Viewpoint

Importance of Cultural Competence in Supervisory Relationships

Anu Subramanian[a]

Purpose: The purpose of this article is to discuss the importance of cultural competence in the area of supervision. The article uses a fictional scenario to consider the value of open conversations about cultural experiences and differences to begin a supervisory relationship.

Conclusion: It is important for clinical educators to be aware of their cultural identity, gather knowledge about other cultures, and develop positive attitudes about different cultures. Clinical educators should use their supervisory meetings to initiate discussions related to cultural influences and differences to ensure supervisee success.

A strong working alliance between a student clinician and clinical educator/supervisor is central to the development of students' clinical and professional skills. Additionally, in the American Speech-Language-Hearing Association (ASHA) Practice Portal for Clinical Education and Supervision (ASHA, n.d.-b), the supervisory relationship is listed as the first component of the clinical education process, highlighting its foundational nature (ASHA, 2013). One tenet that is key to the development of the supervisory relationship is cultural competence. Cultural differences between the clinical educator and the student can impact the supervisory relationship and the clinical education process. It is now expected that practicing speech-language pathologists exhibit cultural competence in service provision. It is also vital that clinical educators become adept at using cultural competence including cultural humility in their interactions with student clinicians. ASHA's Office of Multicultural Affairs (OMA) has many resources available to support clinical educators, and those resources will be highlighted across all Special Interest Groups on this 50th anniversary of the OMA's inception. For example, the Practice Portal focused on cultural competence (ASHA, n.d.-c) is a valuable resource for practicing clinicians and clinical educators, which includes self-assessments for personal reflection that can benefit supervisors and supervisees.

[a]Department of Communication Sciences and Disorders, University of Iowa, Iowa City

Correspondence to Anu Subramanian: anu-subramanian@uiowa.edu

Editor: Judith Brasseur

Received September 17, 2019
Revision received January 6, 2020
Accepted February 14, 2020
https://doi.org/10.1044/2020_PERSP-19-00078

Publisher Note: This article is part of the Forum: Celebrating the 50th Anniversary of the ASHA's Office of Multicultural Affairs.

Cultural competence comprises understanding and appropriately responding to unique combinations of cultural variables and diversity. The process of developing cultural competence is active, dynamic, and continuous. The steps in developing cultural competence include cultivating awareness of one's own cultural influences, gathering knowledge of different cultures, while developing positive attitudes regarding other cultures, and developing skills to interact and communicate effectively across cultures (Burchum, 2002). Although cultural competence is often discussed as it relates to service delivery, it also applies to the interactions between supervisors and supervisees.

Cultural responsiveness and cultural humility are slightly different in their definitions and are important to consider as part of overall cultural competence. Cultural responsiveness is the ability to learn from and relate to people of your own culture and other cultures. A culturally responsive supervisor acknowledges, demonstrates interest in, has knowledge of, and appreciates the supervisee's cultural experiences (Burkard et al., 2006). The use of the word "responsiveness" implies that a person cannot be completely knowledgeable and skilled in all areas of cultural diversity but is open and can adapt to working with people from different cultures (Garrett et al., 2001). Cultural humility is focused on personal reflection and growth to develop an openness to other cultures rather than gaining knowledge or awareness (Sue et al., 1991). This concept is especially important in supervisory interactions and should be the basis for supervisory (and therapeutic) relationships (Patallo, 2019). Clinical educators/supervisors need to be aware of their own cultural expressions, biases, and prejudices, and discuss them with their supervisees as the first step in cultural humility.

Disclosures
Financial: Anu Subramanian has no relevant financial interests to disclose.
Nonfinancial: Anu Subramanian has no relevant nonfinancial interests to disclose.

Downloaded from: https://pubs.asha.org Tami Cassel on 08/06/2020, Terms of Use: https://pubs.asha.org/pubs/rights_and_permissions

In their role as a clinical educator, a multiculturally competent supervisor incorporates specific cultural discussions and fosters cultural competence in their supervisee (Soheilian et al., 2014). It is important for the supervisor to set the right tone and discuss cultural experiences and differences in an initial supervisory conference (Gardner, 2002). Tohidian and Quek (2017) found that the supervisor's multicultural stance, including initiating conversations about cultural aspects, is integral to developing a culturally competent supervisory relationship. Given the inherent power dynamic in a supervisory relationship, it is incumbent upon the clinical educator to initiate conversations to develop the student's cultural competence.

As a clinical educator from a different race and ethnicity than the majority population in the United States, I am typically engaged in a supervisory relationship with students who are from a different culture than me. This creates an opportunity for me to have open discussions about cultural differences with all my students. In same-race supervisory dyads, conversations about cultural diversities are less likely to occur (Moore, 2011). Rather, such conversations are more likely to occur when a supervisee is from a different race or ethnicity than the supervisor. However, poverty, class, sexual orientation, invisible disability, gender identity, and immigration history are also central to an individual's identity and cultural experience and may not be obvious from meeting a student. Hence, an honest, open conversation initiated by the clinical educator is important in all supervisory relationships and begins with a supervisor's acknowledgement of their cultural experiences. In the next few paragraphs, I will briefly describe two scenarios to illustrate the value of this initial discussion regarding cultural differences using one clinical educator and two students. To maintain anonymity and confidentiality, these are a combination of multiple students and experiences and do not represent a single present or previous student or experience.

Rania and Nancy are undergraduate students working with a clinical educator, Lisa. This is their first clinical experience. Rania is of Middle Eastern descent; Nancy and Lisa are White. All three are cisgender conforming adults who grew up in the United States with no visible disabilities. Nancy comes from a background characterized by generational poverty, including reduced access to health care, single parenting, and is a first-generation college student. Lisa has done some reading on cultural differences and has learned that Middle Eastern cultures prefer a "high power distance," meaning that children learn to be obedient, view supervisors to be experts, defer to the expert, and may not express their own thoughts in the presence of a supervisor (Hofstede, 2011). Lisa is prepared for Rania to be deferential, not answer questions in a large group, and have different norms for eye contact. Meanwhile, Nancy's cultural background is hidden, so Lisa is not aware of Nancy's cultural background.

To begin the semester, Lisa has a group meeting with Nancy, Rania, and three other students assigned to her team. Lisa discusses her supervisory expectations, including timelines and due dates. Following the meeting, she schedules individual supervisory conferences with the students. In her meeting with Rania, Lisa brings up the cultural differences between Rania and her assigned clients. She also acknowledges the cultural differences between them and reassures her that Rania would not be expected to answer questions during group supervisor meetings. Rania is confused because her family immigrated to the United States before she was born, and she is acculturated or assimilated to the majority culture here. Rania is comfortable with the "low power distance" (Hofstede, 2011) used in the American educational system. Lisa's individual meeting with Nancy does not include any cultural discussions, given the similarity in their race and ethnicity. A few days later, Lisa notices that she does not have a lesson plan from Nancy and e-mails to check in. Nancy's e-mail response says, "Hey, Oops…I forgot. Sorry. I'll stop by right now." Lisa is taken aback by the informal tone in the e-mail and the delay in sending the required documents for the first session. When she comes in for the meeting, Nancy reveals that she did not write down the due date for documents and lost her notes from the previous meeting, so she was unable to plan for the first session. Given that the session is in a day, Lisa makes the decision to cancel the client's scheduled session, leaving both Lisa and Nancy feeling uncomfortable.

Although Lisa had some knowledge about cultural differences, she made the error of stereotyping with Rania and not having an open cultural conversation with all of her students, including Nancy. On the recommendation of a friend, Lisa looked at the information about cultural competence available through OMA and ASHA's Practice Portal on clinical education and supervision (cultural influences on clinical education). In her next individual meetings, Lisa exhibited openness and cultural humility by sharing her unique cultural perspectives as a member of a majority culture and how that has impacted her supervision philosophy and practices. Lisa asked open-ended questions about students' cultural background, beliefs, and their impact on learning. She listened carefully, asked follow-up questions, and learned that Rania does not abide by all the cultural norms attributed to Middle Eastern culture, including the power distances.

Similarly, Lisa also learned about Nancy's background in order to become more culturally responsive. She recalled reading about "hidden rules" of behavior that exist within each socioeconomic class (Payne, 2005) and built upon this previous knowledge by revisiting the literature on this topic in order to adhere to evidence-based practice guidelines and acknowledge that culture is ever-changing. Supervisors should emphasize that culture is dynamic and remind students that what they learn today may change 15 years from now. She continued to practice cultural humility by beginning her meeting with Nancy, sharing her expectations and prejudices in supervisory relationships based on her personal experiences. Lisa provided many opportunities for Nancy to share her experiences without stereotyping or generalizing. Given that this was Nancy's

Downloaded from: https://pubs.asha.org Tami Cassel on 08/06/2020, Terms of Use: https://pubs.asha.org/pubs/rights_and_permissions

first exposure to a clinic setting, her knowledge about language use and organizational expectations were different from those of Lisa. An open discussion helped Nancy identify supports that would help her be successful in the clinic setting.

Each of our cultural experiences and backgrounds impacts our learning and communication in unique ways. This is also true for supervisors, supervisees, and clients they serve. To teach a diverse group of students, multicultural supervision practices among clinical educators should become as ubiquitous as cultural competence in clinicians. Discussions of cultural differences can cause some initial discomfort. If each clinical educator/supervisor explores their own cultural experiences and prejudices and is open to change using a reflective process, this discomfort diminishes, creating a strong supervisory alliance. Over its 50 years, the OMA has advocated for clients, students, and practitioners who are culturally or linguistically diverse and created a plethora of resources to help all clinicians and supervisors develop cultural competence. Thus, we, as clinical supervisors, can shepherd new generations of clinicians who champion ASHA's vision of "Making effective communication, a human right, accessible and achievable for all" (ASHA, n.d.-a).

Acknowledgments

The author would like to acknowledge Danai Fannin for inviting this publication and providing suggestions for an earlier draft.

References

American Speech-Language-Hearing Association. (n.d.-a). *About the American Speech-Language-Hearing Association (ASHA)*. https://www.asha.org/about/

American Speech-Language-Hearing Association. (n.d.-b). *Practice Portal: Clinical education and supervision*. https://www.asha.org/Practice-Portal/Professional-Issues/Cultural-Competence/

American Speech-Language-Hearing Association. (n.d.-c). *Practice Portal: Clinical education and supervision: Cultural competence*. https://www.asha.org/Practice-Portal/Professional-Issues/Cultural-Competence/

American Speech-Language-Hearing Association. (2013). *Knowledge, skills and training considerations for individuals serving as supervisors* [Final report, Ad Hoc Committee on Supervision]. http://www.asha.org/uploadedFiles/Supervisors-Knowledge-Skills-Report.pdf

Burchum, J. L. (2002). Cultural competence: An evolutionary perspective. *Nursing Forum, 37*(4), 5–15. https://doi.org/10.1111/j.1744-6198.2002.tb01287.x

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

Gardner, R. (2002). Cross cultural perspectives in supervision. *Western Journal of Black Studies, 26*(2), 98–106.

Garrett, M. T., Borders, L. D., Crutchfield, L. B., Torres-Rivera, E., Brotherton, D., & Curtis, R. (2001). Multicultural supervision: A paradigm of cultural responsiveness for supervisors. *Journal of Multicultural Counseling and Development, 29*(2), 147–158. https://doi.org/10.1002/j.2161-1912.2001.tb00511.x

Hofstede, G. (2011). Dimensionalizing cultures: The Hofstede model in context. *Online Readings in Psychology and Culture, 2*(1), 8. https://doi.org/10.9707/2307-0919.1014

Moore, R. (2011). Supervision and multicultural issues: Supervisors and Supervisees. *SIG 11 Perspectives on Administration and Supervision, 22*(1), 33–39. https://doi.org/10.1044/aas22.1.33

Patallo, B. J. (2019). The multicultural guidelines in practice: Cultural humility in clinical training and supervision. *Training and Education in Professional Psychology, 13*(3), 227–232. https://doi.org/10.1037/tep0000253

Payne, R. K. (2005). *A framework for understanding poverty*. Aha Process.

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

Sue, S., Fujino, D. C., Hu, L. T., Takeuchi, D. T., & Zane, N. W. (1991). Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis. *Journal of Consulting and Clinical Psychology, 59*(4), 533–540. https://doi.org/10.1037/0022-006X.59.4.533

Tohidian, N. B., & Quek, K. M. T. (2017). Processes that inform multicultural supervision: A qualitative meta-analysis. *Journal of Marital and Family Therapy, 43*(4), 573–590. https://doi.org/10.1111/jmft.12219

Downloaded from: https://pubs.asha.org Tami Cassel on 08/06/2020, Terms of Use: https://pubs.asha.org/pubs/rights_and_permissions