



Exploring Race and Diversity in Clinical Supervision.

Information and guidance for supervisors

This guidance is written for the White supervisor with the knowledge that racialised Psychologists have likely been enduring conversations about race throughout their life and will have likely developed their own method of navigating discussions about race with colleagues, supervisors and supervisees. The terms “racialized” and “racially minoritised” are used in order to recognise that some people are actively minoritised by others via social processes shaped by power. A glossary is included within the resource pack to support individuals to develop their repertoire for exploring racism

This guidance and associated materials are suggested to support the clinical supervisor to explore issues of race, difference and diversity within clinical supervision. They should be used alongside wider resources and should not be considered as exhaustive list of tools.

Supervisor personal development

Research indicates that White people have a reduced resilience and stamina for talking about race, this is sometimes referred to as ‘white fragility’. The presence of White Supremacy (the belief that White people are superior and therefore afforded power and preferential treatment at the detriment to other racial groups, particularly Black people) in Western society plays a major part in the systematic avoidance of educating, exploring and reflecting on race. The result is that when confronted with discussions of race, individuals can be faced with shame, discomfort, fear of getting it wrong, indifference and implicit prejudice.

These responses are understandable given the presence of the existent racially biased cultural norms, therefore clinicians must be mindful not to become overwhelmed with feelings of shame and guilt as this results in paralysis, stagnation and the continued centering of White feelings. Research demonstrates that discussing race can evoke so much anxiety that it can block a therapist’s or supervisor’s capacity to think, resulting in a disabled ability to engage in productive exploration. Instead, supervisors are encouraged to look upon such feelings with compassion, recognising that their inner anti-racist may not have been previously encouraged, may not have the full range of language to explore race and may be sensitive to criticism. Clinicians and supervisors must therefore view their emotional reactions with kindness but also, importantly, a sense of responsibility to learn, develop, be accountable and strive for change.

Racial trauma (unlike other traumas) is often internalised yet viewed by others as an inability to cope or manage emotions, often with suggestions that a person is paranoid or sensitive. Within the Clinical Psychology profession, there is a tendency to overlook the impact racism, the external factors that perpetuate racism i.e., systems and institutions, a tendency to avoid exploring trainee experiences on placement and a tendency to overlook the experiences of racialised service users.



Supervision with a trainee from a racialised background.

The supervisor of Clinical Psychologist trainee holds the power in the relationship. It is therefore the responsibility of the supervisor to bring up the conversation of race. The following may be useful considerations:

- Appreciate that the trainee will have a different experience to most of their Dclin peers, and will likely experience multiple microaggressions and racial incidents whilst on placement.
- Ensure that race is discussed whilst contracting the boundaries of the supervisory relationship.
- Ask explicitly how the trainee would feel most comfortable exploring issues of race. Agree how both the trainee and the supervisor will manage discomfort. Agree the procedure for the trainee to bring to the supervisor's attention experiences, micro-aggressions and racism.
- Ensure that the trainee is believed if they raise an issue of racism. Research of Clinical Psychology trainees indicates that when discriminatory experiences are raised on placement, they are often overlooked, dismissed or pathologised. The inaction of bystanders and those in power has been observed at times to be more traumatic and cause longer lasting harm than the incident itself.
- Acknowledge that the trainee may not feel comfortable exploring racism with you, however this should not be assumed, nor should it be forced if they are. It may be appropriate to identify additional support from someone with lived experience of racism if possible.
- Seek additional personal supervision or mentoring (ensure consent is sought first) from someone with similar lived experience, in order to ensure that the minoritised trainee is not responsible for the ongoing education and management of the supervisor's feelings.
- Be mindful not to centre the supervisor's feelings of discomfort, however aim to be transparent, genuine and curious in discussion.
- Whilst every effort should be made to be considerate, it may be useful to hold in mind the White supervisor will likely get it wrong at some point. This can be expected, what is most important is how this is repaired via the process of taking responsibility, demonstrating curiosity and self-directed learning.
- To be culturally competent is to know that racialised communities are not homogenous. Therefore, the only way to know how the trainee can be best supported is to assess their individual experiences and needs. A common assumption that racialised people all experience and respond in the same way perpetuates racial stereotypes.

Supervision with a White trainee.

The majority of primary and secondary care mental health services in the UK have an over-representation of White service users and staff. However trainees and clinicians must still develop cultural competency and a tolerance for understanding exploring and discussing race. This will serve to provide clinicians skills to deliver high quality mental health services to minoritised service users. Additionally, cultural competence and an increased stamina for talking about race will contribute to the goal of equity of access into services and the profession regardless of race. Below are some resources that may structure and help facilitate discussion of race within supervision.

- The 'White Privilege: Unpacking the Invisible Knapsack' (McIntosh, 1988) paper lists 50 examples of white privilege. This is a useful exercise to explore in supervision in order to support the trainee



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to deconstruct their privilege and reflect on how being White has been beneficial to them. This also provides opportunities to reflect on the experience of minoritised others.

- The 'Fifty Ways to Leave... your Racism' (Patel & Keval, 2018) paper explores how racism features within current discourse, explores the presence of whiteness and discusses how academia and the psy-professions have engaged in the perpetuation of racism. The paper lists a range of questions that can be explored within 1:1 and group supervision to prompt the reflection and discussion of privilege, covert racism and systemic racism.
- The 'Social GRRRAACCEESSS and the LUUUTT model' paper provides a range of tools to explore Gender, Geography, Race, Religion, Age, Ability, Appearance, Culture, Class/Caste, Education, Employment, Ethnicity, Spirituality, Sexuality and Sexual Orientation. This document suggests a range of 1:1 and group supervision exercises that may be useful to support the exploration and discussion of difference.
- The 'Cultural Context Model in Clinical Supervision' (Hernandez, 2008) paper is a short article which introduces the Cultural Context Model (CCM). As a model of clinical practice, the CCM uses postcolonial ideas to account for the historical and current impact of oppressive social forces, including sexism, racism, homophobia, and classism in the practice of counselling psychology and family therapy. The CCM posits that liberation is key to healing and defines it as a system of healing that embraces critical consciousness, empowerment, and accountability as guiding principles. For liberation to occur for all members of a family, accountability and empowerment need to operate simultaneously. This may be a useful paper to explore within supervision to reflect on how historical societal structures have served to maintain White Supremacy in society and in Psychology.
- Racism is considered a fundamental cause of adverse health outcomes for racial/ethnic minorities and racial/ethnic inequities in health (Williams, Lawrence, & Davis, 2019) however is often overlooked within mental health and Clinical Psychology services in the UK. In fact, failure to assess perceived racism in mental health scales leads to a failure to account for psychological distress among African Americans, since exposure to racism is an important predictor of psychological problems for this group (Ridley, 2005). Encouraging trainees to use tools such as "The Cultural Assessment Tool" (Developed from Kleinman, Eisenberg and Good, 1978) and the "Everyday Discrimination Scale" may encourage useful discussion with a service user that can later be explored in supervision.

As part of this guidance, we have also included a racism resources list that are useful for the personal development of supervisors and trainees to help broaden their understanding of race, racism and whiteness.

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December 2021