Clinical supervision in transcultural mental health
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The Transcultural Mental Health Centre (TMHC) has run a clinical supervision program for mental health professionals working in the area of cross cultural mental health since 1996 (Zenari, 1997). This program specifically targets those health professionals working in a therapeutic capacity with clients of linguistically or cultural diverse backgrounds. The current program is offered free and small groups of six to ten participants meet for two hours on a monthly basis to discuss cases and review material relevant to clinical case management. Groups are held across metropolitan Sydney and are conducted by qualified professionals including clinical psychologists, a counselling psychologist and a social worker. Participants are given the opportunity to choose their supervisor and location. Contracts are used to ensure all participants contribute and maximize their learning opportunities both within the group and outside the group meeting times with literature relevant to the case material discussed. The following chart summarizes the breakdown of the 34 participants who attended supervision in 1999.

Professional Background of Participants

![Pie chart showing the professional background of participants](image)

TOTAL: 34 completing the program

The aims of this brief paper are twofold. First, to discuss the importance of considering cultural issues in supervision and how these may affect the presentation and interpretation of the culturally different client and the health professionals’ management of this case. Second, to provide a context for best practice in clinical supervision. The paper will outline guidelines that are considered necessary for establishing and maintaining a rewarding supervisory relationship.

The place of culture and cultural techniques in clinical supervision

One of the defining characteristics of the TMHC program is that because of its culturally diverse participants and considerable knowledge they are able to contribute to case discussion about culture and ethnicity. There also exists a strong commitment by its participants to expand their cultural knowledge and competencies in developing culturally appropriate interventions. Sue, Arredondo and McDavis (1992) state that ‘culturally skilled counsellors understand how race, ethnicity and so forth may affect personality formation, vocational choices, manifestation of psychological disorders, help seeking behaviour, and the appropriateness or inappropriateness of counselling approaches’ (p. 482). In supervision, it is important to consider these factors and how the health professional’s own characteristics (such as cultural values and biases, awareness of the client’s world view and their own beliefs, attitudes and skills) influence their ability to appropriately assess and counsel the client. For example, questions in supervision to consider may be ‘is culture an issue in this presentation?’ ‘If so, why and what are the ways that it needs to be dealt with?’ Participants should consider the place of alternative interventions that may be more culturally appropriate for their client, such as traditional healing or spiritual interventions or alternative medicines.
Scope of clinical supervision

In understanding supervision it is important to describe the processes involved. For clinical supervision to work well it is necessary to clearly differentiate it from line management supervision, the latter being an overseeing function for reviewing a health professional’s performance in the workplace according to management standards and practice policies. Clinical supervision aims to develop and maintain a health professional’s competent professional functioning while at the same time safeguarding a client’s care. According to this definition then, supervision involves both a facilitative and evaluative function. That is, clinical supervision develops skills and knowledge application in addition to ensuring that these are professionally applied.

Clinical supervision supports practice and enables health professionals to maintain and promote the standards of care offered to clients. It is a practice-focused professional relationship and involves health professional’s reflecting on their clinical practice guided by a skilled supervisor (Sloan, 1996). For supervision to work well the clinical supervisor should be a person of demonstrated superior ability and knowledge in the area they are providing supervision. The supervisor needs to establish ‘legitimate power’ in the eyes of the health professional in that they should be seen as someone who can provide them with rewards in supervision (knowledge, skills, guidance, reflection on their skills).

Crisante (1997) states supervision should be a ‘collaborative and participatory relationship based on mutual sharing, respect and valuing of difference’ (p. 95). How can supervision involve both a supervisor having ‘legitimate power’ at the same time as being ‘collaborative and participatory’ with its members? It can do this because the supervisor needs to take the stance that they value all contributions made to clinical discussion but at the same time be in a position to direct and facilitate, where appropriate, cultural learning within the group. An example, in the author’s current clinical group, is that all participants are expected to present their clinical work to the group. Issues around the case presentation are discussed and all members are encouraged to present their interpretations and views as to improved case management. Participants are encouraged to examine the relevance of interactional and contextual explanations of the case presentation and other possible interactive effects (e.g. gender, religion). All participants contribute with the final discussion being led by the supervisor who, if having legitimate power, is able to pull together all ideas and recommendations into a framework that can be taken away and used by the presenter. It is also an aim of supervision that all group members learn from the presentation and are in some way able to apply the clinical discussion to their therapeutic work.

The process of clinical supervision should be developed by those involved according to the local circumstances and needs (Cutcliffe & Burns, 1998). In the case of the supervision program offered by the TMHC, supervision is conducted according to the group member’s assessed needs, with participants being offered further education and training as identified and requested. Because the TMHC has over 100 contracted sessional workers (most of who are bilingual), offering language and culturally specific client-based services, it has been very important to clarify the specific needs of those workers who attend this supervision program. Apart from regular contact with their supervisors all sessional workers are offered specific supports (readings and resources) and training relevant to their needs. To this end clinical supervision should be evaluated and assessed as to how it influences care, practice standards and service delivery.

In the TMHC program, annual evaluation has consisted of participants completing a form outlining perceived benefits of their supervision. This year, for the first time, a pre-post measure is being used for participants to assess their perceived changes in knowledge and skills over the duration of the yearly program (Bernard & Goodyear, 1998), in addition to ongoing evaluation of perceived satisfaction levels.

The focus of supervision

Four main categories are identified as important components of clinical supervision. These are:

1. Process Skills

These are described as observable counsellor behaviours - how the health professional interacts with their client. Supervision based on process skills involves reflection on the health practitioner’s communication skills with the client, for example ‘I thought you asked a good question,’ ‘What do you need to consider when engaging female clients from this country?’
2. Conceptualisation Skills
These are thinking skills and refer to what the health professional considers are the major concerns for the client. Without adequate conceptualisation skills, Bernard (1988) states the process skills are relatively useless because even a well executed response, if based on an incorrect assumption on what the client is experiencing or feeling, will not be helpful. Supervision based on conceptualisation skills involves questioning such as 'What do you see as the major themes here?' or 'Where do you see yourself going from here with the client?' or 'Do you need to consider traditional therapies with this client?'

3. Personalisation Skills
These skills are based on the personal attributes of the health professional. Given that clinical work with a client is a very personal activity it is important to recognize the health professional's personal attributes and liabilities which contribute to their role as helper. Possible supervisory comments that address personalisation skills may include 'You were able to deal with that client very well despite it being a difficult interchange' or 'You were quiet when the client said that to you and I wondered what that was about?' or 'How do you make sense of the client's presentation given the context from which they were referred and their expectations of you?'

4. Professional Skills
Bernard & Goodyear (1998) state that professional skills have as much to do with performance outside the therapeutic relationship as within. These skills include report writing, confidentiality, ethics, the use of counselling contracts and related behaviours. Examples of supervisor comments include 'Your behaviour in the session appeared to reflect a certain level of disinterest with what the client was saying. I was wondering why this was the case?' or 'How do you understand the cultural context for this client and what importance does this have?' or 'What might you do if the mother phones you and asks about what you are doing in the session with her son?'

While it is important to keep in mind all of these categories it is noted that they overlap and that each may vary in importance depending on how the health professional is with working with their client. To this end, the role of the supervisor is to choose to focus on which skill or category needs to be emphasized for the health professional's training and development of clinical skills. In the case of group supervision, such as at TMHC, discussion of these four skill areas involves the supervisor asking participants to recognize their strengths and weaknesses in these areas, and upon reflection, discussing as a group what changes might need to occur. In this example, the facilitative and evaluative strategies are used to develop the participants' therapeutic knowledge and skills.

Styles of supervision
No matter what style of supervision is undertaken, video-tape or audio-tape review, role play or verbal recall of sessions, it is important that the health professional feels supported in the development of increased knowledge and awareness of possible solutions to clinical problems (Butterworth, 1996; Cutcliffe & Epling, 1997). While it is recognised that there are many different forms and styles of clinical supervision on offer (Bernard & Goodyear, 1998 provide an excellent review), it is proposed that a developmental model is extremely beneficial for most practitioners. This model encompasses the role of the Teacher (instructional and evaluative procedures), Counsellor (an interpersonal focus looking at the personal growth of the health professional), and Consultant (encouraging the development of the health professional’s own conceptual and cultural insights and therapeutic understanding) (Bernard, 1988).

What theory is used as the basis of supervision for clinical case discussion depends very much on the model used by both the practitioner and the supervisor and it is important to marry the two models. In this way the health professional can develop a sound knowledge and practice base without the confusion of differing theoretical models. Of course if the health professional wanted to learn a new model they would be encouraged to undertake further education and training using that theoretical approach, which may then later be applied in their clinical casework and discussed in supervision. I have found that a systemic model works best for myself in clinical supervision. This theoretical approach considers issues regarding the wider cultural system and the family as it impinges on the individual and how they make sense of their concerns. Particularly for clients of culturally different backgrounds it is helpful to consider their cultural and family system as individual difficulties are often best understood from the context of these influences.
An example comes to mind that was presented for clinical supervision. A man from an African community presented with depression and chronic pain. He fled a tormented past and had successfully managed to care for his young daughter despite chronic pain following a back injury at work soon after arrival in Australia. What was found to be helpful in understanding and working with this man was the discussion of the relevance of traditional healing practices and his desire to explore these options. It was his belief that this intervention would help his back injury and lead to the successful return to a 'normal life'. In supervision we also needed to explore his cultural beliefs, family values and attitudes as this significantly influenced his belief that he had in some way 'let his family down' by leaving his aged and sick father in a depressing environment. Had considerable time not been spent on discussing these issues it is likely that important cultural and family beliefs would not have been explored and the client would have been left feeling misunderstood.

Conclusion
This paper has provided only a brief introduction to the many facets of clinical supervision and the program that exists at the Transcultural Mental Health Centre. A great deal has been written on clinical supervision regarding its practice, definition and benefits but unfortunately little in the area of clinical supervision in cross cultural mental health. What continues to be needed is greater empirical data validating the usefulness of supervision and what makes a good supervisory relationship and good supervision. However, what is already known is that supervision benefits from good preparation, a trusting relationship and a commitment by all parties involved. In cross cultural mental health it is also important that those working together in clinical supervision contribute to continued greater cultural understanding and appropriate clinical intervention.

I would like to thank all those I work with in clinical supervision as this relationship continues to contribute to my understanding and development of knowledge in this area which I hope makes me a better teacher and supervisor.

References
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