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Trainee Perspectives on Relational Cultural Therapy and Cultural Competency in Supervision of Trauma Cases

Jennifer M. Gómez

Wayne State University

Abstract

Supervision is a key part of training in clinical psychology. From my postdoctoral trainee perspective as a Black woman, I reflect on supervision in 1 of my predoctoral practicum at a community clinic where I worked with low-income women with trauma histories. With relational cultural therapy (e.g., Miller, 1976), my clinical supervision was in the feminist multicultural framework (Porter & Vasquez, 1997) and included the complexities of power in the supervisory relationship, openness, collaboration, and critical self-reflection (Arczynski & Morrow, 2017). Moreover, incorporating research perspectives (e.g., betrayal trauma theory, Freyd, 1996; cultural betrayal trauma theory, Gómez, 2018d; microaggressions, Sue, 2010) and cultural competency (Sue, 1978) created a rich learning environment. In this article, I detail 2 case studies to illustrate exchanges in supervision that positively impacted my professional development. In Case Study 1, my supervisor engendered identification of parallel processing through engaging in mutual empathy and relational reconnection regarding racial discrimination from a client. In Case Study 2, my supervisor used a collaborative approach in treatment planning for a Latina client who was in an abusive relationship. Based on these experiences, implications for supervisors include ongoing training in discrimination of diverse minorities and facilitating discussions in supervision about how trainees' and clients' respective societal statuses impact the therapeutic process (e.g., case conceptualizations, treatment planning). Implications for trainees include maintaining a processing journal, in which trainees reflect on their experiences including but not limited to cultural competency to be better prepared to discuss complex issues in supervision.

Abstract

La supervisión es una parte clave de la formación en psicología clínica. Desde mi perspectiva de aprendiz postdoctoral como mujer negra, reflexiono sobre la supervisión en una de mis prácticas predoctorales en una clínica comunitaria donde trabajé con mujeres de bajos ingresos con antecedentes de trauma. Con la terapia cultural relacional (por ejemplo, Miller, 1976), mi supervisión clínica estaba en el marco multicultural feminista (Porter y Vásquez, 1997) e incluía las complejidades del poder en la relación de supervisión, apertura, colaboración y autorreflexión crítica (Arczynski & Morrow, 2017). Además, la incorporación de perspectivas de investigación (por ejemplo, la teoría del trauma de la traición, Freyd, 1996; la teoría del trauma de la traición cultural, Gómez, 2018c; las microagresiones, Sue, 2010) y la competencia cultural (Sue, 1978) crearon un rico ambiente de aprendizaje. En este manuscrito, detallo dos estudios de caso para

Correspondence concerning this article should be addressed to Jennifer M. Gómez, Department of Psychology, Merrill Palmer Skillman Institute, Wayne State University, 71 East Ferry Street, Detroit, MI 48202. jennifer.gomez@wayne.edu.

ilustrar los intercambios en la supervisión que impactaron positivamente mi desarrollo profesional. En el Estudio de caso # 1, mi supervisor generó la identificación del procesamiento paralelo a través de la empatía mutua y la reconexión relacional con respecto a la discriminación racial de un cliente. En el Estudio de caso # 2, mi supervisor utilizó un enfoque colaborativo en la planificación del tratamiento para una cliente latina que estaba en una relación abusiva. En base a estas experiencias, las implicaciones para los supervisores incluyen capacitación continua en discriminación de minorías diversas y facilitar debates en supervisión sobre cómo los estados sociales respectivos de los alumnos y los clientes impactan el proceso terapéutico (por ejemplo, conceptualizaciones de casos; planificación del tratamiento). Las implicaciones para los alumnos incluyen mantener un diario de procesamiento, en el que los alumnos reflexionen sobre sus experiencias, incluidas, entre otras, la competencia cultural, para estar mejor preparados para debatir cuestiones complejas en la supervisión.

Abstract

督导是临床心理学训练的关键部分。作为一名黑人女性和博士后受训者, 我对自己以前在博士前实习时, 在社区诊所中与低收入、有创伤历史的女性的工作经历进行回顾和反思。在使用关系文化疗法 (如 Miller, 1976) 时, 我的临床督导是在女权主义多文化框架 (Porter & Vasquez, 1997) 下进行的, 并且包括了督导关系中的权力复杂性, 开放性, 合作和辩证自我反思等议题 (Arczynski & Morrow, 2017) 。并且, 将研究视角 (如背叛创伤理论, Freyd, 1996; 文化背叛创伤理论, Gómez, 2018c; 微侵犯, Sue, 2010) 与文化能力 (Sue, 1978) 的结合也创造了丰厚的学习机会。在本文中, 我详细描述了两个案例研究, 以展示督导过程怎样地正面促进了我的职业发展。在案例研究一中, 我的督导在来访者出现种族歧视后, 通过互相共情和关系再联结, 发现了平行过程。在案例研究二里, 我的督导在与我讨论对一位处于虐待关系的拉丁裔来访者的治疗计划时, 使用了合作性的方法。基于这些体验, 对于督导的建议包括对不同少数族裔被歧视经历上面的持续训练, 以及促进督导讨论, 以探讨受训者和来访者各自的社会状况怎样影响治疗过程(如案例概念化和治疗计划)。对于受训者的建议包括, 保持处理笔记。受训者可以在笔记中反思自己的经历, 包括但不限于文化能力。受训者从而可以更好地准备在督导中讨论复杂的议题。

Keywords

supervision; relational cultural therapy; feminist multiculturalism; discrimination; cultural betrayal trauma theory

Keywords

supervisión; terapia cultural relacional; multiculturalismo feminista; discriminación; traición cultural teoría del trauma

Keywords

督导; 关系文化理论; 女权多文化主义; 歧视; 文化背叛创伤理论

Supervision is a key part of training in clinical psychology. From my postdoctoral trainee perspective as a Black woman, I have had time to reflect on my 7 years of clinical training

in psychology. Within the framework of relational cultural therapy (e.g., Miller, 1976), my clinical supervision utilized a feminist multicultural framework (Porter, 1995; Porter et al., 1997) and included the complexities of power in the supervisory relationship, openness, collaboration, and critical self-reflection (Arczynski & Morrow, 2017). Incorporating research perspectives (e.g., betrayal trauma theory, Freyd, 1996; cultural betrayal trauma theory, Gómez, 2018c; microaggressions, Sue, 2010) and cultural competency (Sue, 1978) further created a rich learning environment. I would like to highlight supervision experiences that occurred during a predoctoral practicum at a community clinic where I worked with low-income women who had experienced previous child maltreatment and neglect, date rape, revictimization, and current domestic violence. Although I had many positive experiences in my clinical training, two instances in supervision stand out in shaping my trajectory as a clinical psychologist-in-training.

Relational Cultural Therapy, Cultural Competency, and Research

During my practicum at the community clinic, I received training in relational cultural therapy (RCT; Miller, 1976), which is an evidence-informed, feminist approach to psychotherapy (Comstock et al., 2008; Gómez, Lewis, Noll, Smidt, & Birrell, 2016; Jordan, 2010; Miller & Stiver, 1997). The premise of RCT is that relational disconnections from the self and others cause mental distress (Miller et al., 1997). Such disconnections can occur during violence victimization that is perpetrated by close others (Birrell & Freyd, 2006; Gómez et al., 2016), known as betrayal traumas (Freyd, 1996, 1997; Gómez, 2018a; Gómez & Freyd, 2017). Thus, the therapeutic process serves as a site for relational repair, in which the therapist and client engage in mutual growth and empowerment (Miller et al., 1997). As a feminist framework, RCT also grapples with power. Instead of power-over approaches that can hinder a client's agency (Cloitre, 2015), RCT promotes power-with (collaborative) strategies that engage the client in their own therapeutic trajectory. Additionally, this framework facilitates attending to power in the therapeutic relationship—therapist versus client—and in society—White woman versus Black woman (Gómez et al., 2016). As such, cultural competency (Hays, 2008; Sue, 1978), specifically as it relates to power, privilege, and discrimination, is by definition an integral part of RCT (Gómez et al., 2016).

Within RCT, research consistently informed my case conceptualizations. Specifically, I drew upon the literature on microaggressions (e.g., Sue, 2010), which are covert forms of discrimination, such as ignoring the complexity between individuals by communicating that everyone of a particular minority ethnic group will speak or behave the same way (Sue, Capodilupo, & Holder, 2008). Regarding trauma, I utilized research of two theories. First, I incorporated betrayal trauma theory (e.g., Freyd, 1996, 1997; Gómez, 2018a), which suggests that violence that occurs within close relationships has a betrayal that is toxic to individual's mental and physical health. Second, I utilized cultural betrayal trauma theory (Gómez, 2012, 2015a, 2015c, 2017a, 2017b, 2018b, 2018c, 2018d, in press; Gómez & Freyd, 2018), which I was theoretically and empirically developing at the time. In cultural betrayal trauma theory, I propose that within-group violence victimization in minority populations has a cultural betrayal that impacts diverse outcomes (e.g., Gómez, 2018c, 2018d). Taken together, the supervision process between myself, a Black woman, and one

of my supervisors, a White woman, was structured in the RCT framework, with explicit incorporation of cultural competency and research into the therapeutic process.

Case Study 1: Parallel Process in Experiencing Discrimination by a White Client

Anna (pseudonym) was a young, low-income, White woman, who was kind, caring, humorous, artistic, and strong. In psychotherapy, we made progress in reducing her anxiety and self-harming behaviors through addressing the child maltreatment, neglect, and exposure to domestic violence she had experienced. Several months into psychotherapy, Anna told me about the negative impressions she initially had of me as a Black woman. She relayed that she had been worried that I would be like another Black therapist she had worked with previously: I would think her problems were insignificant, indicative of a poor little White girl complex; I would detail Black history to teach her of her privilege; and I would not understand her. She told me these fears in the context of sharing how much she valued psychotherapy with me.

Because addressing relational breaches between the therapist and client is part of RCT (Miller et al., 1997), I brought the hurt I felt to Julie (pseudonym), my middle-aged, White woman supervisor. At first, she did not conceptualize what my client had said as discriminatory, which created a relational breach between her and me. I explained the microaggression literature to her (for a review, see Gómez, 2015b), including the assumption of homogeneity (Sue, 2010; Sue et al., 2008). I further detailed the harm of having to hear of the prejudicial beliefs my client had of me in our earlier sessions. I expressed my frustration of being discriminated against as a Black person in most settings. As a clinical psychologist-in-training, I had wanted to work with my clients without the baggage of oppression.

Julie then engaged in the RCT tenet of mutual empathy (Miller et al., 1997): In empathically listening to my evidence-supported pain, she repaired the relational disconnection between us that stemmed from me feeling misunderstood. Consequently, I experienced empathy for her. I was able to see her as a good person who had been limited by not having personal or professional experience with racial discrimination—both within and outside the therapeutic context. Through her curiosity about my experience (Miller et al., 1997), I was able to reconnect with her. This led to me identifying a parallel process (Friedlander, Siegel, & Brenock, 1989; Tracey, Bludworth, & Glidden-Tracey, 2012) with my client: the way that my supervisor, Julie, had bridged the gap to understand my perspective was the same mutual empathy I would need to repair the relational disconnection I felt with my client. I could engage in curiosity, perspective taking, and empathy to understand Anna’s initial perspective of me and why she chose to share those views with me now. Although bigotry did underlie her view of me as a Black person, I hypothesized that her fears of herself and her problems being judged as insignificant and unimportant may be stemming from her trauma history that was similarly invalidating of her experiences and perspectives. In sharing her initial prejudicial beliefs with me now, I hypothesized that she was identifying her own growth: her ability to trust and connect with someone who appeared to be different from her.

The impact this supervision had on me was profound. First, it was a way for me to see RCT (Miller et al., 1997) in action. I could identify: (a) relational disconnections in both psychotherapy and supervision; (b) my own relational paradox (Miller et al., 1997) of wanting to be connected with both Anna and Julie while simultaneously wanting to retreat following feeling hurt; and (c) the role of mutual empathy in repairing the relational disconnections I had with Anna and Julie. Moreover, my ability to use the research on microaggressions (Sue, 2010) to understand and share my own experience with Anna reaffirmed the place for research in various facets of clinical work. Finally, this supervision experience highlighted what cultural competency (e.g., Sue, 1978) could mean for me as a Black therapist with White clients. I was faced with the reality that I am Black in the room with clients. I realized that I had a role in my position of power as a therapist to engage in cultural competency, even amid being lower societal status as a Black person. I am still learning what that role is, particularly with White clients who are overtly racist. However, this experience taught me that I cannot ethically abdicate my responsibility in cultural competency (American Psychological Association, 2003), even when I am the only minority in the psychotherapy room.

Case Study 2: Mutual Empowerment and Respecting Client Autonomy

Antonia (pseudonym) was a low-income Latina, who was smart, loving, funny, perseverant, and insightful. Antonia began psychotherapy following a domestic violence incident in which her romantic partner had engaged in potentially lethal violence with a weapon. During psychotherapy, Antonia was still in communication with him. Utilizing cultural betrayal trauma theory (e.g., Gómez, 2018c) and other research (e.g., Bryant-Davis, Chung, Tillman, & Belcourt, 2009), I hypothesized that one of the reasons she did not report her boyfriend to the police was the (intra)cultural pressure she felt to protect him, a Latino, from the discriminatory criminal justice system. Our sessions addressed her mental distress and ambivalence related to her abusive relationship, amid escalating violence.

In my supervision with Julie (pseudonym), I discussed my inclinations toward power-over approaches (Miller et al., 1997) with Antonia. Whereas we did have a safety plan in place and were documenting each instance of abuse that Antonia detailed in psychotherapy, I wanted to decide for my client that she should leave her partner. I divulged to Julie my fears around Antonia being murdered if she stayed in this relationship. Julie could have taken a power-over approach with me, in which she demanded that I do not dictate the right decisions to my client because of the importance of respecting the agency and autonomy of those who have been or are currently being abused (Cloitre, 2015; Holland, Cortina, & Freyd, 2018).

Instead, Julie took a power-with (collaborative) approach with me in supervision, in which she decentralized the supervisor-trainee power in the room by identifying our collective helplessness. Moreover, Julie asked me, “If Antonia is murdered by her boyfriend, what would you want her psychotherapy sessions to have been like for her before she died?” With that question, I was able to identify that I would not want her to be dominated, isolated, misunderstood, and silenced in psychotherapy. Rather, I would want to cocreate a space with Antonia in which she could safely explore her feelings, her worries, and her pain

while being supported in her agency, autonomy, and sense of self. Following Antonia safely leaving this relationship months later, she told me how psychotherapy had helped her realize that she was someone worthy of love and could therefore choose to find nontoxic love and connection in other relationships. This result was the personification of RCT (Miller et al., 1997): through power-with approaches, Antonia was able to develop relational connections with herself and me as her therapist, which led her to seek out other healthy relationships outside psychotherapy.

Julie's actions as my supervisor taught me the importance of client agency and autonomy, even when the urge for power-over approaches comes from genuine caring and fear for the client. Professionally, this supervisory experience was a turning point in me learning how to grapple with my own feelings of helplessness, insecurity, and inability to predict a positive future for my clients as a trauma therapist (Danylchuk, 2015). Being able to see myself as someone who is engaging in therapeutic journeys with my clients, instead of a master who will fix the lives of my clients, has since influenced who I am as a clinical psychologist-in-training, teacher, supervisor, mentor, and human.

Implications

In identifying what supervisors and trainees alike can learn from the experiences I detailed above, I think about my own growth from these experiences. The general implication I propose is utilizing feminist multicultural supervision approaches (Arczynski & Morrow, 2017) to incorporate the lived complexity of clients and trainees into supervision. Complexity in the above case studies included the following: the discrimination I experienced from Anna; the fear for safety I had for Antonia; the research on trauma (Freyd, 1997; Gómez, 2017a) and discrimination (Gómez, 2015b); the grappling of power dynamics in psychotherapy (Miller et al., 1997) and supervision; the identification of parallel processes (e.g., Friedlander et al., 1989); and cultural competency (Hays, 2008). Thus, multicultural clinical supervision (Falender, Burnes, & Ellis, 2013) is warranted.

Many of my other supervisors have excluded this complexity, believing it to be irrelevant both to my training and to client well-being. The consequences of shutting down these and other processes are at least 2-fold: (a) It creates a system in which trainees, whose experiences and worldviews differ from the dominant cultural frame of psychotherapy (e.g., objectivity), are silenced, and this can engender discriminatory experiences and less efficacious training for such trainees, who are more likely to be minorities; and (b) it restricts the trainees from giving the best care possible to diverse clientele. In including complexity, trainees—who will become licensed clinicians—are better able to more closely align with the needs of their clients through perceiving them in all their intrapersonal, interpersonal, contextual, and cultural complexity, as opposed to decontextualized individuals with discreet, diagnosable disorders (see Gómez et al., 2016 for a discussion).

One concrete implication for supervisors is to learn about the discriminatory experiences of other minority groups (e.g., diverse ethnic, religious, gender, sexual minorities). Furthermore, without stereotyping, supervisors can facilitate discussions in supervision of

how trainees' identities, experiences of oppression, and interactions with clients' majority identities affect the therapeutic process (e.g., case conceptualization; treatment planning; progress in psychotherapy). Additionally, trainees can keep confidential processing journals, which can engender self-reflexivity, thus making them better prepared to bring these difficult topics into supervision.

Although potentially daunting, incorporating such complexity into supervision can be beneficial for the supervisory triad: supervisor, trainee, and client. Through mutual empowerment and empathy, the supervisor and trainee can grow in this relationship and professionally within themselves. This approach also may help us all collectively heal from the many wounds of race-based incident trauma (Bryant-Davis & Ocampo, 2005) and violence (e.g., Gómez, 2018d).

Conclusion

With relational cultural therapy as its framework, I detailed two trauma case studies that illustrate specific supervision processes (e.g., power-with approaches) in predoctoral clinical training that positively impacted my development as a therapist-in-training. With feminist multicultural supervision approaches (Arczynski & Morrow, 2017), I encourage supervisors to incorporate individual and group-level complexities of trainees and clients, instead ignoring that such differences exist. This includes supervisors' continuing education in discrimination along with facilitating supervision that incorporates how the supervisor's, the trainee's, and the client's minority and majority identities impact the therapeutic process. Through collaboration, supervisors and trainees can cocreate supervision that fosters professional growth while meeting the needs of an increasingly pluralistic profession and society.

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