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The Cultural Context Model in Clinical Supervision

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This article introduces principles from the Cultural Context Model (CCM) on the training of master's and doctoral level mental health professionals to the field of psychology, highlighting its consistencies using critical psychology principles. The main tenets of the CCM are described and illustrated with examples pertaining to clinical supervision. Clinical practice within the model is described to illustrate the learning tasks involved in the supervisory process. This system of clinical theory and practice offers an expanded family paradigm based on an analysis of societal patterns that contribute to social inequality organizing family and community life.

Keywords: cultural context model, post colonial, supervision

Contemporary scholarship in counseling and critical psychology is paying thoughtful attention to articulating the theory and practice of social justice and mental health endeavors (Constantine, Hage, Kindaichi, & Bryant, 2007; Fouad, 2006; Toporek, Gerstein, Fouad, & Roysircar, 2006; Warren & Constantine, 2006). Although this is not a new focus of concern, there is renewed interest in articulating further broader social issues into the counseling field.

Critical psychology, as developed by Fox and Prilleltensky (1997), Prilleltensky (1994), and Prilleltensky and Nelson (2002, p. 145), offers an overarching ethical framework for guiding the construction of theories and professional practices in the mental health field based on an analysis of power, well-being, oppression, and liberation. It is "a position with respect to values, assumptions, and practices." Its application to education is guided by values that embrace a balance between the personal and collective dimensions of well-being and a critical analysis of the social interests determining health practices that benefit people unequally. It encourages a deconstructive analysis of psychological concepts in relation to social location factors such as gender, ethnicity, class, ability, sexual orientation/gender identities and religion. It also favors an interdisciplinary examination of issues and a collective approach to learning. Furthermore, the critical psychology movement represents a paradigm shift in psychology.

The Cultural Context Model (CCM) (Almeida, 1993; Almeida, Dolan-Del Vecchio, & Parker, in press; Almeida & Durkin, 1999; Almeida, Wood, Messineo, & Font, 1998; Dolan-Del Vecchio, 1998) is a social justice approach to working with individuals and families, supporting a collective consciousness of liberation for dismantling linkages of power, privilege, and oppression. Although the critical psychology movement and the CCM developed in a parallel manner, they share common roots in critical pedagogy, feminism, and critical race theory. As a model of clinical practice, the CCM uses postcolonial ideas to account for the historical and current impact of oppressive social forces, including sexism, racism, homoprejucide, and classism in the practice of counseling psychology and family therapy. The CCM posits that liberation is key to healing and defines it as a system of healing that embraces critical consciousness, empowerment, and accountability as guiding principles. For liberation to occur for all members of a family, accountability and empowerment need to operate simultaneously.

The purpose of this article is to introduce principles from the CCM on the training of master's and doctoral level mental health professionals to the field of psychology, highlighting its consistencies with critical psychology principles. This goodness of fit between the CCM and critical psychology may be of value in overcoming some criticisms that have been raised to critical psychology's intellectualism and lack of simplicity and applicability (Rappaport & Stewart, 1997). Both critical psychology and the CCM articulate a paradigm shift in mental health. The former offers an ethical stance and the latter an implementation of this stance. The main tenets of the CCM will be described and illustrated with examples pertaining to clinical supervision and clinical work as it is practiced at the Institute for Family Services, New Jersey. The reader is referred to Almeida (1998, 1999) and Hernández, Almeida, and Dolan-Del Vecchio (2005) for a detailed description of the therapeutic model.

Core Assumptions of the CCM and Key Definitions

Basic concepts will be described in this section to introduce the reader to terms commonly used in critical psychology and the CCM: postcolonial, intersectionality, critical race theory,

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feminism, and critical pedagogy.[1] The reader is encouraged to review the references provided in this section for further understanding of these concepts and bodies of knowledge.

Postcolonial scholarship in various disciplines (Crenshaw, 1997; Spivak, 1991; Foucault, 1975, 1977, 1979) serves as a basis for the CCM. This scholarship addresses the specific issues encountered by societies affected by the historical phenomenon of colonialism. The prefix "post" does not imply that colonialism is a past, but an ongoing "meta" perspective. Postcolonial scholarship articulates discourses that oppose colonization and subordination across the globe by focusing on the multiplicity of personal and community histories articulated alongside larger social dimensions, such as migration, education, health and environmental policies, and economics (Alva, 1995; Loomba, 1998). A postcolonial analysis recommends that therapists consistently attend to these dimensions as a fundamental part of the healing endeavor.

In psychology, postcolonial thinking has been strongly influenced by Frantz Fanon (1963); Foucault (1975), and Spivak (1991), by the psychology of liberation developed by Ignacio Martín-Baró (1982, 1989, 1990) in Latin America, by the critical pedagogy of Paulo Freire (1972), and by feminist thinking (Hare-Mustin, 1994). For example, Comaz-Díaz, Lykes, & Alarcón (1998) proposed the shared ideology of liberation psychology and feminism. Duran and Duran (1995) contributed to rethinking a psychology centered on First Nation people's perspectives, offering therapeutic practices that emphasize liberation and the acknowledgment of the First Nation's genocide and its intergenerational impact. In the context of training, supervisees are introduced to these ideas to assist them in questioning mainstream conceptions about psychological well-being.

The concept of intersectionality refers to an analysis of the dynamic interplay of one's gender identity, ethnicity, sexual orientation, religion, age, disability status, and other diversity characteristics upon multiple aspects of one's identity; including the resources and lack of resources these differences convey upon the individual within their current societal context. This term is used by scholars in Women's, Ethnic and Law studies (Fox-Genovese, 1991; Hancock, 2005; Molina, 2004; Pastrana, 2004;). Feminists within a postcolonial paradigm (Hill, 1989; Williams, 1993; Mohanty, Russo, & Torres, 1991) argue that power is located within the intersectionalities of class, race, culture, ability and sexual orientation, gender identities and religion. Specifically, Spivak (1994) posits that the experience of dominance is as relentless as the experience of oppression. As dominance is normalized, it is rarely questioned. Individuals do not see their role in the structures of dominance neither do they feel morally obligated to effect change. Therefore, the clearer we are about the experience of internalized dominance, the more clearly we can acknowledge its occurrence in daily life, and the more we are able to interrupt the perpetuation of oppression. For example, Peggy McIntosh's pioneer analysis of unearned privileges with regard to race illustrates this issue (2003). In the context of training, supervisees are introduced to using it to identify and articulate how all oppressive/dominant forces might not be equally prominent across situations.

Critical race theory is a school of thought that stresses the socially constructed nature of race. Its ideas have been applied widely in contexts dealing with the institutionalized oppression of racial minorities in the United States (Crenshaw, 1997; Delgado & Stefancic, 2004). Recently, authors have been integrating critical race theory, feminism, and multicultural psychology. For example Reynolds and Constantine (2004) articulated the ways in which feminists and multicultural psychologists have worked in a parallel manner on similar agendas. Bryant et al. (2005) discuss the contributions of African American psychologists to a paradigm shift in the field in spite of the barriers faced in academe. Finally, stemming from the work of Brazilian educator Paulo Freire (1971), critical pedagogy is an educational approach concerned with the issue of power in teaching and learning. It argues that education needs to be informed by philosophies that speak to and empower the lived experience of the majority of learners in a given context.

From a critical psychology perspective, Prilleltensky and Nelson (2002) offer the following principles for guiding the training of clinicians: the attunement to multiple sources of oppression, learning to collaborate and empower clients, de-emphasizing psychopathology in assessment and treatment conceptualization, and a willingness to work in natural settings. Their training guidelines stem from the foundational concepts of power, well-being, oppression, and liberation. These concepts are used as departure points guiding an analysis of the ways in which they play out at societal, community, familial, and individual levels. In addition, change is articulated based on a cycle of inquiry portraying a vision, understanding culture and context, exploring needs, and engaging in action.

Like critical psychology, the CCM uses power and liberation as foundational concepts in the development of practicing therapy and training therapists, social workers, and psychologists. Specifically, the CCM addresses families' health in context by taking into account structural societal issues that create life-threatening situations for those who depend on their social location. It makes visible and works through the intertwined ways in which discourses about gender identities, ability, class, religion, sexual orientation, and ethnicity play out in a family's life. The three key training processes, *critical consciousness, accountability*, and *empowerment*, are fostered through examining how familial and cultural legacies shape the ways we understand, experience, and represent ourselves and others, and through relational safety, developing collaborative learning processes within communities.

Brief Description of the CCM as a Context for Training

Treatment and training are parallel processes within this model. Although there are distinctions, this article will only focus on the similarities within the overall process. Treatment within the CCM starts with an intake in which each family is introduced to two therapists, one of whom will be behind the one-way mirror, while the other will be in the room with the family. Supervisees initially observe the therapy team and later work with another therapist. Throughout the therapeutic process, there are one or more therapists behind a one-way mirror to observe and participate in the process while it occurs and after each session ends. This ensures pathways for creativity, accountability, and teamwork for trainees. Initial information about the presenting problem is taken while all family members are present. Families then start the first phase in the social education therapy phase by joining small same-gender

[1] A description of the CCM model in supervision was published by Hernández (2004).

and same-age (adult, adolescents, and children) groups made up of members of multiple families for eight weeks, meeting once per week. During this time a team of therapists work with each group, presenting didactic materials (video clips, lyrics, articles) to clients, thus raising their consciousness around issues of gender, race, class, culture, and sexual orientation. The conversations between the members of the group and the therapists in response to the didactic material create a framework for identifying and dismantling oppressive norms of family life across cultures. Following the small group social educational phase, families are invited to join larger groups (culture circles) alternating between same gender (once per week) and mixed gender (once per week) on a weekly basis. Intermittent family or couple sessions are undertaken with the entire community, consisting of both men's and women's culture circles.[2] Trainees first observe some of the socioeducation sessions and then join with another therapist to facilitate them. In a parallel manner, trainees discuss with their supervisors and other therapists the same didactic materials. The socioeducational phase of the training places the connection between family and society at the center of therapeutic thinking and intervention because its focus is on how social discourses structure family life.

Training Processes: Critical Consciousness

The process whereby supervisors, supervisees, clients, and communities develop critical consciousness is the first step toward empowerment and accountability. Based on Paulo Freire's (1971) critical pedagogy, "concientización" is defined as the development of a critical awareness of personal dynamics within the context of social and political situations. Critical consciousness is exemplified by an experience of recognizing historical/cultural prescriptions of choices for what they are, and not blindly, as they are "the natural order of things." Critical psychology (Prilleltensky & Nelson, 2002) acknowledges that the causes or consequences of some clinical problems reflect political, economic, and psychological oppression, and that, at a larger level, experiences of such oppression will require structural as well as personal avenues for solutions. In the training of clinicians, supervisors foster conversations about the institutional issues and stories elaborated upon in the supervisory relationship and in the supervisory process to assist students in understanding their role in their communities and the effects of oppression in their lives and in the lives of others.

In therapy, supervisees observe how this process is emphasized from the very beginning in the socioeducation phase and continues in the culture circles. By presenting and discussing didactic materials about the ways in which gender, class, ability, ethnicity, and sexual orientation construct relationships of privilege and oppression, clients learn to think relationally and develop a language to address the intersections of power, privilege, and oppression. Documentaries and film vignettes such as "Joy Luck Club," "Monsoon Wedding," and "Crash" are used in the discussions. Family genograms continue from the initial intake to be constructed within these small same-sex socioeducation groups to explore multigenerational legacies within the families, gendered and racial norms, and immigration patterns throughout time. Culture circles are organized along gender lines because, in the experience of clinicians at the Institute for Family Services, women's and men's development of critical consciousness, empowerment, and accountability occurs at different paces and is best enhanced by a same-sex community. This reorganization by gender creates a context for investigating the different ways dominant patriarchal discourses affect women and men and allow for members sharing a common identity to hold each other accountable and to empower each other with the support of a community. During the supervisory process, supervisees explore the ways in which they learned to value and devalue themselves and others within the contexts in which they were socialized as citizens and professionals.

For example, an immigrant Latina master's student, with a training background serving ethnically diverse low-income families, was engaged in developing critical consciousness by looking at the legacy of the colonial exploitation of indigenous peoples in her family and her own experiences of alienation during training. Although she was born and raised in a country with a large indigenous population, she was never aware of the legacy of privilege in her life by virtue of her ethnicity and class status. Her initial step toward addressing the invisibility of indigenous people in her life emerged when describing her home environment. When she lived across the border, she used to contract an indigenous woman from another province to clean her home; over the years they became very close. When the student commuted to the United States to complete her training, she faced the perils of being an immigrant and had a first glimpse of how the indigenous woman felt when facing discrimination and having to learn a new language and a new system. Her lack of consciousness about her ethnic privilege and the impact of migration were intertwined with a common atmosphere of oppression that Spanish-speaking students face in training.

At her previous clinical-training placement, she was usually assigned Spanish-speaking clients only and, therefore, "specialized" in treating Latin families. By virtue of her ethnicity, she was assigned a heavier and highly difficult caseload in addition to the task of serving as a translator for clients and other clinicians. She learned to suppress the frustration of working mostly with single mothers and children and having supervisors who did not speak or understand Spanish. No one addressed the structural inequality embedded in this practice. Over time, she learned to accept this situation and avoided taking English-speaking clients. She felt incompetent and insecure with white clients. D'Andrea and Daniels (1997) discuss these issues in the context of the challenges that multicultural supervisors face in their work.

Eventually, however, she began to understand the layers of oppression and privilege operating in her own home and in her place of training. The supervision involved examining various layers compounding this situation: (1) a parallel exploration of how her and the indigenous cleaning woman's voices were silenced and normalized and (2) the ways in which context and social location impacted the development of both women's identities in the place of work or training. Specifically, her identity as a therapist overemphasized her expertise on language and working

[2] The term *culture circle* was borrowed from Freire (1971) and expanded by Almeida (1999). It describes a heterogeneous helping community involving families who come for treatment, a team of therapists, and sponsors from the community. The use of this term denotes a break with traditional therapeutic group work in which clients are organized around presenting problems, contracts prohibit clients from social contact, and a focus on each individual in the group receiving equal time.

with poor immigrants from Latin America. She was encouraged to educate herself on the issues of indigenous peoples in her country and trained to work with clients from backgrounds other than her own.

Training Processes: Accountability

The concept of accountability has rarely been articulated in depth and given a priority status in relation to other concepts (i.e., empowerment) in the mental health field. One of the contributions of the CCM that is congruent with critical psychology ethics is its linking empowerment with accountability as transformational processes that need attention simultaneously in the healing endeavor. Accountability is about focusing on the impact we have on each other interpersonally, as a community and as a larger system. Accountability is a family process involving the acceptance of responsibility for one's actions and the impact of those actions upon others. It fosters "reparative action that demonstrates empathic concern for others by making changes that enhances the quality of life for all involved parties" (McIntosh, 2003; Almeida, Parker, & Dolan-Del Vecchio, in press). The following examples illustrate how the CCM applies Spivak (1994) and McIntosh's (2003) ideas on privilege in relation to the therapeutic practices of accountability and empowerment.

In the cultural circles a single parent brings her adolescent sons to be supported and challenged regarding the sons' increasing lack of respect for her; a male client reads his letter of accountability detailing his lack of responsibility to his ex-wife and their adult children; a young professional couple seeks parenting tools for dealing with their overly precocious 3-year-old son, while also trying to balance high powered careers; parents of a 23-year-old daughter celebrate that they have finally launched her following numerous failed attempts. Within each of the culture circles, there are men, women, adolescents, and sometimes children at different trajectories in their treatment. Individuals and families with different presenting problems join with each other to develop stronger and more complex identities as they become more resilient to adversity and suffering in their lives. Supervisees training in this model learn to (a) facilitate that clients embrace and experience a full range of emotions, particularly those emotions (e.g., fear, sadness, insecurity) men frequently avoid due to their traditional commitment to stoicism and control; (b) learn and implement second shift activities (i.e., people and house care); (c) address the ways in which race, class, and gender privilege over others impacts their parenting; (d) discuss openly issues of money, power and parenting; (e) question the norms that guided their own socialization and the ones they use if they are raising their own children.

In congruence with critical psychology values, the CCM promotes balance between self-interest and the interests of one's community and family by discussing and developing tasks to help supervisees distinguish between rights and privileges. Almeida et al (in press) state that rights ensure necessities (i.e., shelter and safety), while privileges convey unearned advantages based upon gender, race, sexual orientation, age, family background, ability, and other human characteristics.

The following example illustrates a particular training experience of an immigrant upper-class Jewish female student working with a middle-class immigrant undergraduate student from México. Although the supervisee's experiences initially agreed with those of the client on immigration and cultural differences, it became clear that their paths to the United States were very different. While the supervisee grew up in a wealthy family and migrated to the United States with her family when a job opportunity was offered to her husband, the client's family migrated from Mexico out of economic necessity. Her parents crossed the border decades ago, leaving their families behind, having no knowledge of English, and having no financial foundation to start a new life. The supervisee was aware that she could not connect with the client around social location issues and preferred to focus her questions and comments around emotions. She defined herself as "white" and was not aware of experiences of discrimination in her life. A key issue in supervision was for the supervisee to understand the implications of her own privileges. She was asked to learn about the racial dynamics of Ashkenazi and Sephardic Jewish communities and discuss these with her classmates and supervisor. In addition, a comparison of her family genogram with the client's genogram helped her to learn to explore how race, gender, and class played out in the client's issues. The distinctive use of the genogram in this case involves the application and expansion of Hardy and Laszloffy's (1995) cultural genogram guidelines with an emphasis on addressing the intertwined legacies of oppression and privilege with shame and pride issues. Within a post colonial framework the goal is to assist the trainee in identifying these legacies, their impact on her work with her clients and how to modify both her stance and interventions with the client.

Training Processes: Empowerment

Almeida et al (in press) conceptualize social justice-based empowerment as one that promotes "power with" rather than power over. Empowerment is not a feeling. Rather, it refers to the development of a voice to represent oneself and one's interests and the participation in practices that challenge any form of oppression. The following example illustrates how an African American female supervisee articulated her process of developing a voice as a professional in her trainee role as a mental health consultant for a nonprofit organization.[3]

> I experienced several red flags with the (nonprofit) Staff that indicated their discomfort with me as a mental health consultant-in-training. As a participant observer in this project I had to observe the consultees interactions among themselves, with program participants and with myself as a consultee. I participated in staff meetings, classroom settings and workshops. My immediate goal was to assess the climate and culture of the organization and to create an observational analysis encapsulated within the existing sociopolitical context of the organization. However, I found myself hardly acknowledged by the staff which included the following patterned behaviors: the male staff forgetting my name, failing to ask me questions directly, not being informed when meeting times and events were changed and/or canceled, and ignoring my suggestions altogether. It was in these interpersonal interactions I found myself shutting down and feeling frustrated.

Cognitive dissonance regarding one's worth and competence is a common experience that supervisees of color face when they

[3] From Hernández, P., Bunyi, B., & Townson, R. (In press). Interweaving ethnicity and gender in consultation: A case study. *Family Psychotherapy.* These quotes are used with permission from the trainee.

leave affirming educational relationships in their training programs or in training settings (Shalonda & Boyd-Franklyn, 2005). This supervisee experienced a dissonance between her successful experiences as a clinician and feeling positive about her identity and feeling insecure about her clinical skills and doubting whether her racial identity was an issue in this practice setting.

> It was within the context of the mentor and trainee relationship in which I first learned to develop my voice because skill development incorporated an environment, which privileged issues of race, gender and class. Developing my voice in a political context meant gaining the opportunity to challenge these issues in a direct but respectful manner. In training, I was encouraged to struggle with complex issues, multifaceted with race, gender, and class constructs. I received encouragement from the SDSU consulting team and found myself strengthened as I gained increasing awareness of how my own cultural and familial experiences have shaped who I am as a clinician.

Furthermore, she presented her work with her supervisor at a major professional conference. This presentation assisted her to engage in dialogue with seasoned professionals and scholars of color, who congratulated her for having had the courage to articulate and discuss her process. The work involved in this presentation assisted her in articulating her ideas and expanded the number of witnesses in her own process of developing a public voice. In turn, the author and supervisor was impacted in strengthening her commitment to reach out and work in interethnic relationships, reassessing the depth of her influence in the trainee, and assuming further risks to embed accountability in training.

Cultural and Family Legacies: Their Integration in Training

The CCM assumes that past relational dynamics and family legacies inform and shape how humans develop, relate, and function. Interactional patterns feed forward into present and future family functioning and unfold to construct a layered map connecting themes over time. Family legacies and family dynamics relevant to training are explored through the construction of three generational genograms (Hardy & Laszloffy, 1995; McGoldrick, Gerson, & Shellenberger, 1999). Because family behaviors derive emotional and normative meaning from sociocultural contexts, the impact of social location as it relates to the intersectionalities of gender, ethnicity, class, and sexual orientation is tracked and explored. Genograms are also useful in assisting trainee therapists to attend consistently to the similarities and differences between them and their clients' diversity of backgrounds. For example, often the similarity of dynamics makes it difficult for students to develop appropriate interventions rather than taking the position they have in their own families.

Relational Safety: The Tensions Between Power and Voice

The concept of relational safety may be considered an application of critical psychology principles. It refers to the coconstruction of a dialogical context in which supervisees and supervisors are able to raise questions, challenge points of view, ponder issues, confront opinions, articulate ideas, and express feelings. However, the supervisory relationship in this model is a hierarchical one and as in any other relationship, power shapes it (Selicoff, 2006). Supervisors take an active role in handling process issues, keeping a focus on the teaching of the model and ethics (Gridley, 2004).

Relational safety refers to the development of critical thinking, empowerment, and accountability in a caring relational environment. Relational safety is constructed over time by actions that demonstrate, little by little, that we care for one another. Building relational safety takes intuition, courage, observation, and action. Its evolution depends on our ability to demonstrate repeatedly that we are able to take responsibility for the risks assumed when we communicate with one another. The following example illustrates how supervisors working with this model addressed issues of privilege and oppression with two postdoctoral supervisees at the IFS.

Isabel, a heterosexual psychologist and practitioner from Spain, and Amalia, a heterosexual psychologist from Latin America trained in the United States, started training at the same time and in very amicable terms. Initially, their genograms shed light on social location factors that would play out in training, for example, Isabel came from an upper-class background and never had concerns about paying for her education or for financing her involvement with women's groups in Central America. Amalia came from a lower-middle class background and paid for her education in the United States with scholarships, loans, and jobs within and outside the university. Over time, supervisors started to notice that Isabel took the role of speaking for Amalia and explaining what she meant in supervision meetings and in culture circles. Even though supervisors observed that Amalia did not ask for this kind of assistance, she was usually silent after Isabel spoke for her. On one occasion, Amalia did simultaneous translation in a culture group involving a Spanish-speaking client. At the time Isabel was with the observing team behind the one-way mirror. During group supervision, Isabel focused her comments on Amalia's knowledge of the Spanish language and how well the translation was done. The pattern described and several situations such as the one illustrated above in the context of their genograms, social locations, histories of migration, and current status were used as the basis to discuss issues of voice and power in training.

From a post colonial perspective, Isabel and Amalia's social identities, legacies of colonialism and histories of migration to the United States were the nodal point to discuss how one spoke for the other with the intention to "help." In this situation, the supervisor made a choice in terms of suggesting a conversation focusing on colonial legacies involving Spain, Latin America, and the United States, issues of voice and representation were discussed. Isabel was challenged to understand and address the impact of her "helping" as a form of oppression over Amalia. In turn, Amalia was challenged to address the impact of her silence and insecurity around Isabel. They engaged in understanding how there are many ways of "helping." In this case, the apparently benevolent "help" from Isabel stemmed from her shame about believing that people of color, especially from Latin America, "could not make it" without her help. She felt that she had to commit to help those in need, and Amalia became one of these people in need. Although Isabel struggled to recognize how privilege and racism were impacting her behavior toward Amalia, she finally admitted that the underlying assumption for her behavior was her belief that her "race" was better than others. As a result of this difficult process, Isabel wrote a letter of accountability to Amalia, and Amalia was

asked to take the risk to lead some activities to strengthen her voice. The supervisors' role in this process involved identifying the issues first observed, designing activities and creating spaces to bring them up, encouraging difficult conversations, assisting both of them to look at the ways in which privilege and oppression operated in their relationship, suggesting readings and keeping everybody focused on the issue at hand. A key role for the supervisor was to recognize the ways in which the supervisees' voices were not socially equal, to keep Isabel accountable for her misuse of power and Amalia empowered to develop a stronger voice.

Developing Collaborative and Learning Processes Within Communities

Critical psychology recommends that practitioners work in a highly participatory and collaborative manner, sharing power and promoting empowerment. Congruent with these principles, the CCM promotes that supervisees and supervisors experience the sharing of power toward their own creation of solutions. Nevertheless, this knowledge is launched from a position of knowledge-building and knowledge-gathering. For example, in the supervision of a student at a university, working on a case involving an immigrant lesbian couple of low socioeconomic status, a gay student reported:[4]

> When the case was discussed in group supervision, the discussion not only gave an overview of the information the team had at hand, but also touched upon my experience and views on the case, as well as the comments and questions of the other students on our clinical team. I once again commented that I thought this couple was in a love relationship, and that it would be a mistake to describe it as simply a roommate relationship. I wondered out loud how (the couple) could be having such intense emotional conflicts with each other if they had been only roommates for the past 15 years. Was their use of "roommate" a way to describe their relationship in words that would be acceptable to their families and society? Could we as a team take the risk of exploring the meaning of their relationship? My supervisor agreed with my comments and validated the importance of the questions I raised. She stated that we would wait to meet these clients and experience them in session to develop a hypothesis about the case. I believe that my peers' affirmation was the result of the freedom they had to express their views and my supervisor's modeling of taking risks to explore the interweaving of social location in family life. As a supervisee, I had never before felt so much support. She was present during all sessions through the one-way mirror and speaker system. I did not feel at all silenced, as I had earlier. In contrast, I felt respected. Previously in my studentship I had found myself alone in a room surrounded by six heterosexuals, who told me that my knowledge—as a gay man—of the gay and lesbian community was inadequate. In this practicum class, instead, I found myself in a room with six heterosexual people who listened to my ideas, gave them credit, and were willing to explore issues based on my views and experience. The gay lens I presented was now valued and sought after instead of being the object of dismissal or ridicule.

The community learners in this clinical practicum consisted of six master's level students in training. They had already incorporated in their training foundational concepts with regard to power, intersectionality, and social location. When this student shared his views on the case, the students and supervisor listened in a respectful and affirming manner, creating relational safety. Having heard his point of view in this training context, the supervisor allowed for a discussion of various ideas about how to work with the couple without putting him in a position where he would have had to defend his views and sexual identity. In turn, the author and supervisor was impacted by the knowledge and experience that the trainee brought to this practicum on Lesbian Bisexual Transgender and Questioning (GLBTQ) issues. She continued to seek training in working with GLBTQ populations.

Conclusion

There is a history of struggling with how to incorporate psychotherapy into social action (Helms, 2003). At times, those seeking a deeper understanding of their personal lives had to give up on integrating therapy with social action. Critical psychology offers an overarching framework of values, assumptions, and practices seeking to reduce or eliminate oppression in society (Prilleltensky & Nelson, 2002). The CCM is a social justice approach congruent with critical psychology's vision. It offers an alternative to shift individualistic therapeutic practices to a community-based model by linking both interpersonal processes and larger systems. Based on the author's clinical and research work on the CCM, there are eight competencies that supervisors may consider in their training and mentoring of clinicians. These competencies are as follows:

- Share your philosophy of supervision with your trainees by assigning readings and discussing in depth the training implications of this paradigm shift (i.e., work on the self of the therapist from this perspective, continuity between clinical work and activism).
- Identify with supervisees their areas of need and interest and discuss how they will be addressed from this perspective and how it is different from other approaches to supervision and clinical work.
- Develop critical consciousness: have supervisees observe first and then join the socioeducation phase of the CCM. Assist them in understanding and articulating personal issues as social issues. Assist them in focusing on the larger picture rather than intrapsychic dynamics.
- Provide coaching in their development of their cultural genograms in supervision: address issues of social location, legacies of loss, migration, privilege, and oppression. Assist them in looking at these legacies through the lens of empowerment and accountability.
- Encourage them to join activities in the training setting that help them expand their critical consciousness about issues that they know the least about.
- Discuss parallel processes between them, their clients, their supervisors, the organization and the larger community.
- Observe the culture circles first and join in as a cotherapist. Start with assisting the supervisee to articulate interpersonal issues in the context of larger social issues and family dynamics.
- Present at professional and activists conferences with trainees (i.e., Multicultural Summit, White Privilege Conference, Association of Women in Psychology).

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[4] From Hernández, P. & Rankin, P. Relational safety in supervision. (In press). *Journal of Marital and Family Therapy*. This quote is used with permission from the trainee.

The author acknowledges that research on this model is still in its infancy and that its application in supervision requires further development. For example, a limitation of the model as presented in this author is that it lacks guidelines or markers indicating what constitutes novice, intermediate, and advanced clinical competence. Authors in this field (Stoltenberg, 2005a, 2005b; Stoltenberg, McNeal, & Delworth, 1988) have developed such stage models and their utility is widely recognized in the profession. Another limitation of this illustration of the CCM is that it misses a thorough discussion of real and perceived power dynamics that play out in graduate training. Although the voices of supervisees were presented throughout the article, future discussions should focus on this issue as it pertains to all supervision models, supervision dynamics in social context, and specifically the CCM.

Finally, this model is the product of a social and cultural milieu embedded in the dialectic of colonial and post colonial societies. It acknowledges its roots in contemporary western thinking in that it is a response to the world view that has marginalized many. However, it is precisely by virtue of this dialectic process that the emergence of new ideas and practices develops. It is a community approach that restores well-being by bringing marginalized identities to the center and making those who have privilege accountable for it.

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