44

Empowering Female Supervisees

A Feminist, Multicultural, and Relational Perspective

MYRNA L. FRIEDLANDER, SUSANA BLANCO,
SHAINA BERNARDI, AND KATHARINE S. SHAFFER

Dominique had been working as a master's level psychotherapist in an urban community agency for about 3 months when her client, Fawza, a 25-year-old immigrant from Iraq, vividly described how she had recently been jumped and raped by two men with knives while she was emptying the trash behind her building complex. A Jamaican American who grew up in a housing project herself, Dominique found it extremely difficult to listen to the details of Fawza's story. Although recognizing that Fawza apparently felt safe enough after 8 weeks in therapy to disclose her trauma experience, Dominique found herself replaying her client's story over and over again in her mind. As the week progressed, Dominique found it increasingly difficult to attend to her other clients, and even her dreams were filled with nightmares about rape. By the following week, she was afraid to walk to work—she repeatedly looked over her shoulder, convinced that she was being stalked by a former boyfriend.

Realizing that her reaction to Fawza's disclosure was extreme, Dominique decided to disclose her fears and nightmares to her supervisor. Having no knowledge of secondary traumatization, the supervisor responded by asking Dominique if she were either "ill prepared" in her graduate training "or else too emotionally unstable to handle the rigors of clinical work."

Dominique shut down. Neither interpretation of her experience was accurate or acceptable. She was certain that her White, apparently middle-class supervisor could not begin to understand the vulnerability she—and other low-income women of color, like Fawza—feel in their daily lives.

607

The supervision relationship was fragile even before this interaction occurred. Since issues of diversity had never before been mentioned by the supervisor, Dominique felt disinclined to bring up these topics. But, at this point, the supervisory alliance was ruptured in the extreme. Feeling highly unsafe, Dominique began to wonder if she really was ill-suited for a career as a therapist.

Elements of this case illustrate pertinent issues in supervision that have come to the forefront of our profession in the past 2 decades, namely the critical importance of the supervisory relationship and the potential for harm (Ellis et al., 2014) when supervisors lack knowledge (in this case, about secondary traumatization); ignore issues of sociocultural diversity, oppression, and privilege; and misuse their authority and power (Nelson & Friedlander, 2001). Indeed, a Task Force of the American Psychological Association (2015), recognizing that the evaluative, involuntary, and gatekeeping aspects of psychotherapy supervision can make it difficult for trainees to engage in the kind of self-examination that is necessary for learning to become a skilled and empathic psychotherapist, recently published a series of *Guidelines for Clinical Supervision*. In these guidelines, which complement the literature on supervision competencies (e.g., Falender & Shafranske, 2007), supervisors are directed to acknowledge the "power differential [as] a central factor in the supervisory relationship . . . the supervisor bears responsibility for managing, collaborating, and discussing power within the relationship" (p. 37).

In this chapter we kept these guidelines and competencies in mind, along with other current scholarship, as a point of departure for our discussion of interpersonally responsive and culturally sensitive supervision that empowers female psychotherapy trainees. The conceptual framework for this discussion reflects our integration of a feminist and multicultural perspective on supervision (Szymanski, 2003, 2005) with a relational approach to critical events in the supervision process (Friedlander, 2012, 2015; Ladany, Friedlander, & Nelson, 2005, 2016; Shaffer & Friedlander, 2015). In our view, supervision is contextual. That is, supervision processes should not be viewed in isolation; rather, they are intertwined with the cultures (broadly defined) of supervisor, supervisee, and client(s); therapeutic processes; and larger social systems (e.g., clinical/academic setting, professional standards).

In our discussion, we focus exclusively on the experience of female trainees, whether they are supervised by women or men. We recognize the well-documented differences in how men and women approach supervision (see review by Doughty & Leddick, 2007) as well as the fact that dyads with a male supervisor and a female supervisee reflect men's privileged and powerful position in society relative to women. We also recognize that the mental health field has been dominated by women for the past 25 years or so. Consequently, today's female supervisors are likely to be more comfortable with the authoritative aspect of supervision than their predecessors who had few, if any, female role models. Indeed, women as well as men need to be aware of how they use their power in supervision relationships. Regardless of gender, the standards of the profession and the supporting literature require all supervisors to balance their power and authority with responsiveness and collaboration.

We begin the chapter with a brief summary of the most pertinent empirical literature since 2003, when the previous chapter on this topic was published in the first *Handbook on Counseling Women* (Barnes & Bernard, 2003). Next, we describe our framework, which integrates feminist, multicultural, and relational perspectives on supervision, along with a brief case illustration. We conclude

with an extended case example and recommendations for future research and dialogue on the empowerment of female trainees.

RECENT RESEARCH ON FEMALE TRAINEES' EXPERIENCES IN SUPERVISION

Strikingly little research on gender in supervision has been published in the past decade. We located few studies on how the cultural aspects of gender contribute to women's experience in supervision and virtually no empirical literature on strategies to empower female supervisees. This omission is unfortunate since it is now well-established that (a) female and male trainees generally have different experiences in supervision (Ladany & Friedlander, 2014; Walker, Ladany, & Pate-Carolan, 2007) and (b) supervisors are not immune to behaving in a gender biased way (Doughty & Leddick, 2007; Nilsson, Barazanji, Schal, & Bonner, 2008).

Broadly considered, much of the recent scholarship focuses on the same issue—gender differences that predominated in the earlier literature. As one example, the supervisees in Miller and Ivey's (2006) study reported that issues of spirituality were discussed more often in same-gender than in opposite-gender dyads. Interestingly, these authors also found that trainees perceived more collaboration in same-gender than in mixed-gender supervision dyads. In another study, Granello (2003) found differences in supervision discourse depending only on the gender of the trainee, not that of the supervisor. Analysis of audiotapes showed that while accepting and building on the comments of female supervisees more often than those of male supervisees, the supervisors in this sample tended to elicit men's opinions more often, and this trend was particularly salient for older male supervisees. Reflecting their less dominant positions as women, the female supervisees

were significantly more likely than their male counterparts to praise their supervisors.

We located only two studies that specifically examined *how* female trainees experience gender issues in supervision. Based on Ladany et al.'s (2005) Critical Events Model of supervision, described later in this chapter, Walker et al. (2007) investigated *gender-related events*, defined as

> interaction[s], process[es], or event[s] in psychotherapy supervision that the trainee felt was directly or indirectly related to, or influenced by (a) the trainee's sex or the client's sex, (b) the social construction of gender, or (c) stereotypes and assumptions of gender roles. (p. 12)

Based on a free response survey, participants' (*N*=111 female supervisees) perceptions of supportive and nonsupportive gender-related events were contrasted. A qualitative analysis revealed that the most supportive of the 167 events were those in which (a) gender or sexual orientation was integrated into the case conceptualization of a client or (b) the supervisor explored the trainee's feelings about gender-related transference or countertransference. By contrast, the most nonsupportive events were those in which the supervisor stereotyped the trainee along gender lines or simply devalued or dismissed the trainee's perspective on a gender-related topic. A troubling finding was that 29% of the gender-related events described by participants were those in which the supervisor's comments were seen as "blatant[ly] inappropriate, sexist, [or] homophobic" (p. 15). Not surprisingly, the supportive events contributed significantly to a strong supervisory working alliance, whereas the nonsupportive ones detracted from the alliance.

In a follow-up study, Bertsch et al. (2014) modified Walker et al.'s (2007) survey and asked trainees, 78% of whom were women, to indicate which interactional sequences in

the Critical Events Model (Ladany et al., 2005), such as *exploration of feelings*, were used by their supervisors during the gender-related events. A qualitative analysis revealed four broad categories of events: gender discrimination, gender identity, attraction, and power dynamics. With the exception of power dynamics within supervision, the three other broad categories contained events that occurred in participants' therapy relationships as well as in their supervisory relationships. According to participants, during the gender-related events their supervisors focused most often on the therapeutic process or on trainees' feelings, skills, self-efficacy, and/or multicultural awareness. Of the various events, only gender discrimination events contributed significantly to participants' perceptions of (a) the supervisory alliance and (b) their supervisors' gender-related competence, notably in the inverse direction. That is, perceptions of the supervisor discriminating against the trainee on the basis of gender uniquely contributed to these trainees' negative experiences in supervision.

INTEGRATING FEMINIST, MULTICULTURAL, AND RELATIONAL SUPERVISION

Feminist Multicultural Supervision

Traditional approaches to psychotherapy supervision have long been criticized by feminist (Nelson et al., 2006; Prouty, 2001; Szymanski, 2003, 2005) and multicultural (Constantine & Sue, 2007; Hardy, 1989; Killian, 2001) scholars alike. Common to both of these perspectives is the contention that traditional models of supervision promote sexist, classist, racist, and heterosexist interventions and interpretations of behavior by ignoring the social and contextual factors that promote relational inequity.

Although a feminist approach to supervision was prominently discussed in the 1990s

(e.g., Porter & Vasquez, 1997), there has been limited research on this perspective. Two studies focused on the use of a feminist approach (by both male and female supervisors) rather than on the impact of this perspective on women trainees in particular. Most recently, Burnes, Wood, Inman, and Welikson (2013) explored how a feminist approach to group supervision was implemented. The qualitative themes revealed that feminist supervisors disclosed their own past fears of inadequacy as a trainee, conducted the group from a "woman-centered" perspective on equality, and initiated discussions of culture, power, and social justice as well as "self-care, nurturance, and emotional connection in relationships" (p. 99). In a 2005 study, Szymanski surveyed supervisors to examine how feminist supervision reflects feminist theories and beliefs. Results indicated that supervisors who reported using feminist practices were most likely to engage in "a critical examination of traditional gender roles, [to have] feelings of anger over sexism, connection with women's communities, commitment to feminist activism, and beliefs that are consistent with various feminist philosophies" (p. 743).

An important conceptual article by Markham and Chiu (2011) called for research on how cultural conceptualizations of women's behavior and traditional gender roles influence female trainees' ability to assert themselves in supervision. In particular, "silencing" (p. 506) occurs when supervisors view women as less capable than men and when, sensing this perception, female supervisees submit and accommodate to their supervisors' authority rather than assert their own experience with confidence. Markham and Chiu pointed out that by virtue of having less power than their supervisors, female supervisees—particularly women of color working with white supervisors—are often left with strong feelings of self-doubt. Consider the following case illustration of "silencing" in supervision:

Leann had been visibly pregnant for several months when she lost her fetus. Upon her return to work 3 weeks later, one of her female clients, Adriana, caringly inquired if "something happened" with Leann's pregnancy and how she was doing. Leann responded by briefly disclosing that she had miscarried, was still grieving, and feeling very sad. Leann had not planned to share this personal information with any of her clients, but when Adriana intuited what had happened, Leann spontaneously disclosed her genuine feelings and current emotional state. Although Leann viewed her disclosure as appropriate in the moment, its intimate nature worried her somewhat.

Here is how the conversation in her next supervision session unfolded:

Supervisor: So, I know this has been a difficult time for you. How are you doing, being back now and doing clinical work?

Leann: I'm doing okay, I guess. Thank you. Actually, I had one experience a few days ago with my client Adriana that I wanted to talk with you about. My pregnancy was brought up in session.

Supervisor: Okay . . . hmm . . . Why don't you tell me how this topic became part of the discussion??

Leann: Well, as you know, I've been working with Adriana for the past 6 months, and we usually meet once per week. So she wondered about my time away from work and asked how I was doing, if something had happened with my pregnancy.

Supervisor: And what did you say?

Leann: I was actually pretty honest with her. I told her that I'd had a miscarriage and that I'm still feeling very sad and dealing with my loss.

Supervisor: What made you decide to share these feelings?

Leann: I'm not entirely sure. I wasn't planning on self-disclosing. . . . Actually, I was hoping we could talk about it today in supervision.

Supervisor: I'm honestly a little surprised you shared this information with her, Leann. This doesn't seem like you.

Leann [embarrassed]: Yeah, well, um, I was kind of taken aback by Adriana's direct questions.

Supervisor: How do you suppose that mentioning your sadness and grief could help your client in any way? Can you help me understand that?

Leann [pause]: I think that's what I wanted to talk to you about . . . I'm not really sure . . .

Supervisor: Because self-disclosures should really only be used when there is a clear therapeutic gain for the client.

Leann: Yeah, um, I guess I was hoping we could talk about that.

Supervisor: I'm disappointed to hear this, Leann. Based on this conversation, I'm not sure you're ready to return to clinical work yet. Your self-disclosure seems self-indulgent. And to be quite honest, it was highly inappropriate. You shouldn't be turning the sessions with your clients onto yourself and your personal problems.

Leann [holding back tears]: Okay, I'm sorry. I won't share this information with anyone else.

This example illustrates how a supervisor disempowered a supervisee. Initially, Leann was invited to share her thoughts about the disclosure to her client, which put her in the position of "knowing" in the supervision relationship (Markham & Chiu, 2011, p. 507). However, when Leann was unable to identify precisely why she shared highly personal information with her client, the supervisor abruptly took on the role of expert. Realizing that her supervisor was displeased, Leann began engaging in self-censorship, a common one-down response on the part of the less powerful person in a relationship, particularly relationships that have an evaluative component (Markham & Chui, 2011).

The supervisor in this case interpreted Leann's lack of explanation for her self-disclosure as indicative of poor clinical judgment. Rather than create a space for Leann to explore what prompted her self-disclosure—perhaps she was feeling particularly fragile in that moment, or perhaps she sensed that Adriana's questions were a bid to strengthen their bond in light of their obvious social class differences—the supervisor silenced and reprimanded her. Such silencing minimizes the importance of feelings in women's relationships. Moreover, the supervisor's choice of power over involvement with Leann is not consistent with a feminist approach to supervision. Paradoxically, Leann's genuine response to Adriana's concern for her exemplified "leveling" the client/therapist hierarchy, which is one way to enhance collaboration in feminist psychotherapy.

Clearly Leann felt unsafe in this supervision session, if not in her entire experience of supervision. Safety is essential for supervisees to disclose their internal experiences as well as to thoroughly and frankly reveal what is transpiring in their work with clients (Bernard & Goodyear, 2014). Consistent with both feminist and multicultural models of supervision, safety and a strong alliance are promoted when supervisees are encouraged to openly discuss the power differential along with issues of race/ethnicity, gender, and sexual orientation (Bernard & Goodyear, 2014; Mehr, Ladany, & Caskie, 2010). Encouraging frank disclosure is of particular importance since supervisees consistently report regularly withholding relevant information from their supervisors due to anxiety, doubt, and fears of repercussion (Mehr et al., 2010).

From a feminist perspective, competent supervision requires collaboration, attention to power dynamics, maintenance of appropriate boundaries, examination of the construct of gender, attention to diversity, social activism, authenticity, emotional connection and expression, openness, and reflective analysis (Porter, 2010; Porter & Vasquez, 1997). Similarly, competent multicultural supervision requires supervisors to be aware of their own cultural identities (including their worldviews, values, biases, and assumptions); initiate conversations on diversity issues (broadly defined) as they pertain to the supervisee-client and the supervisor-supervisee relationship; and promote the exploration, integration, and implementation of culturally sensitive assessments, strategies, and interventions (Ancis & Ladany, 2010; Falender & Shafranske, 2010).

The integration of feminist and multicultural approaches to supervision allows trainees to develop critical clinical skills that may otherwise be ignored in traditional supervision. Specifically, as suggested by Porter (2010), some objectives of feminist multicultural supervision include teaching supervisees to use culturally centered interventions; to become aware of relationship issues so as to be able to disclose their affective reactions in therapy as well as in supervision; to be self-reflective and open to feedback; to be prepared to use consultation and individual and group supervision to challenge their biases, worldviews, and assumptions; and to

become engaged in community activities, social justice, and advocacy. Furthermore, both models emphasize authenticity and openness, collaboration, an analysis of power inequities in the supervision relationship, as well as self-reflection and self-disclosure on the part of supervisors and trainees (Ancis & Ladany, 2010; Porter, 1995, 2010; Szymanski, 2003).

RELATIONAL SUPERVISION: THE CRITICAL EVENTS MODEL

Only one theoretical perspective on supervision directly addresses how to work with gender-related dynamics in supervision. The Critical Events Model (CEM; Ladany et al., 2005, 2016) is a task analytic relational approach that was developed from the literature and its authors' clinical and supervisory experiences. Fundamental to the model is the paramount importance attributed to discourse about the supervision experience, which is viewed in a "figure versus ground" relationship with discourse on the supervisee's experience with clients. That is, at times the supervisory relationship is in the foreground, such as when the alliance is being built or when ruptures in the alliance are being repaired (Friedlander, 2015); at other times, the supervisee's relationship with a client takes center stage, with the supervisory relationship in the background.

From the perspective of the CEM, supervision—like psychotherapy—consists of a series of events, or episodes, in which specific *tasks* are worked on; these tasks are common, occur frequently, and culminate in mini-outcomes. One such task involves repairing gender-related misunderstandings (Ladany et al., 2005); the authors described tasks within several other critical events, including heightening multicultural awareness, managing sexual attraction, remediating skill difficulties and deficits, negotiating

role conflicts, working through countertransference, and addressing problematic attitudes and behavior.

According to the CEM, a critical event begins with a *marker*, that is, a comment or indirect signal from a supervisee that she is struggling with some aspect of her work with a specific client, with her training in general, or with her experience of supervision (Ladany et al., 2005, 2016). Once a marker is recognized by the supervisor as requiring attention to a specific supervision task, the critical event then moves to the *task environment*, which consists of sequences of interactions (one or more verbal exchanges) between supervisor and supervisee. Eleven non–mutually exclusive interactional sequences were defined by Ladany et al. (2005, 2016): focus on the supervisory alliance, focus on the therapeutic process, explore feelings, focus on countertransference, attend to parallel processes, focus on self-efficacy, normalize experience, focus on skill, assess knowledge, focus on multicultural awareness, and focus on evaluation—the first five of which are the most clearly relational (Shaffer & Friedlander, 2015). These interactional sequences may be used alone or in combination to move the supervisee toward a *resolution*. In the CEM, the resolution refers to the outcome or accomplishment of the task in terms of self-awareness, knowledge, skills, or the alliance.

Some critical events end quite poorly, as illustrated by Leann feeling criticized and shamed for an intimate self-disclosure to her client. Also recall the example at the beginning of this chapter, in which the supervisor asked Dominique, who was suffering from secondary traumatization, whether she was either "ill prepared" in her graduate training "or else too emotionally unstable to handle the rigors of clinical work." In this case, the supervisor failed to recognize the marker of a countertransference event, which should

have been clear when Dominique revealed her fears and nightmares after listening to her client's rape trauma. Instead, the supervisor viewed Dominique's reactions to the client as signaling a different task altogether, namely the need to evaluate the supervisee's competence. Consistent with a skill deficit event, the supervisor used the interactional sequences, focus on skill and focus on evaluation. The event ended with a decline in Dominique's self-efficacy ("Can I actually be a therapist?") along with a severe rupture to the supervisory alliance.

Ideally, if Dominique's disclosure had been seen as "marking" a countertransference event, the supervisor would have used different interactional sequences, perhaps beginning by exploring feelings, focusing on counter-transference, and normalizing Dominique's experience of secondary traumatization. The event might have been resolved successfully if the supervisor had then encouraged Dominique to discuss how she felt after having revealed such personal material in supervision (focus on the supervisory alliance).

The supervision discourse in this case might have taken a different turn altogether, if Dominique had felt able to broach the racial and social class differences between her client (and herself) and the supervisor. Perhaps only the most self-confident supervisee would be willing to do so, especially in the absence of groundwork having been laid for such a conversation. As Markham and Chiu (2011) eloquently wrote,

> Privileged discourses around professional status, gender, and race both reveal and advance power by specifying the "superiority" of some groups (e.g., supervisors, men, whites) and the "inferiority" of others (e.g., supervisees, women, persons of color) . . . [which] can manifest, for supervisees, doubt, worry, inadequacy, and a fear of speaking up. (p. 506)

If Dominique's supervisor was operating from a feminist/multicultural perspective, and if the encouragement of conversations about power and privilege had taken place at the outset of supervision (note the 2015 APA *Guidelines for Clinical Supervision* referenced earlier), perhaps this supervision session would have ended differently.

EXTENDED CASE EXAMPLE

Lucia, a 28-year-old, first generation Latina graduate student, was participating in weekly group and individual supervision in an outpatient setting. The oldest of five children, Lucia had immigrated to the United States from Ecuador when she was 10 years old. Always encouraged to excel in school, Lucia prided herself in knowing that she would be the first of her family not only to graduate from high school but also to earn an advanced degree on a full academic scholarship.

Unlike many of her peers in graduate school, Lucia lived at home with her parents in order to help care for her four younger siblings; she commuted over an hour each way to school in order to be as available as possible to her family. One of her siblings was a 15-year-old girl, who was beginning to learn how to drive. Lucia often referred to her sister as being "like my daughter," due to the amount of time Lucia had spent with her in a parental role.

Lucia had been working with Ana, a 45-year-old Honduran mother who had lost her 16-year-old daughter in a tragic car accident. Two years after the accident, Ana was experiencing symptoms of "overwhelming" depression. After two sessions, Lucia presented the case in group supervision, where she was the only female supervisee and the only person of color. In her initial presentation to the group, she described Ana's symptoms, followed by the treatment plan. Having received support for her views on the case,

Lucia proceeded to plan her sessions with Ana accordingly.

During her third session with Ana, Lucia found herself reluctantly explaining the treatment plan, which followed an evidence-based cognitive behavioral treatment protocol. Lucia was aware of her own anxiety and was surprised to find herself stumbling as she explained the protocol to Ana, despite having had a fair amount of experience with the manual, which she had previously implemented with confidence and ease. Nevertheless, she proceeded along in her explanation of the proposed treatment. After a tense silence, Ana adamantly refused to participate in the plan, stating forcefully, "*All* I agree to do in here is talk about losing my daughter."

Lucia returned to group supervision, visibly upset with her client, telling the group, "I don't know what to do with someone who doesn't want to do the work." When Lucia referred to Ana as "resistant," she received the support of her peers, all of whom agreed with Lucia's interpretation of the client's behavior. Listening to the group discuss the case, the supervisor noted that Lucia was becoming more withdrawn. She answered all of her male peers' questions with one-word responses, which was quite different from her typical level of engagement.

Hearing the others' comments about her client, Lucia began realizing that she actually did not see Ana as resistant after all, nor did she believe that Ana's reactions to the death of her daughter were related to cognitive distortions. Lucia found herself thinking about her own sister and then felt a tremendous amount of sadness for her client. At this point, Lucia realized that she had failed to share her empathic feelings with Ana. She remembered the first session, in which Ana expressed gratitude for "finally being able to speak Spanish in therapy," and recognized that this grieving mother had a deep need to be understood.

Lucia had never mentioned Ana's comment to her peers and wondered, perhaps like Ana had, whether in this group supervision context she herself would ever be fully understood. It was then that she noted the parallel between her approach to Ana and the approach of her peers toward herself. That is, Lucia keenly felt that her emotional reactions to the experience of her client were being ignored. Rather, Lucia's peers offered her concrete behavioral suggestions about how to pressure the client to accept the treatment plan.

What the group members did not know, and what Lucia feared to tell them, was that for the first time, she saw the evidence-based approach that she had been taught to use as limiting her ability to be authentic with her client. Lucia worried about being judged negatively by her peers and by her supervisor, especially as none of them were Latino. Diversity issues had never been discussed in the group, and an experiential approach to therapy was not highly regarded in her graduate program. Indeed, Lucia worried that she would fail practicum if she let her true feelings be known, and failure would clearly disappoint her and her family.

At this point, the supervisor recognized Lucia's discomfort as an event marker (Ladany et al., 2005, 2016), although the precise nature of the task was not altogether clear at first. However, guided by a feminist/multicultural perspective, the supervisor was mindful of the gender and racial imbalance in the group as well as the preferential treatment men often receive in supervision (e.g., Chung et al., 2001). Moreover, the supervisor was aware that conflicts related to ignorance or dismissal of the cultural concerns of a client cause stress for supervisees, decrease their satisfaction with supervision (Nelson & Friedlander, 2001), and hinder client care (e.g., Burkard et al., 2006).

For these reasons, the supervisor initiated the task environment (Ladany et al., 2005, 2016) with a focus on the supervisory alliance in order to prioritize Lucia's safety within the group. So as not to increase Lucia's sense of vulnerability, rather than invite her to explore her here-and-now feelings, the supervisor decided to self-disclose: "I'm so sad for this woman. I can't imagine how I'd go on if I lost my child." When the group remained silent, the supervisor continued by normalizing Lucia's experience: "If I were in your position, Lucia, this case would be really hard for me." Lucia nodded in agreement but said nothing, still visibly upset. The supervisor then addressed the group as whole: "I also wonder if we're missing any important cultural factors here by pushing a cognitive behavioral therapy agenda and focusing only on the client's behavior and cognitive processes rather than on her very real and upsetting feelings" (focus on multicultural awareness).

Aware of the power differential in this context, the supervisor used authoritative power constructively to provide group members with an important reflective opportunity, while simultaneously inviting them to collaborate in exploring their emotional reactions to the client and understanding the relevant cultural issues. Since the supervisor acted without power exploitation, Lucia and her male peers began to see the client and her life situation quite differently. Lucia finally broke her silence, asserting that the conversation was helping her access her empathy for Ana. Two of the group members agreed with her, albeit not forcefully.

Although this critical event was not fully resolved in the group setting, and Lucia continued to fear negative repercussions, she felt strong enough to assert herself more fully and honestly in a subsequent individual session with the same supervisor. As Lucia began disclosing her sense of being an

"imposter," it became clear to the supervisor that Lucia was suffering from a "crisis in confidence" (Ladany et al., 2005, p.187). As the session continued, the supervisor encouraged Lucia to talk, first, about her reactions to the group process (exploration of feelings) and second, about her reactions to Ana's challenge (focus on countertransference). The event progressed to include broader discussions of Lucia's fear of evaluation (focus on evaluation), the power dynamics in supervision (focus on the supervisory alliance), her gender and ethnic identities (focus on multicultural awareness), and finally, how she could consider challenging members of the group (attend to parallel process and focus on self-efficacy) and begin to take a more experiential and culturally sensitive approach to her work with Ana (focus on the therapeutic process). Although Lucia chose not to be as vulnerable in group supervision as she was in individual supervision, she nevertheless felt empowered by this supervision event. This empowerment in turn began a deeper reflective process that helped Lucia grow as a person, as a trainee, and as a clinician.

CONCLUSION

Although the Critical Events Model (Ladany et al., 2005, 2016) was not developed specifically to empower female trainees, its relational underpinning fits well with an integrative feminist/multicultural perspective on supervision. Moreover, the CEM goes beyond feminist and multicultural theories by proposing specific interactional strategies that empower trainees to address relational impasses with their supervisors.

Indeed, there is some evidence that an explicitly relational focus is highly valued by supervisees. In a recent program of research Shaffer and Friedlander (2015) identified five of Ladany et al.'s (2005, 2016) 11 interactional sequences (focus on the supervisory

alliance, focus on the therapeutic process, explore feelings, focus on countertransference, and attend to parallel processes) as constituting a single relational factor. In two studies with broad samples of trainees, representing multiple clinical disciplines, over 80% of whom were women, greater use of these sequences on the part of supervisors (as perceived by supervisees) was significantly associated with an "interpersonally sensitive" style of supervision, with a strong supervisory alliance, and with supervisees' positive experiences in supervision. Additionally, use of these five key behaviors in a recent supervision session mediated the association between supervisees' alliance perceptions and evaluations of their supervisors. In other words, the supervisor's use of these key relational strategies was the mechanism by which a strong alliance contributed to a favorable view of the supervisor (Shaffer & Friedlander, in press).

For future research, we recommend investigating small sample studies of supervision processes and outcomes. Outcomes need to go beyond satisfaction with supervision to include client outcomes. In particular, we suggest expanding on the work of Walker et al. (2007) and Bertsch et al. (2014), who surveyed trainees for their experience of gender-related events in supervision. One possible next step in this line of research would involve comparing and contrasting observed gender discussions in supervision sessions in order to elucidate the relational strategies that distinguish successful from unsuccessful outcomes (see Ladany et al., 2005, for a discussion of using a task analytic methodology to study critical supervision events).

The various other critical events in Ladany et al.'s model (2005, 2016; e.g., sexual attraction, countertransference, and role conflict) could easily lend themselves to the same kind of empirical scrutiny, with particular attention to gender dynamics from a feminist/ multicultural perspective. Importantly, future researchers could investigate the association between client outcomes and supervisors' use of specific feminist-relational strategies in supervision.

How, then, can we empower our female trainees in supervision? We believe the key to doing so requires academic programs to provide graduate students with knowledge about supervision theory and research in order to broaden their perspective on the supervision process and enhance their ability to think broadly and critically about the unique needs of female trainees. In the context of supervision itself, a strong alliance sets the groundwork for an explicitly relational focus when discussing issues pertaining to gender and the intersection of gender and other social identities. Empowerment happens, first, when supervisors explicitly invite trainees to consider the ways in which oppression and privilege (around gender, race/ethnicity, and social class in particular) and power dynamics in the therapeutic and supervision relationships adversely affect collaboration and safety.

In sum, we invite all readers of this chapter, trainees as well as supervisors, to take a step toward empowerment by initiating a discussion of these important topics during their next supervision session.

REFERENCES

Ancis, J. R., & Ladany, N. (2010). A multicultural framework for counselor supervision. In L. J. Bradley & N. Ladany, L. (Eds.), *Counselor supervision: Principles process, and practice* (4th ed., pp. 53-94). New York, NY: Brunner-Routledge.

American Psychological Association. (2015). Guidelines for clinical supervision in health service psychology. *American Psychologist, 70,* 33-46.

Barnes, K. L., & Bernard, J. L. (2003). Women in counseling and psychotherapy supervision. In

M. Kopala & M. A. Keitel (Eds.), *Handbook of counseling women.* (pp. 535-545). Thousand Oaks, CA: Sage.

Bernard, J. M., & Goodyear, R. K. (2014). *Fundamentals of clinical supervision* (5th ed.). Boston, MA: Pearson.

Bertsch, K. N., Bremer-Landau, J. D., Inman, A. G., DeBoer Kreider, E. R., Price, T. A., & DeCarlo, A. L. (2014). Evaluation of the critical events in supervision model using gender related events. *Training and Education in Professional Psychology, 8,* 174-181.

Burkard, A. W., Johnson, A. J., Madson, M. B., Pruitt, N. T., Contreras-Tadych, D. A., Kozlowski, J. M., Hess, S. A., & Knox, S. (2006). Supervisor cultural responsiveness and unresponsiveness in cross-cultural supervision. *Journal of Counseling Psychology, 53*, 288-301.

Burnes, T. R., Wood, J. M., Inman, J. L., & Welikson, G. A. (2013). An investigation of process variables in feminist group clinical supervision. *The Counseling Psychologist, 41,* 86-109.

Chung, Y. B., Marshall, J. A., & Gordon, L. L. (2001). Racial and gender biases in supervisory evaluation and feedback. *Clinical Supervisor, 20,* (1).

Constantine, M. G., & Sue, D. W. (2007). Perceptions of racial microaggressions among Black supervisors in cross-racial dyads. *Journal of Counseling Psychology, 54,* 142-153. doi: 10.1037/0022-0167.54.2.142

Doughty, E. A., & Leddick, G. R. (2007). Gender differences in the supervisory relationship. *Journal of Professional Counseling, Practice, Theory, and Research, 35*, 17-30.

Ellis, M. V., Berger, L., Hanus, A., Alaya, E. E., Siembor, M. J., & Swords, B. A. (2014). Inadequate and harmful clinical supervision: Revising the framework and assessing occurrence. *The Counseling Psychologist, 42,* 434-472.

Falender, C. A., & Shafranske, E. P. (2007). Competence in competency-based supervision practice: Construct and application. *Professional Psychology: Research and Practice, 38,* 232-240.

Falender, C. A., & Shafranske, E. P. (2010). Psychotherapy-based supervision models in an emerging competency-based era: A commentary. *Psychotherapy: Theory, Research, Practice, Training, 47,* 45-50. doi:10.1037/a0018873

Friedlander, M. L. (2012). Therapist responsiveness: Mirrored in supervisor responsiveness. *The Clinical Supervisor, 31,* 103-119.

Friedlander, M. L. (2015). Use of relational strategies to repair alliance ruptures: How responsive supervisors train responsive therapists. *Psychotherapy, 52,* 174-179.

Granello, D. (2003). Influence strategies in the supervisory dyad: An investigation into the effects of gender and age. *Counselor Education and Supervision, 42,* 189-202.

Hardy, K. V. (1989). The theoretical myth of sameness: A critical issue in family therapy training and treatment. *Journal of Psychotherapy and the Family*, *6*(1/2), 17-33.

Killian, K. D. (2001). Differences making a difference: Cross-cultural interactions in supervisory relationships. *Journal of Feminist Family Therapy, 12*, 61-103.

Ladany, N., & Friedlander, M. L. (2014). Sex and gender in professional psychology and training. In B. Johnson & N. Kaslow, (Eds.), *Oxford handbook of education and training in professional psychology.* (pp. 419-436). New York, NY: Oxford University Press.

Ladany, N., Friedlander, M. L., & Nelson, M. L. (2005). *Critical events in psychotherapy supervision: An interpersonal approach*. Washington, DC: American Psychological Association.

Ladany, N., Friedlander, M. L., & Nelson, M. L. (2016). *Supervision essentials for the Critical Events Model of psychotherapy supervision*. Washington, DC: American Psychological Association.

Markham, L., & Chiu, J. (2011). Exposing operations of power in supervisory relationships. *Family Process, 50,* 503-515.

Mehr, K. E., Ladany, N., & Caskie, G. I. L. (2010). Trainee nondisclosure in supervision: What are they not telling you? *Counselling and Psychotherapy Research, 10,* 103-113.

Miller, M. M., & Ivey, D. C. (2006). Spirituality, gender, and supervisory style in supervision.

Contemporary Family Therapy: An International Journal, 28, 323-337.

Nelson, M. L., & Friedlander, M. L. (2001). A close look at conflictual supervisory relationships: The trainees' perspective. *Journal of Counseling Psychology, 48*, 384-395.

Nelson, M. L., Gizara, S., Crombach, H. A., Phelps, R., Steward, R., & Weitzman, L. (2006). A feminist multicultural perspective on supervision. *Journal of Multicultural Counseling and Development, 34*, 105-115. doi:10.1002/j.2161-1912.2006.tb00031.x

Nilsson, J. D., Barazanji, D. M., Schal, C. L., & Bonner, A. D. (2008). Gender and sexual orientation in supervision. In A. K. Hess, A. D. Hess, & T. H. Hess, (Eds.). *Psychotherapy supervision: Theory, research, and practice.* (2nd ed., pp. 560-575). New York, NY: Wiley.

Porter, N. (1995). Supervision of psychotherapists: Integrating anti-racist, feminist, and multicultural perspectives. In H. Landrine (Ed.), *Bringing cultural diversity to feminist psychology: Theory, research, and practice* (pp. 163-175). Washington, DC: American Psychological Association. doi: 10.1037/10501-000

Porter, N. (2010). Feminist and multicultural underpinnings to supervision: An overview.

Women and Therapy, 33, 1-6. doi:10.1080/02703140903404622

Porter, N., & Vasquez, M. (1997). Covision: Feminist supervision, process, and collaboration. In J. Worell & N. G. Johnson, (Eds.), *Shaping the future of feminist psychology.* (pp. 155-171). Washington, DC: American Psychological Association.

Prouty, A. M. (2001). Experiencing feminist supervision. *Journal of Feminist Family Therapy, 12,* 171-203.

Shaffer, K. S., & Friedlander, M. L. (2015). What do "interpersonally sensitive" supervisors do and how do supervisees experience a relational approach to supervision? *Psychotherapy Research*. Advance online publication. doi: 10.1080/10503307.2015.108877

Szymanski, D. M. (2003). The Feminist Supervision Scale (FSS): A rational/theoretical approach. *Psychology of Women Quarterly, 27*, 221-232. doi: 10.1111/1471-6402.00102

Szymanski, D. M. (2005). Feminist identity and theories as correlates of feminist supervision practices. *The Counseling Psychologist, 33*, 729-747.

Walker, J. A., Ladany, N., & Pate-Carolan, L. M. (2007). Gender-related events in psychotherapy supervision: Female trainee perspectives. *Counselling and Psychotherapy Research, 7*, 12-18.