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Racial and Ethnic Minority Supervisees' Experiences in Clinical Supervision

Destiny Chanel Hill
Walden University

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Walden University

College of Social and Behavioral Health

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Destiny Chanel Hill

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Review Committee

Dr. Katarzyna Holloway, Committee Chairperson, Counselor Education and Supervision
Faculty

Dr. Geneva Gray, Committee Member, Counselor Education and Supervision Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2025

Abstract

Racial and Ethnic Minority Supervisees' Experiences in Clinical Supervision

by

Destiny Chanel Hill

MS, Philadelphia College of Osteopathic Medicine, 2015

BA, Rowan University, 2013

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Counselor Education and Supervision

Walden University

February 2026

Abstract

Clinical supervision practices, although essential to counselor development, often reflect limited cultural competence among supervisors contributes to unclear expectations, conflicting roles, and isolation, leading to stress, negative internalization, and compromised professional development. The purpose of this hermeneutic phenomenological study was to explore the lived experiences of racial and ethnic minority supervisees in clinical supervision within the mental health counseling profession. The research question was: What are the lived experiences of racial and ethnic minority supervisees who have been involved in clinical supervision? The framework guiding the study was hermeneutic phenomenology. Data from interviews with eight participants were analyzed using the hermeneutic circle. Nine themes emerged, including cultural bias and neglect, ethical concerns, stress, nondisclosure, hierarchical power dynamics, and the positive influence of cultural humility, sensitivity, and collaboration. Findings may inform more culturally responsive and effective supervisory practices for diverse populations.

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Dedication

First and foremost, thank you Jesus for starting this work in me and entrusting me with it. Your guidance, love, grace, and mercy are absolutely astounding. This work is dedicated to all marginalized people and groups within the mental health counseling profession at all levels: clients, supervisees, faculty, counselors and counselor educators, and those in training. Harm, discrimination, unchecked biases, prejudice, generalizations, and so on have no space within the profession of mental health counseling, and this work is a contribution to the advocacy for support and human rights that should be afforded to all people. A sincere thank you to all participants who so boldly shared their experiences and truly made this work what it is. Thank you for trusting me to tell your stories; it is not taken for granted. To my church family, thank you for uplifting me when I could not see the forest from the trees; prayer changes things. I dedicate this work to my family, loved ones, and friends. Each and every one, and I'm sure so many others not mentioned, was significant to this journey so far, my drive, and this successful completion of such a complex body of work. Thank you.

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Chapter 1: Introduction to the Study

In this section, I provide an overview of my study. This overview includes the historical context related to my topic, the relevance and importance of my topic, and the scope of my study. Additionally, I outline the foundational perspectives that inform the study's focus and highlight how this research contributes to existing scholarship and professional practice.

Background

Clinical supervision is an essential component of the counseling profession, as underscored by Bernard and Goodyear (2019), serving as a critical mechanism for training and educating counselors to ensure high-quality client care through gatekeeping and feedback processes. The ethical principle of “do no harm” is established in the American Counseling Association’s (ACA, 2014) code of ethics, which mandates that counselors maintain the highest standards of client welfare (Preamble, A.4.a., A.5.c., A.6.b., A.6.c., A.6.e., A.10.e., A.11.c., B.2.a., B.2.c., B.2.d., B.6.e., C.2.b., C.2.g., C.7.b., C.7.c., E.5.d., E.13.d.). However, this principle is absent in explicit references to the clinical supervision of supervisees, raising concerns about the ethical considerations inherent in the supervisory relationship.

In addition to the emphasis on multicultural competence and awareness within the counseling dynamic (Anders & Martin Kivlighan, 2023; Gillem et al., 2016; Rudecindo et al., 2024; Vasquez & Johnson, 2022; Weisman de Mamani et al., 2023), there is a notable gap in research regarding the necessity for clinical supervisors to exhibit similar levels of competence and cultural awareness in their supervisory roles. Although the

clinical supervisor's perspective had been extensively studied, there was a paucity of research offering insights from the racial and ethnic minority supervisee's viewpoint to inform clinical supervision and counseling profession practices. The minimal research addressing the experiences of racial and ethnic minority supervisees further expanded this dearth of information within clinical supervision and the counseling profession. This gap impedes counselor educators' ability to effectively teach, train, support, and serve supervisees, particularly those from racial and ethnic minority backgrounds. This is especially true considering that relational dynamics appear to be a minimal consideration for many clinical supervisors (Koçyiğit, 2022). A significant proportion of racial and ethnic minority supervisees, ranging from 20% to 40%, experience harm due to ineffective or harmful supervision practices (Cartwright, 2019). Researchers had focused on psychotherapy skills and theoretical application within clinical supervision. However, insufficient attention had been given to the interplay of individual factors, such as supervisor responsiveness, and relational factors, such as the quality of the supervisory relationship and the management of relational ruptures (Cartwright, 2019). These factors can substantially influence the likelihood or unlikelihood of harmful supervision.

Harmful supervision can be categorized into two contexts: prelicensure, which refers to supervision required for initial licensure, and postlicensure, which pertains to supervision needed to maintain an existing license (McNamara et al., 2017). Prelicensure supervisees are vulnerable and disempowered within the hierarchical supervisory relationship, often fearing repercussions that could negatively impact their licensure prospects (McNamara et al., 2017). In the current study, I focused on racial and ethnic

minority supervisees at a variety of license levels and types to gain insight into their clinical supervision experiences at all levels. Despite the ACA's (2014) guidelines on client care, more research is needed to explore the implications of clinical supervision practices, especially in relation to racial dynamics (McNamara et al., 2017).

Using a hermeneutic phenomenological design, I explored the experiences of racial and ethnic minority supervisees at all license levels within the counseling profession, focusing on their experiences of clinical supervision. The aim of this research was to enhance the understanding of counselor educators and practitioners regarding the experiences of racial and ethnic minority supervisees within the clinical supervisory dynamic. Through this study, I sought to inform and promote more effective advocacy and support strategies for racial and ethnic minority supervisees, thereby contributing to more equitable and effective supervision practices.

Problem Statement

Although clinical supervision is essential for fostering independent practice among clinicians, it often reflects the perspectives of White majority individuals, neglecting diverse viewpoints (Bernard & Goodyear, 2019; Constantine & D. W. Sue, 2007). Despite the recognized importance of multicultural competence in counselor supervision (L. C. J. Wong et al., 2013), open discussions about race and culture—termed “broaching”—are often absent or ineffective, potentially leading to detrimental supervisory dynamics (Bayne & Branco, 2018; King et al., 2020; McNamara et al., 2017).

The principle of “do no harm,” emphasized for counselors providing client care (ACA, 2014; Council for Accreditation of Counseling and Related Educational Programs [CACREP], 2015), is less rigorously applied in clinical supervision. Racial and ethnic minority supervisees frequently encounter unclear expectations, conflicting roles, and feelings of isolation, often exacerbated by supervisors’ limited cultural competence (Falender et al., 2013; Henfield et al., 2012; Nilsson & Duan, 2007). These challenges can result in negative internalization, mental health issues, and performance struggles, thereby compromising supervisory effectiveness (Ammirati & Kaslow, 2017). There remains a significant research gap regarding the experiences of racial and ethnic minority supervisees within the clinical supervision context, particularly regarding how ineffective broaching practices can hinder their counseling effectiveness (Wilcox et al., 2022). To address this gap, I employed a hermeneutic phenomenological approach to explore the nuanced experiences of racial and ethnic minority supervisees within clinical supervision. Through this investigation, I aimed to enhance understanding that may inform more effective clinical supervisory practices for diverse populations.

Purpose of the Study

My purpose in using a hermeneutic phenomenological investigation was to explore the experiences of racial and ethnic minority supervisees within a clinical supervisory relationship. By using a hermeneutic phenomenological design, I addressed a significant gap in the literature concerning the needs of racial and ethnic minority supervisees at various license levels and types within clinical supervision. By conducting this study, I endeavored to advance understanding of the racial and ethnic minority

supervisee experience and inform supervisory practices by exploring potential practices of cultural humility and discussion of supervisory relational dynamics.

By focusing on the lived experiences of racial and ethnic minority supervisees, I aimed to reveal the specific dynamics of clinical supervision. The insights gained from this study may contribute to a deeper understanding of how current supervisory practices affect racial and ethnic minority supervisees, which may inform the development of more inclusive and effective supervision practices for racial and ethnic minority supervisees. Through the study findings, I sought to provide valuable insights that may inform clinical supervision practices at a variety of license levels and types for diverse cultural considerations, thereby fostering more equitable and supportive supervisory relationships.

Research Question

What are the lived experiences of racial and ethnic minority supervisees who have been involved in clinical supervision?

Theoretical Framework

This study included a framework of hermeneutic phenomenology to address the lived experiences of racial and ethnic minority supervisees within clinical supervision relationships. Heidegger, a prominent philosopher influenced by Husserl, extended the principles of phenomenology to explore the nature of human existence and perception (Pietkiewicz & Smith, 2012). Husserl's phenomenology focused on understanding individuals' perceptions of objects and events, emphasizing the subjective experience of phenomena (Pietkiewicz & Smith, 2014). In contrast, Heidegger's approach sought to delve deeper into the nature of human experience, foregrounding the individual's lived

experiences within their “lifeworld,” a term Heidegger used to describe the contextually embedded reality of human existence (Neubauer et al., 2019).

Hermeneutic phenomenology, as developed by Heidegger, builds on phenomenology by shifting the focus from describing phenomena to interpreting the meanings and layers that underly human experiences (Neubauer et al., 2019). Before the advent of hermeneutic phenomenology, phenomenological research predominantly utilized bracketing—a method of setting aside preconceptions to explore phenomena through a predetermined categorical system (Pietkiewicz & Smith, 2012). Heidegger’s innovation was to argue that the understanding of reality is inherently shaped by the “lifeworld,” which is more nuanced than a predetermined categorical system. This was a concept Heidegger termed *Dasein* (Peoples, 2021).

Hermeneutic phenomenology is used to uncover and interpret the layers of meaning beneath the surface of experiences, rather than focusing solely on the superficial aspects of phenomena. This approach aligns with Heidegger’s notion of the hermeneutic circle, which posits that understanding is an iterative process in which new insights are continuously integrated into existing knowledge. The hermeneutic circle is a crucial component of hermeneutic phenomenology because it integrates the researcher’s subjective experiences and worldview with a broader, holistic understanding of the phenomenon under investigation, thereby enhancing overall comprehension (Suddick et al., 2020). This interpretive movement resonates with Heidegger’s notion of *Mitsein*, or Being-with, which underscores the relational nature of existence wherein each individual embodies their own *Dasein* and lived experiences. As engagement with the experiences

of others informs and reshapes a person's understanding of themselves, the hermeneutic circle becomes essential to this process, reflecting Heidegger's (1962) assertion that "knowing oneself is grounded in Being-with" (p. 161). Within this framework, hermeneutics serves a fundamental role by enabling a deep and nuanced understanding of the complex experiences of specific populations, including those aspects that may be deemed marginal (Alsaigh & Coyne, 2021). This methodological approach is used to achieve a thorough understanding of phenomena by probing the subtleties of lived experiences.

Additionally, the concept of the fusion of horizons (engaging with multiple worldviews simultaneously) plays a significant role in the hermeneutic circle. This process involves analyzing the similarities and differences among various narratives, worldviews, and experiences, thereby clarifying the conditions necessary for the emergence of knowledge (Alsaigh & Coyne, 2021). By exploring the lived experiences of individuals, researchers use hermeneutic phenomenology to facilitate a deeper appreciation of the complex interplay between experience and interpretation, thereby contributing to a more nuanced understanding of human existence. Supporting this approach, Macgregor et al. (2023) advocated for the inclusion of narratives from marginalized groups to enhance their epistemological perspectives. Macgregor et al. (2023) argued that traditional ways of knowing have been predominantly shaped by White, elite men within a patriarchal American society, and that incorporating diverse narratives is crucial for expanding the understanding of epistemological perspectives.

Nature of the Study

A qualitative approach was well-suited for the current study due to its focus on exploring the meanings individuals ascribe to their experiences and the world around them. Qualitative researchers aim to gain deep insights into phenomena, especially in contexts in which there is limited preexisting data (Burkholder et al., 2020). This was relevant in the investigation of the experiences of racial and ethnic minority supervisees within clinical supervision because this area was underexplored. By employing qualitative methodology, I sought to capture the nuanced perspectives and lived experiences of these supervisees, thereby contributing to a more comprehensive understanding of their unique challenges and contexts.

Racial and ethnic minority supervisees frequently encounter distinct challenges within the clinical supervision framework, particularly with respect to their comfort levels in articulating struggles and concerns (Soheilian et al., 2014). The complexity of these challenges is exacerbated when clinical supervisors fail to model effective broaching techniques or model such techniques ineffectively, which is common in many helping professions due to inconsistent training and lack of competency-based models (Falender, 2018). This inefficiency can lead to detrimental outcomes not only for the supervisees, who may internalize negative experiences, but also for the clients they serve. Racial and ethnic minority supervisees may experience diminished confidence in their ability to engage in critical conversations with clients, thereby compromising the therapeutic relationship and the effectiveness of clinical practice (Soheilian et al., 2014).

The objective of the current study was to explore the nuanced experiences of racial and ethnic minority supervisees within the context of clinical supervision. By adopting a hermeneutic phenomenological approach, I sought to provide a rich, interpretive account of these experiences, offering deeper insights into the effects, if any, of clinical supervisory practices on racial and ethnic minority supervisees (see Starr, 2010). Hermeneutic phenomenology serves as a framework for interpreting the complex, layered, and nuanced nature of human experiences (Neubauer et al., 2019).

Definitions

Broaching: Broaching is a practice within the counseling profession that involves the direct examination of racial and cultural factors to understand how these elements may affect the counseling relationship and its dynamics. This approach entails discussing and exploring the potential influences of racial and cultural considerations on the therapeutic process and interactions between counselor and client. By acknowledging and addressing these factors, broaching aims to enhance the therapeutic alliance, promote cultural sensitivity, and facilitate more effective and empathetic engagement in the counseling context (Bayne & Branco, 2018).

Clinical supervision: Clinical supervision is a continuous and evaluative process characterized by its hierarchical structure. This process engages a clinical supervisor—an individual with advanced expertise and experience—who provides consultation, instruction, and support to a supervisee—a less experienced professional in the field. The importance of clinical supervision is underscored by its role in ensuring the quality and effectiveness of the services rendered by the supervisee to clients. This supervisory

framework is crucial as the supervisee progresses toward achieving independent licensure for independent practice (Bernard & Goodyear, 2019).

Color-blind approach: A color-blind approach is one which asserts that racial issues either do not exist or are unimportant (Morgan, 2018). Individuals who implement this type of approach reinforce a view of Eurocentrism, which fails to recognize the richness and uniqueness within racial and ethnic diversity (Fu, 2018).

Cultural humility: Cultural humility is conceptualized as a lifelong process that necessitates ongoing self-awareness, awareness of others, and critical reflection. It is integral for fostering robust relationships and engaging effectively with diverse populations. Unlike cultural competence, which often implies a definitive mastery of knowledge about different cultures, cultural humility recognizes that such mastery is unattainable. Instead, it emphasizes an acknowledgment of a person's limitations and a commitment to continuous learning and growth. This approach fosters a more dynamic and respectful engagement with cultural diversity, underscoring the importance of adaptability and humility in professional and interpersonal interactions (Fisher-Borne et al., 2015).

Culture: Culture is characterized by a set of shared attributes, including language, food, values, beliefs, and historical experiences (American Psychological Association [APA], 2024a). Culture is transmitted generationally within social groups through processes of socialization and education. This transmission of cultural elements fosters continuity and coherence within a group, shaping both individual and collective identities. By perpetuating these shared attributes, culture provides a framework or lens

that people can use to understand and interact with the world, thereby influencing social practices, norms, and communal bonds across successive generations.

Dasein: *Dasein* signifies our being-in-the-world and our inextricable connection to our lived experiences (Peoples, 2021).

Ethnicity: Ethnicity is a classification of individuals based on shared cultural attributes, including language, food, values, beliefs, and historical experiences. The construct of ethnicity includes common cultural practices and traditions that connect individuals within a particular group, distinguishing them from others (APA, 2024b). Unlike race, which is primarily concerned with perceived physical characteristics, ethnicity pertains to the cultural and social dimensions of identity, reflecting the collective experiences and heritage that shape group cohesion and self-identification.

Harmful supervision: Harmful supervision refers to a form of clinical supervision wherein the practices of a clinical supervisor result in psychological, emotional, and/or physical harm, and potentially trauma, to a supervisee. Such detrimental practices may encompass harassment, abuse, microaggressions, and violations of a supervisee's personal and professional boundaries (Ellis et al., 2014). These negative supervisory practices undermine the effectiveness of the supervisory process and can significantly affect the well-being and professional development of the supervisee.

Hermeneutic circle: The hermeneutic circle is a spiral process in hermeneutic phenomenology, in which understanding continually changes as new knowledge is added to old knowledge (Peoples, 2021).

Intersectionality: Intersectionality refers to the analytical framework that examines the complex and interconnected nature of an individual's social identities, including, but not limited to, gender, race, sexual orientation, and socioeconomic class. This concept, articulated by scholars such as LaMantia et al. (2015), underscores the importance of understanding how these intersecting identities collectively shape an individual's experiences, opportunities, and social realities. By considering the multifaceted interactions between various aspects of identity, intersectionality provides a nuanced perspective on how systemic inequalities and privileges are experienced and perpetuated across different social contexts.

Intersectionality theory: Intersectionality theory, as an advanced methodological framework within the health sciences, provides a nuanced approach to understanding marginalization by incorporating both macro and micro-level considerations pertinent to specific phenomena (Abrams et al., 2020). This theoretical approach underscores the dynamic interplay between identity and power, capturing the intricate and multifaceted lived experiences of individuals whose identities intersect in complex ways. By addressing how various social categories such as race, gender, and socioeconomic status, interact to shape experiences of privilege and oppression, intersectionality theory allows for the facilitation of a more comprehensive analysis of health disparities and social inequalities (Abrams et al., 2020).

Majority: A racial majority includes individuals whose societal racial categorization holds the majority of political powers, social norms, and practices overall.

This racial categorization includes non-Hispanic White individuals (United States Census Bureau, 2014).

Microaggression: Comments and/or actions, whether conscious or subconscious, that convey derogatory, dismissive, and/or negative messages to people of color (Constantine & D. W. Sue, 2007; D. W. Sue et al., 2008). These forms of racism and discrimination can occur in multiple contexts and on a daily basis for racial and ethnic minorities which can contribute to further psychological distress and marginalization of racial and ethnic minorities (D. W. Sue et al., 2008).

Minority: A racial and ethnic minority includes individuals whose societal racial categorization and ethnicity hold a history of marginalization, oppression, and being disempowered in society. This racial categorization includes any group other than non-Hispanic White individuals (United States Census Bureau, 2014).

Mitsein: *Mitsein* indicates “Being-with,” and embodies interpersonal relationship dynamics as each individual encompasses their own unique *Dasein* (Heidegger, 1962).

Race: Race is a socially constructed concept that categorizes individuals based on perceived physical characteristics, such as skin color and facial features. The construct of race establishes and perpetuates a sociopolitical hierarchy, reinforcing power differentials and social stratification. As a man-made construct, race lacks a basis in biological determinism but plays a significant role in shaping social relations and institutional structures, thereby influencing access to resources, opportunities, and systemic advantages or disadvantages (APA, 2024c).

Assumptions

There are assumptions in all research; however, within hermeneutic phenomenology, biases are recognized as part of an individual's understanding (Suddick et al., 2020). My assumptions within this current study were that racial and ethnic minority supervisees experience harmful supervision and that the experiences of harmful supervision influence racial and ethnic minority supervisees on personal and professional levels. As a racial and ethnic minority supervisee who has encountered harmful supervision, my assumptions within this current study were informed by my personal and professional experiences and interactions. I was open to revisions as I utilized the process of the hermeneutic circle with increased data and knowledge.

Scope and Delimitations

The scope of this study included racial and ethnic minority supervisees—or individuals who racially identify as any race(s) other than non-Hispanic White (United States Census Bureau, 2014)—who have been involved in clinical supervision at any point in time as a supervisee. The delimitations of this study included majority supervisees—or non-Hispanic White individuals (United States Census Bureau, 2014)—who have not been involved in clinical supervision as a supervisee. Majority supervisees were excluded from this current study due to my intention to focus on the racial and ethnic minority supervisee vantage point.

Limitations

Human participants serve as the primary source of data in qualitative research (Yip et al., 2016). Because this current study explored sensitive topics relevant to racial

and ethnic minority supervisee experiences, participants may have been hesitant to fully disclose their experiences due to limited familiarity or rapport with the interviewer (see Myers & Neuman, 2007). This apprehension could have restricted the richness of the data collected. Furthermore, participants may have modified their responses to conform to perceived social acceptability or to avoid potential negative repercussions with their clinical supervisor, particularly if a supervisory relationship was ongoing (see Myers & Neuman, 2007). Such adjustments in responses can introduce bias and compromise the validity of the data. Additionally, the limited sample size may not speak to the rich experiences of all participants within this population.

Significance

Harmful clinical supervision represents a critical area of study due to its potential effects on minority supervisees, who subsequently serve a diverse clientele (Ladany et al., 1997). Clinical supervision is indispensable for the progression of the counseling profession, yet its implementation is not standardized, reflecting the inherent complexity of both counseling practices and supervisory processes. The intricate nature of clinical supervisory practices reflects the diversity and complexity of individuals involved, each with their own biases, experiences, worldviews, and interpersonal styles interacting within the supervisory dynamic (McNamara et al., 2017; Middleton et al., 2011).

Clinical supervision has been recognized as a specialized focus, wherein supervisors are charged with significant responsibilities related to the professional identity development of counselors, gatekeeping, and ensuring client welfare (Koçyiğit, 2022). However, it has been observed that many supervisors model their supervisory

practices based on their own experiences of clinical supervision, whether these experiences are positive or negative (Koçyiğit, 2022). This practice of supervisors implementing what has worked for them is of a limited scope that does not encourage what may be appropriate for those who differ from them. Furthermore, implementing this practice can contribute to harmful supervision due to a lack of inclusive practice considerations, such as broaching. Although supervisees frequently attempt to discuss power dynamics within supervision, this is often done with limited success (R. M. Cook et al., 2018). This underscores a power imbalance in the supervisory relationship, wherein supervisors may have the discretion to address or ignore these power dynamics. This situation persists despite the requirement for minimally adequate supervision to address power dynamics effectively (Ellis et al., 2014). Although the principle of “do no harm” is emphasized in client care by organizations such as the ACA (2014) and CACREP (2015), this principle is less rigorously applied to the clinical supervision of supervisees. There remains limited consensus and understanding regarding clinical supervisory practices.

Through this research, I aimed to inform this area of study and increase information to access in hopes of helping to address the needs of minority supervisees within clinical supervision dynamics. The findings from this research have the potential to foster social change by illuminating societal issues through the narrative of experiences shared by racial and ethnic minority supervisees, thereby contributing to a broader understanding of these issues (see Starr, 2010). There is a need for increased attention to the experiences of racial and ethnic minority supervisees, particularly concerning cultural dynamics and racial and ethnic minority supervisees’ personal and professional identity

within the clinical supervisory relationship (Wilcox et al., 2022). Exploring qualitative inquiry could be instrumental in capturing how clinical supervisors' cultural humility and engagement with cultural opportunities affect racial and ethnic minority supervisees' experiences by informing the experiences of racial and ethnic minority supervisees. Understanding these experiences may inform a better understanding of personal and professional influences, relational dynamics, and racial and ethnic minority supervisee satisfaction within the clinical supervision relationship (Wilcox et al., 2022). This perspective aligns with Cartwright's (2019) observation that there is a lack of research focusing on the experiences, narratives, and interpersonal processes of supervisees.

Summary

In this section, I summarized the main points of this chapter, and I provide a transition for the next chapter (see Peoples, 2021). Although clinical supervision is an imperative practice that requires detail and skill on the part of the clinical supervisor, there is little knowledge of the racial and ethnic minority supervisee experience within this dynamic. The ethical mandate of "do no harm" is firmly established to apply to counselors' work with clients; however, this same mandate is not as firmly established within the clinical supervision relationship between clinical supervisor and racial and ethnic minority supervisee. Gaining insight into this dynamic may inform the personal aspects related to racial and ethnic minority supervisees, as well as the professional aspects related to the clients these racial and ethnic minority supervisees serve in the counseling profession. Through this hermeneutic phenomenological study, I aimed to elucidate the experiences of racial and ethnic minority supervisees, focusing on the

importance of the culture of the counseling profession and broaching within the clinical supervision dynamic. By gaining more insight into this area of study, there may be an opportunity to inform a deeper comprehension of how current supervisory practices affect racial and ethnic minority supervisees for the development of more inclusive and effective supervision practices.

Chapter 2: Literature Review

Clinical supervision is a critical aspect of counselor training, encompassing education, feedback, and gatekeeping processes as counselors work toward independent licensure (Bernard & Goodyear, 2019). Although counselors are ethically mandated to do no harm in client care (ACA, 2014), this mandate is not always extended to the clinical supervisory relationship that governs clinical practice. Racial and ethnic minority supervisees and faculty frequently report experiencing microaggressions, including intentional and unintentional verbal, behavioral, and/or environmental degradations directed toward people of color (D. W. Sue et al., 2008), in educational and agency training settings, perpetrated by peers, faculty, and clinical supervisors (Curtis-Boles et al., 2020; McNamara et al., 2017; Nair & Cain Good, 2021; R. Wong & T. Jones, 2018). These microaggressions, if left unaddressed, can lead to mental health distress, isolation, emotional withdrawal, and a compromised learning environment (Curtis-Boles et al., 2020; R. Wong & T. Jones, 2018).

To practice effective clinical supervision, clinical supervisors are required to engage in the process of broaching or discussing the cultural and racial factors influencing client concerns (Day-Vines et al., 2007; Day-Vines et al., 2021). However, broaching is infrequently integrated into current clinical supervision practices (Bayne & Branco, 2018), and its absence, along with a lack of cultural competence, can harm the supervisory relationship and client outcomes (Haskins et al., 2013; C. T. Jones et al., 2019; L. C. J. Wong et al., 2013). Racial and ethnic minority supervisees, in particular,

may face persistent racism and oppression that further undermine their well-being and affect the counseling dynamic (Bernstein, 2021).

In this literature review, I examined the dynamics of clinical supervision from the perspective of racial and ethnic minority supervisees, with hopes of revealing how current practices can affect their professional development and mental health. In this review, I explored the historical context of clinical supervision and cultural competence, the systemic inequalities affecting racial and ethnic minority supervisees, and the harmful practices that may perpetuate these challenges. By identifying gaps in the existing literature, I sought to provide insight for necessary support for racial and ethnic minority supervisees and their clients.

Literature Search Strategy

My search strategy involved retrieving scholarly books and research articles from reputable databases, including EBSCO Discovery, SAGE Journals, ProQuest Digital Dissertations, and Google Scholar, available through Walden University. Keywords used in the search included *multicultural humility*, *cultural humility*, *cultural sensitivity*, *cultural responsiveness*, *cultural awareness*, *multicultural counseling competence*, *multicultural competence*, *multicultural supervision*, *multicultural orientation framework*, *culturally competent supervision*, *cultural sensitivity*, *broaching*, *harmful supervision*, *ineffective supervision*, *abusive supervision*, *effective supervision*, *cross-cultural supervision*, *gatekeeping*, *post-graduate supervision*, and *do no harm*. Additionally, references from the bibliographies of articles reviewed were included in the

search process. Inclusion criteria were limited to peer-reviewed publications from the past 5 years.

Theoretical Framework

Phenomenology is a qualitative research approach through which researchers explore individuals' lived experiences to understand the meaning of a phenomenon through shared themes (Neubauer et al., 2019; Prosek & Gibson, 2021). By exploring phenomenon from the perspectives of those who have directly encountered that phenomena, researchers using phenomenology as a theoretical foundation are able to provide insights into the “how,” “what,” and “why” of individual experiences, revealing the psychological, cultural, and social factors that shape behaviors, emotions, and cognitions (Alhazmi & Kaufmann, 2022; Prosek & Gibson, 2021). This approach allows for a deeper understanding of complex human experiences, fostering empathy and improving client welfare (Prosek & Gibson, 2021).

Heidegger posited that our understanding of reality is shaped by our “lifeworld,” encapsulated in the concept of *Dasein* (Peoples, 2021). The hermeneutic circle, a process of integrating new insights into existing knowledge, is closely aligned with *Dasein*, allowing researchers to facilitate the exploration of the complexities of lived experiences (Alsaigh & Coyne, 2021; Suddick et al., 2020). The fusion of horizons, integral to the hermeneutic circle, allows for engagement with multiple worldviews simultaneously (Alsaigh & Coyne, 2021).

The hermeneutic circle is an ongoing process through which understanding of being, or *Dasein*, unfolds (Gadamer, 1976). This process is influenced by time and

history, with meaning derived from the interaction of parts and the whole, as understanding of one illuminates the other (Gadamer, 1976). This interplay suggests that an understanding of clinical supervision, for example, is incomplete without examining the experiences of racial and ethnic minority supervisees. Knowledge and understanding are interconnected, with interpretation shaped by both the nature of a phenomenon and its purpose (Gadamer, 1976).

Interpretation, as a circular process, adds depth to common knowledge and requires ongoing reflection; reflection, in turn, involves questioning assumptions and developing more nuanced perspectives (Gadamer, 1976). Time is not static and is experienced through the lens of past, present, and future, with a person's mood and disposition emerging from being-in-the-world (Gadamer, 1976). Gadamer, while influenced by Heidegger's rejection of a distinct "I" or "other," emphasized the importance of otherness, asserting that openness to differing perspectives fosters curiosity and strengthens a person's views (Gadamer, 1976). Engaging with alternative experiences challenges our assumptions and deepens self-reflection, avoiding the reinforcement of echo chambers (Gadamer, 1976).

This research draws on the hermeneutic circle to highlight the unique experiences of individuals—*Dasein*—within established phenomena, enriching the understanding of clinical supervision by revealing new dimensions of these experiences. Furthermore, this approach aligns well with my intended study purpose and research question, which are designed to be open-ended to encourage the nuanced lived experiences of study

participants to be stated in their own, unique ways, further enhancing epistemological understandings as a result (Macgregor et al., 2023).

Literature Review Related to Key Variables and/or Concepts

In this section I review a variety of factors that are associated with the phenomenon being explored. This includes, and is not limited to, historical context of clinical supervision, clinical supervision dynamics, factors that can affect minority supervisees, and factors that can influence minority clients within the mental health counseling profession. Collectively, these areas provide a foundational understanding of the contextual and relational elements that inform the experiences of racial and ethnic minority supervisees within clinical supervision.

Defining Clinical Supervision

Clinical supervision is a critical practice in counseling, which allows clinical supervisors to bridge the gap between theoretical knowledge and practical application, while ensuring high-quality client care through effective gatekeeping and feedback (Bernard & Goodyear, 2019; Koçyiğit, 2022). Clinical supervision is a vital aspect of the development of supervisees, through clinical supervisors supporting supervisee progress toward independent licensure; however, it also involves an inherent power differential, as clinical supervisors influence recommendations for licensure decisions, gatekeeping, and clinical practices (Bernard & Goodyear, 2019). Effective clinical supervision requires clinical supervisors to maintain collaboration, safety, and flexibility to meet the individualized needs of supervisees (Koçyiğit, 2022; Roscoe et al., 2022).

Despite its widespread use across health and social science disciplines, there is a lack of a universally accepted definition and framework of clinical supervision, complicating its implementation (Bernard & Goodyear, 2019; Roscoe et al., 2022). Currently, the most widely accepted definition of clinical supervision consists of clinical supervisors with relevant clinical and clinical supervisory experience, approved by licensure boards, to guide supervisees who are working with clients and seeking independent licensure (Bernard & Goodyear, 2019). Variations in terminology and practices across disciplines, each with distinct ethical codes, complaint processes, and scope, further challenge standardization (Bernard & Goodyear, 2019). Addressing these inconsistencies is essential to improving the effectiveness and consistency of clinical supervision and, by extension, enhancing client care (Bernard & Goodyear, 2019).

Historical Evolution and Key Models of Clinical Supervision

Clinical supervision, once viewed as a natural extension of counseling experience, is now recognized as a distinct process requiring specialized training (Falender, 2018; Spowart & Robertson, 2024). The Association for Counselor Education and Supervision [ACES] formalized this distinction in 1990, emphasizing the need for training, credentialing, and licensure (Borders et al., 2014). Although culturally sensitive clinical supervision models exist, such as those by Ladany et al. (2015) and Ancis and Ladany (2001), many clinical supervisors remain unfamiliar with these approaches (Roscoe et al., 2022). Moreover, traditional models, often rooted in White, Eurocentric, westernized, middle-class perspectives, are not always applicable to diverse populations (Constantine & D. W. Sue, 2007).

Clinical supervision training, which began in the 1980s, initially consisted of trainers focused on psychotherapy-based models, integrating theoretical orientations with developmental needs (Bernard & Goodyear, 2019). While collaboration and teaching are prioritized in these models, they differ from psychotherapy interventions by including evaluative components and the clinical supervisor focusing on client welfare (Fickling et al., 2019). Developmental models, popularized in the 1980s, include the clinical supervisor addressing professional competence, yet often overlooking cultural differences (Bernard & Goodyear, 2019). Newer models, like the Discrimination Model and Synergistic Model for Multicultural Supervision, include the clinical supervisor aiming to address multicultural awareness and skill remediation; however, the foundation of these models also includes an assumption of the clinical supervisors' competence in these areas (Bernard & Goodyear, 2019) despite the potential for limited training in cultural awareness (Roscoe et al., 2022).

Despite the development of models that challenge traditional hierarchical structures, many clinical supervisors lack training in these approaches (Bernard & Goodyear, 2019; Ladany et al., 2013). The clinical supervisory relationship is shaped by supervisors' and supervisees' personal and professional experiences, orientations, interpersonal dynamics, and cultural values (Bernard & Goodyear, 2019). Many clinical supervisors apply techniques filtered through their preferred counseling orientation, and/or based on their own clinical supervision experiences—whether positive or negative (Koçyiğit, 2022), both of which potentially limit the adaptability of clinical supervision to the comfort and needs of the clinical supervisor over those of the supervisee and client

(Bernard & Goodyear, 2019). This lack of alignment with effective and ethical clinical supervisory standards often results in deficit-focused practices that fail to address the complexities of supervisee and client concerns (Koçyiğit, 2022). Despite its importance for professional identity development, inconsistent training remains a significant challenge in clinical supervision (Herbert, 2016). Additionally, current clinical supervision models have been designed to primarily focus on evaluation of supervisees, with insufficient pedagogy to prepare doctoral students for the complexities of clinical supervisory roles (Broadwater et al., 2022).

Core Components and Objectives of Clinical Supervision

Meta-competence and competence are both essential for effective clinical supervision. Meta-competence refers to advanced skills that licensed mental health professionals develop through formal training and clinical supervision (Bernard & Goodyear, 2019), while competence involves knowledge, performance, and outcomes (Falender et al., 2004). Although these competencies are expected of licensed professionals, many clinical supervisors lack formal training in clinical supervision, despite being tasked with guiding supervisees toward proficiency in these areas (Bernard & Goodyear, 2019; Falender et al., 2004). The assumption of a natural progression of these developed skills without intention mirrors previous thoughts of the natural progression from counselor to clinical supervisor, which have since been identified as misinformation (Falender, 2018; Spowart & Robertson, 2024).

Clinical supervision is integral to shaping the professional identity and skills of supervisees, but it remains a complex and multifaceted process, involving personal

biases, cultural values, and interpersonal dynamics (Bernard & Goodyear, 2019; Koçyiğit, 2022). Clinical supervisors play a vital role in shaping professional identity and various skills of supervisees, particularly in counseling and clinical supervisory contexts (Herbert, 2016). Similar to counseling practices, there is no universal “right” in implementation of clinical supervision and the processes are extremely complex. Simply put, we are complex people, with our own biases, experiences, worldviews, inter- and intrapersonal styles working with others who are unique in the same (Bernard & Goodyear, 2019; Koçyiğit, 2022).

Fiscalini (1997) embodied this complexity perfectly, having stated, “...the supervisory relationship is a relationship about a relationship about other relationships... (where) the supervisee is constantly interacting and relating with the supervisor in the process” (p. 30). Some complexity of clinical supervision includes the moving parts and separate yet intersected dynamics of the clinical supervisory relationship, supervisee development, and client care (Wilcox et al., 2022). In fact, a struggle for novice therapists, and arguably clinical supervisors of varying developmental levels, is the need to quickly adjust to the changing needs within the complex relational context of the clinical supervision dynamic (Friedlander, 2012). Supervisors-in-training must learn to navigate this complexity, including learning clinical supervision models, ethical practices, and cultural competencies (Borders et al., 2014). However, many clinical supervisors receive insufficient training in these areas, particularly in providing ongoing formative feedback or meta-supervision (Bernard & Goodyear, 2019).

Evaluation

Evaluation is a critical but often misunderstood aspect of clinical supervision; one that distinguishes clinical supervision from counseling and teaching (Bernard & Goodyear, 2019). Many clinical supervisors view evaluation as a one-time event, but it should be viewed as an ongoing process involving formative feedback that is culturally sensitive, goal-oriented, and action-driven (Bernard & Goodyear, 2019). While timely, constructive feedback is essential for multicultural supervision by way of contribution to competence in skills (L. C. J. Wong et al., 2013), unclear and destructive feedback, such as microaggressions or judgmental comments, can undermine the clinical supervisory process by contributing to negative supervisory experiences, affecting both clients and supervisees (Ammirati & Kaslow, 2017; Constantine & D. W. Sue, 2007; Ramos-Sánchez et al., 2002). Researchers have identified that supervisees' self-evaluations often differ from clinical supervisors' assessments in terms of expression, emotionality, and cultural value orientations (Helms, 1982, as cited in D. A. Cook & Helms, 1988).

Black trainees, in particular, often perceive their clinical supervisors as reluctant to provide constructive feedback due to concerns of appearing racist (Constantine & D. W. Sue, 2007), which often contributes to the supervisee seeking support, guidance and validation from peers while relying on clinical supervisors solely to approve licensure hours (Reiser & Milne, 2017). Furthermore, lack of effective and constructive feedback can influence supervisees' self-efficacy and confidence in working within the mental health profession due to the supervisee perceiving doubt from the clinical supervisor that is in place to guide and foster professional growth and development (Morrison & Lent,

2018). The hesitation of clinical supervisors to provide effective feedback may reflect implicit biases that influence evaluative processes (Constantine & D. W. Sue, 2007). Decision-making in evaluation, shaped by personal belief systems according to a values-based perspective (Levitt & Moorhead, 2013), underscores the importance of examining potential values and biases. However, most ethical decision-making models fail to consider the influence of culture and worldview (Trahan & Lemberger, 2014), despite evidence that race and ethnicity influence ethical decisions for racial and ethnic minority supervisors (Levitt et al., 2022).

Currently, the ACA code of ethics (2014) leaves the selection of decision-making models to the individual practitioner (Letourneau, 2016), and the *ACA practitioner's guide to ethical decision making* (Forester-Miller & Davis, 1996) does not include the complexities of situational context (Letourneau, 2016). Moreover, biases such as leniency, strictness, or central tendency can distort evaluations, hindering both clinical supervisor and supervisee development (Bernard & Goodyear, 2019; Gonsalvez & Freestone, 2007). Overall, little attention has been given to how evaluation and assessment of professional skills and competencies may be influenced by cultural values, norms, perspectives, and worldviews (Goodrich & Shin, 2013).

Balance of Administrative and Clinical Tasks

Clinical supervisors manage multiple responsibilities, including administrative tasks, client care, and supervisee development (Bernard & Goodyear, 2019). These roles intersect with formative (professional development), normative (client welfare and gatekeeping), and restorative (preventing burnout) aspects of clinical supervision (Joshua

Bradley & Becker, 2021). Despite the importance of restorative outcomes, such as supervisees preventing burnout, many clinical supervisors still focus primarily on formative and normative functions, although a strong clinical supervisory relationship is seen as a protective factor against burnout (Fukui et al., 2019). More specifically, faculty clinical supervisors within educational settings focus on formative domain tasks, while site clinical supervisors at agencies for direct client care focus on normative domain tasks (Joshua Bradley & Becker, 2021). Additionally, the overlap of clinical and administrative roles often complicates clinical supervisory practices, particularly when communication between agencies and academic institutions is lacking (Bernard & Goodyear, 2019; L. C. J. Wong et al., 2013). For example, site clinical supervisors may hesitate to document trainee competence issues due to concerns about potential legal repercussions if such reports are shared with faculty clinical supervisors and academic programs (Dean et al., 2018). CACREP (2024) encourages orientation for site clinical supervisors to ensure they understand the academic program's professional requirements and expectations (4.I). However, confusion often arises regarding privileged information and the potential for remediation when competence issues emerge (Dean et al., 2018). While site and faculty supervisors share responsibility for evaluation, gatekeeping, and professional development, their roles and focuses differ (Dean et al., 2018).

Gatekeeping

Gatekeeping, an essential aspect of clinical supervision, ensures that supervisees meet professional standards (Bernard & Goodyear, 2019). However, clinical supervisors must navigate ethical challenges, such as conflicts of interest and cultural competence, to

avoid exploitation and maintain appropriate boundaries (Fly et al., 1997). Gatekeeping concerns often stem from clinical supervisors' perceptions of problematic behaviors, attitudes, and characteristics that may affect a supervisee's competency (Brown-Rice & Furr, 2015). These perceptions, often shaped by Eurocentric standards (Constantine & D. W. Sue, 2007), can disadvantage racial and ethnic minority supervisees. Faculty members from privileged backgrounds, who frequently serve as clinical supervisors, may act as gatekeepers for supervisees from marginalized groups (Goodrich & Shin, 2013). This is supported by a study in which 75% of faculty and 74% of students ($N = 335$) reported observing professional competence issues among colleagues and peers (Brown-Rice & Furr, 2015). Although the ACA code of ethics (2014) includes an outline of guidelines for gatekeeping of students and supervisees, it does not address gatekeeping of faculty and counselor educators (Brown-Rice & Furr, 2015).

Informed consent is essential to ensure supervisees understand their responsibilities and expectations (Bernard & Goodyear, 2019). Ethical breaches, such as inadequate documentation or failure to provide timely feedback, can compromise the supervisory process and lead to legal consequences (Bernard & Goodyear, 2019). While some legal cases have arisen from trainee dismissals due to cultural disagreements in clinical practice (e.g., *Keeton v. Anderson-Wiley*, 2011; *Ward v. Wilbanks*, 2009), scholars within the literature have rarely addressed the connection between evaluation and cultural differences (Goodrich & Shin, 2013). The standards of the mental health profession are often filtered through Eurocentric lenses (Constantine & D. W. Sue, 2007), complicating the balancing of personal, collectivist, and cultural values for racial and

ethnic minority clinical supervisors and supervisees (Levitt et al., 2022). Consequently, racial and ethnic minority professionals often lack clear guidance in training or literature (Levitt et al., 2022), with Black therapists expressing a need for mentors familiar with the nuances of Black identity (Goode-Cross & Grim, 2016).

Gatekeeping decision-making is systemic, involving layered considerations at both micro and macro levels (Goodrich & Shin, 2013). However, authors of the *ACA practitioner's guide to ethical decision making* (Forester-Miller & Davis, 1996) positioned decision-making as the responsibility of a single actor, rather than acknowledging its systemic nature (Letourneau, 2016). Counselor education programs themselves can be seen as multifaceted systems, with gatekeeping requiring attention to various interconnected factors (Goodrich & Shin, 2013; Letourneau, 2016). Despite this, exploration of contextual factors which influence evaluation and gatekeeping remains underdeveloped (Goodrich & Shin, 2013).

Ethical Effectiveness of Clinical Supervision

Despite the growing body of research on effective clinical supervision, there is less focus on harmful or ineffective clinical supervision (Cartwright, 2019). Additionally, inconsistencies between site and university clinical supervisors regarding ethical issues, such as the previously mentioned concerns regarding site clinical supervisors' hesitancy to document identified problems of professional competence for the student trainee/supervisee (Dean et al., 2018), can create confusion for supervisees and hinder the supervisees' professional development (Lee & Cashwell, 2001). Ultimately, the effectiveness of clinical supervision hinges on the clinical supervisor's ability to navigate

the complexities of the clinical supervisory relationship, such as managing personal biases, cultural values, and interpersonal dynamics (Bernard & Goodyear, 2019; Koçyiğit, 2022); addressing the clinical supervision and counseling relationships as separate yet intertwined dynamics (Fiscalini, 1997); implementing effective clinical supervision models within clinical supervision, training the supervisee how to implement effective counseling models within the counseling relationship, conduct ethical practice, and maintain a culturally humble stance (Bernard & Goodyear, 2019; L. C. J. Wong et al., 2013); balance formative, normative, and restorative domains for supervisee and client welfare (Joshua Bradley & Becker, 2021); conduct ethical decision-making for client care support and supervisee evaluation within the context of gatekeeping (Bernard & Goodyear, 2019); address diverse cultural needs, and foster a supportive and ethical learning environment (Bernard & Goodyear, 2019).

The ACA code of ethics (2014) includes limited acknowledgement regarding faculty and clinical supervisors responsibility to address personal concerns and ethical behaviors (Brown-Rice & Furr, 2015), although there is stark consideration of counselor's responsibility to address these areas (A.4.b., C.2.g., F.8.d.). Following current ethical competence practices, clinical supervisors and faculty may teach counselors *what* to think instead of *how* to think (Falender & Shafranske, 2007). This approach places emphasis on correct and incorrect decisions yet fails to explore and address nuance in context of circumstances (Falender & Shafranske, 2007), such as varying values, beliefs, and cultures (Levitt et al., 2022). Continuing education, without focusing on personal and professional identities informing each other through personal(al)-as-profession(al)

(Middleton et al., 2011) growth, perpetuates limited quality of client care (Falender & Shafranske, 2007).

Although ethical codes, such as the ACA code of ethics (2014), were designed to acknowledge multicultural counseling, the integration of sociopolitical and sociocultural considerations remains slow (Pettifor, 2001). The Hippocratic oath, established in 400 B.C. as the first known professional code, introduced the ethical principle of “do no harm,” a foundation that continues to influence ethical standards in the medical and social science professions (Perkin, 1980; Askitopoulou & Vgontzas, 2018a). Harm, as conceptualized in these ethical frameworks, encompasses both inadvertent harm from applying correct treatments and harm from the negligent application of incorrect treatments, representing an intersection of moral and legal concerns (Jonsen, 1978). Over time, contemporary care has become increasingly influenced by socioeconomic factors, which has contributed to limited access to quality care for marginalized communities (Askitopoulou & Vgontzas, 2018a).

The development of regulatory standards, such as informed consent, are primarily aimed at protecting both clients and professionals, rather than establishing a theoretical ethical foundation (Pettifor, 2001). The APA a leader in western psychology, adopted the first ethical code, followed by the ACA for the counseling profession in 1961 (Firmin et al., 2019; Pettifor, 2001). Critics argue that ethical codes are ethnocentric, shaped by the dominant culture’s values, which can lead to the acculturation of those outside the cultural norm (Bersoff, 1995; Pedersen, 1995, 1997). For example, the diagnostic criteria in the Diagnostic and Statistical Manual of Mental Disorders [DSM] reflects a

Eurocentric worldview, often overlooking cultural, religious, and spiritual practices outside the Eurocentric paradigm (Pettifor, 2001). This emphasis on western individualism can conflict with collectivist cultural perspectives, resulting in forced acculturation where individuals must abandon their cultural identities for societal acceptance (Pettifor, 2001). Thus, while diversity is promoted within the ACA code of ethics (2014), further training and support are necessary to ensure equitable, culturally sensitive care that bridges differing worldviews (Pettifor, 2001).

The term multiculturalism encompasses the complex and diverse nature of culture, which challenges the universalistic models of human behavior often used in psychology (Pedersen, 1991). A narrow definition of culture, focusing on race, ethnicity, and sociocultural heritage, provides a more specific lens for understanding the sociocultural and sociopolitical experiences of racial and ethnic minorities in the U.S. (Pedersen, 1991). Broad definitions of culture, which include variables such as age, sex, and socioeconomic status, may overlook the nuances of specific cultural identities (Pedersen, 1991). For this current study, a narrow definition of culture will be used to explore the experiences of racial and ethnic minorities in the American context.

Clinical Supervisory Relationships and Dynamics

The quality of the clinical supervisor-supervisee relationship, shaped over time, significantly influences the development and application of professional skills (Bernard & Goodyear, 2019). This underscores the importance of relational factors in contemporary clinical supervision models, especially considering the reduced autonomy of supervisees to choose clinical supervisors compared to clients choosing therapists

(Bernard & Goodyear, 2019; Fickling et al., 2019). Helping professionals, including counselors and clinical supervisors, bring personal experiences and biases into their work (i.e., personal attachment styles influencing clinical supervision relational dynamics) (Bennett et al., 2008), which can influence interactions with clients and supervisees (Middleton et al., 2011). Personal (informal) and professional (formal) critical incidents can significantly shape the development of multicultural counseling competency for White American counseling professionals (Delsignore et al., 2010), highlighting the importance of both personal and professional factors in clinical supervision. In this context, clinical supervisors' perceptions of supervisees' abilities—known as other-efficacy—can influence supervisee self-efficacy and the supervisory working alliance (Morrison & Lent, 2018). Moreover, co-created spaces between clinical supervisors and supervisees foster openness and vulnerability, enhancing both the supervisory alliance and self- and other efficacy (Safran & Kraus, 2014).

Parallel Process

A critical concept in clinical supervision is the parallel process, where relational dynamics in one dyad (clinical supervisor-supervisee or supervisee-client) are mirrored in the other (Bernard & Goodyear, 2019). In other words, parallel process occurs when a supervisee, consciously or unconsciously, adopts the clinical supervisor's or client's behaviors and perceptions within the counseling or supervision dyads (Drinane et al., 2021). While this can be constructive in spaces where equitable care is modeled, it can also perpetuate cultural concealment and harm if negative modeling occurs (Drinane et al., 2021). Negative supervisory experiences can undermine a supervisee's self-efficacy

and confidence, potentially damaging the counseling relationship (Ramos-Sánchez et al., 2002). Though not universally present in all clinical supervisory relationships (Zetzer et al., 2020), parallel process is common and should be made conscious by the clinical supervisor, especially in the context of culturally attuned clinical supervision (Sarnat, 2019; Zetzer et al., 2020).

Supervisee Nondisclosure

Self-disclosure, by supervisees and clinical supervisors, is integral to the clinical supervision process as it fosters warmth and empathy—key skills counselors are encouraged to demonstrate with clients (Boyle & Kenny, 2020). Clinical supervisors expect supervisees to disclose relevant information, such as mental health history, that may affect therapeutic effectiveness (Pisani, 2005; Boyle & Kenny, 2020). Such disclosures help clarify the balance between personal and professional aspects, reinforcing the concept of “persons-as-professionals” (Middleton et al., 2011).

While therapist self-disclosure can enhance the counseling dynamic, clinical supervisor self-disclosure may be perceived as inappropriate by supervisees (Mehr & Daltry, 2021). Conversely, supervisee nondisclosure—when supervisees withhold information from clinical supervisors—often occurs when the supervisory working alliance, defined as the collaborative bond and agreement on goals (Bordin, 1983), is weak. Factors such as the clinical supervisor’s cultural competence or humility can significantly influence the likelihood of supervisee nondisclosure (R. M. Cook et al., 2020; Hutman & Ellis, 2019). Supervisee nondisclosure can serve as a protective

mechanism for both the supervisee and their clients, particularly in contexts where cultural humility is perceived as low (Ertl et al., 2023).

A strong clinical supervisory alliance fosters supervisee self-disclosure, but it requires additional elements such as modeling, validation, and clarification (Staples-Bradley et al., 2019). Lack of these elements may lead supervisees to withhold information to avoid disrupting the clinical supervisory relationship (Staples-Bradley et al., 2019). Supervisees often adjust their behavior to make their clinical supervisors more comfortable, which may include concealing their cultural identities and avoiding discussions about clients' cultural backgrounds (Drinane et al., 2021; Morgan, 2018; Nelson & Friedlander, 2001). This cultural concealment, whether focused on the supervisee or the client, is linked to dissatisfaction with the supervisory dynamic (Drinane et al., 2021). Withholding such information (e.g., cultural identity and client cultural background) hinders effective evaluation and can result in questionable client care (Drinane et al., 2021; Reiser & Milne, 2017). Supervisees may perceive a lack of safety in discussing cultural concerns if supervisors dismiss and/or indirectly discourage these topics (Drinane et al., 2021).

Power Dynamics Within Clinical Supervision

The inherent power dynamics within clinical supervision further complicates the disclosure process. Newer counselors, particularly those at the master's level, often lack clear expectations of clinical supervision and tend to defer to their clinical supervisors, who may or may not address power dynamics within the clinical supervisory relationship (R. M. Cook et al., 2018). Ignoring these dynamics, particularly in terms of privilege and

discrimination, can perpetuate harmful behaviors (Ladany, 2014). A rigid clinical supervisory approach that limits critical thinking and autonomy can hinder supervisee development (Ammirati & Kaslow, 2017), highlighting the need for responsiveness and flexibility from clinical supervisors (Friedlander, 2012, 2015).

Recognizing and addressing power differentials in clinical supervision, particularly in relation to racial and ethnic minority supervisees, is essential for fostering a supportive and ethical clinical supervisory environment (Reiser & Milne, 2017).

Clinical supervisors must navigate these complexities to promote both personal and professional growth. Researchers have shown that when clinical supervisors acknowledge their personal reactions within the clinical supervisory context, it enhances relational safety between the supervisee and clinical supervisor, thereby strengthening the clinical supervisory working alliance and facilitating further growth (Hagler, 2020).

Historical Context of Cultural Sensitivity

In this section, I describe the history of cultural competence and cultural humility, as well as institutional and systemic factors that can influence the clinical supervision profession and counseling field. This discussion highlights how evolving understandings of multiculturalism and social justice have shaped expectations for ethical and culturally responsive supervision practices. Additionally, it situates these developments within broader sociocultural and professional contexts that continue to inform the training, evaluation, and support of counselors and clinical supervisors.

Cultural Competence and Humility

Cultural competence, defined as the ongoing process of self-awareness, other-awareness, and advocacy in working with diverse clients, is integral to counselor education (Broadwater et al., 2022). It involves navigating the intersections of social contexts (e.g., discrimination, political unrest) and social identities (e.g., race, gender, sexual orientation) (Inman & Ladany, 2014). Initially developed in response to health disparities in marginalized groups, cultural competence gained traction in medical and nursing professions before extending to the counseling profession (Fisher-Borne et al., 2015). Unlike traditional competence frameworks, which focus on practitioners' comfort with others, the practice of cultural humility emphasizes self-awareness, flexibility, and accountability in addressing barriers (Fisher-Borne et al., 2015).

Cultural competence has expanded beyond self-awareness and skills to include supervisee-counselor development, clinical supervisor awareness, and the dynamic relationships between clinical supervisor, supervisee, and client. It also emphasizes the intersection of identities and socioenvironmental factors (Inman & Ladany, 2014; Sadowsky et al., 1994). However, systemic influences on cultural competence remain underexplored (Inman & Ladany, 2014). Multicultural and Social Justice Counseling Competencies [MSJCC], adopted by the ACA in 2015, provide a framework for addressing sociocultural dynamics in counseling and clinical supervision, but practical application remains challenging due to a lack of specific skills (Day-Vines et al., 2021; Fickling et al., 2019).

Cultural humility, characterized by an attitude of self-awareness and mutual learning, plays a critical role in the therapeutic alliance and clinical supervisory working alliance, allowing for professionals to reduce racial microaggressions, and facilitate relational repairs (Vandament et al., 2021; Zhu et al., 2021). Despite its importance, research on the theoretical development and influence of cultural humility is limited (Zhu et al., 2021). It is particularly vital for addressing relational ruptures in clinical supervision, especially when White supervisors work with racial and ethnic minority supervisees (Vandament et al., 2021). By demonstrating cultural humility, clinical supervisors can foster a positive working alliance and enhance supervisee cultural competence (Ladany et al., 1997; Watkins Jr. et al., 2019).

In counseling and clinical supervision, many argue that cultural competence and humility are interconnected, with an emphasis on a lifelong learning process of culturally responsive practices (Broadwater et al., 2022; Mosher et al., 2017; Patallo, 2019). Cultural competence development is seen as a shared responsibility among supervisees, clinical supervisors, and training programs, all of which are influenced by systemic and cultural contexts; however, systemic-based cultural influences on competence remain insufficiently addressed in the literature (Inman & Ladany, 2014). The ACA code of ethics (2014) includes a mandate for the inclusion of diversity and cultural considerations in all professional activities, including clinical supervision (F.11.c.). Effective broaching, or engaging in discussions about cultural issues, is essential for establishing cultural humility and preventing non-disclosure in clinical supervision (Day-Vines et al., 2021).

Influences of Cultural Sensitivity in Clinical Supervision and Outcomes

Competence in clinical supervision requires knowledge, skill, and the ability to achieve desired outcomes; however, many clinical supervisors lack formal training to foster these competencies (Falender et al., 2004). Despite the mandates from prominent professional organizations, such as the APA (2017), ACA (2014; A.2.c., B.1.a., C.5., E.5.b., E.8., F.2.b., F.11), National Board for Certified Counselors [NBCC] (2023), and CACREP (2024; 3.B., 6.B.1.d., 6.B.2.l., 6.B.3.l., 6.B.4.l., 6.B.5.l.), which include a requirement of the integration of multiculturalism into training and education, there remains a limited understanding of how to effectively implement these components within professional practice (Galán et al., 2024).

Supervisees, often unable to terminate clinical supervision relationships due to a lack of autonomy within the clinical supervisory relationship, may resort to nondisclosure as a coping mechanism when they perceive clinical supervisor incompetence, which can exacerbate harmful dynamics (Fickling et al., 2019). According to researchers, some clinical supervisors fail to address multicultural and social justice [MCSJ] issues, potentially leading to inadequate or damaging supervision (Ellis, 2017; L. C. J. Wong et al., 2013). The racial identity of clinical supervisors, particularly their awareness of racism and oppression, plays a critical role in shaping the clinical supervisory dynamic and the quality of clinical supervision, especially when clinical supervisors' racial ego statuses influence their interactions with supervisees (Helms, 1990; Ladany et al., 1997). White clinical supervisors, in particular, may lack cultural knowledge or adopt a color-blind approach, hindering effective clinical supervision (Constantine, 2001; Das et al.,

2024; Fuertes & Brobst, 2002). White faculty can also impose westernized, Eurocentric views, values, and expectations on racial and ethnic minority students (Goodrich & Shin, 2013). In contrast, Black counselors and clinical supervisors, who often face greater demands for cultural competence due to the diversity of clients they serve, may foster racial identity development in supervisees more effectively (Ladany et al., 1997). However, the limited number of Black and minority clinical supervisors may present a challenge for this effective development (see CACREP Vital Statistics, 2023).

The mental health and psychology professions operate within broader cultural contexts, with novice and minority supervisees often assimilating, or separating a person's culture to adopt the dominant culture (Bowskill et al., 2007), to be accepted within counseling culture, working with clients and clinical supervisors (Nilsson & Anderson, 2004; D. W. Sue & D. Sue, 2003). Attempts to separate microlevel contexts, such as the clinical supervision dynamic, from macrolevel contexts, such as the prevailing cultural atmosphere, can cause harm to supervisees on personal and professional levels (Upshaw et al., 2019) by aligning with a Eurocentric view and dismissing the reality faced by racial and ethnic minority supervisees.

Personal qualities and personality traits significantly influence counselors' selection and application of theoretical frameworks, as well as their clinical interactions (L. C. J. Wong et al., 2013). A counselor's life philosophy, shaped by their worldview, values, and culture, informs their theoretical orientation and approach, guiding their actions toward themselves and others (D. A. Halbur & K. V. Halbur, 2019). The counselor's life philosophy may be used to influence therapeutic goals, techniques, and

interventions. While this process is well-recognized in counseling, its role in clinical supervision remains underexplored. Counseling and clinical supervision dynamics are shaped by the counselor's worldview and belief systems (D. W. Sue & D. Sue, 1990), suggesting these factors can also significantly influence the clinical supervisory relationship. Researchers in one study found clinical supervisors were more likely to discuss clients' cultural identities than the supervisees' cultural identities or their perceptions of cultural factors, highlighting a gap in training on self-reflection and cultural considerations (Galán et al., 2024). The limitation regarding cultural training within mainstream psychology, which often centers on western ideologies, leaves counselors unprepared for diverse cultural contexts (Sodowsky et al., 1994). By instilling "one-size-fits-all," or all-encompassing models through western ideologies, racism and discrimination can be perpetuated (Levitt et al., 2022). This inadequacy in diverse training can contribute to professional distress, including feelings of incompetence, burnout, and career attrition (Therriault & Gazzola, 2008), specifically for racial and ethnic minority counseling professionals. Such stressors can further lead to relational ruptures within and emotional withdrawal from clinical supervision and counseling relationships, which may be exacerbated by experiential avoidance (Bernstein, 2021).

Similar to therapy, a safe and empathetic clinical supervisory relationship is crucial for effective clinical supervision (Sodowsky et al., 1994). Cultural worldviews, which reflect personal values, are shaped by individual experiences (Levitt et al., 2022). Although conversations about race, ethnicity, and culture can be challenging for many Americans, especially White Americans, they are essential for fostering cultural

competence and cultural humility among supervisees (Constantine, 1997; Utsey et al., 2005). In a study of 300 participants, researchers found that 76% of participants reported that racial and social justice issues, including diversity, equity, and inclusion, are not adequately addressed within program curricula (Galán et al., 2024). Moreover, when these topics are discussed, they are often confined to a single lecture or course (Galán et al., 2024). Researchers also indicated that implicit bias is prevalent in the general population and among counselor trainees (Boysen & Vogel, 2008), highlighting a parallel between microlevel (individual) and macrolevel (societal) contexts.

Addressing MCSJ Issues

The sociopolitical climate of the 1960s and 1970s, such as civil rights movements and advancements, influenced multicultural counseling competencies [MCC] (Mollen & Ridley, 2021), which preceded MSJCC. MSJCC, which are endorsed by the ACA (Ratts et al., 2015), offers broad considerations of guidelines (e.g., consider self-awareness and the client worldview) for counselors to provide culturally responsive care; however, lack of specific skills makes the practical application of broaching these areas difficult (Day-Vines et al., 2021). In other words, clinical supervisors-in-training who prioritize MCSJ issues often find alignment with their values but struggle with practical application due to insufficient training (Spowart & Robertson, 2024).

Presently, there is no clarity regarding definitions of MSJCC, as well as culture within these contexts, which all contribute to the complexity in application of these constructs (Hays, 2020). Graduate training programs that neglect these factors may result in clinical supervisors' difficulties in addressing MCSJ issues in practice (Jernigan et al.,

2010). Additionally, opinions vary on how cultural sensitivity is developed—some believe it can be cultivated through remediation, while others view it as an inherent disposition (Freeman et al., 2019). Novice clinical supervisors have often expressed uncertainty about addressing diversity, and even senior clinical supervisors have sought clearer guidance on how to broach these issues (King & K. Jones, 2019). The ACA (2014) emphasizes the importance of personal awareness and competence through supervised experience and training, noting that clinical supervisors must address interpersonal competencies that affect clients, the clinical supervisory relationship, and professional functioning (C.2.a.). Although the ACA code of ethics (2014) emphasizes that counselor values and biases do not overpower client needs (A.4.b.; Merrell-James et al., 2019), it is imperative self-reflection is encouraged for counselors, supervisees, faculty, clinical supervisors, and counselor educators to be aware of values and biases. Therapists and clinical supervisors develop competencies at varying rates, with basic clinical supervision skills typically acquired during graduate training; however, further requirements depend on specific regulatory bodies and state guidelines (Falender et al., 2004).

Empathy and a Color-Blind Approach

Empathy in clinical supervision, which involves understanding supervisees' and clients' worldviews, is essential but insufficient on its own to drive social justice advocacy (Das et al., 2024). A color-blind approach, which ignores racial differences, may result from clinical supervisors lacking self-awareness regarding biases (Constantine & D. W. Sue, 2007). This type of approach can lead to relational ruptures and harm

marginalized clients, violating ethical principles like non-maleficence (see ACA, 2014; Das et al., 2024). Counselors-in-training with color-blind racial attitudes often struggle to empathize with clients, which can perpetuate harm and hinder therapeutic progress (Constantine, 2001; Fuertes & Brobst, 2002). Furthermore, Eurocentrism or western ideals can produce culturally insensitive treatment recommendations that are inapplicable to diverse populations (Constantine & D. W. Sue, 2007).

Many scholars and educators have considered color-blind approaches to be a more subtle and modern form of racism that perpetuate the status quo of overt racism and White supremacy by allowing White Americans to express racial attitudes without challenge (Utsey et al., 2005). Individuals who adhere to these approaches assert that racial issues either do not exist or are unimportant, thus rendering such issues unable to be addressed or changed (Morgan, 2018). Furthermore, through use of color-blind perspectives, there is a reinforcing of a view of individuals through the lens of Whiteness, failing to recognize the richness and uniqueness within racial diversity (Fu, 2018). Moving beyond a color-blind approach requires not only acknowledging race and ethnicity, but also requires considering sociopolitical and sociocultural differences, as well as the historical and contextual factors that often shape experiences and worldviews (Morgan, 2018).

Institutional and Systemic Factors

Supervisees are socialized to view their clinical supervisors as authoritative figures who hold the expertise to evaluate their readiness for professional practice, reinforcing a hierarchical dynamic that often promotes the idea of assimilation within the

counseling profession (McNamara et al., 2017). This idea is echoed within university settings and academia, which can include a dominant culture that counselors and clinical supervisors often assimilate to (Henfield et al., 2012). Despite the noted importance of support and community with peers for successful academic program completion (Henfield et al., 2011), Black students may isolate and not acknowledge their true selves in order to assimilate to the culture in academic programs (Drinane et al., 2021; Morgan, 2018).

The clinical supervision dynamic is compounded by the APA's emphasis on the clinical supervisor's role in gatekeeping, which includes protecting the public through evaluation and oversight (Ellis et al., 2017). However, the complexity of clinical supervision challenges the notion that client care and supervisee development can be easily separated (Fiscalini, 1997). The ACA includes emphasis on client care, yet systemic factors have often led to clinical supervisory practices that prioritize organizational goals, including the culture of the organization, over supervisee and client well-being (Roscoe et al., 2022). The oversight provided by codes of ethics is intended to guide practice; however, social constructivism suggests that these codes are subject to interpretation due to their creation by multiple individuals (Cottone, 2001). The ACA code of ethics (2014), for example, mentions prioritization of client welfare (Section C., C.2.g.), but there is limited explicit mention of the welfare of the student within the context of clinical supervision, despite the potential influence of one's welfare on the other (Letourneau, 2016). Additionally, it has been argued that the definitions of therapeutic relationships within governing bodies, such as codes of ethics, require further

exploration to capture the nuance and complexity inherent in these relationships (Goode-Cross & Grim, 2016). For instance, the ACA code of ethics outlines the importance of maintaining professional boundaries (A.6.b) and ensuring clinical supervisor competence (F.7.a, F.7.b, F.7.c.), yet these guidelines may not fully account for the dynamic interplay between supervisee and client welfare within the clinical supervisory process. It can be argued that such considerations call for a more comprehensive examination of the therapeutic relationship, while acknowledging its multifaceted nature.

Many clinical supervisors have reported conflicts between administrative duties and clinical responsibilities, particularly when organizational systems dominate the clinical supervisory relationship (Thrower et al., 2020). Furthermore, clinical supervision requires specialized training, but such training is not universally mandated by licensing bodies, potentially contributing to a status quo that perpetuates existing systems on macro and micro levels without progressive change (Reiser & Milne, 2017). Presently, there continues to be limited research on ethical practices in clinical supervision and credentialing bodies often lack policies to address the ethical dilemmas clinical supervisors and supervisees face (Lee & Cashwell, 2001).

Addressing racial and systemic inequalities within clinical supervision is essential, as power dynamics, stress, and racial trauma (Pieterse, 2018) can influence the clinical supervisory working alliance (Taylor & Ellis, 2023). Clinical supervisors, particularly those from racial and ethnic minority backgrounds, who advocate for social justice often experience negative institutional consequences, including isolation and emotional withdrawal (Thrower et al., 2020). White clinical supervisors, in contrast, may

avoid discussing race, reflecting a regressive institutional climate that stifles necessary conversations about racial identity and cultural competence (Thrower et al., 2020). These regressive dynamics, where the clinical supervisor's racial identity status lags behind that of the supervisee, can harm supervisees, particularly Black and other racial and ethnic minority supervisees, potentially leading to feelings of incompetence, isolation, and confusion (Jernigan et al., 2010). 100% of 300 doctoral-level clinical psychology graduate students reported there being no assessment of clinical supervisors' progress toward cultural humility (Galán et al., 2024). This report perpetuates the traditional clinical supervision stance in which the clinical supervisor is the all-knowing expert in place to teach the less informed supervisee.

The limited effective mechanisms to report and address harm experienced by racial and ethnic minority supervisees further perpetuate systemic inequalities, resulting in a lack of accountability and continued harm (Ammirati & Kaslow, 2017). Consequently, supervisees, particularly racial and ethnic minority supervisees, often rely on peers for support and may adjust their behaviors to appease clinical supervisors and secure clinical hours or licensure approvals (Reiser & Milne, 2017). Black therapists expressed feeling insufficiently prepared by their academic training programs to effectively address nuances related to working with other Black people as clients (Goode-Cross & Grim, 2016). These clinical supervisory dynamics often mirror broader societal structures of inequality, Eurocentrism, and White supremacy, underscoring the need for a more inclusive and accountable approach to clinical supervision (Hyttén & Bettez, 2011).

Racial Identity Development

Understanding the clinical supervision experiences of Black and other racial and ethnic minority supervisees necessitates an exploration of the potential significance of racial identity, race, and racism. Racial identity, as outlined in Helms's racial identity theory (1990, 1995), consists of encouragement for marginalized individuals to recognize various forms of racism and oppression while addressing internalized racism and its effect on both personal and professional development. Racial identity, which influences multicultural counseling competency (Middleton et al., 2011), is imperative for shaping attitudes, values, and beliefs beyond race alone, acting as a protective factor against the psychological effects of racism-related stress (Neblett Jr. et al., 2012). Despite the increasing complexity of racial categorization due to multiracial identities (Jensen, 2021), racial identity development remains essential for culturally sensitive and ethically sound clinical supervision (Drinane et al., 2021; Jernigan et al., 2010). Presently, racial and ethnic minorities are viewed as the automatic experts of multiculturalism (Levitt et al., 2022). It can be argued that this mindset and approach undermine the significance of racial identity development because racial and ethnic minorities overall are not monoliths (Goode-Cross & Grim, 2016).

In the people of color model, Helms (1995) provided insight into a working model of thoughts, feelings, and behaviors related to experiences of racial stimuli for racial and ethnic minorities. These statuses range from the racial and ethnic minority individual not associating with specific racial terminology, to redefining internalized racist beliefs about self and others, to becoming aware of racial inequality and oppression while recognizing

strengths and weaknesses of all racial groups. Conversely, White racial identity development was distinguished as a separate process, including vicarious or direct awareness of Black individuals and other racial and ethnic minorities, White individuals reverting to Whiteness ideologies when cross-racial interactions are too painful and/or confusing, self-reflection to address a person's part in upholding racism and oppression through Whiteness ideologies, and ultimately no longer perceiving race as a threat (Helms, 1995). While these two models and processes are distinct, they both involve an immense amount of self-reflection and awareness with the opportunity to revert to previous comfort in ignorance.

White individuals, particularly in the United States of America, can often avoid confronting their racial identity, as noted by Terry (1981) —“To be White in America is not to have to think about it. Except for hard-core racial supremacists, the meaning of being White is having a choice of attending to or ignoring one's own Whiteness” (p. 120). This statement still holds true, with White individuals having expressed difficulty describing themselves as White and having reported an ability to identify race of others before themselves (Utsey et al., 2005). Furthermore, it is noted there can be lack of identity salience with privilege (S. R. Jones & McEwen, 2000) and identity salience can differ based on context due to intersectionality of all unique social identities (C. T. Jones et al., 2021). However, silence or inaction from Black and other racial and ethnic minority individuals in response to racial issues can perpetuate harmful stereotypes and uphold systemic inequalities (Curtis-Boles et al., 2020). On a macrolevel, Black Americans face a devaluation of their identity within western, American society (D. W.

Sue et al., 2008) and encounter a lack of diversity in educational systems (Perry et al., 2009). The growing demand for cultural competence in counseling education is driven by demographic shifts and the need to address systemic disparities in mental health care access for racial and ethnic minorities (Goodman et al., 2004). Presently, surface-level exploration of race-related topics is most common within counseling and clinical supervisory dynamics (Utsey et al., 2005).

On a microlevel, racial and ethnic minority supervisees at predominantly White institutions [PWIs] often experience racial hostility, tokenism, and cultural isolation, which mirror the macrolevel societal structures of White supremacy, Eurocentrism, and structural inequality (Curtis-Boles et al., 2020). These experiences often lead to feelings of powerlessness, alienation, and diminished self-efficacy (Curtis-Boles et al., 2020; Nair & Cain Good, 2021). Many marginalized students cope by disengaging from classroom participation or by internalizing their experiences (Curtis-Boles et al., 2020). In contrast, White students may either defend their perspectives or reflect on their role in perpetuating racial injustice (Dunn et al., 2022). These dynamics also extend to clinical supervision relationships, wherein supervisees, particularly from marginalized groups, may disengage as a coping mechanism (Curtis-Boles et al., 2020; Nair & Cain Good, 2021).

Professional identity, which encompasses both interpersonal and intrapersonal aspects, is shaped by personal characteristics and external factors such as societal experiences (Dollarhide et al., 2013). The creators of the person(al)-as-profession(al) transtheoretical framework posit that identity development is influenced by

sociohistorical contexts, including family, cultural exposure, and experiences of privilege and oppression (Middleton et al., 2011). Initially proposed by Delsignore et al. (2010) and later revised to include racial identity and personal attributes in the personal domain, with the counseling dyad as the professional domain (Middleton et al., 2011), the creators highlighted the interplay between personal and professional identities. The component of the personal domain significantly influences professional counseling practice (Middleton et al., 2011), and this dynamic can also be applied to clinical supervision. Understanding how sociocultural, racial, and sociohistorical factors shape self-awareness and perceptions of others is critical for both counseling and clinical supervision (Ratts et al., 2016). It is recommended that counseling professionals engage in self-reflection to identify biases and privileges, recognizing their potential influence on work with clients from diverse backgrounds (Utsey et al., 2005). This same reflective process is vital in clinical supervision, though it remains underexplored.

Racism and Microaggressions

Racism can manifest in three forms: individual racism, which is based on the belief in White superiority; institutional racism, through which economic and social advantages for White individuals are upheld by laws and policies; and cultural racism, through which Whiteness is embedded as the societal norm (Helms, 1995). Racial attitudes may be inherited from the history of racism within American society (Constantine & D. W. Sue, 2007) and racism occurs within a sociopolitical framework (Morgan, 2018). Microaggressions, often overlooked as trivial (Constantine & D. W. Sue, 2007), are often frequent experiences for racial and ethnic minority supervisees and

faculty, contributing to long-term mental and physical health effects (Wong-Padoongpatt et al., 2017). Microaggressions, such as color-blindness or statements like “people are people,” ignore the importance of race, ethnicity, and culture (Constantine & D. W. Sue, 2007). In counseling and clinical supervision, this manifests as applying traditional theories and techniques to diverse populations where they may be ineffective (Levitt et al., 2022). Such practices contribute to a color-blind approach within both contexts, which can be detrimental to racial and ethnic minority supervisees and clients (Hook et al., 2016). Furthermore, these experiences of microaggressions can perpetuate stereotypes and force minority individuals to educate others about racial misconceptions while enduring isolation themselves (Hubain et al., 2016).

Faculty members, especially those with dominant social identities, often perpetuate cultural ethnocentrism, marginalizing racial and ethnic minority students and faculty (Curtis-Boles et al., 2020). This lack of support can exacerbate the challenges racial and ethnic minority students often face, contributing to feelings of invisibility, fear, and disengagement (Curtis-Boles et al., 2020). Cultural differences, such as passivity and reservedness, were found to contribute to supervisees’ disengagement from clinical supervision due to the supervisee experiencing discomfort within clinical supervision settings (Curtis-Boles et al., 2020; L. C. J. Wong et al., 2013). Furthermore, the absence of racial dialogue in educational settings limits opportunities for addressing racial identity and microaggressions, resulting in unaddressed harm that undermines students’ wellbeing (Pasque et al., 2013; D. W. Sue et al., 2008), contributing to students experiencing helplessness, lack of safety, confusion, stress, and worry (L. C. J. Wong et al., 2013).

The underrepresentation and misrepresentation of racial and ethnic minorities in academic training contributes to internalized racism and psychological distress, affecting students' confidence and self-efficacy (Rasheed Ali et al., 2004; Willis et al., 2022). Although Black clients often prefer Black counselors (Shell et al., 2021), enrollment in counseling programs by Black students has decreased annually since 2020 (CACREP, 2020, 2021, 2022, 2023). Despite these challenges, many racial and ethnic minority students, who were historically marginalized from the counseling profession, are drawn to the counseling profession to advocate for social justice and challenge cultural inequities (Hannon et al., 2024). Black students in particular have been found to have the task of maintaining their safety, cultural identity, academic performance, and overall wellness, while yet enduring all forms of racism and oppression (H. A. Jones et al., 2018).

Race and Ethnicity Within Counseling and Clinical Supervision Dynamics

Black counselors often use collectivist language, such as “we” and “us,” when discussing the mental health of Black clients, reflecting a shared cultural perspective (Summers & Lassiter, 2021). This also aligns with highlighting the links between racism, race-related stress, burnout, and secondary trauma (Shell et al., 2021). Because Black clients often seek Black counselors, these counselors face an elevated risk of secondary traumatic stress, experiencing both their clients' race-related stress and their own (Shell et al., 2021). 87.74% of 300 doctoral-level clinical psychology graduate students expressed dissatisfaction with clinical training regarding treatment of racial trauma and effective ways to address racial discrimination (Galán et al., 2024), highlighting the

significance of this concern and the need for further support in training. Furthermore, Black counselors viewed engagement with clients as extending beyond traditional assessment and treatment, recognizing the influence of historical and ongoing oppression related to their clients' experiences (Summers & Lassiter, 2021). Black counselors may utilize techniques such as self-disclosure, drawing from their Black identity and in-group knowledge of Black American culture, to normalize Black clients' experiences and enhance their therapeutic relationships (Boyd-Franklin, 2003; Goode-Cross & Grim, 2016). This creates a unique dynamic that Black counselors may not experience with clients from other racial or ethnic groups (Goode-Cross & Grim, 2016). However, some Black client-counselor dyads may struggle to connect due to factors such as socioeconomic status, perceived therapist privilege, and differing views on racial identity (Boyd-Franklin, 2003; Goode-Cross & Grim, 2016). Additionally, it is important to consider intersectionality, as no group is homogenous (Goode-Cross & Grim, 2016).

While many researchers have focused on broaching related to White clinical supervisors, broaching is essential for counselors of all backgrounds (Bayne & Branco, 2018). Additionally, 81.7% of 2,000 clients report experiencing racial microaggressions during counseling (Hook et al., 2016) and 53% of 120 students reported experiencing microaggressions when seeking mental health services within a university setting (Owen et al., 2014), underscoring the widespread effects of microaggressions on both individual therapy and the broader dynamics of counseling and clinical supervision. Faculty members often lack respect for student differences and promote assimilation into program and mental health profession cultures, which leads students to conceal their true

identities (Henfield et al., 2012). These experiences can undermine the therapeutic alliance, fostering distrust within the relationship (Hook et al., 2016; Owen et al., 2014). A similar dynamic can be observed in counseling and clinical supervision, wherein the failure to address racism and the influence of White supremacy reinforces the status quo (Morgan, 2018). While microaggressions and the absence of race and culture-related discussions have been shown to negatively affect relational dynamics, the therapeutic alliance, and participant wellbeing (Galán et al., 2024), these effects within clinical supervision remain insufficiently explored.

Despite increasing attention to racial dynamics in clinical supervisory relationships, including the importance of cultural competence and addressing cultural issues, there remains a significant gap in research on the experiences of minority supervisees encountering harmful supervisory dynamics. This gap is particularly evident in post-graduate settings, where race, ethnicity, and culture are often overlooked. It can be argued that researchers within the current counseling supervision literature tend to adopt a cultural relativism perspective, rather than critically examining the effects of race and racism on individuals' psychological experiences (Morgan, 2018).

Harmful Clinical Supervision

Harmful clinical supervision refers to instances where supervisees experience physical, emotional, and/or psychological harm due to unethical practices by the clinical supervisor, such as sexual harassment, boundary violations, or microaggressions (R. M. Cook & Ellis, 2021; Ellis et al., 2014). Despite an ethical mandate to “do no harm” (ACA, 2014), harmful clinical supervision is underreported, unrecognized, and

inadequately addressed (McNamara et al., 2017). Ellis et al. (2014) distinguished harmful clinical supervision from inadequate clinical supervision, the latter referring to situations wherein clinical supervisors fail to meet minimal standards but do not directly cause harm. These minimal standards include competence in ethical practices, cultural awareness, and attention to power dynamics in the clinical supervisory relationship (Ellis et al., 2014). Harmful clinical supervision may include macro and microaggressions and a failure to address these issues, which can adversely affect the supervisee and their clients (Ellis et al., 2014).

The prevalence of harmful clinical supervision has ranged from 35% to 40% (Ellis et al., 2014; Hutman et al., 2023). Prelicensure supervisees, in particular, are at greater risk due to their hierarchical and disempowered position within the clinical supervision relationship (McNamara et al., 2017). Harmful clinical supervision can lead to issues such as moral distress, performance concerns, emotional dysregulation, and trauma responses, which negatively affect both supervisee development and client care (Ammirati & Kaslow, 2017; Reiser & Milne, 2017). The influences of harmful clinical supervision often extend beyond the immediate clinical supervisory relationship, affecting career development, self-esteem, and professional attitudes (Ladany et al., 1996; Ramos-Sánchez et al., 2002). Power imbalances within the clinical supervision relationship can exacerbate relational ruptures, which can prevent effective learning and contribute to withdrawal behaviors (Friedlander, 2012). Insecure feelings and a lack of open communication can further damage the clinical supervisory alliance, leading to

diminished learning outcomes and long-term professional consequences (Cartwright, 2019).

Harmful clinical supervision, when left unaddressed, can lead to supervisees internalizing negative experiences, experiencing somatic and/or mental health issues, declining work performance, and disengagement from the counseling profession (Ammirati & Kaslow, 2017). Public acts of harmful clinical supervision can contribute to socialized silence of the supervisee (Hernández & McDowell, 2010). Clinical supervisors must engage in self-reflection and ensure effective two-way communication to prevent harmful supervision and increase support the supervisee's development (Ammirati & Kaslow, 2017). Moreover, harmful clinical supervision can have vicarious effects on client care, as supervisees may be influenced by unethical clinical supervisory practices and this influence may present in the supervisee's clinical work through phenomenon such as parallel process (Bernard & Goodyear, 2019; Drinane et al., 2021; Ramos-Sánchez et al., 2022).

Vicarious liability holds clinical supervisors accountable for the actions of supervisees, which underscores the need for ethical clinical supervisory practices to ensure both supervisee and client wellbeing (R. M. Cook & Ellis, 2021). However, inconsistent regulations and lack of clinical supervisor training across jurisdictions contribute to the prevalence of harmful clinical supervision (R. M. Cook & Ellis, 2021). The current framework for clinical supervision is codified as supervisor-protective, focusing on protecting clinical supervisors from legal liability rather than addressing harmful clinical supervision directly (Ellis et al., 2017). In contrast, a supervisee-

protective stance, which acknowledges the vulnerability of supervisees within the hierarchical structure of clinical supervision, empowers supervisees to report harmful experiences without fear of retribution (McNamara et al., 2017). This approach recognizes the need for both structural and ethical reforms to ensure the welfare of supervisees and the integrity of the clinical supervisory process.

Harmful Clinical Supervision Related to Racial and Ethnic Minority Supervisee Experiences

Harmful clinical supervision can be a traumatizing experience, triggering the fight-flight-freeze response, which exacerbates emotional distress and impedes the ability to gain perspective on the situation (Reiser & Milne, 2017). There are strong correlations between racism, race-related stress, burnout, and secondary traumatic stress [STS], highlighting that Black mental health therapists are particularly vulnerable to STS (Shell et al., 2021). As mentioned previously, these therapists face the dual burden of experiencing both their clients' race-related stress and their own, as Black clients often seek care from Black practitioners (Shell et al., 2021).

Harmful clinical supervision, which is emphasized as unethical practice, may include microaggressions and dismissive behaviors, contributing to significant emotional and professional harm (McNamara et al., 2017). The complexity of harmful clinical supervision lies in its multifaceted nature, with various harmful behaviors often occurring concurrently, making it difficult to isolate specific actions (McNamara et al., 2017). The invisibility of harmful clinical supervision mirrors the broader invisibility of racial and ethnic minority supervisees and faculty in the counseling profession (Curtis-Boles et al.,

2020; Ellis et al., 2017). The lack of acknowledgment of harmful clinical supervision creates a systemic issue that perpetuates marginalization, with no current remediation efforts to address the concerns of many supervisees (Ellis et al., 2017; McNamara et al., 2017). This ongoing issue reflects broader societal dynamics, where systemic inequities are often overlooked, reinforcing the challenges faced by racial and ethnic minority professionals within and outside the profession (Curtis-Boles et al., 2020).

Broaching

Ruptures in the clinical supervisory relationship are particularly pronounced for racial and ethnic minority supervisees, whose heightened perceptions of prejudice exacerbate uncertainty about clinical supervisor expectations and negatively affect their clinical supervision experience (Nilsson & Duan, 2007). Harmful clinical supervision further compounds these issues by fostering an environment marked by distrust, a lack of safety, and reduced self-efficacy, potentially leading to mental health concerns and/or trauma responses (Reiser & Milne, 2017). In response, supervisees may resort to emotionally taxing coping strategies to avoid jeopardizing their career advancement, despite the significant concerns posed by harmful clinical supervision (McNamara et al., 2017).

Broaching, defined as discussing racial, ethnic, and cultural considerations within therapeutic contexts, has been expanded to include clinical supervision to manage relational ruptures and enhance cross-cultural interactions (Day-Vines et al., 2021; C. T. Jones & Branco, 2020). This process occurs in three key areas: the clinical supervisory relationship, case conceptualization, and the counselor-client relationship (Fickling et al.,

2019). It is particularly critical in cross-cultural clinical supervision, where failure to broach cultural issues can harm the counseling and clinical supervisory relationships (Haskins et al., 2013). Broaching is a therapeutic risk that could initially offend the client, or arguably the supervisee and/or clinical supervisor, by evoking negative emotions and insights; however, safe therapeutic and clinical supervisory environments allow for reflection, vulnerability, and shared growth of all parties involved (Morgan, 2018). Broaching should be a shared responsibility between clinical supervisor and supervisee, with attention to the supervisee's cultural identity and the broader cultural context (Bayne & Branco, 2018). However, racial and ethnic minority supervisees report broaching issues more frequently than their clinical supervisors, indicating a gap in the clinical supervisor's engagement with race and culture (Jernigan et al., 2010).

The practical application of broaching remains challenging for many supervisees, especially in the face of cultural incompetence from clinical supervisors (Day-Vines et al., 2021). Factors influencing broaching include self-efficacy, comfort level, cultural competence, and past experiences (Day-Vines et al., 2021). However, clinical supervisors' cultural incompetence can lead to passive withdrawal from supervisees, who may avoid addressing these issues to protect their professional standing (Friedlander, 2015). Effective broaching requires clinical supervisors to be proactive, culturally competent, and able to facilitate a supportive, open environment for discussion, promoting supervisee growth and reducing relational ruptures (Bayne & Branco, 2018). Cross-racial counseling and clinical supervision dynamics afford opportunities for broaching, yet broaching rarely occurs in these contexts (Day-Vines et al., 2021).

Although clinical supervisors disagreed, supervisee participants reported in-house clinical supervisors rarely broach the topic of cultural identity (Galán et al., 2024). When broaching does occur, it may not result in a positive outcome if conducted ineffectively (Constantine & D. W. Sue, 2007). Ineffective broaching can occur when a counselor introduces discussions of racial identity despite an individual expressing that racial identity is not a salient aspect of their current circumstances, or when generalized assumptions are made about an individual's experiences without considering the nuanced aspects of their identity and the salience of that identity in a given context (Bayne & Branco, 2018).

Barriers to broaching include uncertainty about the language to use, when and how to broach, and concerns about offending clients (Bayne & Branco, 2018). While broaching is often seen as the counselor's responsibility, there is a tendency among counselors to follow the client's lead in these discussions, reflecting a broader discomfort with addressing race and culture directly (Bayne & Branco, 2018). This aligns with clinical supervisor preferences for indirect broaching, which avoids making assumptions about the salience of particular identities (C. T. Jones & Welfare, 2017). This passive approach contrasts with best practices and creates additional pressure on racial and ethnic minority supervisees to take the lead in discussions about race and culture, conflicting with the ethical guidelines of the ACA (2014) to promote cultural competence (Patallo, 2019). Ultimately, broaching serves as a critical tool in challenging dominant cultural norms and addressing systemic injustices, promoting a more inclusive and culturally informed approach to clinical supervision (King, 2021). It is important to note that

broaching practices may change throughout counselors' and clinical supervisors' careers with new experiences in personal and professional contexts (Day-Vines et al., 2013).

Considering this, it is also important to note that expertise is not required for broaching—humility is (C. T. Jones et al., 2021).

Racial and Ethnic Minority Supervisees Within Clinical Supervision

Clinical supervision is a multifaceted process with significant responsibilities (Bernard & Goodyear, 2019; Falender, 2018; Spowart & Robertson, 2024). Despite its importance for counselor development and client welfare (ACA, 2014), limited attention has been given to the quality of the clinical supervisory relationship, particularly as it pertains to racial and ethnic minority supervisees (Constantine & D. W. Sue, 2007; Helms & D. A. Cook, 1999). This neglect undermines the effectiveness of clinical supervision for racial and ethnic minority supervisees and clients, who have been historically marginalized in receiving adequate care (Fisher-Borne et al., 2015). Inattention to racial and cultural dialogue in clinical supervision can easily model to supervisees the perceived unimportance of the same dialogue in counseling relationships, contributing to continued marginalization of already marginalized communities (Inman, 2006).

While clinical supervisors recognize the importance of strong clinical supervisory relationships for managing relational dynamics, few acknowledge the cultural considerations essential to effective clinical supervision (Koçyiğit, 2022). This disconnect is evident in supervisees' perceptions of clinical supervisors' cultural competence, their ability to foster supervisee cultural growth, and their attention to

clients' cultural needs (R. M. Cook et al., 2020; Ellis, 2017; King & K. Jones, 2019; Ladany et al., 1997; Reiser & Milne, 2017; L. C. J. Wong et al., 2013). Moreover, few researchers have explored harmful clinical supervision from the supervisee's perspective, particularly regarding the absence of cultural considerations and experiences of microaggressions (Ellis et al., 2017). Few scholars have addressed the impact of racism experienced by racial and ethnic minority counselors, including the effects of internalized racism on self-efficacy and psychological distress (Rasheed Ali et al., 2004; Willis et al., 2022).

The emotional and psychological toll of harmful clinical supervision is well documented, with supervisees often resorting to coping strategies to avoid hindering their career progression (McNamara et al., 2017). However, few researchers have focused specifically on the extent of clinical supervisors addressing or not addressing race, ethnicity, and culture in the clinical supervisory process. There is a lack of structured training in cultural humility for clinical supervisors in which regulations and competencies exist for clinical supervision; however, multicultural frameworks are not uniformly incorporated into clinical supervisor training (Wilcox et al., 2022). The APA has adopted multicultural guidelines for clinical supervision, but these have not been integrated into the ACA standards, which currently focus only on cultural competencies in counseling services (Wilcox et al., 2022).

Summary

In this chapter, I provided a comprehensive review of the literature and identified gaps concerning the lived experiences of racial and ethnic minority supervisees in clinical

supervision (Fisher-Borne et al., 2015; Koçyiğit, 2022; Wilcox et al., 2022; Willis et al., 2022). I addressed the historical evolution of clinical supervision models (Bernard & Goodyear, 2019; Falender, 2018; Fickling et al., 2019), the limitations of these models (Bernard & Goodyear, 2019; Broadwater et al., 2022; Constantine & D. W. Sue, 2007; Koçyiğit, 2022; Ladany et al., 2013; Roscoe et al., 2022), and the development of cultural competence within the clinical supervisory context (Broadwater et al., 2022; Day-Vines et al., 2021; Inman & Ladany, 2014). Systemic issues, including the history and limitations of broaching, as well as harmful clinical supervision experiences faced by racial and ethnic minority supervisees were discussed in relation to the apparently limited display of cultural competence in clinical supervision (Curtis-Boles et al., 2020; Ellis et al., 2017; McNamara et al., 2017; Pieterse, 2018; Roscoe et al., 2022; Thrower et al., 2020). In this chapter, I also emphasized the complex dynamics between clinical supervisors, supervisees, and clients (Bernard & Goodyear, 2019; R. M. Cook et al., 2020; Hutman & Ellis, 2019; Staples-Bradley et al., 2019; Zetzer et al., 2020), highlighting the effects of racism, microaggressions, and systemic frameworks on broaching discussions (Bayne & Branco, 2018; Day-Vines et al., 2021; C. T. Jones & Branco, 2020; King, 2021; Reiser & Milne, 2017).

Through this chapter, I further explored the challenges faced by racial and ethnic minority supervisees, including issues within academic training and post-graduate supervision, where culturally insensitive practices persist (Curtis-Boles et al., 2020; McNamara et al., 2017; Willis et al., 2022). I also noted the experiences of racial and ethnic minority clinical supervisors and faculty, underscoring the need for broaching and

culturally responsive approaches at multiple levels (Curtis-Boles et al., 2020; Hook et al., 2016). Although existing literature has primarily emphasized cultural issues within counseling, the current study specifically explored the experiences of racial and ethnic minority supervisees within the context of clinical supervision. This focus was maintained regardless of the racial identities of the clinical supervisors and was informed by Helms' (1995) model of racial identity development.

Through this current study, I aimed to inform counselor educators and clinical supervisors in addressing the needs of racial and ethnic minority supervisees, particularly in managing harmful clinical supervision experiences through the integration of broaching. By centering on the lived experiences of racial and ethnic minority supervisees, I sought to further inform these experiences for social change and enhance understanding of these issues. In the following chapter, I outline the methodology for achieving these objectives.

Chapter 3: Research Method

In this chapter, I present the research design, methodology, and rationale addressing my role as the researcher. I discuss the selection of participants and instrumentation along with research procedures. In addition, this chapter includes a discussion of hermeneutic phenomenology as the theoretical framework guiding the current study, and a description of the research design, participant selection, data collection procedures, and data analysis methods. Issues of trustworthiness and ethical considerations are addressed to ensure the richness and integrity of the study.

Research Design and Rationale

In this study, I explored the phenomenon of the lived experiences of racial and ethnic minority supervisees within the context of clinical supervision. The research question for this study was the following: What are the lived experiences of racial and ethnic minority supervisees' who have been involved in clinical supervision? I used a hermeneutic phenomenological approach (see Neubauer et al., 2019) because it allowed me to elicit rich descriptions and personal meanings of lived experiences related to racial and ethnic minority supervisees within the context of clinical supervision. Although there are other methods related to a phenomenological approach, these methods did not align with the focus of my study. For example, consensual qualitative research is used to develop a theory by building on participants' experiences of a phenomenon (Prosek & Gibson, 2021). Because the purpose of my study was not to develop a theory, consensual qualitative research was not appropriate for my study. Furthermore, a case study approach is used to explore phenomena within specific cases (e.g., clients, groups,

communities) to develop a theory, evaluate a program, and assess intervention effectiveness (Prosek & Gibson, 2021). This approach was considered but did not meet the requirement of focusing on lived experiences. A hermeneutic phenomenological approach was determined to be most appropriate for my study in that insight could be provided from the people who experience the phenomenon being explored (racial and ethnic minority supervisees' experiences within the context of clinical supervision) to foster a deeper understanding of complex human experiences (see Prosek & Gibson, 2021).

Role of the Researcher

As the researcher conducting a hermeneutic phenomenological study, I acknowledged that all experiences are subjective, and all experiences add to the understanding of the phenomenon being studied by way of the hermeneutic circle (see Suddick et al., 2020). In hermeneutic phenomenology, a researcher holds a viewpoint that individuals are all being-in-the-world, or *Dasein*, of which sharing and exploring each other's experiences adds to self-reflection and the understanding of the parts and the whole that are encompassed in phenomenon (Gadamer, 1976). Through my engagement with multiple worldviews simultaneously, the hermeneutic circle influenced me as the researcher and my participants to provide a deeper epistemological understanding of the phenomenon being studied (see Alsaigh & Coyne, 2021; Macgregor et al., 2023).

Because assumptions are connected to perceptions and biases cannot be separated from the individual and *Dasein*, it is imperative that assumptions and experiences be noted as such and not established as fact (Peoples, 2021). Furthermore, it was imperative

the assumptions and experiences were revisited as part of the process of the hermeneutic circle for me to remain consciously aware of the changes of perception, as well as the potential influence on data interpretation for this current study. Through my exploration of the hermeneutic circle and the combination of new and old information, insight into the parts of racial and ethnic minority supervisees' experiences and the whole of clinical supervision became available. Journaling allowed for me to outline what I understood about the phenomenon prior to data analysis, as well as for me to explore how understanding changed, if at all, with the introduction of new information from others' experiences and reflections throughout the current study (see Peoples, 2021).

Given my experiences as a racial and ethnic minority supervisee, I entered this research with preconceptions related to the topic of my research. To mitigate the influence of these fore-conceptions, I engaged in reflexive journaling throughout data interpretation, which enabled me to identify potential projections, biases, and assumptions. During interviews, I asked clarifying questions to minimize the risk of leading participants or filtering their responses through my own *Dasein*. In the analytic process, I utilized the hermeneutic circle to inform old knowledge I brought to the study and new knowledge I gained as a result of the participants' narratives within the study.

Methodology

In this section I discuss a description of the research design, participant selection, data collection procedures, and data analysis methods. I also address issues of trustworthiness and ethical considerations to ensure the richness and integrity of the

current study. This chapter ends with a summary of each section as well as what can be expected in the subsequent chapter of this current study.

Participant Selection Logic

I aimed to have participants that identified as racial and ethnic minority supervisees and that have been engaged in clinical supervision within the mental health counseling profession, past and/or present, in the United States. The inclusion criteria for participants were as follows:

- postgraduate (post-master's degree) supervisees (prelicensed or postlicensed) within the mental health counseling profession
- racial and/or ethnic minority supervisees (e.g., African American, Indian American) within the mental health counseling profession
- supervisees who are currently or have been in clinical supervision for licensure within the mental health counseling profession
- supervisees who reside in the United States
- individuals who are 18-years or older

For this current research study, I used a purposeful sampling strategy with snowball sampling for participant selection. Participant recruitment occurred through my professional networks, social media counseling groups through platforms such as Facebook and LinkedIn, Walden University's student participant pool, and personal and professional referrals. An invitation to participate included details regarding the purpose of the study, informed consent, interview procedures, confidentiality measures, risks and benefits of being interviewed, and contact information for the researcher regarding any

questions and/or concerns. This invitation was distributed via email and professional forums. I also reviewed the inclusion criteria with each participant prior to conducting the interviews to ensure each participant met the inclusion criteria mentioned above for the current study. Qualitative research designs typically focus on quality over quantity with smaller sample sizes (Patton, 2015). A sample size of 8 to 12 participants was the goal to reach data saturation, which is the point when data stops yielding new information with observations (Guest et al., 2006).

Instrumentation

Semistructured interviews, which include general questions that are related to the research question (Kallio et al., 2016), were conducted for data collection. By using semistructured interviews, there was opportunities for unanticipated information to be relayed from participants' experiences (Peoples, 2021). An interview guide which included open-ended questions was developed for data collection from racial and ethnic minority supervisee participants who had been involved in clinical supervision within the mental health counseling field. Sample interview questions included:

- “Can you describe your experience of clinical supervision as a racial and ethnic minority supervisee?”
- “Can you tell me about any benefits, if any, you faced during your experience of clinical supervision?”
- “Can you tell me about any challenges, if any, you faced during your experience of clinical supervision?”

Each interview lasted approximately 60 to 90 minutes and was conducted via a secure video-conference platform, depending on the participant's availability, preferences, and geographic location. Interviews were audio-recorded to ensure participant privacy and researcher ability to code effectively. A consent form was completed by the participant prior to the start of the interview. After I conducted initial interviews, I scheduled follow up interviews that lasted approximately 15 to 30 minutes with each participant as needed. I used these follow up interviews to clarify any previous information relayed and to identify any necessary missing information (i.e., misunderstandings, areas that may have required additional context, incomplete statements) for well-rounded data (see Peoples, 2021). In addition to interviews, I journaled to become aware of and maintain awareness of any personal biases that arose so I could engage in self-reflection and replace any biased thoughts with new information obtained through research and curiosity of others' experiences (see Gadamer, 1976; People, 2021).

Procedures for Recruitment, Participation, and Data Collection

I initiated purposeful sampling and snowball sampling for participant recruitment following approval from Walden University's Institutional Review Board [IRB]. Participant recruitment occurred through my professional networks, , social media counseling groups through platforms such as Facebook and LinkedIn, Walden University's student participant pool, and personal and professional referrals.

Once participants consented to participate in the study, data analysis was conducted after each completed interview. Data collection continued until data saturation

was reached. Prior to starting the initial and follow up interviews, I reviewed the informed consent with each participant, discussed confidentiality, highlighted the participant's ability to withdraw from the study at any time, and reviewed that confidentiality was to be accomplished by use of pseudonyms of all participants. Following the interviews, I saved, transcribed, and reviewed the audio recordings. Through reviewing the recording, I was able to note *what* was said and *how* it was said, making notations for information heard (see Peoples, 2021). Once any missing data (i.e., misunderstandings, areas that may require additional context, incomplete statements) or data that was misunderstood was noted, I scheduled follow up interviews to clarify information gathered and to allow the participant to elaborate on previous responses provided (see Peoples, 2021).

Data Analysis Plan

To understand the data as a whole made up of parts, both of which are significant to understanding the phenomenon being explored, I used Peoples (2021) data analysis flow chart. The steps to this flow chart included the following:

Step 1: Read the Entire Transcript and Delete Irrelevant Information

I read the transcript to capture the participant's entire experience and deleted any repetitive statements such as "um," "uh," "well," or "you know."

Example of Step 1

Original Transcription. "Yeah totally like are you are you one of those Arabs that I'm gonna like are you like it's always are you Egyptian and I'm like once because like now they narrowed me down they're like okay she's got to be Arab or like South

Asian or something and it's like okay close enough but um it's always Egypt because I feel like that's a very palatable one people love the pyramids but um I love Egypt don't get me wrong I'm I if I look Egyptian that's great but it's just um it's kind of going for the palatable choice I think which is very like also telling so it's almost like yeah that like putting in a box sort of idea it's like you know you just like there is a very like uh common um like push to make people palatable like if you're from a country I've never heard of then I'm kind of like no thank you so I think that that's um yeah okay interesting I like the way you put that because yeah that's how it feels."

Revision. She reflected on the ways in which others attempted to categorize her racial and ethnic identity, stating she was often "narrowed down to something that is palatable to others," a process that frequently excluded her Arab identity and led to her "being put in a box" for the comfort of others.

Step 2: Identify Missing Information and Schedule Follow Up Interviews

After removing any irrelevant and/or repetitive information, I explored the transcripts to identify any context and statements that may have needed clarification. I performed this step to ensure the richness of data from the completed interviews. Once I identified any context and statements that may have needed clarification, I asked further clarifying questions to address these areas in follow up interviews, which were scheduled with the participants at their convenience.

Example of Step 2

Although I initially had no clarifying questions for P5, I extended an invitation to each participant for a follow up interview in the event they desired to adjust any

statements made in any way from the initial interview. Upon speaking with P5 in the follow up interview, I asked clarifying questions from additions she made to her initial statements. An example is as follows:

P5: “I remember thinking the word serious. And I think serious just meant like, after I talked to you, I thought about how serious it is to take – supervisors really must take it seriously – their duty to associates, their duty to like their companies, the duty to like really be on top of trends, on top of the different theories, on top of – just like, being able to really take it seriously, their job.”

Interviewer: “Okay, so with that, do you think the profession generally teaches and trains and holds that seriousness of what supervision is?”

P5: “No one talked to us about like what supervision is, what to expect as a trainee, because if we don’t talk about (it) as a trainee, a lot of people don’t go to their doctorate.”

Step 3: Create a Final Transcript for Each Interview

I transcribed follow up interviews and inserted all missing information into the respective initial interview transcript.

Follow Up Interview 1

Researcher: “This is a space if you have anything, any questions, comments, concerns, anything that you want to adjust in the transcript as well.”

Participant: “I remember thinking the word serious. And I think serious just meant like, after I talked to you, I thought about how serious it is to take – supervisors really must take it seriously – their duty to associates, their duty to like their companies, the

duty to like really be on top of trends, on top of the different theories, on top of – just like, being able to really take it seriously, their job.”

Interviewer: “Okay, so with that, do you think the profession generally teaches and trains and holds that seriousness of what supervision is?”

P5: “No one talked to us about like what supervision is, what to expect as a trainee, because if we don’t talk about (it) as a trainee, a lot of people don’t go to their doctorate.”

Final Transcript

Participant: “I realized ... I never had what it was supposed to be ... It wasn’t a bad experience, but I left feeling like I don’t know if I fully became the clinician that I could have been. No one talked to us about like what supervision is, what to expect as a trainee, because if we don’t talk about (it) as a trainee, a lot of people don’t go to their doctorate.”

Step 4: Journaling (i.e., Stepping into a Hermeneutic Head Space)

I articulated personal biases in documenting my thoughts, feelings, and opinions throughout data analysis. By acknowledging my own preconceptions, I was able to hold a dialogue between my experiences and assumptions through old knowledge as well as how participants’ experiences contributed to new knowledge.

Step 5: Construct Preliminary Meaning Units

I created potentially significant pieces of data by identifying data that revealed a feature or trait related to the phenomenon being explored.

Example of Step 5

P1's experiences of being "narrowed down to something that is palatable to others" and "being put in a box" for the comfort of others were identified as related to a preliminary meaning unit of identity erasure. This unit describes P1's perception that her identity was not welcomed in certain settings.

Step 6: Construct Final Meaning Units

I created final meaning units from the previously created preliminary meaning units. This step allowed me to further organize the rich data, so that themes could be created in the next step.

Example of Step 6

Question 1: All right. So, to start, can you tell me what you identify as far as race, ethnicity, culture, if you feel comfortable?

Preliminary meaning unit 1: P1 described her minority identity as not being welcomed within her clinical training environment. This was evidenced by P1's description of being "narrowed down to something that is palatable to others" and "being put in a box" for the comfort of others.

Final meaning unit: I identified identity erasure as a final meaning unit within the experiences of P1. This final meaning unit encompassed P1's description of being "narrowed down to something that is palatable to others" and "being put in a box" for the comfort of others. This step allowed me to further organize the rich data, so that themes could be created in the next step.

Step 7: Combine Final Meaning Units Into Collective Themes

I created themes from the previously created final meaning units. This step allowed me to display the consistent flow of parts and whole within the data collected to deepen my understanding of each participants' experiences.

Example of Step 7

I identified a theme of "Attending PWIs," which contains all the shared experiences noted from several participants. This theme encompassed the settings in which most minority supervisees expressed their marginalized identity not being welcomed, as well as the concept of identity erasure, tokenism, and isolation that often accompanied the experiences of lack of diversity within the PWI settings (academic and clinical settings alike).

Step 8: Organize Themes Into Situated Narratives

I organized participants' experiences under the specific interview or survey question the experience related to. Meanings of the experiences were captured with use of direct quotes from participants. The identified themes from the previous step were compiled with at least one quotation underneath from the situated narrative.

Example of Step 8

Participant 1 described her clinical training site as a "predominantly white facility with predominantly white clinicians and predominantly white clients." She reflected on the ways in which others attempted to categorize her racial and ethnic identity, stating she was often "narrowed down to something that is palatable to others," a process that frequently excluded her Arab identity and led to her "being put in a box" for the comfort

of others. Participant 1 also recalled feeling isolated during discussions centered exclusively on Christian scripture, noting that “those moments (religious conversations focused on bible text) felt very isolating,” particularly as someone who identifies with a different faith tradition (Islam). These experiences reinforced her sense of exclusion within the predominantly white and culturally homogenous clinical setting. Additionally, she reflected on the burden of tokenism, stating, “If you’re the only BIPOC person in the room, like, now you suddenly represent everybody,” underscoring the pressure she felt to speak on behalf of entire communities in predominantly white spaces.

Step 9: General Narrative

I organized each participant’s responses and data into a collective, general description by highlighting the participants’ meanings of their experiences into general categories. This step allowed me to identify common themes within the data obtained.

Example of Step 9

Most participants were trained within PWIs (both clinical and academic settings) and reported minimal diversity, racial and ethnic minority representation, or culturally sensitive training. P1 described tokenism, P2 noted lack of systemic support, and P3 observed that minority clients avoided campus counseling centers. Others emphasized White-majority client bases (P4), language-related clinical supervisory gaps (P6), and working in a “not super diverse state” (P7). Such dynamics often compounded isolation and raised questions of belonging for the minority supervisee.

Step 10: General Description

I created a cohesive general description of all identified major themes from the data obtained.

Example of Step 10

These experiences are compounded by the structural realities of predominantly White institutions, where training and teaching often lack diversity, racial and ethnic minority representation, and culturally sensitive frameworks. Within these contexts, tokenism, identity erasure, and the absence of culturally attuned models sustain Eurocentric norms and reinforce institutional mistrust among minority clients, who often avoid such services altogether.

Step 11: Phenomenological Reflection

This step allowed me to appreciate the interconnected parts and whole of the data obtained, modifying understanding through introduction of new knowledge through the hermeneutic circle (see Gadamer, 1976; Peoples, 2021). This process reflected a hermeneutic phenomenological study.

Example of Step 11

Mitsein emerged as a recurrent phenomenon within the relationships inherent to clinical supervision and within the relational dynamics and clinical supervision influences. Many clinical supervisors functioned as free-floating subjects alongside minority supervisees, a stance that contributed to deficiencies in understanding, connection, and empathy. These unhelpful clinical supervisory dynamics reflected limited expressions of *Mitsein* and, consequently, suggested restricted self-knowledge on

the part of the clinical supervisor, as “knowing oneself is grounded in Being-with” (Heidegger, 1962, p. 161). *Mitsein* was also evident in interactions between minority supervisees and their clients, as the counseling relationship often mirrored the dynamics of the clinical supervisory relationship.

Issues of Trustworthiness

To address potential issues of trustworthiness, I included the following procedures to assure validity from Creswell and Poth (2017), as cited in Peoples (2021):

Credibility

To ensure credibility, or trustworthiness, of the research findings, I engaged in prolonged engagement and observation with participants. Each interview lasted approximately 80 minutes and was conducted via Zoom with cameras on, allowing for mutual observation and the development of rapport. Trust was fostered through a semistructured interview format that encouraged a natural flow of conversation led by the participant. Throughout the interviews, I asked clarifying questions to ensure accurate understanding of each participants lived experiences. Asking clarifying questions also minimized the risk of leading participants or filtering their responses through my own *Dasein*. As trust deepened, participants appeared more comfortable and willing to share intimate details of their experiences. These interviews produced rich, detailed accounts that facilitated the identification of patterns and themes as parts and whole representations of the participants’ experiences, capturing the complexity and nuance of racial and ethnic minority supervisees lived experiences and connected to the context of the phenomenon that was explored for this study. Credibility was further strengthened

through triangulation during data analysis, as multiple participants described similar experiences, thereby reinforcing the identified themes and supporting alignment with the overall phenomenon under investigation (Cooper & Lilyea, 2022).

Dependability

To ensure dependability, or the ability of the study to be replicated, I provided a detailed explanation of this research process, and I followed each step as was described. Future researchers who explore the same phenomenon within a similar context should be able to yield comparable findings if they repeat the steps that have been detailed in this current research.

Transferability

To ensure transferability, or generalizability, of this current research, I detailed how the microlevel experiences can relate to macrolevel contexts within the themes, the general summary, and especially the general description as the racial and ethnic minority supervisee participants' experiences may be similar to insights about other populations with similar experiences. It is important to carefully consider the context of the setting, the characteristics of the participants, and the nuances of their lived experiences prior to making any attempt to generalize the findings.

Confirmability

To ensure confirmability, or the protection of the research from personal bias, I identified and openly discussed potential areas of bias in Chapter 3. I maintained a journal as I gathered data from participants' experiences so that I could engage in the hermeneutic circle by consistently adjusting old and new knowledge through the process

of reflection. My consistent goal throughout this process was to remain attuned to the interplay of old and new knowledge, using reflection to refine my understanding. Through reflexive journaling, I not only revisited and revised personal biases and assumptions, but I also allowed those biases to generate the critical questions necessary for ongoing thought revision within the hermeneutic circle. Although I inevitably brought assumptions to my understanding of participants' experiences, I consistently asked clarifying questions to determine whether these assumptions were accurate or influenced by my own background. This process of interrogating and checking my assumptions with the participants throughout the interviews prevented overgeneralization and reinforced the understanding that each individual possesses a unique experience of being-in-the-world (*Dasein*), further shaped through interactions with others, or *Mitsein*. With every reexamination of my assumptions, I discovered new understanding and meaning. Although different interpretations conflicted at times between me and the participants' understanding, with further discussion and clarifying questions, these interpretations settled into a clearer and more coherent meaning for a more detailed understanding of the phenomenon that was studied.

Ethical Procedures

Ethical approval was obtained from Walden University's IRB before the study was conducted, and data was collected. Once ethical approval was obtained, each participant received informed consent to ensure each participant was aware of the purpose of the study, their rights as participants of the study, and measures taken for participant confidentiality. All data was stored in secure digital files, double-locked via

password protection, and pseudonyms were used in the reporting of findings. Any identifiers used following data collection were stored separately from all coded data as an added effort to ensure participants confidentiality.

Summary

In this chapter, I outlined the methodology, research design, and rationale as my role as the researcher. Participant recruitment, instrumentation, data collection procedures, ethical considerations, issues of trustworthiness, and data analysis methods were also discussed. In the following chapter I present findings of the study, highlight themes that have emerged from participant experiences, and provide a general description of the themes within the data to further highlight the parts and whole of data obtained for this hermeneutic phenomenological study.

Chapter 4: Results

In this study, I sought to fill the gap in existing literature by exploring racial and ethnic minority supervisees' experiences within the context of clinical supervision. The purpose of this study was to explore racial and ethnic minority supervisees' experiences and gain insights into these experiences within the clinical supervision context. The research question for this study was the following: What are the lived experiences of racial and ethnic minority supervisees who have been involved in clinical supervision? In this chapter, I outline the themes that emerged from the data, provide detailed descriptions of these themes, and interpret the themes through a hermeneutic phenomenological lens.

Setting

I conducted semistructured interviews via Zoom, which is a virtual platform. Because of the virtual platform, interviews took place in various confidential locations that were comfortable for the participants. I conducted follow up interviews in the same manner. I conducted follow up interviews to create space for clarifying questions from me and the participants. Although I did not provide participants with their full transcripts during this stage, the follow up interviews allowed participants to add, remove, or adjust information from the initial interviews as needed. I found that most participants did not identify clarifications or revisions, nor did I, because the initial interview conversations were comprehensive and conclusive. I was unaware of any factors that may have influenced the participants or their experiences during the interview process.

Demographics

I present the demographic information collected from participants in Table 1. Demographic information includes participant number (to preserve confidentiality), racial and/or ethnic identity (central to the research question and inclusion criteria because participants were required to identify as racial and/or ethnic minority supervisees), gender identity (to support transferability), clinical supervision participation details (as required for participation), licensure status (to distinguish supervision experiences as pre or postlicensure), and other salient characteristics (to reflect participants' emphasis on intersectionality during interviews).

The sample consisted of seven women and one man. Most participants received supervision during both master's-level training and after graduation, while one participant was supervised only during her master's program and another participant during her doctoral practicum. Participants represented diverse racial and ethnic backgrounds: one Arab, three Black/African American (with varied self-identifying language), one South Asian/Indian, one Afro Latina/Dominican, one Salvadoran American, and one Mexican American. In keeping with participants' emphasis on intersectionality, I used the participants' own words to describe salient characteristics; in addition, one participant identified as having a disability and one as being bilingual. I categorized licensure status as prelicensed (graduated but not yet provisionally licensed), provisionally licensed (working toward independent practice), or postlicensed (independently licensed).

Table 1*Demographics of Participants*

Participant number	Racial/ethnic identity	Gender identity	Clinical supervision level	Licensure status	Other aspects of identity mentioned
P1	Arab	Female	Supervised during master's program	Prelicensed	
P2	Black	Female	Supervised during master's program and post master's program	Provisionally licensed	
P3	South Asian/Indian	Female	Supervised in doctoral practicum	Prelicensed	Has physical disability
P4	African American	Male	Supervised during master's program and currently being supervised post-master's program	Provisionally licensed	
P5	African American/Black	Female	Supervised during master's program and post master's program	Postlicensed (LMFT)	
P6	Afro Latina/Dominican	Female	Supervised during master's program and currently being supervised post master's program	Provisionally licensed	
P7	Salvadoran American	Female	Supervised during master's program and currently being supervised post master's program	Postlicensed in one state (LMHC); provisionally licensed in another state	Bilingual
P8	Mexican American	Female	Supervised during master's program and post master's program	Postlicensed (LMFT)	

Note. Prelicensed = participant has graduated a master's program and is not yet provisionally licensed. Provisionally licensed = participant has graduated a master's program and is licensed as an associate to gain supervised hours as they work toward independent licensure. Postlicensed = participant is independently licensed. LMFT = Licensed marriage and family therapist; LMHC = Licensed mental health counselor.

Data Collection

This current study had eight participants, all of whom identified as postgraduate (after master's degree); prelicensed or postlicensed supervisees; mental health professionals; racial and/or ethnic minorities; currently and/or had been at any point a supervisee in clinical supervision for licensure within the mental health counseling profession; resided in the United States; were 18 years or older. Walden University's IRB approved me to recruit participants from Walden University's participant pool, social media (specifically Facebook and LinkedIn), snowball sampling, and my personal and professional networks. Participants who were interested in being interviewed for the study reached out to my Walden University student email address, which was posted as a contact on my social media invitation. Through my Walden University student email address, I sent each interested participant the informed consent; once participants responded with "I consent" via email, we scheduled Zoom meetings to conduct the initial interview. Zoom links were scheduled at the convenience of the participants. At the beginning of the Zoom call, all participants were provided an opportunity for questions and I reviewed the study criteria, study topic, and purpose of the study with each participant prior to beginning the interview. I also reminded all participants that only the audio of the call would be recorded, the minimal risk associated with the study, contact for potential distress that may have arose from the interview questions, that participation in the study was voluntary, and that participation could be stopped at any time. I used the semistructured interview protocol for all interviews and after the review of the current

details, each participant was given the option to either have their camera on or off depending on their comfort level.

The interviews ranged between 45 and 90 minutes, were audio recorded, and were transcribed immediately after interview completion. I scheduled follow up interviews with participants at the end of initial interviews. I conducted the follow up interviews via Zoom; each completed follow up interview was audio recorded and transcribed immediately after completion. I completed follow up interviews as needed for any clarifying questions from myself and to provide a space for the participants if they decided to clarify any information provided in the initial interview. This step was taken for well-rounded data to be obtained (see Peoples, 2021). I reminded participants of this purpose at the beginning of the follow up interviews, which altogether ranged between 5 and 20 minutes.

I followed the initial plan for the data collection process without any deviations and/or unexpected circumstances. I also scheduled interviews and follow up interviews at the convenience of the participants. If no clarifying questions or information was needed from myself or the participants, I did not complete follow up interviews. I reviewed all interview questions between interviews to ensure the interview questions appropriately addressed the research question of the current study. Upon having conversations with participants, one interview question was added, which asked participants to provide advice to racial and ethnic minority supervisees entering the clinical supervision context within the mental health counseling profession. Although this question was not directly related to my research question, it was an area that was addressed by several participants

in the study without prompting. I stored all transcripts securely and double locked them via password protection.

Data Analysis

To understand the data as a whole made up of parts, both of which are significant to understanding the phenomenon being explored, I used Peoples (2021) data analysis flow chart. The steps to this flow chart included the following:

1. Read the entire transcript and delete irrelevant information: I read the transcript to capture each participants entire experience and to delete any repetitive statements such as “um,” “uh,” “well,” or “you know.”
2. Identify missing information and schedule follow up interviews: After removing any irrelevant and/or repetitive information, I explored the transcripts to identify any context and statements that may have needed clarification. Once identified, I asked further clarifying questions to address these areas in follow up interviews, which were scheduled with the participants at their convenience.
3. Create a final transcript for each interview: I transcribed follow up interviews and inserted all missing information into the respective initial interview transcript.
4. Journaling (i.e., stepping into a hermeneutic head space): I articulated personal biases in documenting my thoughts, feelings, and opinions throughout data analysis. By acknowledging my own preconceptions, I was able to hold a dialogue between my experiences and assumptions through old

knowledge as well as how the participants experiences contributed to new knowledge.

5. Construct preliminary meaning units: I created potentially significant pieces of data by identifying data that revealed a feature or trait related to the phenomenon being explored.
6. Construct final meaning units: I created final meaning units from the previously created preliminary units. This step allowed me to further organize the rich data, so that themes could be created in the next step.
7. Combine final meaning units into collective themes: I created themes from the previously created final meaning units. This step allowed me to display the consistent flow of parts and whole within the data collected to deepen my understanding of each participants experiences.
8. Organize themes into situated narratives: I organized participants experiences under the specific interview or survey question the experience related to. Meanings of the experiences were captured with use of direct quotes from the participant. The identified themes from the previous step were compiled with at least one quotation underneath from the situated narrative.
9. General narrative: I organized each participant's responses and data into a collective, general description by highlighting the participants meanings of their experiences into general categories. This step allowed me to identify common themes within the data obtained.

10. General description: I created a cohesive general description of all identified major themes from the data obtained.
11. Phenomenological reflection: This step allowed me to appreciate the interconnected parts and whole of the data obtained, modifying understanding by introduction of new knowledge through the hermeneutic circle (see Gadamer, 1976; Peoples, 2021). This process reflected a hermeneutic phenomenological study.

Evidence of Trustworthiness

To address potential issues of trustworthiness, I included the following procedures to assure validity from Creswell and Poth (2017), as cited in Peoples (2021):

Credibility

To ensure credibility, or trustworthiness, of the research findings, I engaged in prolonged engagement and observation with participants. Each interview lasted approximately 80 minutes and was conducted via Zoom with cameras on, allowing for mutual observation and the development of rapport. Trust was fostered through a semistructured interview format that encouraged a natural flow of conversation led by the participant. Throughout the interviews, I asked clarifying questions to ensure accurate understanding of each participants lived experiences. Asking clarifying questions also minimized the risk of leading participants or filtering their responses through my own *Dasein*. As trust deepened, participants appeared more comfortable and willing to share intimate details of their experiences. These interviews produced rich, detailed accounts that facilitated the identification of patterns and themes as parts and whole

representations of the participants experiences, capturing the complexity and nuance of racial and ethnic minority supervisees' lived experiences connected to the context of the phenomenon that was explored for this current study. Credibility was further strengthened through triangulation during data analysis, as multiple participants described similar experiences, thereby reinforcing the identified themes and supporting alignment with the overall phenomenon under investigation (Cooper & Lilyea, 2022).

Dependability

To ensure dependability, or the ability of the study to be replicated, I provided a detailed explanation of this research process, and I followed each step as was described. Future researchers who explore the same phenomenon within a similar context should be able to yield comparable findings if they repeat the steps that have been detailed in this current research.

Transferability

To ensure transferability, or generalizability, of this current research, I detailed how the microlevel experiences can relate to macrolevel contexts within the themes, general summary, and especially the general description, as the racial and ethnic minority supervisee participants' experiences may be similar to insights about other populations with similar experiences. It is important to carefully consider the context of the setting, the characteristics of the participants, and the nuances of their lived experiences prior to making any attempt to generalize the findings.

Confirmability

To ensure confirmability, or the protection of the research from personal bias, I identified and openly discussed potential areas of bias in Chapter 3. I maintained a journal as I gathered data from participants experiences so that I could engage in the hermeneutic circle by consistently adjusting old and new knowledge through the process of reflection. My consistent goal throughout this process was to remain attuned to the interplay of old and new knowledge, having used reflection to refine my understanding. Through reflexive journaling, I not only revisited and revised personal biases and assumptions, but I also allowed those biases to generate the critical questions necessary for ongoing thought revision within the hermeneutic circle.

Although I inevitably brought assumptions to my understanding of participants' experiences, I consistently asked clarifying questions to determine whether these assumptions were accurate or influenced by my own background. This process of interrogating and checking my assumptions with the participants throughout the interviews prevented overgeneralization and reinforced the understanding that each individual possesses a unique experience of being-in-the-world (*Dasein*), further shaped through interactions with others, or *Mitsein*. With every reexamination of my assumptions, I discovered new understanding and meaning. Although different interpretations conflicted at times between me and the participants understanding, with further discussion and clarifying questions, these interpretations settled into a clearer and more coherent meaning for a more detailed understanding of the phenomenon that was studied.

Results

The following are the results of data collection and analysis. Through pursuing insight into the lived experiences of racial and ethnic minority supervisees within the context of clinical supervision, I utilized a hermeneutic phenomenological lens, through which multiple worldviews were held simultaneously for a deeper epistemological understanding of the phenomenon being studied (see Alsaigh & Coyne, 2021; Macgregor et al., 2023). My biases and assumptions coexisted with the participants worldviews; my assumptions and biases were not established as fact but rather considered in a holistic manner within the context of *Dasein* (Peoples, 2021).

I upheld the hermeneutic circle, an important part of hermeneutic phenomenological research, in which I held my worldview and the worldview of the participants simultaneously, while self-reflecting and attempting to understand the parts and wholes of the phenomenon from all worldviews presented (see Gadamer, 1976; Peoples, 2021). Through implementation of the ongoing process of the hermeneutic circle, I acknowledged my assumptions and biased belief that racial and ethnic minority supervisees and clients were harmed as a result of a lack of cultural humility, sensitivity, and broaching (or minimal broaching) at the hands of clinical supervisors. Although I held these assumptions and biases, I maintained flexibility to gain insight into other potential perspectives and experiences that were within and outside of my range of assumptions and biases.

As the participants narratives unfolded, their lived experiences, or *Dasein*, became clear—the clinical supervision relationship is a hierarchical dynamic comprised

of several layers of pressure for racial and ethnic minority supervisees. First, I provide a description of participant demographics, followed by a description and table of themes identified. I then provide nine themes and three subthemes, which are as follows: Theme 1: Concern regarding supervisor's recommendations; Subtheme 1.1: Experiencing bias from clinical supervisor; Subtheme 1.2: Experiencing cultural neglect in clinical supervision; Subtheme 1.3: Experiencing ethical ruptures in clinical supervision; Theme 2: Experiencing support from culturally sensitive clinical supervisors; Theme 3: Seeking/receiving alternate supervision; Theme 4: Experiencing stress and self-doubt in clinical supervision; Theme 5: Attending PWIs; Theme 6: Experiencing lack of preparation for supervision and practice; Theme 7: Experiencing clinical supervision as a hierarchy; Theme 8: Being assigned minority clients based on race/ethnicity; Theme 9: Responsibility to racial and ethnic minority clients. I also provide a general narrative, general description, hermeneutic phenomenological reflection, and a summary (see Table 2).

Table 2*Thematic Meaning Units*

Theme	Participant							
	P1	P2	P3	P4	P5	P6	P7	P8
Theme 1: Concern regarding clinical supervisor's recommendations	X	X	X	X	X	X	X	X
Subtheme 1.1: Experiencing bias from clinical supervisor	X			X	X		X	X
Subtheme 1.2: Experiencing cultural neglect in clinical supervision	X		X		X	X		
Subtheme 1.3: Experiencing ethical ruptures in clinical supervision		X			X	X		
Theme 2: Experiencing support from culturally sensitive clinical supervisors	X	X	X	X	X	X	X	X
Theme 3: Seeking/receiving alternate supervision	X	X	X	X	X	X	X	
Theme 4: Experiencing stress and self-doubt in clinical supervision	X		X		X	X	X	X
Theme 5: Attending PWIs	X	X	X	X		X	X	
Theme 6: Experiencing lack of preparation for supervision and practice	X	X		X	X	X	X	
Theme 7: Experiencing clinical supervision as a hierarchy	X	X	X	X				
Theme 8: Being assigned minority clients based on race/ethnicity			X	X		X		
Theme 9: Responsibility to racial and ethnic minority clients		X					X	

Illustrated Themes

This section provides quotes and summaries of all of the themes from Table 2 in the order they are listed on Table 2.

Theme 1: Concern Regarding Clinical Supervisor's Recommendations

Participants reported that their clinical supervisors lacked the ability to address cultural considerations and often relied exclusively on their own preferred frameworks. Some participants described instances in which supervisors generalized or conflated race, ethnicity, and culture when making treatment recommendations. Some participants noted that clinical supervisors' biases at times overshadowed clients' needs and their needs as supervisees. Ethical concerns regarding clinical supervisors' clinical recommendations were also raised. I organized this section into the subthemes of bias, cultural neglect, and ethical ruptures in supervision to capture the rich data, complexity, and contextual variation described by participants. I developed this structure to provide greater specificity within Theme 1, as the breadth of experiences and contexts described by participants necessitated a more granular analytic framework.

Subtheme 1.1: Experiencing Bias From Clinical Supervisor

P1 recalled a clinical supervisor often "went on a soapbox about her(self)" during case discussions and once required supervisees to watch a Tucker Carlson interview during group supervision. P1 also expressed concern after hearing from a peer that the same supervisor had completed an intake session with a client and "spent the entire session just talking about Trump and how amazing he is." Reflecting on this incident, P1 questioned, "where does this fit into a counseling session?"

P4 described a clinical supervision experience involving a couple's therapy case in which he and his supervisor held differing perspectives on the client's presenting concerns. He explained, "I think the supervisor was focusing on one area for the client and I felt both areas were important. I was that one who was hearing all of it." To manage this divergence, P4 stated that he adopted a "middle ground approach," integrating elements of his supervisor's recommendations while still maintaining his own clinical perspective.

P5 reflected on the constraints of her clinical supervisor's perspective, stating, "she was a psychologist, so she didn't look at things from like an MFT lens."

P7 stated

I felt as though my site supervisor... didn't have too much experience supervising individuals... as far as like a teacher, instructor--(he) kind of struggled. I felt like I was grasping at straws... trying to figure out what to do with these kids and how to help them. Supervision didn't necessarily align with my desire or intent to want to be more strategic and problem-solving focused... He was very optimistic and just positive psychology all the way. [It was] hard to learn other clinical skills... because they were very narrow.

P8 discussed the challenges of working under multiple clinical supervisors at a single site, which often led to confusion due to inconsistent guidance. She stated

I noticed conflicting ways to approach things, so it would kind of leave me in confusion... Like, okay what is the best route or how do I support my client in the best way? One [clinical supervisor] would kind of lean more towards like a CBT

approach... another would be more of like a narrative approach... Finding my niche was difficult... I felt like I lost that, finding that part of me.

Subtheme 1.2: Experiencing Cultural Neglect in Clinical Supervision

P1 described a clinical supervisor that displayed limited case conceptualization skills, specifically when it came to addressing racial and ethnic minority client concerns. She stated, “Attachment totally plays a part in everything in life, but can we not explore some trauma here? ... She [supervisor] breezed through so many cases, but when it came to minorities, it was like, a dismissive thing. Like, no, little Black boys are being traumatized too.” She also recounted a particularly distressing moment when her supervisor conflated cultural, ethnic, and religious identities while discussing a case conceptualization for a Muslim Moroccan client. She stated the supervisor began, “We need to understand the cultural implications... with them being Muslim Moroccans,” but then hesitated, appearing visibly uncomfortable. She [supervisor] attempted to justify her comment by referencing a friend’s military service in Afghanistan, stating, “because I had a friend who served in Afghanistan... and what my friend told me as he was serving there was that the amount of little boys and girls that were raped on a daily basis by the Afghans.” P1 described this moment as deeply concerning and illustrative of the supervisor’s cultural insensitivity.

P3 described challenges navigating different cultural dynamics and misunderstandings, specifically related to her collectivist/eastern background and her clinical supervisor’s individualistic/western background. She recalled an instance in which her clinical supervisor questioned, “Oh, but what does your client want?” when

she was working with a racial and ethnic minority client from a collectivist culture, to which she reflected, “What about the lack of understanding that sometimes individual happiness is correlated to the happiness of the community?” She emphasized that “there was a gap in the clinical supervisor’s understanding of why me and the client were struggling so much with more systemic issues.”

When considering navigating cultural considerations for clients, P5 recalled thinking, “How do I navigate here culturally wise, race and ethnicity, but also them bringing in trauma?” She highlighted the importance of considering both “generational trauma” and “systemic trauma” in her clinical work but expressed frustration that her clinical supervisor did not provide sufficient guidance, stating, “You don’t know how to help me understand how to help them unpack those things... She [supervisor] wouldn’t not just hear me, maybe I felt like I wasn’t heard, I wasn’t seen.” She reflected, “I think sometimes it kept me in a place where I could have kept sessions on a surface level.”

P6 reflected on substantial cultural disconnects with her master’s program clinical supervisor, stating, “She only spoke one language, so there was no way to kind of explain to her what things meant in the culture.” P6 recalled a specific incident when working with a Muslim client who was experiencing conflict within her family. She recalled that her supervisor asked, “Oh, why she doesn’t move out,” to which P6 responded, “Well, my client is Indian, she’s Muslim, and she doesn’t move out until she gets married... that is the way this culture works.” Upon reflection, P6 stated she felt culture was largely dismissed by this clinical supervisor, stating, “She had a very difficult time understanding what was appropriate, was not appropriate.”

Subtheme 1.3: Experiencing Ethical Ruptures in Clinical Supervision

P2 described ethical concerns within her clinical internship site, describing the site as understaffed and noncompliant with state regulations and the terms of the internship agreement, characterizing this experience as one of the more troubling aspects of her clinical training. She stated

I spoke up and said if the state comes in today and sees a provisionally licensed person running group with 27 clients... and they said, oh it's out of ratio, so we'll split the group. Morally I was conflicted because you know, that is not what these adolescents parents are paying. That's not what insurance is paying for. Insurance is saying they should have group twice a day.

P5 described her clinical supervisor's responses as vague and ultimately disengaging, stating, "I couldn't even tell you exactly because I blocked it out; I don't even try to go that far back into working there."

P6 discussed being dismissed by her clinical supervisor. She stated

Especially seeing clients that look like me, sound like me... it was very difficult for me to convey [cultural components] to her. Even then, she [clinical supervisor] kind of just shrugged it off and was like, okay, see you next week.

Theme 2: Experiencing Support From Culturally Sensitive Clinical Supervisors

Participants described positive clinical supervisory experiences, marked by emphasis of a non-hierarchical approach, empathy, modeling, and support from clinical supervisors. It is noted that most clinical supervisors mentioned in this theme were not

assigned clinical supervisors within clinical placements during racial and ethnic minority supervisees clinical training.

P1 described her university clinical supervisor as having provided proactive instruction, particularly in staying informed about social changes and attending to clients' salient identities through an intersectional lens. She emphasized that this supervisor taught her "more of what to do" in practice. For example, she recalled a class discussion on sexuality where a peer asked, "What is demisexual?" and the supervisor responded by reminding students, "You really need to stay up on the times." P1 reflected, "That day for me was really big because... we need to be very attuned to this and it's really important, but also, she [supervisor] had a really good balance of... just let them come to you... So that's where a lot of ... what you should do versus... what you should not do and how to implement that."

P2 described her post-master's White male supervisor as demonstrating cultural humility by openly addressing topics of race, ethnicity, and culture, including issues such as hair discrimination experienced by Black women, which she expressed contributed to safety and rapport building. She reflected, "From the looks of him, you would think he wasn't culturally diverse... [but] we have a cultural respect for one another."

P3 highlighted the value of her clinical site supervisor's non-hierarchical style, describing it as "a shared process of co learning." She also reported feeling more "genuine" with supervisors who fostered psychological safety. She recalled her clinical site supervisor having displayed cultural awareness when addressing client complexities, stating,

He expressed a similar kind of helplessness and frustration saying that ‘I don’t know how to help a client whose family has so much clout in their life’s decisions’... We navigated that grief together... and he asked me, ‘How can you hold space for the dichotomy of your client’s feelings without letting it affect you so deeply?’ So he, I think, played a role in... me being able to navigate that.

She also recalled another experience in which her clinical site supervisor displayed empathy when she had a death in the family, stating, “I, for the first time, was experiencing an American supervisor on site thinking about things other than just my clinical performance,” which she described as “very affirming” compared to her eastern cultural background where “only your professional performance matters.” This experience shaped her emerging supervisory philosophy, with her stating, “I was able to translate that experience into the compassion I bring to the supervision space.”

P4 recounted a clinical supervisor’s deep engagement during a high-risk client situation, stating, “She was prepared to be actively engaged in whatever the outcome was going to be... I was really appreciative of that.”

P5 described seeking external, paid supervision from White, LGBT supervisors, which she found highly supportive. She reflected

I don’t know their training, but they really helped me. They held space for me and was probably like, one of the first times... I thought I would have really gotten that from another person of color, but for them to be able to allow me the space to come in... (figure out) what my therapeutic style was... unpack... weaknesses...

share what my hardships were... to have this space where I could actually tell this person, I got my own stuff going on... I felt confident leaving that experience.

P6 credited a clinical supervisor with foundational clinical development, stating, “She gave me all of my clinical skills... they’re all due to her.” She described her post-master’s clinical supervision as “so wonderful,” having highlighted its structure and depth. P6 stated, “It was a case conceptualization of every single client... my supervisor briefed herself so well... and did role play with me, which ended up helping me so much... I felt comfortable enough to tell [clients]... what are these services; why are we in their house; what are we providing.”

P7 described an experience with a previous clinical supervisor in which she took a risk by sharing cultural concerns, stating

So I eventually did share with her [supervisor] and I feel like that kind of opened the door for us to have more personal interactions because she was able to empathize with that child being the only child of color in a pre-k through 12 in rural South Dakota ... It was so refreshing and so nice... I didn’t have to go up in battle for my client by any means.

P7 also described a sense of ease and authenticity when working in a Latine cultural context with another clinical supervisor that understood the context, noting it eliminated the need to “dance around” conversations about identity.

Although P8 acknowledged the inherent power dynamics in clinical supervision, stating, “At the end of the day, like, this is my boss... how much do I open up,” she found safety in a clinical supervisor’s vulnerability and authenticity. Of this experience,

she stated, “I had really great rapport with her. I was able to be vulnerable, which is something that I was afraid to do... It was like a slow progression over time, but just her being open allowed me to be open in those more raw moments.”

Theme 3: Seeking/Receiving Alternate Supervision

Participants described various strategies for adjusting to or disengaging from the clinical supervision setting following experiences of discomfort with their clinical supervisors. In some cases, this included withholding information and limiting interactions to only have discussions required to fulfill clinical supervision hour requirements and conclude the clinical supervisory relationship. Participants identified multiple factors that influenced the clinical supervisory dynamic, which often contributed to relational ruptures. Participants also noted alternate sources of support outside of assigned clinical supervisors, such as academic institutions, peers, or secondary clinical supervisors.

P1 recalled an instance of racial bias when her supervisor entered the waiting area and remarked, “Why does the waiting area smell like weed? It must be that Black woman that’s sitting out there.” P1 reflected, “There’s so many clients here—[it] could have been anyone, but okay.” Following this experience, which, among others, led her to feel unsafe in individual supervision, P1 asked peers to join her in supervision for triadic supervision and only shared minimal information required to complete supervision, stating

I’m gonna keep my mouth shut from now on. I’m never gonna speak in this place... My school only allowed one-on-one [supervision]... Just for my own

comfort, I was like, I don't want to be by myself with this lady... I'm never staffing something with her again... I kept it professional.

P2 described being reassigned across multiple clinical floors and working under several supervisors, each with distinct styles, dynamics, and responsibilities. She further noted she relied on peer support and guidance to complete her clinical work, stating

After a while, I was just like, you just got to keep your head down and get your hours at this point to be done. There was one White lady who was finishing up her hours and she is the one who took me under her wing... She was really helpful, but then she finished her hours and immediately, promptly left [the facility].

As P3 compared her clinical supervisory experiences, specifically related to discussing a client with a potential personality disorder diagnosis, she stated

My university supervisor focused on me and what I could do differently, whereas my site supervisor was more curious to see why the misunderstanding was happening. My site supervisor did not judge me for having a reaction. [He had] a more nuanced understanding [of cultural considerations].

P4 reflected on the role of age in shaping the effectiveness of clinical supervision, noting how his perspective regarding age accompanying experience shifted with clinical supervision experiences. He stated

At first, I saw that [age] as a bonus because I felt like she [previous supervisor] had more wisdom, more insights, more experience... I believe my current supervisor is a better match for me in terms of her experiences, her background, and just some of the things and areas where we're able to connect when we're

talking about client matters... She [previous supervisor] wasn't doing as much counseling at the time, and she was like, past retirement age and so she wasn't as active in counseling as she was previously.

P5 described intentionally seeking clinical supervision outside of her assigned clinical supervisory relationship, despite it being "upsetting" to have to pay for and seek additional help, explaining

I actually sought outside supervision to help me with what you're asking [discussions of race, ethnicity, and culture]. I had two different outside supervisors. Instead, I sought out additional supervision from other individuals because, like, you [clinical supervisor] can't help me.

P6 noted her master's level supervision focused on marketing over clinical skill building, while supervision after graduation from her master's program was largely superficial as "something to check off the box." She recalled a specific incident in which she sought support from her university clinical supervisor after experiencing discrimination at her clinical placement site, stating, "My professor and my university field office director attended the office... it was a conversation of what type of private practice they were running, but also what treatment they were doing to their interns... I only had 50 hours left... so we decided to discharge all of my clients... my internship ended very dramatically." Following these negative experiences, P6 stated, "Every time I did a home visit... I had to be built back up and I honestly wouldn't be as confident as I am today if it wasn't for that supervisor who took her time to really break it down, but to also shake some bad habits."

P7 recounted a supervisory experience in which language and culture were central. She described an unhelpful supervisory response following her attempt to explain the rationale for a treatment referral to a Spanish-speaking family who did not understand why they had been referred to treatment, stating, “I remember my supervisor at that time just kind of focusing on the fact that it was not my job to do the investigating and to make the connections and to like, make it make sense for them. Rather, my job was to support the child and to implement a treatment to help the child leave the facility.” In contrast, she reflected on a more supportive experience with another clinical supervisor, noting, “Although my mentor is also a White man, he speaks Spanish and has traveled to Spanish-speaking countries and [is] very aware of the barriers, especially the language and the cultural barriers. So that’s been a breath of fresh air.”

Theme 4: Experiencing Stress and Self-Doubt in Clinical Supervision

Participants described experiencing internalized pressure to present themselves in a manner they believed would be acceptable to their clinical supervisors, often striving for what they perceived as perfection. Several participants also recounted instances in which they doubted their own clinical judgment during clinical supervision. Additionally, participants detailed actions taken to assimilate to the clinical supervisory environment and to align with the preferences of their clinical supervisors.

P1 reflected on the difficulty of recognizing and trusting her reactions to her supervisor’s biased remarks, expressing self-doubt and stress in doing so. She explained

It took me that long to really be able to place like, this is who this lady is... I was like, am I being sensitive?... I’m not trusting my intuition and I’m not trusting my

physical bodily reactions to something. As much as I'm trying to like, no we must have evidence... you feel like this, you don't need evidence... She literally said that... the Black woman (referring to the supervisor's assumption of the Black woman smelling like weed in the waiting area) or Arabs are like rapists (referring to the supervisor's generalizing racial, ethnic, and cultural assumptions in a case conceptualization). She literally said that, so yeah, it was a big learning moment for sure to... not be confused. Let's just listen to yourself and that's okay.

P3 expressed internalized stress and self-doubt in several contexts (clinical supervision, peer comparisons, client interactions). She stated, "I've always felt like I had to be the 99th percentile of the class to feel worthy enough for my supervisor to respect me." P3 also expressed some White clients questioned her competence (e.g., asking her what degrees she has), which led P3 to her consider, "Am I doing this right? Or is it that just because my colleagues have a clearer accent that when we say the same thing it lands differently with them?... I felt I was at a disadvantage and like I was failing at practicum. Not because I didn't know how to be a therapist, but because I struggled with acclimating to the culture."

P5 described the emotional toll of early clinical experiences, particularly the internal pressure to meet high professional expectations despite feeling underprepared or insecure. She reflected, "I was like, I'm crumbling under the additional weight of feeling like I need to be all there for my clients, I need to perform, I need to... not be perfect, but I was struggling with just feeling like I was doing things well... Having the credentials that I have now has given me the confidence to assert myself and say what I have to say

and walk into rooms, but where I was then is where I say it really affected my confidence. I wouldn't stand up for myself or assert myself."

P6 expressed self-doubt with clinical work during her master's program clinical training, stating, "I would never feel like I was good at my job, I always felt like I was learning."

P7 reflected on the initial hesitation she experienced when considering whether to bring culturally relevant concerns to her clinical supervisor, who was a White woman nearing retirement, stating, "At the beginning, I was very hesitant to bring any sort of concerns to her in regard to clients from different backgrounds because I was acknowledging... some of the areas that I was sent to [were] very, very white." She recalled a specific incident when she felt it necessary to broach race and culture for a client, stating

I don't think it was until I came into a situation where I was like, I truly have no idea what to do for this kiddo that I started to think, well maybe I will ask my supervisor and see if they have any ideas and maybe I don't even have to mention the race. And I was like, no I should (mention race) so they better understand... How do I change the whole climate of a school that is against this child?

P8 described stress related to disclosure and imposter syndrome, stating

At the end of the day, this is my boss, like, this is my supervisor, you know. There is a line to how far, you know, how much do I open up? Like, is it safe to be able to talk about these raw moments, because, then I am like, okay, what am I capable... again, the imposter syndrome.

Theme 5: Attending PWIs

Participants reported that most practicum and internship settings lacked diversity, with predominantly White supervisors, clinicians, and clients. This contributed to feelings of isolation among racial and ethnic minority supervisees. Several participants emphasized the importance of racial and ethnic minority representation, highlighting the positive effects of having racial and ethnic minority clinical supervisors, instructors, and peers on their sense of support and belonging. Participants also noted experiences related to their racial and ethnic minority identities within PWIs, noting challenges regarding perceptions of not belonging in the PWI settings.

P1 described her clinical training site as a “predominantly White facility with predominantly White clinicians and predominantly White clients,” and stated, “If you’re the only BIPOC (Black, Indigenous, and People of Color) person in the room, like, now you suddenly represent everybody.” P1 recalled she was often “narrowed down to something that is palatable to others,” a process that frequently excluded her Arab identity and led to her “being put in a box” for the comfort of others.

When describing her clinical training site as a predominantly White institution, P2 stated, “They put us [racial and ethnic minority supervisees] on different opposing days. So I couldn’t really build up rapport... there wasn’t a support system per se, culturally speaking. There certainly wasn’t any Black therapists... I’ve not seen a Black supervisor ever.” P2 also noted the significance of racial and ethnic minority representation in academic settings, which she also noted were predominantly White institutions from her

experiences, noting two Black faculty members who assisted in her progression within the counseling profession through support and modeling.

P3 discussed working with racial and ethnic minority clients, including first-generation and transfer students, some of whom avoided campus counseling services due to a lack of racial and cultural representation. P3 noted, “[There were] the ones that wanted to stay on in therapy but didn’t have an association with or refused to go to the counseling center on campus because most of the therapists are White.” Reflecting on her own sense of marginalization within the profession, P3 recalled questioning, “When am I going to ever feel like I belong to this profession and this country? ...Racism now is so much more about accent... No one at home has trouble understanding me. Most people don’t have trouble understanding me, but that seems different at a PWI with not as much diversity.”

P4 expressed he worked in a predominantly White community with mainly White clients, stating “When I was receiving supervision the first time, it was in a predominantly White community and so the vast majority of my clients were White.”

P6 described working in a predominantly White practice during her master’s program and noted challenges in conveying cultural nuances to clinical supervisors who were unfamiliar with Hispanic culture and the Spanish language, explaining, “Sometimes you don’t have another word to translate what’s going on with the client and you got to use their exact words to describe what’s happening and that’s really beneficial for me.”

P7 described working in a “not super diverse state,” mentioning, “Some of the areas that I was sent to were very, very White. Some of the schools were privileged in that sense.”

Theme 6: Experiencing Lack of Preparation for Supervision and Practice

Participants reported experiences wherein clinical supervisors often displayed what not to do in practice rather than providing clear guidance on effective clinical approaches. Participants concerns spanned a range of issues, including appropriate, ethical, and culturally sensitive practices. Several participants highlighted the critical role of racial and ethnic minority representation and modeling in facilitating the acquisition of effective and appropriate clinical skills. Additionally, participants described feeling inadequately prepared in multiple domains, such as documentation, expectations for clinical supervision, the pace of clinical sites, and the delivery of clinical care.

P1 reflected that her internship clinical supervisor primarily demonstrated what not to do in clinical practice and did not provide guidance on cultural sensitivity. P1 stated, “Supervision didn’t necessarily teach me how to navigate multicultural aspects, but it taught just don’t do certain things, don’t say certain things, like be really mindful.” P1 later added, “I may just need to get different supervision in the future.”

P2 described her site clinical supervisors as generally teaching her what not to do, stating, “I learned a lot of what not to do... (and that’s) not how you do that... I had to be assertive in my own learning... I just learned as I went along... I had to be independent and seek, it wasn’t ever that they... volunteered the information.” A critical incident involved what P2 described as unethical conduct by her site clinical supervisor, a

Hispanic woman, toward a Black adolescent client during group treatment. When the supervisor was confronted by the adolescent client's mother about an inappropriate comment she [supervisor] said to the client in a group setting, P2 reported, "The supervisor blatantly lied – I never said that," and noted that the clinical supervisor refused to provide upper management's contact information to the client's mother. The client's mother ultimately filed a complaint, which escalated to the CEO of the clinical site. Following a meeting with the CEO, the clinical supervisor reportedly apologized to P2 and P2 was reassigned to another clinical supervisor and clinical floor thereafter.

P4 reported feeling underprepared during practicum, particularly with documentation and progress notes. He stated, "I really didn't... feel prepared. I wasn't sure with the progress notes if I was writing too much at first and what content to include and not include. So that first semester was really a learning experience for me." This challenge persisted into internship, where "the real focus was on what was happening in the session... not so much on the paperwork side of it... Maybe by the time I became licensed is when I feel like I was doing a better job... not just in the session, but as far as the progress notes as well."

P5 reflected that her clinical supervision did not align with what she later learned in her doctoral supervision course, stating, "I realized... I never had what it was supposed to be... It wasn't a bad experience, but I left feeling like I don't know if I fully became the clinician that I could have been." She characterized her master's level supervision experience as "surface level," with group sessions often dominated by the supervisor's personal conversations rather than clinical dialogue. She described practicum for clinical

training as fast paced, stating, “Things started moving pretty rapidly... you really have to... pick it up or else... you’re just like, dang, I’m making mistakes left and right.”

P6 described a clinical supervision experience as “laissez faire... less organized and more focused on getting the actual supervision out of the way.” P6 reported she first learned about the role of structure in clinical work only later in clinical supervision, expressing she learned, “there’s structure for CBT... you’re building rapport, but every session is not a trauma dump.” She continued

In my (initial) internship, I was taught to go through intake just asking questions... To check things off and it’s done... There was no treatment plan, there was no mental health assessment, there was nothing... It was chewing up the hour to get paid. And then there was supposed to be a time in the session where the person tells me all of their... the trauma dump, and that was not normal. And that is not normal of a clinical intake... that is not normal. This is actually the moment... to ask the client... what are you here for, what are your expectations, what do you need.

P7 noted that the assessment tools and approaches in her clinical supervision were specific to the agency context, stating, “One of my sites was a juvenile justice detention center and that site supervisor was very much focused on, these are the assessments that we do... we’re able to provide just minimal support because they’re awaiting their court hearings... Clinically I’m not sure that it did too much for me because I don’t use any of those screeners now.” P7 recalled being assigned half the cases on the unit and being instructed to create workshops based on client needs, stating, “It was something that I

was just kind of volun-told to do.” Although P7 had completed a group therapy course with peers in an educational setting, she contrasted this with the clinical site in which she was charged to lead groups for “eight- to ten-year-old boys... with little to no support,” having noted that in class, group responsibilities were shared between peers.

Theme 7: Experiencing Clinical Supervision as a Hierarchy

Participants’ accounts illuminated the inherent power dynamics embedded within the clinical supervision relationship between supervisee and clinical supervisor. Several participants described experiences of cultural dissonance, particularly tensions arising between eastern and western cultural frameworks.

P1 reflected on the influence of societal and clinical supervisory hierarchies, noting, “It’s like an Arab thing of like, authority figures. Like, you just don’t challenge authority. So I’m trying to teach myself... it’s okay to challenge authority.”

Acknowledging the clinical supervisor’s power to “sway... my kind of path,” she cited an example in which a peer “essentially got fired [from clinical supervision] and delayed graduation... and no one has the real reason of like what went on.” After comparing the peer’s account with the clinical supervisor’s, P1 concluded, “this person [clinical supervisor] has a lot of power and has the potential to be able to mess things up for you... so I was like, I’m not gonna let that happen to me. Head down... She said this thing and it made you feel a way, but... I’m not gonna change her mind, this is just who she is.”

P2 described a practicum environment characterized by cliques and a supervisor-protective stance, noting, “The clinicians there were buddy, buddy... all hung out together... so there was conversations happening that I wasn’t quite privy to.” Following

an incident that caused discomfort, she reported, “Because my supervisor was part of the shenanigans, I went to her supervisor... the director of clinical training.” However, P2 discovered that the director “was cool with all of them,” and after explaining the situation, “she [director of clinical training] looked at me like, well why didn’t you just get up and go.” P2 expressed, “No one was supportive of me. Rather than address the situation, they moved me to IOP.”

P3 reflected on cultural clashes in supervision, having noted her supervisor’s directive, “You need to be able to assert yourself and disagree with me.” She contrasted this with her cultural background, stating, “I come from a more collectivist and hierarchical culture; I thought I was being respectful... It was very culturally shocking for me... It doesn’t feel right to say no ... to my service commitment in the profession... I think there was a lack of understanding of the power dynamic for me as a younger brown woman and him [supervisor] as an older White man.” She also described a critical incident in which a White client said, “I wanted to major in IT, but they outsourced all the jobs to your people in India.” P3 recalled “smiling through it” and using humor because “otherwise, I wouldn’t know what to do with it.” Upon reflecting on her supervisor’s encouragement for her to address it in the moment with the client, she stated, “Even though my client was younger than me, he was a White male and I’m sitting here as this international student with an accent who doesn’t really know the country... I felt like I was the wrong therapist for that client because race was not discussed. No one told me what I could or should have said.”

P4 described a discussion in clinical supervision regarding a treatment recommendation for which he held a different viewpoint from his clinical supervisor, stating

I didn't use any language that would have suggested that I was being combative or that I was being disagreeable. You know, I was using language that communicated I was just trying to get a better understanding, because based upon what was being shared, I wasn't fully grasping the aspect of communication ... It was me not coming across as though I had an equal contribution in the conversation... I was very mindful of not communicating anything that would suggest that I felt like I knew what I was talking about... I always felt like, well, she's the more experienced person and, you know, she's been doing this a lot longer. So, kind of like, you know, she's always right in terms of her feedback.

Theme 8: Being Assigned Minority Clients based on Race/Ethnicity

Most participants reported being assigned clients from racial and ethnic minority backgrounds, primarily within PWIs. Participants also noted that these assignments were often made without any accompanying discussion regarding the racial or ethnic dynamics inherent in the clinical supervisory or clinical context.

P3 stated, "One of my first clients was assigned to me because of my South Asian heritage."

P4 recalled being assigned a biracial client previously seen "for some time" by his White clinical supervisor. P4 stated, "I got the impression that my supervisor felt as though, because of the client's biracial dynamic, the client would probably connect more

with me.” P4 noted that no direct conversation about race occurred between him and the supervisor regarding the referral, and that race was not discussed within the counseling sessions, as the client did not raise the topic of race for discussion. Reflecting on the experience, P4 stated, “I’ve come to realize there are some clients who prefer certain people, you know, who look like them.”

P6 described being referred exclusively racial and ethnic minority, Spanish-speaking clients in a predominantly White setting during her master’s clinical internship, stating

Yeah, I remember having a conversation with my supervisor in my master’s program. And the conversation went as, I’m getting all of these brown clients.

Why am I getting all of these brown clients? And her [clinical supervisor] reason for it was saying that they had asked for me. So they requested someone who was ethnic and that’s why I was receiving all of them.

After raising concerns with her supervisor, P6 reported she felt “punished” when she was assigned a White adult client “completely out of my age bracket and focus, with multiple serious diagnoses, including schizophrenia.” P6 reflected, “It was kind of like a punishment for even questioning why I did not get other clients, so they threw me their worst one... someone completely out of my scope... [The client] shouldn’t have even been seeing an intern.” P6 described the referral as “risky” and racially charged, adding, “I felt like they were discriminating against me and punching me down.”

Theme 9: Responsibility to Racial and Ethnic Minority Clients

Some participants reported assuming primary responsibility for racial and ethnic minority clients, particularly when their clinical supervisors demonstrated limited cultural understanding or responsiveness. Participants also highlighted gaps in the provision of culturally informed care for these clients.

P2 expressed a commitment to serving underrepresented populations, stating, “Immediately after my master’s program I decided that the demographic and population that I wanted to cater to would be at-risk youth or anybody in the BIPOC (Black, Indigenous, and People of Color) community because there is a lack of representation and I wanted to fill that gap... We would go to get them [Black clients] to outpatient to discharge them with no Black counselors and all of the families would be like, that’s all we got, and I was like, this is a gap.”

P7 described a strong sense of responsibility toward racial and ethnic minority clients, stating

Being a Spanish-speaking provider, I almost feel like a responsibility to provide those explanations (for referrals to clinical services) to them so that they feel a bit more at ease as to why their child is here and understand that their child is here to get better... Once I was told by my supervisors, like, that’s not your job, stay within your scope of practice. And I was like, well, then that mission is canceled. So how can I provide support in a different way within my scope of practice?

General Narrative

In this section, I provide a general narrative of all themes that have been identified in the current research study. This general narrative consists of a collection of the lived experiences of participants and is organized by themes. I support each theme with examples drawn from participants' experiences to illustrate the essence of their perspectives and provide a rich, authentic representation of the data.

Participants frequently perceived supervisors as culturally unresponsive, describing rigid thinking, narrow frameworks, and bias. Examples included overt political bias (P1), ethical challenges in understaffed settings (P2), tension between collectivist and individualist perspectives (P3), and clinical supervisors narrow client focus (P4). Others noted the absence of intersectional or decolonizing frameworks (P5), minimization of cultural care (P6), lack of structure (P7), and disorienting supervisory inconsistency (P8). Following clinical supervisory ruptures, most participants adopted coping strategies to endure rather than engage in clinical supervision. These included limiting disclosure (P1), "keeping her head down" (P2), or disconnecting due to cultural, age, and/or clinical practice differences (P3, P4). One participant paid for external supervision after concluding her clinical supervisor "could not help her" (P5). Most participants described internalized stress and self-doubt, particularly in PWIs, where implicit pressure to perform or conform was pronounced. P1 delayed trusting her judgment to avoid being labeled "hypervigilant," P3 felt compelled to perform at the "99th percentile," and P5 and P7 hesitated to raise cultural concerns with White clinical supervisors. Others voiced fears of inadequacy (P6) or vulnerability (P8). Such narratives

reflected the emotional strain of perfectionism, accent-based bias, and the weight of advocating for racial and ethnic minority clients.

Most participants were trained within PWIs (both clinical and academic settings) and reported minimal diversity, racial and ethnic minority representation, or culturally sensitive training. P1 described tokenism, P2 noted lack of systemic support, and P3 observed that minority clients avoided campus counseling centers. Others emphasized White-majority client bases (P4), language-related clinical supervisory gaps (P6), and working in a “not super diverse state” (P7). Such dynamics often compounded isolation and raised questions of belonging for the racial and ethnic minority supervisee. Most participants felt underprepared for both clinical supervision and counseling practice, often being left to navigate complex situations without sufficient guidance from their clinical supervisor. Reports included limited culturally responsive strategies (P1), ethical violations (P2), uncertainty about documentation (P4), minimal feedback (P5), billing prioritized over treatment (P6), and lack of direction with clinical assignments (P7). Positive experiences emerged when clinical supervisors modeled empathy, humility, and relational safety. Examples included co learning (P3), active engagement with client crisis (P4), structured collaboration (P6), freedom from “dancing around” cultural issues, resulting in psychological safety (P7), and mutual openness (P2, P5, and P8). Such dynamics facilitated authenticity and growth. For most participants, clinical supervision was experienced as hierarchical, with cultural differences intensifying the imbalance for some (P1, P3).

Participants described managing communication carefully (P4) or being reassigned after self-advocacy (P2). These accounts highlight the need for more collaborative, culturally responsive clinical supervisory practices. Some participants reported being assigned racial and ethnic minority clients within PWIs, typically by White clinical supervisors who framed these assignments as forms of cultural matching but provided little culturally responsive dialogue or supervisory support. These assignments were perceived as tokenizing (P3, P4) and, in one case, included retaliatory action from the clinical supervisor when challenged (P6). Finally, some participants assumed primary responsibility for racial and ethnic minority clients where clinical supervisors lacked cultural awareness. Examples included bridging systemic care gaps for Black clients (P2) or supporting Latine families in translation contexts (P7), sometimes under the clinical supervisor's caution to remain "within scope."

General Structure

In this section, I provide a general description, which consists of taking the microlevel lived experiences of the individual participants and connecting them to the overall macrolevel phenomenon of the study. The experiences of the racial and ethnic minority supervisees within this study exemplify Heidegger's notions of *Dasein*; interpretation, or fore-sight/fore-conception; *Mitsein*; the hermeneutic circle. *Dasein* is evident with the racial and ethnic minority supervisees understanding of being-in-the-world, including their worldview of how they perceive themselves, others, and how they perceive how others perceive them. Interpretation, or fore-sight/fore-conception, is evident with the racial and ethnic minority supervisees reflection and development of

more nuanced perspectives when considering their clinical supervision experiences thus far. This displays how the racial and ethnic minority supervisees experiences may have changed through the lens of past, present, and future. *Mitsein*, or being-with, is evident in the interpersonal interactions that are embedded within the clinical supervision context. Through a hermeneutic circle process of integrating new insights into existing knowledge, the racial and ethnic minority supervisees continued making sense of their lived experiences, consistently adjusting parts of old knowledge and new as discussion unfolded.

Racial and ethnic minority supervisees fore-conception when they enter the clinical supervision context, especially in initial clinical supervision which often occurs during master's-level or doctoral-level educational programs, is that there will be clinical, intentional, and supportive practices from clinical supervisors. The racial and ethnic minority supervisees discussions around the various nuances that can influence racial and ethnic minority supervisees experiences within the clinical supervision context illuminated their understanding of the world on a macrolevel, as well as their understanding of dynamics within the clinical supervision context and counseling profession on a microlevel. Through the clinical supervision experiences, participants gained new insight into the challenges of being racial and ethnic minority supervisees within the clinical supervision dynamic.

Mitsein emerged as a recurrent phenomenon within the relationships inherent to clinical supervision and within the relational dynamics and clinical supervision influences. Many clinical supervisors functioned as free-floating subjects alongside racial

and ethnic minority supervisees, a stance that contributed to deficiencies in understanding, connection, and empathy. These unhelpful clinical supervisory dynamics reflected limited expressions of *Mitsein* and, consequently, suggested restriction of self-knowledge on the part of the clinical supervisor because “knowing oneself is grounded in Being-with” (Heidegger, 1962, p. 161). *Mitsein* was also evident in interactions between racial and ethnic minority supervisees and their clients, as the counseling relationship often mirrored the dynamics of the clinical supervisory relationship. For instance, surface-level discussions and the absence of broaching in clinical supervision frequently translated into similarly limited engagement in counseling. Conversely, clinical supervisory dynamics characterized by security and support enabled supervisees to engage in deeper self-reflection, guide clients, and in some cases, supervisees who chose to serve as supervisors were able to guide their supervisees in their own processes of self-discovery. Helpful clinical supervisory behaviors, such as intentional broaching and empathy, were frequently mirrored within supervisees own clinical practice and extended beyond the clinical supervisory context, evidenced by racial and ethnic minority supervisees who described continuing to implement positive actions modeled by their clinical supervisors.

A salient and recurring theme across the population of racial and ethnic minority supervisees is a perceived lack of cultural responsiveness among clinical supervisors, noted by rigid thinking, narrow application of treatment frameworks, and the presence of apparently unchecked bias. These clinical supervisory limitations not only appear to impede racial and ethnic minority supervisees ability to engage in culturally informed

clinical practice; these limitations also point to a broader systemic issue rooted in Eurocentric and individualistic models of mental health care. The rigid adherence to these dominant models by clinical supervisors appear to perpetuate assimilation to the culture seemingly established within the mental health profession, which mirrors the macrolevel American, westernized culture and lens. Racial and ethnic minorities who note these experiences display how conformity to dominant norms is often rewarded, while cultural differences are treated as deviant and/or deemed irrelevant. The conflation of cultural and religious beliefs, minimization of culturally sensitive care, and the resistance to collective perspectives reflect how Eurocentric norms continue to define professional competence, marginalizing alternative worldviews and experiences.

In response to ruptures within the clinical supervisory dynamic, most racial and ethnic minority supervisees seek support outside of their assigned clinical supervisory context, adopting coping strategies such as nondisclosure, emotional disengagement, and/or paying for external clinical supervision, all of which are aimed at enduring rather than engaging with the supervisory process with the assigned clinical supervisor. Such withdrawal underscores the protective strategies racial and ethnic minority supervisees may employ in environments they perceive as unsafe, despite the embedded power dynamics, revealing how systems of oppression can manifest through microlevel relational dynamics. Withdrawal and other coping skills to emotionally separate from the clinical supervisory relationship often leads to internalized stress and self-doubt, where most racial and ethnic minority supervisees feel implicit pressure to perform, conform,

suppress instinct, avoid vulnerability, and prove competence within PWI contexts to protect themselves from judgement and/or dismissal.

It can be argued that these dynamics contribute to racial battle fatigue, or the psychological, physiological, and behavioral responses (e.g., social withdrawal and self-doubt) resulting from racial and ethnic minorities experiencing racism and racial microaggressions (Smith et al., 2011). This connection echoes broader social hierarchies in which marginalized professionals can tend to overcompensate for perceived deficits while carrying the emotional and ethical burdens of advocating for themselves as racial and ethnic minorities as well as advocating for the racial and ethnic minority clients these marginalized professionals may serve. The weight of perfectionism, accent bias, and the suppression of authenticity highlight how professional norms within clinical supervision mirror systemic racism and racialized professional gatekeeping.

These experiences are compounded by the structural realities of PWIs, where training and teaching often lack diversity, racial and ethnic minority representation, and culturally sensitive frameworks. Within these contexts, tokenism, identity erasure, and the absence of culturally attuned models sustain Eurocentric norms and can reinforce institutional mistrust among racial and ethnic minority clients, who often avoid such services altogether. As a result, racial and ethnic minority supervisees may not only question their belonging to the mental health counseling profession; they may also witness firsthand how professionals within institutions may be unable to effectively serve diverse communities, which can exacerbate racial disparities in care.

In addition, most racial and ethnic minority supervisees feel underprepared for counseling practice and clinical supervision, citing insufficient guidance, ethical violations on the part of the clinical supervisor(s), minimal feedback, and overemphasis on billing and documentation. This reflects a professional culture that often prioritizes standardization and procedural compliance over relational and cultural skill-building, which can perpetuate systemic gaps in developmental support. Despite these challenges, many racial and ethnic minority supervisees describe clinical supervision as most effective when grounded in empathy, cultural humility, and relational safety.

Counternormative practices, such as co learning, mutual vulnerability, and affirmation of cultural realities, can provide spaces of liberation in which power is shared, and cultural identity is validated as an asset. Importantly, these positive experiences often transcend same-race dynamics because cultural humility and collaboration across racial differences can foster safety and belonging. However, clinical supervision remains inherently hierarchical, and this hierarchy can be intensified when racial and ethnic minority supervisees cultural frameworks conflict with westernized models of authority.

Navigating these tensions often requires racial and ethnic minority supervisees to carefully manage communication, engage in self-advocacy, and/or take on advocacy roles for racial and ethnic minority clients, despite institutional systems that rarely account for power differentials. Some racial and ethnic minority supervisees are assigned racial and ethnic minority clients by White clinical supervisors under the apparent guise of cultural matching, yet these assignments are often void of culturally responsive support or dialogue. This practice often reinforces tokenism, placing disproportionate responsibility

on racial and ethnic minority supervisees while leaving clinical supervisors unexamined. In some cases, supervisees face retaliation for questioning these practices, illustrating the superficiality and risks of unjustified cultural matching. Relatedly, some racial and ethnic minority supervisees often assume primary responsibility for racial and ethnic minority clients, especially in contexts where clinical supervisors lack cultural awareness, stepping into these roles out of ethical commitment, cultural affiliation, and recognition of systemic care gaps. While these efforts reflect resilience and dedication to equity, they also underscore the disproportionate burden placed on racial and ethnic minority supervisees to compensate for institutional and clinical supervisory shortcomings, mirroring the broader societal expectation that marginalized individuals shoulder responsibility for addressing systemic inequities while constrained by the very systems that perpetuate these inequities.

Overall, these themes and experiences illuminate how clinical supervision is deeply embedded in macro and microlevel systems of power, racialization and institutional control. Some experiences also display that, despite these systemic factors, some clinical supervisors and racial and ethnic minority supervisees ascribe to transformative clinical supervision and counseling models rooted in cultural humility, equity, and relational safety. These experiences also display that those within the counseling profession generally encourage a one-size-fits-all for clinical supervisors and supervisees. General frameworks that do not support diverse circumstances and intersectionality are common as well. A macrolevel analysis suggests that achieving culturally responsive clinical supervision is not solely the responsibility of individual

clinical supervisors or supervisees, but requires systemic transformation in the values, practices, and policies that govern clinical training as a whole.

Summary

In this chapter, I focused on the results of the current study. I reviewed data collection and analysis techniques and details, identified thematic meaning units and illustrated themes, and provided a general narrative and general description. Participants from the current study indicated that most racial and ethnic minority supervisees experience bias, lack of cultural responsiveness, and ethical concerns from clinical supervisors; most racial and ethnic minority supervisees seek and/or receive support outside of assigned clinical supervisors; most racial and ethnic minority supervisees experience stress and self-doubt in clinical supervision; most racial and ethnic minority supervisees attend and are trained in PWIs; most racial and ethnic minority supervisees experience inadequacy in preparedness for clinical supervision and clinical settings; many racial and ethnic minority supervisees experience support from certain clinical supervisors who are outside of their assigned clinical supervision dynamic; many racial and ethnic minority supervisees experience clinical supervision as a hierarchy; some racial and ethnic minority supervisees are assigned racial and ethnic minority clients based on race/ethnicity; some racial and ethnic minority supervisees experienced personal and professional responsibility to racial and ethnic minority clients. Each of these identified themes within a microlevel clinical supervision context are connected to macrolevel contexts within society generally, which highlights the general experiences of racial and ethnic minority supervisees within clinical supervision contexts. In the

following chapter, I review discussion, conclusions, and recommendations resulting from the current study.

Chapter 5: Discussion, Conclusions, and Recommendations

In Chapter 5, I interpret the findings from the current study and compare these findings to relevant prior research. Significant findings are discussed, limitations of the current research are highlighted, recommendations for future research are provided, implications for positive social change are displayed, and conclusions are presented. In this chapter, I also integrate results from the current study with existing literature to contextualize the findings within a broader context and to demonstrate the contribution of the current findings to current knowledge and practice.

Interpretation of the Findings

In this section, I revisit some of the key topics highlighted in Chapter 2 and compare them with the findings of the current study, which was conducted to explore racial and ethnic minority supervisees' experiences and gain insights into those experiences within the clinical supervision context. Although not all previous research is addressed, I highlight and connect the relevant research that is comparable to the current study findings.

Core Components and Objectives of Clinical Supervision

As noted in previous literature, novice therapists and clinical supervisors at varying developmental levels struggle to adapt to the evolving and complex relational demands of clinical supervision (Friedlander, 2012). Supervisors-in-training are expected to navigate clinical supervision models, ethical standards, and cultural competencies, yet many receive inadequate preparation, particularly in areas of formative feedback and metasupervision (Bernard & Goodyear, 2019; Borders et al., 2014). This inadequate

preparation was also a recurring theme in the present study, albeit within a distinct context. Most racial and ethnic minority supervisees reported feeling inadequately prepared for clinical supervision and clinical settings. This finding may be an indication that unpreparedness in the mental health counseling profession is systemic in nature, transcending context yet reappearing consistently across clinical supervisory relationships.

In alignment with prior concerns about clinical supervisors experiencing difficulty with the overlap of clinical and administrative roles, particularly when agencies and academic institutions lack clear communication (Bernard & Goodyear, 2019; L. C. J. Wong et al., 2013), participants in the current study reported similar challenges. Some clinical supervisors emphasized procedural and administrative tasks over developmental guidance, leaving little space for clinical skill-building (P2, P6). Participants also noted limited instruction on documentation (P4) and treatment planning (P6), insufficient formative feedback (P5), and the assignment of complex responsibilities without adequate direction (P7). Participants in the current study further reinforced the literature by documenting how some clinical supervisors often relied on their preferred theoretical orientations (see Koçyigit, 2022), which were implemented rigidly and without cultural responsiveness, thereby failing to address the developmental and cultural needs of supervisees and their clients. One racial and ethnic minority supervisee described the confusion resulting from varied clinical supervisory approaches within a single training site (P8), echoing the concern in previous research regarding inconsistent theoretical guidance (see Herbert, 2016).

Furthermore, participants from the current study reported that such inconsistencies and gaps contributed to supervisees' tendencies to overcompensate, often resulting in heightened stress, self-doubt, and a sense of misalignment during clinical supervision, which is a period intended to foster professional identity formation (Bernard & Goodyear, 2019). These findings stand in direct tension with the ACA's (2014) mission to promote the professional development of counselors while cultivating respect for diversity, suggesting that many approved clinical supervisors, mandated to uphold this mission, often fall short in practice. Together, previous researchers and present findings indicated that systemic inadequacies in supervisory and clinical preparation are reproduced in ways that can disproportionately affect racial and ethnic minority supervisees and clients, raising significant concerns about the equity and effectiveness of counselor training in its present state.

Evaluation

As outlined in the literature, evaluation in clinical supervision is often misperceived by clinical supervisors as a singular event rather than an ongoing, developmental process that should be culturally sensitive, goal-oriented, and action-driven (Bernard & Goodyear, 2019). Constructive and formative feedback is recognized as central to supervisees growth and the development of multicultural competence (L. C. J. Wong et al., 2013), whereas inconsistent, unclear, or biased feedback, often manifested through microaggressions, judgmental comments, or dismissive interactions, can erode the clinical supervisory alliance, impede learning, and ultimately harm client care (Ammirati & Kaslow, 2017; Constantine & D. W. Sue, 2007; Ramos-Sánchez et al.,

2002). Decision making in evaluative contexts is often influenced by clinical supervisors' personal belief systems, which highlighted the need to interrogate the ways in which values and biases shape clinical supervisory practices (Levitt & Moorhead, 2013). Consistent with these observations, some participants in the current study reported confusion and distress in response to inconsistent and/or biased feedback. For instance, P1 described her clinical supervisor altering evaluation ratings without explanation, which suggested an evaluative process guided more by personal beliefs than observable performance. P3 recalled experiencing microaggressions from a client in session and a lack of clinical supervisory support within the clinical supervisory context, thereafter, leading to a supervisory rupture that not only undermined trust but contributed to P3 receiving support outside of this clinical supervision context. Similarly, P4 noted that the quality of feedback he received appeared to improve only after licensure, when he may have been perceived as more competent. These accounts illustrate the implicit hierarchies and shifting evaluative standards embedded within clinical supervisory relationships.

Although not central to the research question of the current study, one participants reflections on the relational and cultural dimensions of evaluation deepen these findings by offering practical insight into what constitutes constructive feedback. P3 emphasized the importance of creating evaluative spaces where racial and ethnic minority supervisees can “struggle, fail, or be vulnerable in the room” without fear of judgment and/or being held to higher standards that can be imposed on marginalized groups. For P3, evaluation was most effective when embedded in empathy and psychological safety, conditions that fostered authenticity and growth. She further shared how these insights shaped her own

clinical supervisory practices, wherein she intentionally asks American supervisees to reflect on cultural identity with the recognition that “who you are as a person translates to who you are as a therapist.” Such accounts affirm previous researchers’ calls for evaluation as a relational and culturally attuned process (L. C. J. Wong et al., 2013) while simultaneously extending it by illustrating how supervisees can transform difficult evaluative experiences into more inclusive and responsive clinical supervisory practices. Together, the previous literature and current findings underscore that it is often unhelpful for evaluation to be reduced to static, performance-driven assessments, and that evaluations can instead be understood as dynamic, culturally situated dialogue that meaningfully supports supervisees development and clients overall wellbeing.

Balance of Administrative and Clinical Tasks

Previous researchers highlighted that while restorative outcomes such as supervisees prevention of burnout are critical, clinical supervisors often continue to focus on formative and normative functions over restorative ones, despite the well-documented role of the clinical supervisory relationship as a protective factor against burnout (Fukui et al., 2019). In academic contexts, faculty clinical supervisors have been noted to prioritize formative functions (e.g., teaching and skill building), whereas site clinical supervisors have often emphasized normative functions (e.g., gatekeeping, policy adherence), with overlapping administrative and clinical demands further complicating clinical supervisory practices, particularly when communication between training sites and institutions is inconsistent (Bernard & Goodyear, 2019; Joshua Bradley & Becker, 2021; L. C. J. Wong et al., 2013). Findings from the current study reinforced these

observations while extending them through the perspectives of racial and ethnic minority supervisees, who also experienced clinical supervisory relationships as protective for professional development and personal wellbeing.

Participants in the current study also described significant variability in the quality of clinical supervisory relationships across contexts. Participants reported that while some clinical supervisors modeled empathy, co learning, and cultural responsiveness that fostered feelings of safety and authenticity (e.g., P3, P6, P7), other clinical supervisors were perceived as unhelpful when clinical supervision was reduced to administrative oversight and/or when relational alignment was lacking. P2, for instance, described her clinical site supervisor and management as failing to uphold ethical and institutional agreements, reflecting how administrative priorities can eclipse developmental needs and compromise the clinical supervisory alliance. These findings align with the assertion that the relational dimension of clinical supervision serves as a critical buffer against burnout (Fukui et al., 2019); the findings also underscore that when normative and administrative demands take precedence, the developmental and cultural needs of racial and ethnic minority supervisees are often overlooked. Such imbalances can not only erode the relational foundation of clinical supervision but can also diminish the effectiveness of clinical supervision as a protective factor, ultimately rendering the clinical supervision relationship as insufficient in supporting the growth and professional development of racial and ethnic minority supervisees.

Gatekeeping

Scholars in previous literature have underscored that the standards of the mental health profession within America are largely shaped by Eurocentric frameworks, which often complicate the integration of personal, collectivist, and cultural values for racial and ethnic minority clinical supervisors and supervisees (Constantine & D. W. Sue, 2007; Levitt et al., 2022). This misalignment leaves racial and ethnic minority professionals with insufficient guidance in both training and the scholarly literature (Levitt et al., 2022), a gap reflected in the experiences of Black therapists who have expressed the critical need for mentors attuned to the complexities of Black identity and development (Goode-Cross & Grim, 2016). Consistent with these findings, participants within the current study revealed that racial and ethnic minority supervisees frequently encountered clinical supervision framed primarily through Eurocentric lenses, often resulting in cultural dissonance and neglect of collectivist considerations. For example, P3 and P6 described not feeling seen or heard by their clinical supervisors when considering collectivist frameworks for client care, a sentiment that illustrates the narrow application of the dominant Eurocentric frameworks. In addition, most supervisees reported minimal racial and ethnic minority representation in their training contexts, with much of their education and training occurring within PWIs wherein diversity was often scarce and cultural sensitivity and responsiveness was often lacking. This lack of racial and ethnic minority representation appeared to compound feelings of invisibility and marginalization for most racial and ethnic minority supervisees within the current study, underscoring how Eurocentric orientations in clinical supervision not only limit cultural

responsiveness but can also exacerbate the challenges racial and ethnic minority supervisees face in navigating professional development overall.

Ethical Effectiveness of Clinical Supervision

Previous researchers emphasized that the effectiveness of clinical supervision depends on the supervisory capacity to manage the relational complexities inherent to the clinical supervisory dynamic, including the navigation of personal biases, cultural values, and interpersonal processes (Bernard & Goodyear, 2019; Koçyiğit, 2022). This involves maintaining the distinction and interconnectedness of clinical supervision and counseling relationships (Fiscalini, 1997) while ethically implementing clinical supervisory and counseling models that uphold cultural humility and prioritize client welfare (Bernard & Goodyear, 2019; L. C. J. Wong et al., 2013). Central to this work is the balance of formative, normative, and restorative functions, which are critical for supervisee growth, professional accountability, and client protection (Joshua Bradley & Becker, 2021), alongside ethical decision making, gatekeeping responsibilities, and attentiveness to sociopolitical and cultural contexts (Bernard & Goodyear, 2019; Pettifor, 2001).

Despite the ethical mandate to “do no harm” (ACA, 2014; Askitopoulou & Vgontzas, 2018a; Perkin, 1980), clinical supervisory practices frequently remain shaped by Eurocentric and individualistic orientations, which are often at odds with collectivist worldviews, thereby perpetuating forced assimilation and cultural erasure (Pedersen, 1991; Pettifor, 2001). In alignment with these concerns, results from the current study indicated that while some racial and ethnic minority supervisees experienced effective and supportive clinical supervision, some described harmful and/or inadequate clinical

supervisory practices, including culturally insensitive treatment recommendations, identity erasure, tokenism, microaggressions, psychological harm, internalized stress with the perception of an unsafe and unsupportive clinical supervision environment, and pressures to assimilate. These experiences contradict ACA (2014) ethical standards, which require clinical supervisors to address diversity within clinical supervisory relationships (F.2.b) and prepare supervisees to serve diverse clients (F.1.a).

Some racial and ethnic minority supervisees in the current study reported rejecting clinical supervisory guidance they deemed harmful, instead turning to external support to safeguard both their own wellbeing and that of their clients. Moreover, many racial and ethnic minority supervisees in the current study highlighted the importance of intersectionality, having noted that their clinical supervisory challenges extended beyond race to include intersecting characteristics such as gender, religion, and immigration status, which underscored the layered nature of marginalization within clinical supervisory contexts.

Clinical Supervisory Relationships and Dynamics

Previous researchers have demonstrated that both personal (informal) and professional (formal) critical incidents significantly shape multicultural counseling competency for White American counseling professionals, illustrating how personal and professional factors are deeply intertwined within clinical supervision (Delsignore et al., 2010). Clinical supervisors perceptions of supervisees abilities, or other efficacy, can directly influence supervisees self-efficacy and the clinical supervisory working alliance (Morrison & Lent, 2018), while co created clinical supervisory spaces characterized by

openness and vulnerability enhance both the relationship and efficacy for clinical supervisors and supervisees (Safran & Kraus, 2014).

Results from the current study built upon these insights, as racial and ethnic minority supervisees consistently emphasized the inseparability of personal and professional identity, with some framing their training experiences around the notion of the “person as professional.” For instance, P4 stressed the importance of clinical supervisors not making assumptions about competence but instead tailoring feedback and support to supervisees developmental needs, while other racial and ethnic minority supervisees in the current study underscored how spaces of openness and vulnerability within clinical supervision fostered trust, strengthened confidence, and enhanced professional growth. Through these findings, it can be suggested that the relational qualities identified in prior literature are vital for effective clinical supervision and may hold heightened significance for racial and ethnic minority supervisees, whose personal and cultural identities are often inseparable from their professional roles. With this in mind, it is important to consider that racial and ethnic minority supervisees may rely on co created, safe clinical supervisory spaces to fully engage in their overall development.

Parallel Process

A critical concept in clinical supervision has been found to be the parallel process, in which relational dynamics in one dyad (clinical supervisor–supervisee or supervisee–client) are mirrored in the other (Bernard & Goodyear, 2019). Previous researchers suggested that while parallel processes can foster growth when clinical supervisors model equitable and culturally responsive interactions, harmful dynamics may also be

replicated, thereby perpetuating silence around critical cultural variables and undermining supervisee development (Drinane et al., 2021; Sarnat, 2019). Negative clinical supervisory dynamics can undermine supervisees self-efficacy and, by extension, compromise the therapeutic alliance they establish with clients (Ramos-Sánchez et al., 2002). In response to these risks, researchers emphasized the need for culturally attuned supervision that explicitly identifies and addresses such harmful patterns to promote ethical and effective clinical practice (Zetzer et al., 2020). Results from the current study extended this dialogue, with participants illustrating how parallel process can function even when unacknowledged by name. For example, P3 disclosed that she had not addressed race, ethnicity, or culture with clients because her clinical supervisors had not modeled or validated such discussions, thereby mirroring lack of broaching and clinical supervisory avoidance in her clinical work. P2 similarly reported that the lack of racial and ethnic minority representation in clinical supervision not only shaped her awareness of this omission but also galvanized her commitment to serve underrepresented populations. Some participants also described how negative clinical supervisory experiences informed a conscious effort to diverge from negative clinical supervisory practices when they themselves became clinical supervisors (e.g., P3 explicitly chose to “do the opposite” of what she had experienced in clinical supervision). Through these findings, many participants within the current study resonated with and reinforced the ACA code of ethics (F.7.a), which calls upon counselor educators to serve as ethical and professional role models, which further emphasizes the ethical imperative of making parallel process and cultural broaching explicit within clinical supervision.

Supervisee Nondisclosure

The dynamics of disclosure and nondisclosure are central to the clinical supervisory alliance, with prior researchers having noted that while therapist self-disclosure can enhance counseling relationships, clinical supervisor self-disclosure has often been viewed as inappropriate (Mehr & Daltry, 2021). However, participants from the current study challenged this notion because racial and ethnic minority supervisees reported that limited, intentional clinical supervisor self-disclosure fostered openness and encouraged them to share vulnerable experiences, such as self-doubt and stress. This aligned with literature on supervisee nondisclosure (SND), which has often occurred in contexts lacking cultural humility and/or support (R. M. Cook et al., 2020; Hutman & Ellis, 2019). Most participants described withholding concerns to protect themselves and/or their clients (Ertl et al., 2023; Staples-Bradley et al., 2019) and avoiding cultural topics to preserve relational harmony (Drinane et al., 2021; Morgan, 2018; Nelson & Friedlander, 2001).

While SND can be protective, it can also undermine evaluation and client care (Reiser & Milne, 2017). In the current study, participants noted that SND often followed relational ruptures marked by cultural insensitivity, leading supervisees to adopt a “survival mindset” that limited risk-taking and developmental engagement. Some participants concealed identity, altered behavior, and suppressed cultural concerns to accommodate some clinical supervisors that did not display cultural awareness and humility, which highlighted how clinical supervisory climates that lack cultural

attunement can perpetuate professional stagnation and can contribute to racial and ethnic minority supervisees unpreparedness within the mental health counseling profession.

Power Dynamics Within Clinical Supervision

Power dynamics within clinical supervision have been widely recognized as a potential barrier to open disclosure and effective learning, particularly for novice counselors who may lack clarity around clinical supervisory roles and expectations (R. M. Cook et al., 2018). When these dynamics remain unexamined, especially in relation to privilege and systemic inequities, those who uphold the dynamics can perpetuate harmful behaviors and reinforce rigid clinical supervisory approaches that limit critical thinking and professional development (Ammirati & Kaslow, 2017; Friedlander, 2012, 2015; Ladany, 2014). Results from the current study reflected and extended these concerns because most participants perceived clinical supervision as hierarchical, often assuming their clinical supervisors held inherently superior expertise. In cases where power differentials were left unaddressed, racial and ethnic minority supervisees frequently reported feeling powerless and unsupported, sometimes having sought support, validation, and affirmation outside the clinical supervisory relationship.

These experiences aligned with existing literature on the risks of unexamined authority in clinical supervision, and participants also pointed to more constructive alternatives. When supervisors actively acknowledged power imbalances and adopted a collaborative, culturally responsive stance, supervisees described feeling more prepared, supported, and validated. P1 expressed a desire for “different supervision,” having highlighted the absence of mutual understanding in her experience, while P5 reflected on

not realizing until later that her clinical supervision lacked the qualities it “was supposed to” embody.

Although tangential to the research question of the current study, P1’s recommendations underscored key findings by advocating for clinical supervisor humility and relational sensitivity. She emphasized that “licensed counselors have feelings too,” cautioning clinical supervisors against viewing their authority as “law,” and urging them to “step down from the pedestal” to meet supervisees at their developmental level, further stating, “I’m a baby in this field; get down on my level.” These reflections deepened the conversation in the literature by illustrating how culturally attuned, egalitarian clinical supervision practices not only mitigate harm but can also promote supervisee growth, confidence, and professional identity development.

Cultural Competence and Humility

Cultural competence, defined by self-awareness, other awareness, and advocacy, has been emphasized in counselor education literature as essential for ethical and effective practice (Broadwater et al., 2022). Building upon this, cultural humility has offered a more dynamic approach, grounded in ongoing self-reflection, openness, and accountability in addressing systemic and interpersonal barriers (Fisher-Borne et al., 2015). In clinical supervision, cultural humility has been shown to strengthen relational alliances, particularly in cross-racial dyads, by reducing racial microaggressions and enabling relational repair (Vandament et al., 2021; Zhu et al., 2021). A key pathway to enacting this humility is through the broaching of cultural issues, which fosters trust and reduces supervisee nondisclosure (Day-Vines et al., 2021).

Through the current study, participants supported and expanded these findings, revealing that most racial and ethnic minority supervisees experienced a lack of both cultural competence and humility in their clinical supervisory relationships. Clinical supervisors were often perceived as rigid, lacking flexibility, and demonstrating minimal other awareness or advocacy. These conditions appeared to have left supervisees feeling dismissed, silenced, and/or unsupported, particularly when navigating some cross-racial dynamics. Through these findings, participant experiences mirrored concerns raised in the literature about the harmful effects of unacknowledged cultural differences and the absence of relational responsiveness.

Participants in the current study also affirmed that when cultural humility was present, even minimally, it significantly influenced supervisee wellbeing in a positive manner. Participants such as P3, P5, and P7 reported increased feelings of safety, openness, and validation when clinical supervisors engaged with them collaboratively and acknowledged cultural dynamics. Although broaching was infrequent and/or ineffective in some cases, its effective use in other cases was associated with more positive clinical supervision experiences, reinforcing its role, as emphasized in existing literature, in cultivating culturally responsive supervision aligned with ethical standards (ACA, 2014, F.7.a).

Influences of Cultural Sensitivity in Clinical Supervision and Outcomes

Despite clear mandates from professional organizations such as the APA (2017), ACA (2014), NBCC (2023), and CACREP (2024) requiring the integration of multiculturalism into counselor education and supervision, the practical implementation

of these standards remains underdeveloped, with minimal guidance on *how* to embed cultural responsiveness into clinical supervision (Galán et al., 2024). This gap was reflected in the present study because several participants described clinical supervision that avoided or minimized discussions of race, ethnicity, and culture, which often resulted in relational ruptures and emotional disengagement. For example, P6 reported that White supervisors consistently avoided race, ethnicity, and culture conversations, which resulted in generalized care and limited cultural attunement, while P5 turned to external supervision when assigned supervisors demonstrated actions which appeared to reflect cultural incompetence.

Prior researchers indicated that White supervisors often adopt “color-blind” approaches, rely on Eurocentric frameworks, and/or lack sufficient cultural knowledge, which can force racial and ethnic minority supervisees to assimilate, conceal their identities, and/or endure microaggressions such as identity erasure and inequitable treatment (Bowskill et al., 2007; Constantine, 2001; Das et al., 2024; Fickling et al., 2019; Fuertes & Brobst, 2002; Goodrich & Shin, 2013; Levitt et al., 2022; Nilsson & Anderson, 2004; D. W. Sue & D. Sue, 2003; Upshaw et al., 2019). Participants in the current study echoed these patterns. P1 and P2 described strategies of assimilation, which included adapting language and minimizing cultural issues in attempts to avoid being labeled as difficult. P2 and P6 recounted experiencing retaliatory behavior from clinical supervisors after they named discriminatory dynamics. The retaliatory behaviors from clinical supervisors reinforced supervisor-protective norms within agencies and highlighted how supervisor-protective norms can reproduce the very inequities

researchers have warned against. At the same time, prior scholarship and current findings demonstrated the transformative potential of culturally responsive supervision.

Researchers have emphasized that cultural humility, relational trust, and supervisor openness can foster supervisee safety, growth, and retention (Goodrich & Shin, 2013; Upshaw et al., 2019).

Importantly, when topics of race, ethnicity, and culture were effectively broached, which often occurred outside the formal clinical supervision setting, racial and ethnic minority supervisees in the current study reported enhanced preparedness and confidence in meeting client needs. Although not central to the research question of the current study, recommendations from P4 and P5 reinforced these findings by underscoring the importance of equity, relational trust, and clinical supervisor humility. P4 urged clinical supervisors to avoid assuming racial and ethnic minority supervisees have inherent cultural expertise and for supervisors to treat racial and ethnic minority supervisees on equal footing with non racial and ethnic minority peers. P5 emphasized the need for clinical supervisors to demonstrate curiosity, build rapport, and invest in supervisee development, having noted that the absence of trust within a clinical supervision context left her feeling unseen and closed off to feedback from her clinical supervisor. These reflections expanded the dialogue with existing literature by illustrating how failure to integrate multicultural competence and cultural humility into clinical supervision can perpetuate harm, while affirming that equitable, attuned, and relationally grounded clinical supervision can foster safety, growth, and retention for racial and ethnic minority supervisees.

These results illustrated a dynamic interplay between prior concerns and current realities. Previous researchers identified risks of “color-blindness,” Eurocentrism, and cultural avoidance; participants accounts confirmed these harms while also having demonstrated the protective power of cultural humility and equity-oriented supervision. By situating racial and ethnic minority supervisee voices directly within the context of existing scholarship, participant responses within this study not only affirmed prior critiques but also advanced the conversation by highlighting concrete pathways through which culturally attuned supervision can support the development and retention of racial and ethnic minority supervisees.

Addressing MCSJ Issues

Clinical supervisors-in-training who value MCSJ principles often struggle to translate these commitments into practice due to limited training and guidance (Spowart & Robertson, 2024). Novice and experienced clinical supervisors reported uncertainty in addressing diversity and called for clearer frameworks to support broaching racial, ethnic, and cultural topics in clinical supervision (King & K. Jones, 2019). Although the ACA code of ethics (2014) has noted the need to prevent personal values from interfering with client care (A.4.b; Merrell-James et al., 2019) and includes a call for active engagement with diversity within the clinical supervisory relationship (F.2.b), participant experiences within the current study illustrated a significant gap between ethical standards and clinical supervisory practices. Some participants expressed broaching was rarely initiated by some assigned clinical supervisors, which illustrated supervisor avoidance of MCSJ topics in some cases. P7, for example, recalled being told to “stay within her scope of

practice” when she attempted to advocate for racial and ethnic minority clients referral concerns. This instruction from a clinical supervisor reflected a rigid and risk-averse approach that constrained P7’s advocacy and appeared to reflect the clinical supervisor’s discomfort with MCSJ principles.

Racial and ethnic minority supervisees in the current study reported they often found positive, culturally responsive clinical supervision through external sources, which suggested that many assigned clinical supervisors failed to meet ethical expectations and appeared to contribute to experiences of harm, bias, and/or invalidation. This report aligned with previous researchers identification that insufficient training in cultural responsiveness can compromise supervision and client care (King & K. Jones, 2019; Spowart & Robertson, 2024). Participant experiences in the current study further underscored that racial and ethnic minority supervisees faced systemic barriers to advocacy and identity validation, which was often exacerbated by clinical supervisors apparent unexamined biases and lack of cultural humility.

Although not central to the research question of the current study, P2’s reflections reinforced these findings through emphasis that racial and ethnic minority identities are “hardly ever openly accepted” and encouragement for clinical supervisors to “be open to what you don’t know.” P2 challenged superficial inclusion efforts, having stated, “inclusive doesn’t mean included.” P2 also described the retraumatizing burden of having to explain racial trauma to culturally unaware clinical supervisors. Through these insights, P2 highlighted how the lack of identity affirmation and cultural responsiveness in clinical supervision can perpetuate ethical breaches, diminish trust, and undermine the

development of racial and ethnic minority supervisees, which raises critical implications for training, supervision, and institutional accountability.

Empathy and a Color-Blind Approach

Previous researchers have shown that color-blind approaches in clinical supervision—those that minimize or ignore racial and cultural differences—often stem from a lack of supervisor self-awareness regarding implicit biases, particularly among White clinical supervisors (Constantine & D. W. Sue, 2007). Consistent with this, participants in the current study described supervisors who avoided or dismissed cultural concerns, which echoed prior critiques of color-blindness. For instance, P3, P5, and P6 reported supervisory relationships where cultural identities were minimized, which arguably contributed to feelings of harm, erasure, and invalidation.

Researchers have also suggested that “color-blind” approaches undermine the supervisory alliance and can perpetuate harm to marginalized clients, which raises ethical concerns related to nonmaleficence (ACA, 2014; Das et al., 2024). This ethical concern was mirrored in the present study, with P5 having noted that her supervisor’s failure to acknowledge cultural dynamics not only ruptured the supervisory relationship but also appeared to limit therapeutic progress, which was an outcome that aligned with previous warnings about the ethical risks of color-blind supervision. Researchers have also demonstrated that counselors-in-training who adopted color-blind attitudes struggled to empathize effectively with clients from diverse backgrounds, which reduced therapeutic efficacy (Constantine, 2001; Fuertes & Brobst, 2002). Participants accounts in the current study reinforced this point, as several described feeling that their supervisors avoidance

of race, ethnicity, and culture left them ill-prepared to engage with diverse clients, which highlighted the direct influence of supervisory color-blindness on clinical practice.

Finally, researchers have argued that reliance on Eurocentric or westernized treatment models often resulted in culturally incongruent care, particularly when these frameworks fail to incorporate clients' sociopolitical, historical, and cultural contexts (Constantine & D. W. Sue, 2007; Fu, 2018; Morgan, 2018). Similarly, participants in this study described having received rigid, westernized clinical guidance that felt disconnected from their clients lived realities. This alignment between previous literature and supervisee experience underscores the ongoing relevance for clinical supervisors that actively engage cultural identities, acknowledge systemic influences, and resist color-blind paradigms in order to promote ethical, effective, and culturally responsive practice.

Institutional and Systemic Factors

Previous researchers have demonstrated that supervisees are socialized to perceive clinical supervisors as authoritative gatekeepers who are responsible for determining professional readiness, a dynamic that reinforces hierarchical norms within the counseling profession and often pressures supervisees toward assimilation (McNamara et al., 2017). Participants in the current study echoed these dynamics, with P1, P2, P3, P6, and P7 having described how they navigated predominantly White clinical spaces by assimilating, adjusting communication, or concealing aspects of identity to avoid being labeled as problematic. These strategies aligned with patterns of identity erasure and emotional withdrawal documented in prior research (Goode-Cross & Grim, 2016; Reiser & Milne, 2017).

For Black and other minority supervisees, scholars note that such hierarchical expectations are compounded by pressure to conceal cultural identities, despite findings that peer support and cultural affirmation are essential for persistence and well-being (Drinane et al., 2021; Henfield et al., 2011; Morgan, 2018). Consistent with this, many participants in the current study reported turning to peer networks for affirmation and developmental support when assigned supervisors failed to provide adequate cultural responsiveness. Although professional mandates such as the ACA code of ethics (2014) emphasize client welfare and require multicultural competence in clinical supervision (F.2.b, F.7.c, F.11.a, F.11.b, F.11.c), and CACREP (2024) standards call for diverse and culturally responsive training (1.H, 3.A.4, 3.B, 3.G.7), participants in the current study reported that these standards were inconsistently upheld within PWIs. Many participants described supervisors as rigid and Eurocentric, with supervisors having relied on their own counseling training and theoretical orientations rather than models specific to clinical supervision, which reportedly limited flexibility and cultural responsiveness within the clinical supervision context. P2, P5, and P6, for example, recounted supervisor-protective behaviors and institutional cultures that prioritized organizational image over supervisee and/or client wellbeing, which was an observation that mirrored systemic inequities that have been documented in the literature (Pieterse, 2018; Roscoe et al., 2022).

Scholars have also noted that institutional resistance to social justice in clinical supervision has contributed to racial and ethnic minority supervisees experiences of isolation, burnout, and disengagement (Jernigan et al., 2010; Taylor & Ellis, 2023;

Thrower et al., 2020). Participants in the current study affirmed these concerns, with P5 and P7 having described relational ruptures and internalized stress when supervisors avoided racial discussions, engaged in rigid theoretical adherence, and discouraged acknowledgment of client racial trauma. Similarly, P7 recalled being actively discouraged from social justice advocacy, while P2 and P6 reported being dissuaded from challenging inequitable practices. These accounts highlighted how systemic patterns noted in the literature appear to persist at the lived experience level for racial and ethnic minority supervisees.

Racial Identity Development

Previous researchers have emphasized that racial identity development plays a crucial role in fostering multicultural counseling competence and serves as a buffer against racial stress (Middleton et al., 2011; Neblett Jr. et al., 2012), yet the assumption that racial and ethnic minority clinicians inherently possess multicultural expertise risks oversimplifying diverse identity experiences (Goode-Cross & Grim, 2016; Levitt et al., 2022). This tension has reflected systemic inequities faced by Black and other racial and ethnic minority individuals, including limited racial and ethnic minority representation and ongoing marginalization within PWIs and counseling education (Curtis-Boles et al., 2020; D. W. Sue et al., 2008). Participants experiences in the current study corroborated these findings, having revealed that racial and ethnic minority supervisees frequently encounter tokenism, racial isolation, and superficial engagement with racial and cultural issues in clinical supervision, often within Eurocentric frameworks that can perpetuate identity erasure and emotional disengagement (P2, P5).

Consistent with Utsey et al. (2005), the avoidance of meaningful dialogue on race, ethnicity, and culture in clinical supervision appeared to limit supervisees capacity for advocacy and self-efficacy, as evidenced by reports of nondisclosure and internalized stress (P3, P7). While bias and privilege can be present among clinical supervisors and supervisees, lack of self-reflection can undermine efforts toward culturally responsive clinical supervision, which is aligned with calls in the literature for intentionality and accountability in addressing systemic and interpersonal inequities (Ratts et al., 2016). Thus, the study participants extended prior research by underscoring the benefit of implementing clinical supervisory models that integrate cultural humility, validate diverse identities, and actively challenge structural oppression to promote supervisee wellbeing and professional growth.

Racism and Microaggressions

Previous researchers highlighted that microaggressions, often minimized as trivial, are pervasive experiences for racial and ethnic minority supervisees and faculty, with the potential for accompanying significant long-term mental and physical health consequences (Constantine & D. W. Sue, 2007; Wong-Padoongpatt et al., 2017). Microaggressions reinforce harmful stereotypes and place the burden of education on racial and ethnic minority individuals, frequently in isolation (Hubain et al., 2016). Cultural traits such as passivity or reservedness may exacerbate supervisee disengagement due to discomfort within clinical supervisory settings (Curtis-Boles et al., 2020; L. C. J. Wong et al., 2013), with Black students facing the compounded challenge of maintaining cultural identity and wellbeing amid systemic racism (H. A. Jones et al.,

2018). Consistent with this literature, racial and ethnic minority supervisees in the present study reported having experienced microaggressions that fostered isolation and internalized stress. For instance, P3 recounted a microaggression that involved a White client. She reported her clinical supervisor questioned her response of “making a joke of it” in the session instead of more directly addressing it in the moment with the client, which left her feeling unsupported and uncertain about how she addressed the incident. Across most participants in the current study, there was a preference for direct broaching of race, ethnicity, and culture issues; avoidance or passive handling appeared to engender persistent discomfort in clinical supervision. Similar experiences of prejudice, internalized stress, marginalization, racism, and oppression were reported by Hispanic, South Asian, and international supervisees (P3, P6, P7), which mirrored broader patterns of marginalization and internalized stress documented in the literature, underscoring the continued importance for intentional, culturally responsive clinical supervisory practices.

Race and Ethnicity Within Counseling and Clinical Supervision Dynamics

Previous scholars have underscored the centrality of collectivist language among Black counselors as a way to affirm shared identity and resilience amid systemic oppression (Summers & Lassiter, 2021). Despite this emphasis, widespread dissatisfaction with training on racial trauma persists; for example, 87.74% of doctoral-level clinical psychology graduate students reported insufficient preparation to address such concerns (Galán et al., 2024). This lack of adequate preparation was echoed by participants in the current study, several of whom described insufficient training in how

to address racial trauma, which led them to seek external supervision and resources to uphold ethical and culturally responsive care (P5).

Prior researchers emphasized that failing to integrate intersectionality risks flattening diverse lived experiences, since racial and ethnic groups are not monolithic (Goode-Cross & Grim, 2016). Consistent with these concerns, many participants in the current study stressed the importance of intersectionality in understanding supervisee and client needs, with some (P2, P3) describing how the ability to broach race and culture was often developed reactively through supervisory encounters, sometimes affirming, but often marked by avoidance or harm. Scholars also warned that the persistence of racial microaggressions within therapeutic contexts (Hook et al., 2016) and university mental health services (Owen et al., 2014) signals a broader culture of assimilation that can suppress identity expression and undermine trust in professional relationships (Galán et al., 2024; Henfield et al., 2012). Participants in the current study provided equivalent accounts, having described how institutional cultures shaped by Eurocentric and supervisory norms contributed to experiences of isolation, hypervigilance, cultural erasure, and racism. These findings illustrated how the systemic patterns identified in the literature manifested directly in the lived experiences of racial and ethnic minority supervisees, which reinforced the continued significance of clinical supervision frameworks that not only recognize cultural complexity but also create intentional space for intersectional and identity-affirming dialogue.

Harmful Clinical Supervision

Previous researchers noted that prelicensed clinicians are particularly vulnerable as they work to fulfill requirements for initial independent licensure (McNamara et al., 2017). In the current study, I examined the experiences of racial and ethnic minority supervisees across varying license levels and types. Through their experiences, participants of the current study revealed that there can be themes of vulnerability, disempowerment, and/or fear of repercussions as significant concerns with varying levels of licensure status. These factors not only threatened participants licensure prospects (see McNamara et al., 2017) but also appeared to hinder their personal and professional development.

Harmful clinical supervision, which encompasses boundary violations, microaggressions, sexual harassment, and failures to address these concerns, remains underreported despite ethical mandates to “do no harm” (ACA, 2014; R. M. Cook & Ellis, 2021; Ellis et al., 2014). While harmful supervision is distinguished from the more prevalent but still damaging inadequate supervision, which is defined as failing to meet ethical, cultural, or professional standards (Ellis et al., 2014), both forms can exacerbate power imbalances, relational ruptures, and withdrawal behaviors, thereby compromising supervisee wellbeing, professional development, and client care (Cartwright, 2019; Friedlander, 2012; Hernández & McDowell, 2010; Ladany et al., 1996; Ramos-Sánchez et al., 2002). Current clinical supervisory structures often privilege a supervisor-protective stance focused on liability, rather than a supervisee-protective model that acknowledges hierarchical vulnerability and encourages safe disclosure (Ellis et al., 2017;

McNamara et al., 2017). Consistent with this literature, racial and ethnic minority supervisees in the current study often did not label their experiences as “harmful,” yet contextual indicators such as self-doubt, internalized stress, silence and/or nondisclosure, and emotional disengagement suggest otherwise.

Many participants in the current study described experiences that appeared to align with harmful clinical supervision, while most participants experiences appeared to align with inadequate supervision, highlighted by dismissive responses, lack of advocacy, and/or the perceived need to seek external support. P5 emphasized that most racial and ethnic minority supervisees “don’t receive effective clinical supervision,” and P8 noted a lack of standardized clinical supervision practices. These findings highlighted a persistent gap between ethical guidelines, which require clinical supervisors to address multiculturalism in supervision (ACA, 2014, F.2.b), and actual practice. Despite ACA’s (2014) stated mission to promote professional development and multicultural competence, participants in the current study revealed that harmful and inadequate supervision remains pervasive, particularly for racial and ethnic minority supervisees, which is in direct contradiction to the fundamental ethical principle of nonmaleficence (ACA, 2014).

Harmful Clinical Supervision Related to Racial and Ethnic Minority Supervisee Experiences

Black therapists often carry a dual burden of navigating both their clients’ race-related stress and their own, which can be compounded by harmful or inadequate clinical supervision that fails to address these intersecting pressures (Shell et al., 2021). Previous

researchers highlighted how such harmful supervision, particularly when left unacknowledged or unremedied, mirrors systemic marginalization and reflects broader structural inequities within and beyond the counseling profession (Curtis-Boles et al., 2020; Ellis et al., 2017; McNamara et al., 2017). In alignment with these findings, some participants in the current study reported being disproportionately assigned minority clients, often without adequate training or supervision, reflecting an implicit bias that minority supervisees are naturally more equipped to support minority populations (P4, P5, P6, P7). This expectation was further complicated by a lack of support from predominantly White supervisors, many of whom avoided or dismissed race, ethnicity, and culture topics, even when broached by supervisees themselves (P5, P6, P7).

Consistent with the literature on supervisor avoidance and supervisee marginalization, these omissions often led supervisees to feel unseen and unsupported, prompting most participants to seek validation and guidance outside the formal clinical supervisory relationship. While only P6 described receiving institutional support in addressing clinical supervision concerns directly with her clinical supervisor, most supervisees engaged in personal coping strategies to endure harmful and/or inadequate supervision. Despite recognizing the dysfunction of these dynamics, few minority supervisees expressed opportunities for broader advocacy efforts to challenge the systems enabling such harm, which potentially reinforces a cycle of silence, harmful, and inadequate contexts for future minority supervisees. However, some participants offered informal advice for future supervisees, emphasizing the importance of self-advocacy and the need to exit clinical supervisory relationships that are unsafe or fail to meet

developmental needs. These insights reflect both the resilience and the constrained agency of minority supervisees operating within supervisory systems that remain largely unaccountable to the ethical imperative to “do no harm” (ACA, 2014).

Broaching

Ruptures in the clinical supervisory relationship are particularly salient for racial and ethnic minority supervisees, whose increased sensitivity to perceived prejudice can heighten uncertainty around expectations and can impair supervisory engagement (Nilsson & Duan, 2007). Prior researchers highlighted how harmful supervision, marked by microaggressions, avoidance, or cultural incompetence, can erode trust, diminish self-efficacy, and provoke emotional withdrawal, often leading supervisees to adopt self-protective behaviors such as nondisclosure or reliance on external support (Friedlander, 2015; McNamara et al., 2017; Reiser & Milne, 2017).

In response to such ruptures, broaching, defined as the intentional discussion of race, ethnicity, and culture factors, has been recommended as a protective supervisory strategy to foster repair, cultural responsiveness, and connection (Day-Vines et al., 2021; Fickling et al., 2019). However, consistent with studies citing barriers such as fear of offense, lack of confidence, and role ambiguity (Bayne & Branco, 2018; Haskins et al., 2013; C. T. Jones & Branco, 2020), minority supervisees in the current study reported that broaching was either absent or indirect, among some clinical supervisors. This passivity appeared to place the burden of initiating such dialogue on supervisees, often exacerbating internalized stress and relational distancing, particularly in some cross-racial dyads (P1, P3, P5, P6). Clinical supervisors’ apparent preference for indirect or non-

assumptive approaches to identity salience (C. T. Jones & Welfare, 2017) appeared to conflict with ethical expectations for cultural competence (ACA, 2014) and with best practices emphasizing engagement over expertise (C. T. Jones et al., 2021), which can ultimately compromise the therapeutic relationship and the effectiveness of clinical practice (Soheilian et al., 2014). These findings were mirrored in some participants' behavior, with some reporting their clinical supervisors avoided broaching and they were uncertain of how to broach with clients as a result, suggesting a learned pattern of disengagement, which can influence client care. Importantly, P7's recommendations, though not central to the research question of the current study, illuminated a potential corrective, as she emphasized the value of clinical supervisors who position themselves as "co-learners," validate diverse experiences, and initiate open conversations that promote shared growth. Her reflections align with the broader literature on relational repair, humility, and collaborative supervision (Bayne & Branco, 2018), underscoring how intentional broaching and egalitarian approaches can mitigate harm and foster culturally responsive supervisory alliances.

Racial and Ethnic Minority Supervisees Within Clinical Supervision

A lack of racial and cultural dialogue in clinical supervision risks signaling to supervisees that such discussions are unimportant to clinical practice and thereby reinforces systemic marginalization within both clinical supervisory and counseling relationships (Inman, 2006). While scholars have acknowledged the importance of a strong clinical supervisory alliance, the integration of the cultural responsiveness necessary for effective clinical supervision appears to remain limited, which arguably

leaves supervisees with limited guidance on navigating identity-related dynamics (see R. M. Cook et al., 2020; Ellis, 2017; King & K. Jones, 2019; Koçyiğit, 2022; L. C. J. Wong et al., 2013). This omission is particularly concerning, given evidence that inadequate supervision, especially when devoid of broaching, can negatively affect supervisee development, cultural self-efficacy, and client care (Ellis et al., 2017; Rasheed Ali et al., 2004; Reiser & Milne, 2017). Echoing these findings, racial and ethnic minority supervisees in the current study frequently reported clinical supervisors who avoided or indirectly addressed race, ethnicity, and culture, which appeared to minimize participants salient identities and the salient identities of clients.

P3, for instance, noted that she was unaware broaching could occur in a counseling relationship due to the lack of modeling and broaching from her assigned clinical supervisor within the clinical supervision relationship, though she later integrated positive practices in her own clinical supervisory work following positive clinical supervisory experiences. Some participants initially mirrored some of their clinical supervisors avoidance of race, ethnicity, and culture topics in clinical supervision and client sessions, with the notable exception of P7, which appeared to indicate a broader pattern of learned disengagement. Through these findings, participants in the current study revealed how the absence of cultural dialogue and clinical supervisor modeling can perpetuate internalized stress, imposter syndrome, and a diminished sense of professional legitimacy.

Though not central to the research question of the current study, P8's reflections further illuminated these dynamics, as she described clinical supervision that prioritized

productivity over interpersonal meaning, which appeared to exacerbate feelings of inadequacy and prompted a reminder to P8 that “therapists are humans too.” She emphasized the value of clinical supervisors who make space for reflection and recognize supervisees humanity, having noted that such practices can help counter negative self-perceptions and foster deeper client connections. P8’s insights aligned with the broader literature which advocated for cultural humility, supervisor rapport, and the validation of supervisees lived experiences as protective factors within oppressive systems (see Willis et al., 2022). Together, these findings underscore how clinical supervisory practices that integrate cultural responsiveness and support supervisee wellbeing can help mental health counseling professionals move beyond performative inclusion toward relational and ethical accountability.

Limitations of the Study

One limitation of the current study is the small sample size. Although a smaller sample size is common with qualitative research, as compared to quantitative research, small sample sizes can potentially leave out additional relevant experiences (see Peoples, 2021). Another limitation is the gender identification of the participants of the current study. Seven participants identified as female and one participant identified as male. Participants of the current study appeared to be open and honest in the interviews regarding their experiences; however, with self-reporting, there is always a chance information can be withheld for confidentiality concerns or presented in such a way to seem more socially acceptable (Myers & Neuman, 2007). It is possible these limitations may have had an impact on the transferability of the research.

Recommendations

This section consists of recommendations for future research regarding the experiences of racial and ethnic minority supervisees. First, future researchers could further examine how broaching cultural identities and differences can be integrated as an ongoing practice across academic coursework, clinical training, and clinical supervision rather than treated as a singular curricular event. Prior researchers have noted that racial and social justice content is often addressed superficially or limited to isolated lectures (Galán et al., 2024), and the findings of the current study echoed this concern. Future researchers could explore how sustained and developmentally sequenced broaching practices are implemented, perceived, and experienced by racial and ethnic minority supervisees, as well as the conditions, if any, that may support or hinder their effectiveness.

Additionally, an investigation of supervisees' perspectives on what constitutes meaningful, nonsuperficial engagement with multicultural issues may offer insight into how programs and supervisors can move beyond "check-the-box" approaches to culturally responsive supervision. This recommendation aligns with the ACA ethical code for counselor educators to "infuse material related to multiculturalism/diversity into all courses and workshops" (ACA, 2014, F.7.c). Findings from the current study indicated that when cultural differences are ignored or minimized, supervisees can experience inadequate and/or harmful supervision. Given the persistence of implicit bias among counselor trainees (see Boysen & Vogel, 2008) and the broader neglect of race and racism within counseling research (see Morgan, 2018), counselor education programs

and accrediting bodies could move beyond cultural relativism to critically engage issues of power, privilege, and oppression. Through systemic embedding of broaching within counselor training, further support could occur for the promoting of more ethical, culturally responsive, and effective supervision and practice.

Second, future researchers could investigate potential integration and application of MCSJ principles in academic training contexts. Although some participants in the current study referenced academic contexts, this was not a central focus of the current study. Previous researchers have indicated that faculty members who advocated for MCSJ competencies and equity faced institutional pushbacks and isolation (Hyttén & Bettez, 2011). This topic is one that could be explored further. It is noted that most supervisees in the current study expressed supportive clinical supervisors that disrupted the status quo of ineffective clinical supervision practices; however, because the current study did not focus on clinical supervisors, the experiences of supervisors regarding these actions and their potential consequences were not present.

Third, while I explored racial and ethnic minority supervisees experiences of feeling misunderstood or unsupported in clinical supervision, I did not explicitly examine the psychological effects of racism, oppression, prejudice, marginalization, and so on, on supervisees wellbeing. Participants in the current study described coping strategies such as emotional disengagement and “blocking out” negative experiences, as well as experiencing greater comfort with culturally responsive supervisors, both White and racial and ethnic minorities, which suggested that negative clinical supervisory dynamics may compromise supervisee wellbeing and, by extension, client care. For instance, P5

reported having addressed client concerns only at a “surface level” due to insufficient supervisory guidance. Future researchers could examine how race, clinical supervision experiences, and psychological outcomes intersect, if at all, with the aim of strengthening support for racial and ethnic minority supervisees and ensuring high-quality client services.

Fourth, it may be important to consider the potential influence of intersecting identity characteristics in understanding supervisee experiences. Although the primary focus of the current study was race, ethnicity, and culture, several participants noted the salience of additional identity characteristics, such as language and disability, in shaping their clinical supervision experiences. Intersectionality, defined as the unique interplay of multiple social identities and the ways in which these intersections influence how individuals are perceived and treated within society (LaManatia et al., 2015), can provide a useful framework for situating these insights. Given that self-efficacy can be shaped in part through interpersonal interactions, particularly within the context of clinical supervision, acknowledging intersectional identity characteristics may provide insight into how, if at all, these dynamics can influence supervisees self-efficacy, relational experiences, and ultimately, client care (Bernard & Goodyear, 2019).

Fifth, future researchers may find value in examining the in-depth experiences of collectivist approaches related to the clinical supervision context. Such inquiry may provide insight into whether implementation of collectivist approaches has an influence on the supervisory processes and relational dynamics. Participants in the current study described tensions between eastern/collectivist cultures and western/individualistic

cultures related to perceptions and experiences within the clinical supervision relationship. Given these observations, future researchers may also benefit from integrating an intersectional framework to capture the nuanced, multilayered experiences that may emerge when cultural orientation intersects with other identity dimensions and characteristics.

Sixth, findings from the current study indicated that clinical supervisor self-disclosure was perceived as beneficial when it was used sparingly and with clear intentionality. Future researchers could meaningfully extend this insight by examining supervisees' perspectives on what constitutes limited and intentional disclosure within the context of clinical supervision relationships. Such work may help clarify the specific conditions, if any, under which supervisor disclosure may influence safety, foster vulnerability, and support supervisee development. Additionally, further inquiry could explore how these forms of disclosure may influence the broader counseling relationship, including, but not limited to supervisees' willingness to broach concerns, supervisees sense of connection to supervisors, and supervisees development of parallel practices with clients. This line of research may hold potential to inform best practices regarding the ethical and developmentally appropriate use of supervisor self-disclosure.

Implications

Gaining deeper insight into the lived experiences of racial and ethnic minority supervisees begins with acknowledging the historical progress made within counselor education and clinical supervision, while also recognizing that much work remains to be done. As previously discussed, the complexity of clinical supervision is captured by

Fiscalini (1997), who stated, "...the supervisory relationship is a relationship about a relationship about other relationships... (where) the supervisee is constantly interacting and relating with the supervisor in the process" (p. 30). This multilayered dynamic resonates with Heidegger's concepts of *Dasein* and *Mitsein*, particularly the assertion that "knowing oneself is grounded in Being-with" (Heidegger, 1962, p. 161) The overarching implication is clear. When racial and ethnic minority supervisees are inadequately supported and/or remain unaware of the effects of unhelpful, insufficient, or even harmful clinical supervisory practices and expectations, the consequences can extend beyond the clinical supervisory dyad. Such shortcomings have the potential to not only undermine the professional development and wellbeing of racial and ethnic minority supervisees but also risk perpetuating harm to the marginalized clients they may serve.

Conclusion

The purpose of this phenomenological study was to examine the lived experiences of racial and ethnic minority supervisees within the clinical supervision context, with attention to the ways cultural and ethnic identity, race, and supervisory dynamics influenced their development and practice. Through the findings of this study, it was revealed that clinical supervision is not a neutral process; rather, it is shaped by power, culture, and relational dynamics that can directly influence supervisees professional growth and the quality of care provided to clients. It can be argued that, at a macrolevel, the culture of American society reflects Eurocentric norms that position whiteness as the default, a dynamic that inevitably permeates professional training contexts (see Constantine & D. W. Sue, 2007; Fu, 2018; Henfield et al., 2012). Within mental health

counseling, this broader influence arguably manifests as a distinct professional culture that often requires racial and ethnic minority supervisees, who can be perceived as cultural outsiders, to assimilate into dominant frameworks during clinical supervision in order to gain acceptance and professional legitimacy (see Morgan, 2018).

A central theme across participants accounts in the current study was the absence of racial and cultural broaching within clinical supervision. When clinical supervisors neglected to engage in these discussions, supervisees often mirrored this omission with clients, which perpetuated silence around critical issues of identity and difference. Conversely, when participants in the current study reported that clinical supervisors modeled empathy and broaching, participants described greater preparedness, confidence, and the ability to foster authentic relationships with clients. These findings affirmed the significance of *Mitsein*, or *Being-with* (Heidegger, 1962), as clinical supervision grounded in relational presence and mutual understanding arguably empowers supervisees to meaningfully connect with both themselves and others.

Through sharing their experiences, participants in the current study also suggested some effects of the burden of harmful and/or inadequate clinical supervision. Participants reported experiences of imposter syndrome, emotional disengagement, and feelings of powerlessness, particularly when cultural differences and considerations were ignored. Conversely, moments when clinical supervisors validated supervisees perspectives, slowed down, and encouraged reflection, were experienced as transformative by most racial and ethnic minority supervisees, which reportedly positively influenced self-efficacy, clinical and professional confidence, willingness to take risks, and relational

dynamics within the counseling and clinical supervision dyads. These dynamics illustrated Fiscalini's (1997) notion that supervision is "a relationship about a relationship about other relationships" (p. 30), with implications that can extend far beyond the supervisory dyad.

The findings in the current study pointed to the potential benefits of systemic changes in counselor education, training, and supervision. MCSJ concerns are less likely to be beneficial for racial and ethnic minority and non-racial and ethnic minority individuals when they are confined to isolated lectures or courses, as past researchers have documented (Galán et al., 2024). Instead, counselor educators and clinical supervisors may consider intentionally embedding cultural responsiveness across curricula, supervision, and professional development opportunities, as mandated by the ACA code of ethics (2014). Without such efforts, racial and ethnic minority supervisees may remain vulnerable to harmful supervision, and the clients they serve may receive care that fails to honor their cultural realities.

In closing, participants from the current study demonstrated that supporting racial and ethnic minority supervisees is both a moral and professional advantage. Clinical supervision, when practiced with intentionality, cultural humility, and relational authenticity, can foster growth, resilience, and more equitable client care. Returning to Heidegger's (1962) assertion that "knowing oneself is grounded in Being-with" (p. 161), it may be helpful for the profession to embrace supervision as a relational process that shapes not only supervisees but also the clients and communities they serve.

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Appendix A: Social Media Invitation

Interview study needs minority counselor supervisees

There is a new study about the experiences of racial and ethnic minority supervisees who are and/or have been in clinical supervision for the mental health counseling profession. This study could help clinical supervisors better understand minority supervisees' needs within the clinical supervision dynamic. For this study, you are invited to describe your experiences within clinical supervision.

About the study:

- Initial 60 - 90 minute phone interview that will be audio-recorded (no video-recording)
- To protect your privacy, the published study will not share any names or details that identify you

Volunteers must meet these requirements:

- Post-graduate (post-master's degree) supervisees (pre-licensed or post-licensed) within the mental health counseling profession.
- Racial and/or ethnic minority supervisees (e.g., African American, Indian American) within the mental health counseling profession.
- Supervisees who are currently or have been in clinical supervision for licensure within the mental health counseling profession.
- Supervisees who reside in the U.S.
- Individuals who are 18-years or older.

This interview is part of the doctoral study for Destiny Hill, a Ph.D. student at Walden University. Initial and follow up interviews are intended to take place by July 2025. Please message *school email provided* privately to express interest in participating. You are also welcome to forward this information to others who might be interested. Thank you!

Appendix B: Semistructured Interview Questions

1. Can you describe your role and how long you have been involved in clinical supervision?
2. What is your racial, ethnic, and cultural background (if comfortable sharing)?
3. Tell me about your first experience being supervised in a clinical setting.
4. Can you give an example of a time when race, ethnicity, and culture were discussed – directly or indirectly - in clinical supervision? If not, can you discuss how race, ethnicity, and culture remained separate in clinical supervision?
5. Can you describe an experience where you felt supported or understood by your clinical supervisor? If not, can you describe an experience where you felt misunderstood or uncomfortable in clinical supervision?
6. Has clinical supervision influenced the way you interact with clients from different backgrounds? Please explain.
7. Can you describe a specific clinical supervision session that stood out to you positively and/or negatively?
8. Can you walk me through a situation in clinical supervision where you had to navigate a challenge or conflict?
9. Looking back, is there a moment from clinical supervision that still affects how you see yourself as a person and professional today?