is triggering distress for you.

If after the survey, you are feeling discomfort and would like some information and/or resources on emotional support please follow the links below:

https://talkingtherapies.rdash.nhs.uk/self-help/

https://overcoming.co.uk/14/Help-for-Mental-Health

What data will be collected?

The anonymous survey responses will be collected online and will include the collection and use of personal data that is special category data according to General Data Protection Regulation (2018); this includes information on ethnicity; gender identity; religious beliefs and your job role from which you can be potentially uniquely identified. This confidential personal data will be stored and used for analysis using encryption and password protected access only.

Will my participation be confidential?

Your participation and the information collected about you 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 for monitoring purposes and/or to carry out an audit of the study to ensure that the research is complying with University regulations. All 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 kept securely and separately

from your survey responses. 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 to take part, please 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.

What will happen to the results of the research?

The project will be written up as part of a 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. This study will also aim to publish the research findings with the new developed measure. It is hoped that clinicians can used the measure in clinical practice.

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: Paola De Luca (pdl1e20@soton.ac.uk); Research supervisors: Prof. Margo Ononaiye (m.s.ononaiye@soton.ac.uk); Dr Bianca Vekaria; & Dr. Peter Phiri.

What happens if there is a problem?

If you have any concerns about any aspect of this study whatsoever, you can email the Chief Investigator Paola De Luca (pdl1e20@soton.ac.uk) or the Primary Research Supervisor Professor Margo Ononaiye (m.s.ononaiye@soton.ac.uk) 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 Head of Research Ethics and Clinical Governance (023 8059 5058, rgoinfo@soton.ac.uk).

Data Protection Privacy Notice

For the purposes of data protection law, the University of Southampton is the 'Data Controller' for this study, we will need to use information from you for this research project.

This information will include your demographic information. People will use this information to do the research or to check your records to make sure that the research is being done properly.

We will keep all information about you safe and secure.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no one can work out that you took part in the study.

What are your choices about how your information is used?

- You can stop being part of the study at any time, without giving a reason, but we will keep all anonymous information about you that we already have.
- We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

Where can you find out more about how your information is used?

You can find out more about how we use your information:

- The Human Regulatory Authority (HRA) protects and promotes the interests of patients and the public in health and social care research, More information can be found at www.hra.nhs.uk/information-about-patients/
- the leaflet available from [**www.hra.nhs.uk/patientdataandresearch**]
- by sending an email to University's Data Protection Officer (data.protection@soton.ac.uk).
- by asking one of the research team or from our general privacy policy.
- by sending an email to rgoinfo@soton.ac.uk, or by ringing us on 023 8059 5058.

The University of Southampton will keep the anonymised data information about for 10 years after the study has finished.

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 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.

Appendix P- Online Debriefing Form (Sample Two)

Debriefing Form

Study Title: Devising a new questionnaire which measures cultural humility in clinical supervision.

Ethics/ERGO number: 89941 / **IRAS number:** 337750

Researcher(s): Paola De Luca, Dr Margo Ononaiye, Dr Bianca Vekaria & Dr Peter Phiri

University email(s): pdl1e20@soton.ac.uk

Version and date: Version 2, 03.04.2024

Thank you for taking part in our research project. Your contribution is very valuable and greatly appreciated.

Purpose of the study

The aim of this part of the research was to formally assess a new measure of cultural humility for use in clinical supervision. We were particularly interested in assessing if the measure is a valid scale for clinicians to use in clinical supervision.

It is expected that by creating and assessing the new scale, it can help support clinicians in the field to continue to develop their cultural humility and have implications for the diverse population that clinicians work with in the UK. Your data will help our understanding of developing and validating an appropriate cultural humility measure for clinicians in the UK.

Confidentiality

Results of this study will not include your name or any other identifying characteristics.

Study results

If you would like to receive a copy of the final research paper once the project is completed, please let us know by using the contact information on this form. It is up to you whether you would like to receive study results. Please note that by contacting us, your participation in the study might be no longer anonymous, but the researcher will not know what information you provided.

Further support

If taking part in this study has caused you discomfort or distress, you can contact the following organisations (listed below) for support. As the survey could be a sensitive or emotive topic due to it centring around culture, ethnicity and values, we would guide you to the below information and resources on emotional support if you feel like it would be useful for you:

https://talkingtherapies.rdash.nhs.uk/self-help/

https://www.mind.org.uk/

https://overcoming.co.uk/14/Help-for-Mental-Health

Further reading

If you would like to learn more about this area of research, you can refer to the following resources:

- Gonzalez, E., Sperandio, K. R., Mullen, P. R., & Tuazon, V. E. (2021). Development and initial testing of the multidimensional cultural humility scale. *Measurement and Evaluation in Counseling and Development*, *54*(1), 56-70. https://doi.org/10.1080/07481756.2020.1745648
- Hook, J. N., Davis, D. E., Owen, J., Worthington Jr, E. L., & Utsey, S. O. (2013). Cultural humility: Measuring openness to culturally diverse clients. *Journal of Counseling Psychology*, *60*(3), 353-366. https://doi.org/10.1037/a0032595

Further information

If you have any concerns or questions about this study, please contact Paola De Luca at pdl1e20@soton.ac.uk who will do their best to help.

If you remain unhappy or would like to make a formal complaint, please contact the Head of Research Integrity and Governance, University of Southampton, by emailing: rgoinfo@soton.ac.uk, or calling: + 44 2380 595058. Please quote the Ethics/ERGO number which can be found at the top of this form. Please note that if you participated in an anonymous survey, by making a complaint, you might be no longer anonymous.

Thank you again for your participation in this research.

Appendix Q- Descriptive Statistics of CCHS and MCHS (Sample Two)

Descriptive statistics of CCHS and MCHS full scale and subscales

Descriptive Statistics		
	M	*SD*
CCHS full scale	49.98	5.93
Awareness and Self-reflection	25.56	2.99
Openness in Clinical Practice	8.61	2.13
Supportive Interactions	14.80	2.23
MCHS full scale	69.87	7.78
Openness	15.23	1.77
Self-Awareness	13.60	2.44
Ego-less	12.41	2.97
Supportive Interactions	13.13	2.36
Self-reflection and Critique	15.50	1.75

Note. N = 249. M: mean; SD: standard deviation

Supplementary Materials

Initial CCHS Measure – Round 1 Delphi

Instructions: Cultural Humility is an on-going process of self-reflection, self-development, and self-evaluation whilst embracing the diversity and complexity of one's own, and others' cultural backgrounds. This scale aims to provide a tool to assess a clinician's current level of cultural humility to enable a platform for further growth and development within clinical supervision.

Using the scale below, please indicate the **extent to which you agree or disagree with how important** the following items are to be included in a scale to develop cultural humility in clinical supervision:

Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1	2	3	4	5	6

OPENNESS

1. In clinical practice, I feel confident to ask culturally sensitive questions.
2. I don't let the fear of getting it wrong interfere with being culturally curious within my clinical work.
3. Cultural discussions play a central role in supervision.

SELF-AWARENESS

4. I feel confident identifying and discussing my own cultural values and beliefs in supervision.
5. I am aware when I feel unsure about how to work with cultural diversity.
6. I prioritise being able to seek support when I am unsure about how to work with cultural diversity.

EGOLESS

7. I always take time to collaboratively explore a client's cultural background in my clinical work.
8. In supervision, I discuss the clinical impact of working with cultural beliefs which are different to my own.
9. Educating myself about different cultures is an important part of my values as a clinician.

SUPPORTIVE INTERACTION

10. Embracing cultural diversity within my work is a positive experience.

11. I take an active approach in creating a safe space to discuss culture and diversity within my clinical setting.
12. When I notice a cultural difference that is impacting clinical work, I feel it is important to discuss in supervision.

SELF-REFLECTION AND CRITIQUE

13. I reflect on my own conscious and unconscious cultural biases.
14. I take time to reflect with openness and curiosity when my belief system is being challenged.
15. I seek opportunities to learn more about different cultures to help shape my clinical practice.

Round 2 Delphi

University of Southampton

Clinician Cultural Humility Scale

Instructions: Cultural Humility is an on-going process of self-reflection, self-development, and self-evaluation whilst embracing the diversity and complexity of one's own, and others' cultural backgrounds. This scale aims to provide a tool to assess a clinician's current level of cultural humility to enable a platform for further growth and development within clinical supervision.

Using the scale below, please indicate the **extent to which you agree or disagree with how important item 3 is** to be included in a scale to develop cultural humility in clinical supervision:

Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1	2	3	4	5	6

OPENNESS

1. In clinical practice, I feel confident to ask culturally sensitive questions. **Mean score = 5.12**
2. I don't let the fear of getting it wrong interfere with being culturally curious within my clinical work. **Mean score = 5.09**

To rate:

3. In supervision, I am open to discussing the role of culture in my clinical work. **Mean score of previous item = 4.91**

SELF-AWARENESS

4. I feel confident identifying and discussing my own cultural values and beliefs in supervision. **Mean score = 5.24**
5. I am aware when I feel unsure about how to work with cultural diversity. **Mean score = 5.12**
6. I prioritise being able to seek support when I am unsure about how to work with cultural diversity. **Mean score = 5.21**

EGOLESS

7. I always take time to collaboratively explore a client's cultural background in my clinical work. **Mean score = 5.03**

8. In supervision, I discuss the clinical impact of working with cultural beliefs which are different to my own. **Mean score = 5.12**
9. Educating myself about different cultures is an important part of my values as a clinician. **Mean score = 5.53**

SUPPORTIVE INTERACTION

10. Embracing cultural diversity within my work is a positive experience. **Mean score = 5.32**
11. I take an active approach in creating a safe space to discuss culture and diversity within my clinical setting. **Mean score = 5.29**
12. When I notice a cultural difference that is impacting clinical work, I feel it is important to discuss in supervision. **Mean score = 5.61**

SELF-REFLECTION AND CRITIQUE

13. I reflect on my own conscious and unconscious cultural biases. **Mean score = 5.18**
14. I take time to reflect with openness and curiosity when my belief system is being challenged. **Mean score = 5.26**
15. I seek opportunities to learn more about different cultures to help shape my clinical practice. **Mean score = 5.33**

CCHS Measure – Part Three – Clinicians

Clinician Cultural Humility Scale

This scale aims to measure current levels of cultural humility within your clinical practice. This questionnaire is based on the five pillars of cultural humility * and should be completed by clinicians to inform current levels of cultural humility within their clinical practice. The tool is designed to enable and inform culturally based discussions within clinical supervision.

Instructions: Please take a moment to read and reflect on each statement and then rate your level of agreement with each item in direct consideration of your current clinical work.

Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1	2	3	4	5	6

OPENNESS

1. In clinical practice, I feel confident to ask culturally sensitive questions.
2. I don't let the fear of getting it wrong interfere with being culturally curious within my clinical work.
3. In supervision, I am open to discussing the role of culture in my clinical work.

SELF-AWARENESS

4. I feel confident identifying and discussing my own cultural values and beliefs in supervision.
5. I am aware when I feel unsure about how to work with cultural diversity.
6. I prioritise being able to seek support when I am unsure about how to work with cultural diversity.

EGOLESS

7. I always take time to collaboratively explore a client's cultural background in my clinical work.
8. In supervision, I discuss the clinical impact of working with cultural beliefs which are different to my own.
9. Educating myself about different cultures is an important part of my values as a clinician.

SUPPORTIVE INTERACTION

10. Embracing cultural diversity within my work is a positive experience.

11. I take an active approach in creating a safe space to discuss culture and diversity within my clinical setting.
12. When I notice a cultural difference that is impacting clinical work, I feel it is important to discuss in supervision.

SELF-REFLECTION AND CRITIQUE

13. I reflect on my own conscious and unconscious cultural biases.
14. I take time to reflect with openness and curiosity when my belief system is being challenged.
15. I seek opportunities to learn more about different cultures to help shape my clinical practice.

CCHS Measure – Final Version

Clinician Cultural Humility Scale (CCHS)

(De Luca, Ononaiye, Vekaria & Phiri 2025)

This scale aims to measure current levels of cultural humility within your clinical practice. This questionnaire should be completed by clinicians to inform current levels of cultural humility within their clinical practice. The tool is designed to enable and inform culturally based discussions within clinical supervision.

Instructions: Please take a moment to read and reflect on each statement and then rate your level of agreement with each item in direct consideration of your current clinical work.

Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1	2	3	4	5	6

Awareness and Self-reflection						
1. I prioritise being able to seek support when I am unsure about how to work with cultural diversity.	1	2	3	4	5	6
2. I feel confident identifying and discussing my own cultural values and beliefs in supervision.	1	2	3	4	5	6
3. I take time to reflect with openness and curiosity when my belief system is being challenged.	1	2	3	4	5	6
4. In supervision, I am open to discussing the role of culture in my clinical work.	1	2	3	4	5	6
5. When I notice a cultural difference that is impacting clinical work, I feel it is important to discuss in supervision.	1	2	3	4	5	6
Openness in Clinical Practice						
6. In clinical practice, I feel confident to ask culturally sensitive questions.	1	2	3	4	5	6
7. I don't let the fear of getting it wrong interfere with being culturally curious within my clinical work.	1	2	3	4	5	6
Supportive Interactions						
8. Educating myself about different cultures is an important part of my values as a clinician.	1	2	3	4	5	6
9. I seek opportunities to learn more about different cultures to help shape my clinical practice.	1	2	3	4	5	6
10. I take an active approach in creating a safe space to discuss culture and diversity within my clinical setting.	1	2	3	4	5	6

Scoring:

The CCHS comprises 10 items measured using a 6-point Likert scale. To obtain a total score on the measure, add all responses together. There is no reverse coding. Maximum score for the total of the subscales = 60 and the minimum score = 10. To obtain a score for each subscale, add the responses of each item of the three subscales shown below.

Items included in the three subscales:

- Aw = Awareness and Self-reflection: 1,2,3,4,5
  (scores range from a minimum of 5 to maximum of 30)
- Op = Openness in Clinical Practice: 6,7
  (scores range from a minimum of 2 to maximum of 12)
- Su = Supportive Interactions: 8,9,10
  (scores range from a minimum of 3 to a maximum of 18)

Higher scores indicate current areas of cultural humility strength.

Lower scores indicate current areas for further cultural humility development, and it is important to set yourself an action plan within supervision in order to develop further in this area.

	Subscale	Score
Aw	Awareness and Self reflection	
Op	Openness in Clinical Practice	
Su	Supportive Interactions	
Overall Score		
Comments/ Action Plan:		