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Layered Cultural Processes: The Relationship Between Multicultural Orientation and Satisfaction With Supervision

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Supervision has been called the "signature pedagogy" of psychotherapy, and recent literature has emphasized the importance of multicultural processes in supervision. Despite the recent advances in the area of multicultural orientation, much of the existing work on the application of multicultural orientation to clinical supervision, however, has been conceptual rather than empirical. In the present study, we extended the multicultural orientation framework (MCO) to the context of supervision. In a sample of therapist trainees ($N = 123$), supervisor cultural humility and cultural (missed) opportunities were significantly associated with supervisees' satisfaction with supervision, but only as it pertained to the supervisee's cultural context; supervisor cultural humility and opportunities associated with supervisees' clients' cultural contexts were not significantly related to supervisees' satisfaction. Thus, supervisors' cultural humility attending to cultural opportunities within the supervisory relationship was positively related to supervisees' satisfaction with supervision. Implications and recommendations for research and education/training will be discussed.

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Public Significance Statement
This study demonstrates that clinical supervisors' cultural humility and attention to cultural opportunities in supervision is positively related to supervisees' satisfaction with supervision.

Keywords: multicultural orientation, supervision, multicultural supervision, training

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After four decades of scholarship, psychologists agree that cultural factors and processes play a crucial role in psychotherapy and supervision. Representatives of the American Psychological Association (APA, 2002, 2017) have articulated these values in several iterations of multicultural guidelines, which have drawn heavily from the tripartite multicultural competencies model: multicultural knowledge, awareness, and skills (MCC; Sue et al., 1982, 1992). These guidelines also have implications for the training of psychologists. As clinical supervision is the "signature pedagogy" of psychotherapy (Bernard & Goodyear, 2019, p. 2), scholars have noted the importance of cultural processes to clinical supervision (e.g., APA, 2018, Falender et al., 2013, 2014; Hook et al., 2016). However, compared to the empirical literature on multicultural counseling (Bernard & Goodyear, 2019; Goodyear et al., 2006), the empirical study of multicultural supervision is relatively new and underdeveloped, and the research that does exist focuses mostly on the MCC model.

The prevailing MCC model, based on Sue et al.'s (1982, 1992) initial work, posits three components requisite for competent practice with diverse populations: multicultural knowledge, multicultural awareness, and multicultural skills. Although some research does suggest that therapists' MCC is related to psychotherapy processes and outcomes, overall the MCC construct has been difficult to measure (Drinane et al., 2016; Lantz et al., 2018; Tao et al., 2015; Wilcox et al., 2020). Additionally, the skills dimension has been difficult to capture at all, and thus is often not measured. The MCC model has often been applied to articulating training standards (Arredondo et al., 1996; Sue et al., 1982, 1992), which was a crucial foundation for the multicultural movement within psychology. Wilcox et al. (2020), however, highlighted that despite the proliferation of these training standards, the therapists in their sample overwhelmingly did not attend to sociocultural considerations in their case conceptualizations. The authors noted that we may need to deepen our approach to multicultural training, recommending a new multicultural framework for supervision.

More recently, Owen and colleagues have proposed the *multicultural orientation framework* (MCO; Davis et al., 2018; Owen, 2013; Owen et al., 2011), which is an extension of prior theory, but with a particular focus on cultural processes in psychotherapy. The shift from a competencies framework to an orientation framework has represented an important step forward, as the goal of clinical training is to help therapists gain a clinical lens (e.g., theoretical orientation) and way of being in their everyday interactions with clients and systems. The focus of the MCO framework is on cultural processes that may underlie the formation of a strong therapy alliance. Initial theorizing proposed three pillars: cultural humility, cultural opportunities, and cultural comfort. Cultural humility, considered the core construct of MCO (Davis et al., 2018), involves one's ability to cultivate an open, other-oriented interpersonal stance toward another person's cultural identities and experiences (Hook et al., 2013; Tervalon & Murray-Garcia, 1998). Cultural opportunities involve moments or markers within each session in which the therapist or supervisor has an opportunity to explore the client's (or supervisee's) cultural identities (Owen et al., 2016). Cultural comfort involves the degree to which therapists or supervisors can engage cultural themes with a degree of ease and confidence (Drinane et al., 2016).

There is a mounting body of evidence highlighting that MCO, particularly cultural humility and cultural (missed) opportunities, influences clients' experiences of therapy. In the present study of MCO in clinical supervision, we examined cultural humility and cultural opportunities because they focus on cultural processes in session; cultural comfort, on the other hand, has historically been operationalized as general comfort in session rather as culturally-specific processes (see Pérez-Rojas et al., 2019 for recent developments). Studies have demonstrated a positive correlation between therapy outcomes and clients' ($n > 6{,}000$) perceptions of their therapists' cultural humility as well as therapists' ability to attend to cultural opportunities (e.g., Hook et al., 2013; Owen et al., 2014). For example, researchers have found therapists' cultural humility to be related to the therapeutic working alliance as well as to therapy outcomes (Hook et al., 2013; Owen et al., 2014, 2016). Cultural humility has also been found to moderate the relationship between cultural missed opportunities and therapy outcomes, serving as a buffer for cultural missed opportunities (Owen et al., 2016). Therapists' cultural humility has even been found to be related to clients reporting fewer and less severe microaggressions in therapy (Hook et al., 2016). Thus, the emerging body of research supports the importance of therapists' cultural humility to therapy.

Therapists' recognition of, and attention to, cultural opportunities (or markers) in therapy has also been demonstrated to be important to therapy processes and outcomes. That is, when therapists miss cultural markers in therapy, it can have deleterious effects. Drinane et al. (2018) found that cultural concealment, a subfacet of cultural missed opportunities, was negatively related to therapy outcome. Little is known, however, about how cultural humility and attending to cultural opportunities are fostered in therapists and cultivated throughout training. For this reason, scholars (e.g., Crockett & Hays, 2015; Inman, 2006) have noted that it is particularly important to examine cultural processes in supervision, as supervision is one of the primary avenues of training psychotherapists.

Multicultural Supervision

Clinical supervision can be defined as a hierarchical, evaluative, relationship-based intervention provided over time to a newer member of a profession (i.e., supervisee) by a more experienced member of that profession (i.e., supervisor), which is meant to help foster supervisee growth, monitor the supervisee's work and client welfare, and provide the context and basis for gatekeeping

(Bernard & Goodyear, 2019). As clinical supervision is a primary mode of teaching psychotherapy skills, supervision is considered a set of requisite competencies in its own right (Fouad et al., 2009). APA-Accredited programs must provide training in clinical supervision (APA, 2018), and Guidelines for Clinical Supervision are available from the APA (2015). That is to say, the importance of clinical supervision is codified throughout the profession.

Multicultural supervision is supervision that attends to and centers on culture and diversity (Hook et al., 2016). Given the importance of clinical supervision to psychotherapy training and the importance of cultural considerations to the provision of psychotherapy, the clinical supervision literature has accordingly also seen an increasing emphasis on multicultural supervision (e.g., Falendar et al., 2013, 2014; Hook et al., 2016). Evidence suggests that supervisor multicultural competence (e.g., Inman, 2006) and attending to cultural variables in supervision (e.g., Gatmon et al., 2001; Toporek et al., 2004) have positive effects on satisfaction with supervision. As such, the importance of multicultural supervision has been built into supervision competency frameworks including the APA's Clinical Supervision Guidelines (APA, 2015).

Yet, given the relational nature of clinical supervision, and that all supervision relationships are inherently multicultural (Bernard & Goodyear, 2019), MCO with its emphasis on ways of *being* may be of particular importance to supervision. Consistent with MCO, in a recent qualitative meta-analysis, Tohidian and Quek (2017) identified that processes critical to successful multicultural supervision include supervisors initiating cultural dialogue, exploring cultural assumptions, honoring diversity, and attending to the multicultural supervisory alliance; they further found that when supervisors provided space for cultural discussion in supervision, supervisees were better able to provide such culturally sensitive spaces for their clients.

Research and training on multicultural issues are centered around the cultural transactions occurring between therapist and client. However, there is a complex yet overlooked dynamic that is unique to supervision which remains unexamined. Supervisees, while tasked with conceptualizing and caring for their clients as cultural beings, remain cultural beings whose identities are present in both the therapy and supervision context. Supervisees are navigating the layered nature of clinical work wherein they are not only a supervisee and a therapist, but also cultural beings whose intersectional identities interact with their clinical work and supervisory development.

According to Watkins et al. (2019), an MCO perspective on supervision is rooted in four foundational assumptions:

1. Supervisor and supervisee are joined together in an educational relationship that involves their co-creation of cultural expressions (i.e., the extent to which culture is given voice in the supervision situation);

2. Although concerned with supervisory behaviors and actions, [multiculturally oriented supervision] is foremost about the attitudes and values (i.e., way of being) that give rise to those very behaviors and actions;

3. Cultural processes, such as cultural humility, are crucial to and pivotal for connecting with supervisees' and clients' most salient cultural identities; and

4. A high degree of [multiculturally oriented supervision] serves as a prime supervisor motivator, stimulating interest in and desire to learn more about one's own as well as the supervisee's and client's cultural perspectives and worldviews (p. 4).

A core question in an MCO approach to supervision is whether supervisors are able to conduct training in a way that acknowledges and engages the cultural identities of their supervisees *and* clients. Some supervisors may initiate discussions about identity and culture with their supervisees, but does that make them more effective supervisors? Despite the critical nature of this question, few studies have examined if cultural identity discussions are employed in supervision and if their focus is on clients or on the supervisees themselves (i.e., do supervisors effectively emphasize the person of the therapist?).

To date, some initial theorizing on the role of MCO within supervision has been offered (e.g., Watkins et al., 2019), and the empirical examination of MCO in supervision is in the nascent stages. One study ([redacted]), however, recently found that cultural humility was related to supervisees' intentional non-disclosure. In another, [redacted] found that cultural humility and missed opportunities were related to the supervisory working alliance. No other studies have empirically examined MCO in clinical supervision; and, no studies have examined processes related to both supervisees' identities and clients' identities. Given the complex nature of the supervisory triad as previously noted, we sought to break down the layered cultural interactions to determine if both supervisee-focused identity conversations and client-focused identity conversations were associated with satisfaction with supervision. That is, rather than examining cultural processes only between supervisor and supervisee, we also examined supervisees' perceptions of cultural humility and cultural opportunities in supervision related to the discussion of clients. We sought to examine the relationship between these MCO pillars and satisfaction with supervision, an important outcome of supervision.

Satisfaction With Supervision

The complexity inherent in clinical supervision is perhaps best exemplified by Fiscalini's (1997) description: "... the supervisory relationship is a relationship about a relationship about other relationships" (p. 30). Supervisors have three primary responsibilities: the supervisory relationship, supervisee development, and client care. Thus, given its importance, complexity, and implications, scholars in clinical supervision have sought to understand what factors are associated with supervisory processes and outcomes. One commonly measured outcome of supervision is satisfaction with supervision, defined as the supervisee's assessment of whether their needs were met in supervision and the quality of supervision (Ladany et al., 1992). Supervisee satisfaction with supervision is considered important for supervisees' engagement and growth (Holloway & Wampold, 1983; Ladany, Ellis, et al., 1999).

Historically, supervisees' satisfaction with supervision has been found to be related to a number of supervision processes and outcomes (Ladany et al., 1996). For example, Ladany, Lehrman-Waterman, et al. (1999) found that supervisees reported greater satisfaction with supervision when their supervisors demonstrated

greater adherence to ethical practices, highlighting the influence of supervisor behaviors on supervisees' satisfaction. Supervisee satisfaction has further been demonstrated to be related to supervisees' willingness to disclose in supervision (Ladany et al., 1996) as well as the bond between supervisor and supervisee (Ladany, Ellis, et al., 1999). Researchers have also found that supervisor multicultural competence and attention to culture are positively related to supervisee satisfaction (e.g., Green & Dekkers, 2010; Inman, 2006; Mori et al., 2009; Nilsson & Dodds, 2006). To date, however, no study has examined satisfaction with supervision in the context of MCO.

The Present Study

The purpose of the present study was to test the relationship between cultural humility and cultural opportunities and supervisory satisfaction. We tested two hypotheses. First, we hypothesized that supervisees' ratings of supervisor cultural humility, both supervisee-focused and client-focused, would be positively associated with satisfaction with supervision. Second, we hypothesized that ratings of supervisor cultural missed opportunities, both supervisee-focused and client-focused, would be negatively associated with satisfaction with supervision.

Method

Participants

The sample consisted of 123 therapist trainees. Participants ranged in age from 22 to 75 ($M = 30.09$, $SD = 6.27$ years), and the majority of the sample identified as White (74.8%, $n = 92$), followed by Asian/Pacific Islander (7.3%, $n = 9$), Biracial/Multiracial (6.5%, $n = 8$), Hispanic/Latinx (6.5%, $n = 8$), Black/African American (2.4%, $n = 3$), Arab American (1.6%, $n = 2$), and Native American/First Nation (.8%, $n = 1$). Most of the sample identified as women (82.9%, $n = 102$), with 15.4% ($n = 19$) identifying as men, and 1.6% ($n = 2$) identifying as gender nonconforming. The sample identified as predominantly heterosexual (77.2%, $n = 95$); 11.4% ($n = 14$) identified as bisexual, 4.1% ($n = 5$) as gay or lesbian, and 7.2% ($n = 9$) identified with a different sexual orientation, declined to answer, or were unsure. Most identified as either Christian (35.8%, $n = 44$) or with no religion (26.8%, $n = 33$), followed by Catholic (13.8%, $n = 17$), Jewish (8.1%, $n = 10$), Muslim (2.4%, $n = 3$), Hindu (2.4%, $n = 3$), or other (10.4%). Relative to others in the U.S., most participants rated themselves as slightly above middle class on the MacArthur Scale of Subjective Social Status ($M = 6.32$, $SD = 1.54$; Adler et al., 2000).

Regarding educational identification, most participants were in PhD (52.0%, $n = 64$) or PsyD (24.4%, $n = 30$) programs, with the remainder of participants (23.5%, $n = 29$) enrolled in Master's programs. Fields represented included clinical psychology (44.7%, $n = 55$), counseling psychology (30.9%, $n = 38$), counseling or mental health counseling (12.2%, $n = 15$), social work (3.3%, $n = 4$), marriage and family therapy (1.6%, $n = 2$), school psychology (1.6%, $n = 2$), combined school/clinical psychology (1.6%, $n = 2$), counselor education (1.6%, $n = 2$), rehabilitation counseling (.8%, $n = 1$), or other (1.6%, $n = 2$). Participants were in years one through eight of their graduate programs ($M = 3.57$, $SD = 1.49$), and reported between one and one hundred months of clinical experience ($M = 29.12$, $SD = 23.33$).

Measures

Participants each rated their clinical supervisors on cultural humility and cultural (missed) opportunities, each along two domains: as they pertained to the supervisee's cultural identities, and as they pertained to the supervisees' clients' cultural identities. Thus, there were four predictors of interest: supervisee-focused cultural humility, client-focused cultural humility, supervisee- focused missed opportunities, and client-focused missed opportunities.

Supervision Cultural Humility Scales

The Supervision Cultural Humility Scales (CHS-S) was adapted for the clinical supervision context (see Appendix A) from the Cultural Humility Scale (Hook et al., 2013). The original CHS is a 12-item, Likert-type scale on which clients rate their level of agreement (from 1 = *Strongly Disagree* to 5 = *Strongly Agree*) with statements about their therapist's cultural humility regarding the client's cultural background(s). Hook et al. (2013) reported Cronbach's alpha for the CHS to range from .86 to .92. For the present study, two versions of the CHS were developed: one which prompted supervisees to rate their supervisor's cultural humility related to the *supervisee's* cultural background(s) (supervisee-focused), and one which prompted supervisees to rate their supervisor's cultural humility related to their *clients'* cultural background(s) (client-focused). For this scale, the items were not edited, but rather the instructions were changed according to which dynamic was being assessed. With the supervisee as the anchor, the instructions read, "Regarding the core aspect(s) of *my* cultural background, my supervisor . . . " and for clients, the anchor was changed to be "Regarding the core aspect(s) of *my client's* cultural background, my supervisor . . . " Sample items that followed these prompts included "Assumes they already know a lot," and "Is open-minded." Cronbach's alphas for the CHS-S supervisee-focused and CHS-S client-focused were .92 and .93, respectively (see Table 1 for descriptive statistics and correlations for all primary variables).

Supervision Cultural Missed Opportunities Scales

The Supervision Cultural Missed Opportunities Scales (CMOS-S) was also adapted for the clinical supervision context (see Appendix B) from the Cultural Missed Opportunities Scale (CMOS; Owen et al., 2015), a 5-item Likert-type scale on which clients rate their agreement from 1 (*Strongly Disagree*) to 5 (*Strongly Agree*) with statements regarding the extent to which their therapists adequately address their cultural backgrounds in session. Owen et al. (2015) reported Cronbach's alpha for the CMOS to be .79. As with the CHS-S, two versions were adapted for the clinical supervision context: one focused on supervisors' missed opportunities regarding *supervisees'* cultural backgrounds, and one focused on supervisors' missed opportunities regarding supervisees' *clients*' cultural backgrounds. Sample statements include "I wish my supervisor would have encouraged me to discuss my cultural background more" (supervisee-focused), and, "My supervisor avoided topics related to my clients' cultural backgrounds" (client-focused). Cronbach's alphas in the present study for the supervisee-focused and client-focused CMOS-S scales were .82 and .87, respectively.

Table 1
Correlation Matrix and Descriptive Statistics

Variables	1	2	3	4	5	*M*	*SD*
1. CHS-S-Client[a]	1.00					4.16	.74
2. CHS-S-Supervisee[b]	.79*	1.00				4.05	.77
3. CMOS-S-Client[c]	−.57*	−.53*	1.00			2.57	1.01
4. CMOS-S-Supervisee[d]	−.49*	−.65*	.69*	1.00		2.64	.90
5. SSQ[e]	.55*	.69*	−.49*	−.62	1.00	3.16	.80

Note. $N = 123$.
[a] CHS-S-Client, Supervision Cultural Humility Scale (Client-Focused),
[b] CHS-S- Supervisee, Supervision Cultural Humility Scale (Supervisee-Focused),
[c] CMOS-S-Client, Supervision Cultural Missed Opportunities Scale (Client-Focused),
[d] CMOS-S-Supervisee, Supervision Cultural Missed Opportunities Scale (Supervisee-Focused),
[e] SSQ, Supervisory Satisfaction Questionnaire (Ladany et al., 1996).
* $p < .05$. ** $p < .01$.

Supervisory Satisfaction Questionnaire

The Supervisory Satisfaction Questionnaire (SSQ; Ladany et al., 1996) is an 8-item self-report measure of trainees' satisfaction with clinical supervision. Each item is answerable on a four-point scale with anchors specific to the question asked, and higher scores indicating greater satisfaction with supervision. Sample items include "Did you get the kind of supervision that you wished?" and, "If you were to seek supervision again, would you come back to this supervisor?" Ladany et al. (1996) observed a Cronbach's alpha of .96 for the SSQ; in the present study, Cronbach's alpha was .96.

Results

Participants who did not complete at least 80% of each measure were moved, and Little's MCAR was not significant. Thus, expectation maximization was used to impute missing values. Five multivariate outliers were removed (Mahalanobis Distance ≥ 24.32), and all assumptions of the general linear model were tested and met. Multicollinearity was not a concern between the independent variables despite their conceptual overlap. No between-group differences were observed on the dependent variables between master's and doctoral trainees, and thus the entire sample was retained.

Our first hypothesis was that cultural humility (client-focused and supervisee-focused) would be associated with greater satisfaction with supervision. To test this hypothesis, we conducted a regression model in which satisfaction with supervision scores were regressed on cultural humility perceptions, both client-focused and supervisee-focused (see Table 2). Results indicated that supervisee-focused perceptions ($t = 6.20$, $p < .001$), but not client-focused ($t = .16$, $p = .87$) perceptions of cultural humility were significantly and positively associated with satisfaction with supervision.

Our second hypothesis was that perceptions of missed cultural opportunities (client-focused and supervisee-focused) would be associated with lower satisfaction with supervision. To test this hypothesis, we regressed satisfaction with supervision scores on missed cultural opportunity scores, both client-centered and supervisee centered. Results indicated that supervisee-centered missed opportunities ($t = -5.33$, $p < .001$), but not client-centered ($t = -1.29$, $p = .20$) missed opportunities, were significantly and negatively associated with satisfaction with supervision. Thus, each hypothesis was partially supported.

Discussion

The present study is one of the first to empirically apply the MCO framework to clinical supervision in a primarily White sample. More specifically, this study separated the supervisory relationship and the experience of cultural humility and cultural (missed) opportunities into two domains: that which is focused on the supervisee and their cultural identities, and that which is focused on the client. Each of our hypotheses was partially supported in that only supervisee-focused cultural humility and cultural missed opportunities were significantly related with supervisory satisfaction. That is, supervisees' experiences of their supervisors as demonstrating cultural humility, and attending to cultural opportunities, within the relationship *between supervisee*

Table 2
Summary of Regression Models Predicting Satisfaction With Supervision

Variables	Coefficients[a] (*SE*)	*t*	*p*
Model 1			
Constant	3.16 (.052)	60.23	<.001
Supervision cultural humility—Client-focused	.02 (.12)	.16	.87
Supervision cultural humility—Supervisee-focused	.70 (.11)	6.20	<.001
Model 2			
Constant	3.16 (.06)	55.78	<.001
Supervision cultural missed Opps—Client-focused	−.10 (.08)	−1.29	.20
Supervision cultural missed Opps—Supervisee-focused	−.47 (.09)	−5.33	<.001

Note. $N = 123$.
[a] These coefficients represent standardized effects.

and supervisor were significantly related to supervisees' satisfaction with supervision; however, supervisees' experiences of their supervisors' cultural humility and cultural (missed) opportunities related to their *clients* was not. Although each of our hypotheses was thus only partially supported, the results are consistent with the primacy of the supervisory relationship. Our results suggest that cultural humility and attending to cultural opportunities in supervision are important to clinical supervision outcomes, but that this importance is primarily driven by the relationship specifically between supervisor and supervisee, rather than supervisors' attention to clients as cultural beings.

Our results are consistent with the importance of the supervisory working alliance and parallel process in supervision. It is possible that the cultural dynamics between supervisor and supervisee account for most of the variance in satisfaction because supervisees' comfort in supervision, and feeling seen and understood in supervision, subsequently has positive effects on their work with clients. Indeed, research suggests creating a supervision environment that is safe and fosters discussion of cultural issues may be the most important aspect of multicultural supervision (Dressel et al., 2007); and, that a stronger supervisory working alliance is related to greater trainee disclosure in supervision (e.g., Gibson et al., 2019; Mehr et al., 2010, 2015; Park et al., 2019), greater supervisee satisfaction with supervision (e.g., Ladany et al., 1999; Park et al., 2019), and greater supervisee self-efficacy and a stronger therapeutic alliance between supervisees and their clients (Park et al., 2019). As well, Crockett and Hays (2015) found that supervisor multicultural competence was significantly related to satisfaction with supervision through the supervisory working alliance.

Additionally, research suggests that supervisor modeling of facilitative interactions in supervision is positively related to client outcomes (i.e., parallel processes; e.g., Tracey et al., 2012). This has also been referred to as the Platinum Rule: Do unto others as you would have others do unto others (Hook et al., 2016; Pawl & St. John, 1998, p. 7). Thus, it is likely that supervisors' attending to their supervisees as cultural beings is facilitative of supervisees' attending to their clients as cultural beings through modeling and parallel process. It may be that MCO in the supervisor-supervisee dyad is more important to MCO in the supervisee's clinical work than MCO directed toward the client by the supervisor, as MCO may not only strengthen the supervisory relationship but also provide the supervisee with an experiential framework with which to demonstrate MCO with their clients. Given the results of the present study, we offer a number of recommendations for research as well as for education and training.

Recommendations for Research

Given the results of the present study, a number of next steps in the study of MCO in clinical supervision are warranted. Our results preliminarily support the importance of cultural humility and attending to cultural opportunities in supervision; however, the literature in this area remains scant. As well, that the majority of our sample identified as White which, while representative of the profession, potentially limits the generalizability of the results to supervisees of color and emphasizes the need for additional research. More empirical research is needed to better understand the processes and effects of multicultural orientation in supervision, especially for supervisees of color. Given the complexity and richness of clinical supervision, future research should qualitatively examine supervisees' experiences of cultural encounters in clinical supervision. Particularly given that MCO is a way of *being* rather than a way of *doing*, qualitative inquiry lends itself well to better understanding the process by which supervisors' cultural humility and attending to cultural opportunities positively influences supervisees' experiences in supervision.

As well, research has demonstrated the importance of the supervisory working alliance to supervision processes and outcomes (e.g., Burkard et al., 2009; Crockett & Hays, 2015; Inman, 2006; Nelson & Friedlander, 2001; Walker et al., 2007), and our results are consistent with the importance of the supervisory relationship. It would be fruitful for future researchers to directly examine the role of the MCO pillars in the supervisory working alliance, directly as well as on supervision outcomes with the working alliance as a mediator. Further, given that difficult cultural processes may lead to ruptures in clinical supervision just as in therapy, future researchers may wish to explore the role of cultural humility, cultural opportunities, and cultural comfort in the context of supervisory ruptures and repairs. Again, it may be particularly important to examine MCO in the context of ruptures and repairs for supervisees specifically. As well, although triadic research poses logistical challenges, one focus of supervision is client care; thus, it would be beneficial for future researchers to also examine the role of MCO in supervision on therapy processes and outcomes with supervisees' clients. Lastly, we also recommend further theorizing and research focus on MCO development in trainees. In particular, it is unclear how MCO develops over time and what specific supervision approaches help promote cultural humiltiy, for example.

Recommendations for Supervision and Training

Both cultural humility and cultural missed opportunities within the context of the supervisory relationship were found to be important in the present study. Our results suggest that attention to supervisees' identities, and cultural dynamics within the supervisory relationship, are important to supervisee satisfaction, at least with a majority-White sample. By overlooking cultural discussions, supervisors may inadvertently miss opportunities to exemplify the intentional application of MCO. At the outset and throughout supervision, it may be beneficial for supervisors to ask their supervisees about the identities they hold and how the salience of each exists in supervision and influences clinical work (i.e., broaching cultural discussions; Jones et al., 2019). Supervisors can check in regularly about whether supervisees feel their intersectional identity is attended to and acknowledged.

If supervisees have difficulty sharing their needs for cultural recognition or processing, supervisors might consider giving permission statements or naming specific identities that are often salient in supervision or therapy (e.g., "For many supervisees, it's important to process their racial or ethnic identity and how it influences supervision and clinical work. Does that fit for you?"). Consistent with research on MCO in therapy (e.g., Owen et al., 2016), this ongoing, interpersonal process may also minimize supervisors' inadvertent microaggressions toward their supervisees, thereby minimizing supervisory ruptures and promoting satisfaction with supervision. In this sense, attending to cultural opportunities in supervision likely cascades into promoting both cultural humility and comfort in supervision.

When supervisors intentionally attend to cultural opportunities or initiate cultural opportunities, they give the supervisee an

opportunity to observe and then model cultural comfort and humility (i.e., parallel process). This would normalize cultural discussions, including process comments (e.g., "I feel as though I've missed the mark in how I asked you about this, what are you experiencing right now?"), thereby demonstrating to the supervisee how to engage clients in cultural discussions.

Consistent with cultural humility as the core construct of MCO, research has demonstrated that cultural humility has a buffering effect even when cultural opportunities are missed in therapy (Owen et al., 2016). Given that preliminary research, including the results of the present study, have demonstrated the importance of cultural humility in the supervisory relationship [(redacted); (redacted)], it is therefore important that supervisors seek to continuously foster their own cultural humility. It is important that supervisors do their own work around exploring their biases and their own cultural identities, both salient and not. Doing so may better allow supervisors to engage the platinum rule (Hook et al., 2016; Pawl & St. John, 1998, p. 7): facilitate the same processes with their supervisees, allowing supervisees to explore their own biases and identities thereby modeling how to do so with their own clients.

Limitations

The results of the present study should be taken in the context of its strengths and limitations. Strengths of the present study include the novel, theory-driven, empirical examination of MCO processes in clinical supervision. Further, our examination was conducted in the context of recognizing the complexity inherent in the supervisory triad, and thus sought to separately examine the role of supervisor cultural humility and cultural (missed) opportunities in the context of both supervisees' identities and clients' identities. The sample studied was diverse and large enough to allow for adequate statistical power for the analyses undertaken. Limitations of the present study included its ex post facto design which only examined supervisee perspectives and collected data from supervisees rather than the supervisory dyad. Demographic information on the supervisors is unknown. Clinical supervision is inherently complex given that it contains at least three individuals and thus multiple interactional dynamics; future research may attend to this complexity through the use of more complex, dyadic or triadic designs that account for the nested nature of supervision. Given the developmental nature of supervision, and that the present study did not assess for supervisee developmental level, future research should examine these relationships controlling for supervisee development as well as potential between-group differences by professional level. Importantly, and although representative of the profession, nearly three-fourths of our sample identified as White. It will be important for future research to seek to replicate the present results, as well as the recommended future directions, specifically with supervisees of color. Still, the results of the present study represent an important first step in better understanding the importance of MCO in clinical supervision.

MCO may be an important paradigm shift in understanding multicultural supervision processes. The results of our study, one of the first published examinations of MCO in clinical supervision, suggest that cultural humility and ability to attend to cultural opportunities in supervision are associated with supervisees' greater satisfaction in supervision, but only as it relates to supervisors' attention to their supervisees as cultural beings, not clients. Although our hypotheses were only partially supported (given that cultural humility and opportunities related to clients were not significant predictors), these results are consistent with the literature on the supervisory working alliance and parallel processes in supervision. Thus, supervisors' ability to attend to their supervisees as cultural beings in clinical supervision appears to be important to supervision outcomes. Scholars should continue to examine the role of MCO in clinical supervision given the importance of supervision to psychotherapy processes and outcomes.

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