Nearly every psychologist has been oriented to the pitfalls of cultural blindness and the need to develop competence in order to be effective in various modalities of practice. What is less understood is the ethical basis for proficiency in working with diverse individuals and groups, particularly in the area of clinical supervision. On the one hand we can say that treating everyone alike is good, and yet on the other hand this view overlooks the fact that a key to understanding every individual is the context of her or his socialization in the many dimensions it may encompass. The lens through which psychologists, students, and supervisees view the comments and actions of others is a key to developing cultural competence.

The APA Ethics Code (Principle E) is unequivocal in stipulating that competence in cultural matters is essential. Standard 7.06 refers to Assessing Student and Supervisee Performance, and Standard 2.01 directly addresses understanding cultural factors as a basis for effectiveness. (APA, 2010).

It is therefore clear that awareness and skill regarding all aspects of culture and diversity are ethical matters, and that they apply directly to supervision. If we think back to our student or professional experiences in training and supervision, how do we remember culture and diversity being addressed? In classrooms and supervisory sessions, was there any concern for cultural implications of assessment, treatment planning, intervention, or to the reactions of those receiving services, or was there little attention to these matters except when problems arose? If the majority of students, clients, supervisees or consultees were white, were their backgrounds and particular world views brought to light? To guide in this process, a very useful set of techniques for introducing multicultural issues in supervision is listed in a workbook on supervision. (Campbell, 2000).

From a student perspective, the following issues have been highlighted by the co-authors of this column:

CC: Cultural experiences, biases, and assumptions can easily shift the direction of supervision and treatment, and are related to cultural transference and countertransference. Finding ways to safeguard against doing harm to the client, especially when the cultural fit might not have been the most appropriate, requires knowledge, skill, and sensitive perception.

Using culturally sensitive and/or culture-specific assessment tools with clients of color is a critical issue. It was noticeable in my experience that measures were culturally biased and rarely provided an accurate picture of the client’s problems. The supervisor indicated that the selection of tests was left to the clinician’s discretion and access to resources, but there was no guidance on how to match culturally appropriate measures with clients.

AR: The fact that I am black does not mean that African American clients will automatically be receptive to me. We cannot always assume that our skin color in itself will allow us to develop rapport. The best supervisors I have had were white, and they really loved the population we worked with and believed true change could be made by anyone. The parallel process at work in supervision has direct effects in supervisees’ work with clients. I also believe that training sites need to provide assessment tools that are appropriate for all of the clients they serve, and whenever possible, conduct outreach in order to broaden the diversity of clientele for trainees to work with. In-service training should also be offered so that assessment and treatment is culturally relevant.

The ethics code, the professional literature and information from students can serve as useful guides for supervisors to develop cultural competence. The keys to greater effectiveness are in obtaining appropriate information, building rapport, and maintaining awareness and sensitivity to the perceptions of supervisees and their clients.

References