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The Relationships among the Experiences of Racial Microaggressions in Supervision, Traumatic Experiences, and the Supervisory Working Alliance in Professional Counselors and Counselors-in-Training

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ACCEPTANCE

This dissertation, THE RELATIONSHIPS AMONG THE EXPERIENCES OF RACIAL MICROAGGRESSIONS IN SUPERVISION, TRAUMATIC EXPERIENCES, AND THE SUPERVISORY WORKING ALLIANCE IN PROFESSIONAL COUNSELORS AND COUNSELORS-IN-TRAINING, by CAROLINE O'HARA, was prepared under the direction of the candidate's Dissertation Advisory Committee. It is accepted by the committee members in partial fulfillment of the requirements for the degree Doctor of Philosophy, in the College of Education, Georgia State University.

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ABSTRACT

THE RELATIONSHIPS AMONG THE EXPERIENCES OF RACIAL MICROAGGRESSIONS IN SUPERVISION, TRAUMATIC EXPERIENCES, AND THE SUPERVISORY WORKING ALLIANCE IN PROFESSIONAL COUNSELORS AND COUNSELORS-IN-TRAINING

by

Caroline O'Hara

Supervision of counseling services is a crucial component to professional counselor development (Bernard & Goodyear, 2009). A common and pervasive threat to cross-cultural interpersonal relationships, such as supervision, is the presence of racial microaggressions (Constantine & Sue, 2007). According to Carter (2007) and Helms, Nicholas, and Green (2012), microaggressions are so damaging, that they may even trigger traumatic responses in recipients. The purpose of this study was to examine the relationships among racial microaggressions in supervision, the supervisory working alliance, and traumatic symptomatology in supervisees. This study collected survey data from 86 participants who self-identified as racial, ethnic, or cultural minority group members and who were counselors-in-training, professional counselors, or counselor educators. Data collection included responses to demographic questions, the adapted Experiences of Black Supervisors Scale (EBSS adapted; Barnes, 2011), the Trauma Symptom Check-list 40 (TSC-40; Elliot & Briere, 1992), and the Supervisory Working Alliance Inventory – Trainee Version (SWAI-T; Efstation, Patton, & Kardash, 1990). Bivariate correlations revealed significant relationships among all three of the main variables. The SWAI-T full-scale scores had a moderate negative correlation with the EBSS (adapted) full-scale scores ($r = -.637$, $p < .01$) and a moderate negative correlation with the TSC-40 full-scale scores ($r = -.372$, $p < .01$). The EBSS (adapted) full-scale

scores had a moderate positive correlation with the TSC-40 full-scale scores ($r = .513$, $p < .01$). Regression analysis yielded a model whereby 40.6% of the variation in the supervisory alliance can be explained by microaggressions in supervision F (1, 48) = 32.752, $p < .01$. Hierarchical multiple regression analysis determined that the presence of traumatic experiences does not add to the predictive capacity of the model. The results suggest that the presence of racial microaggressions is an important impediment to the supervisory working alliance. Implications, limitations, and future directions were provided.

THE RELATIONSHIPS AMONG THE EXPERIENCES OF RACIAL MICROAGGRESSIONS IN SUPERVISION, TRAUMATIC EXPERIENCES, AND THE SUPERVISORY WORKING ALLIANCE IN PROFESSIONAL COUNSELORS AND COUNSELORS-IN-TRAINING

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ABBREVIATIONS

APA	American Psychiatric Association
DSM	Diagnostic and Statistical Manual of Mental Disorders
EBSS	Experiences of Black Supervisors Scale
PTSD	Posttraumatic Stress Disorder
SWAI-T	Supervisory Working Alliance Inventory – Trainee Version
TSC-40	Trauma Symptom Check-list 40

CHAPTER 1

RACIAL MICROAGGRESSIONS, THE SUPERVISORY WORKING ALLIANCE, AND TRAUMATIC EXPERIENCES IN PROFESSIONAL COUNSELORS

Supervision is one of the hallmarks of effective preparation for professional counselors; it involves a relationship built upon trust, respect, and safety (Bernard & Goodyear, 2009). Microaggressions, which are regular offenses that intentionally or unintentionally serve to insult, undermine, and demean the recipient (Sue, 2010), can severely affect any interpersonal relationship, including supervision (Constantine & Sue, 2007; Sue et al., 2007). Since the effects of such common, relentless interpersonal stressors may even be traumatic (Carter, 2007; Helms, Nicholas, & Green, 2012), it follows that exploring supervisory guidelines to prevent and address such issues is needed. Therefore, in this paper, the author will explore the constructs of racial microaggressions, the supervisory working alliance, and traumatic experiences.

Supervision

Counseling supervision offers a unique, interpersonal, professional relationship that aims to promote professional functioning and client welfare through an evaluative, hierarchical relationship that exists over time (Bernard & Goodyear, 2009). Many elements impact the supervisory alliance including supervisor factors, supervisee factors, and supervision processes. The supervisory relationship is one that is inherently laden with power dynamics as the supervisor is in an evaluative position throughout supervision (Crook Lyon & Potkar, 2010).

With the demographic changes in racial and ethnic diversity in the US, it becomes more likely over time that cross-cultural counseling and supervision relationships will exist (Halpert & Pfaller, 2001; Toporek, Ortega-Villalobos, & Pope-Davis, 2004). In

order to promote multiculturally competent counseling practice, it is imperative that supervision sessions directly address constructs and concerns surrounding race, ethnicity, and culture (Constantine, 1997). Although the responsibility to initiate such dialogues lies with the supervisor (Bernard & Goodyear, 2009; Constantine, 2003; Constantine & Sue, 2007), open discussions of race, ethnicity, and culture are still considered taboo and often painful topics (Sue et al., 2007; Utsey, Hammar, & Gernat, 2005). As a result, many supervisors and supervisees do not engage in these kinds of multicultural dialogues (Utsey, Gernat, & Hammar, 2005). However, according to Helms and Cook (1999), if the counselor or supervisor prompts dialogues about race and culture in supervision, then the alliance can be strengthened and discord can be minimized.

Given the importance of race, ethnicity, and culture in counseling supervision, researchers have begun to address the nature of microaggressions in supervision (Constantine & Sue, 2007). According to Helms and Cook (1999), racial microaggressions may impair the supervisory alliance, processes, and outcomes. The primary focus of investigations on microaggressions in supervision has included the perspectives of supervisees who identify as racial or ethnic minority group members. The following section will explore what microaggressions are, how they relate to racism, privilege, and oppression, and how they may manifest in clinical supervision.

Microaggressions

In 1978, Pierce, Carew, Pierce-Gonzalez, and Willis put forth the term *microaggressions*, a term which aims to expose the subtleties of the dynamics embedded in racism, privilege, and oppression.

> The chief vehicle for proracist behaviors are microaggressions. These are subtle, stunning, often automatic, and non-verbal exchanges which are "put downs" of blacks by offenders. The offending mechanisms used against blacks often are innocuous. The cumulative weight of their never-ending burden is the major ingredient in black-white interactions. This accounts for a near inevitable perceptual clash between blacks and whites in regard to how a matter is described as well as the emotional charge involved. (Pierce et al., 1978, p. 66)

Since then, many other scholars have built upon these principles (Smith, Shin, & Officer, 2012; Sue, 2010; Sue et al., 2007) and extended the term to explore the nature and measure the effects of microaggressions on other races and ethnicities (Nadal, 2011; Torres-Harding, Andrade, & Romero Diaz, 2012) as well as other social identities such as gender (Capodilupo et al., 2010; Lewis, Mendenhall, Harwood, & Browne Huntt, 2013), gender identity (Nadal, 2013), and sexual identity (Balsam, Molina, Beadnell, Simoni, & Walters, 2011; Shelton & Delgado-Romero, 2011). Sue and colleagues (2007) noted that "racial microaggressions are potentially present whenever human interactions involve participants who differ in race and culture (teaching, supervising, training, administering, evaluating, etc.)" (p. 284).

Racism, Privilege, and Oppression

In order to understand the nature and nuances of racial microaggressions more fully, an exploration of terms is necessary. Racial microaggressions are closely tied to the constructs of racism, privilege, and oppression. *Racism* is a system of unearned advantages (privilege) and unearned disadvantages (oppression) based upon the social construct of race (Chang, Gnilka, & O'Hara, 2014; Crethar, Torres Rivera, & Nash, 2008). Racism can be intentional or unintentional, overt or covert, hostile or passive, and individual or systemic (Chang et al., 2014). *Privileges* are unearned advantages that are afforded certain groups in a society based on perceived group membership (Chang et al., 2014). *Oppression* includes the unearned disadvantages that exist because of racism and is the result of the restriction of societal equity, access to resources, participation in community and political processes, and public harmony which respects the common good (Crethar et al., 2008). Because the dynamics of privilege, oppression, and racism exist widely and pervasively across individuals, institutions, and US culture, they operate and manifest in supervisory relationships as well (Constantine & Sue, 2007; Hays & Chang, 2003; Sue & Sue, 2012).

Both privilege and oppression are symptoms of social injustice (Chang et al., 2014). For instance, men experience sex privilege, whereas women experience sexism. Heterosexuals experience sexual identity privilege, whereas any other sexual identity (e.g., bisexual, pansexual, asexual, lesbian, gay) experiences oppression based on sexual identity. Cisgender individuals (those with inherent sex and gender congruence) experience privilege based upon gender identity while transgender individuals experience oppression based on gender identity and/or expression. White and European Americans

experience race privilege, while other racial and ethnic groups experience racial oppression and racism. It should be noted that an individual can be privileged and oppressed on multiple levels simultaneously and that the intersection of social identities can create nuanced, dynamic, and idiosyncratic life experiences.

Examples of everyday race privilege include being free from tracking, harassment, or surveillance while shopping, being able to see wide representations of one's race in the media, being able to speak without representing one's entire racial group, or being able to use any method of payment without race being an issue (McIntosh, 1990). The impact of race privilege includes access, assuredness, disconnection, security, obliviousness, and power. In terms of supervisory relationships, although supervisors should be addressing and dismantling privilege and oppression in the supervisory relationship and modeling this for their supervisees' work with clients, it is often the case that White privilege intercedes and prevents White supervisors from engaging in cross-cultural dialogues (Constantine & Sue, 2007; Hays & Chang, 2003).

A metaphorical example of unexamined privilege is that of the moving sidewalk. Such an apparatus propels the people on it in a specific direction, without any effort from the people onboard. For people born onto this moving sidewalk, knowing no other reality, they would likely assume a degree of normality about their lived experience. For these individuals, as they pass by others who are actively moving on their own outside of the moving sidewalk, they may wonder why others progress so slowly – all the while, unable to understand the unearned advantage and momentum that undergirds their lives. This is an example of unearned, unexamined privilege. White Americans progress through life with a host of invisible opportunities and benefits that enrich their lives, many of whom,

all the while, remain blithely oblivious to the horrors and injuries of racism (Constantine & Sue, 2007).

As racism, privilege, and oppression relate to counselor preparation, it is important to note that the majority of counselor educators identify as White or European American (Hanna, Talley, & Guindon, 2000; Hays & Chang, 2003). As a result, it is likely that these individuals are conveying Eurocentric biases and perspectives to counselors-in-training (Hanna et al., 2000; Hays & Chang, 2003; Sue, Lin, Torino, Capodilupo, & Rivera, 2009). Dialogues on race and racism in educational settings are challenging and often originate from microaggressions in classroom discussions or educational resources (Sue et al., 2009). Although counselor educators are ethically mandated to explore social and cultural issues in the classroom and in supervision, the reality is that often these dialogues do not occur or do not unfold well (Constantine, 1997, 2003; Constantine & Sue, 2007; Utsey, Gernat, & Hammar, 2005).

Methods of Microaggression Delivery

In order to understand more about racial microaggressions in supervisory relationships as subtle forms of racism, it is important to examine the ways in which microaggressions are transmitted. People deliver microaggressions via three methods or processes - verbal, behavioral, and environmental (Sue, 2010; Sue et al., 2007). Regardless of the delivery mechanism, the messages are the same. *You are not welcome. You are not worthy. You are inferior*. *You do not belong. Your experiences do not matter. Your reality does not exist*. "Racial microaggressions are brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional,

that communicate hostile, derogatory, or negative racial slights and insults to the target person or group" (Sue et al., 2007, p. 273).

Verbal microaggressions include spoken comments or exchanges (Sue, 2010; Sue et al., 2007). Regarding race, Constantine and Sue (2007) found multiple examples of verbal microaggressions in their investigation of supervision between White supervisors and Black supervisees. One example included a supervisee (participant) who indicated that her supervisor conveyed how pleased he was to see so many Black college students since many of them do not escape the "ghetto" of their childhoods. Behavioral microaggressions include various actions or non-actions (Sue, 2010; Sue et al., 2007). An example may include differential attention to members of different races and various topics during group supervision. Environmental microaggressions encompass contextual, systemic, and situational factors (Sue, 2010; Sue et al., 2007). Environmental microaggressions may or may not be interpersonal in nature. "The term 'environmental microaggression' refers to the numerous demeaning and threatening social, educational, political, or economic cues that are communicated individually, institutionally, or societally to marginalized groups" (Sue, 2010, p. 25). Examples of environmental racial microaggressions may include a counselor education program consisting of all White or European American faculty members, or a supervision group consisting of all White or European American members except for one.

Sue (2010) offered multiple examples of environmental microaggressions including (a) the presence of a Native American mascot of a school or sports team; (b) the exclusion or absence of culturally-appropriate and inclusive cultural practices, literature, or art in a community or workplace, and (c) a disproportionate representation

of European Americans and White males in positions of organizational and institutional leadership and management. Other examples might include the presence of Confederate battle flag emblems in yards, car bumper stickers, or even state flags. In fact, the state flag of Georgia incorporated the Confederate flag design from 1956 through 2001 ("Georgians prefer," 2004) and the state flag of Mississippi incorporates the Confederate flag in its state flag to this day ("For Mississippi," 2012; "Mississippi votes," 2001). The theme that binds these environmental microaggressions is that the group with the institutional and cultural power and privilege (i.e., European Americans and Whites) has the ability to define the parameters of what is *acceptable, true,* and *normal* practice regardless of the impact on historically marginalized groups. Although the *intent* of the messages may range from hostile to oblivious, the *impact* is that those with less societal power feel unwanted, demeaned, misunderstood, invalidated, or unsafe (Sue, 2010; Sue et al., 2007).

Forms of Microaggressions

According to Sue et al. (2007) and Sue (2010), microaggressions can be described along two dimensions that include delivery methods and forms. To review, the three delivery methods of microaggressions are verbal, behavioral, and environmental. Another dimension to microaggressions includes the forms that the microaggressions take. According to Sue et al. (2007), microaggressions take three forms, namely, microassaults, microinsults, and microinvalidations. Racial microassaults are explicit verbal or non-verbal attacks with the intent to harm the target. Racial microinsults encompass verbal or non-verbal insults that are disrespectful, insensitive, and/or demeaning to the person's racial or ethnic heritage. Racial microinvalidations include verbal or non-verbal messages

"that exclude, negate, or nullify the psychological thoughts, feelings or experiential reality of a person of color" (p. 278). Whereas microassaults are often conscious and deliberate, microinsults and microinvalidations tend to be more ambiguous, unconscious, unintentional, and invisible to the perpetrator. To summarize, forms of microaggressions involve the nature of what is said (content) and the effect on the recipient (impact).

In 2007, Constantine and Sue examined the perspectives of Black supervisees in cross-racial supervisory relationships. They found multiple examples of racial microinvalidations and microinsults. For example, supervisees reported that supervisors tended to ignore, dismiss, or avoid discussing race and racial issues in supervision – events that are classified as microinvalidations when using the Sue (2010) and Sue et al. (2007) frameworks. These invalidations negatively impacted the supervisory alliance and contributed to supervisee emotional frustration and disappointment.

Another theme that emerged from the Constantine and Sue (2007) study was that supervisees reported that many supervisors ignored systemic factors and oppressive forces that contribute to client concerns. Instead of engaging in multiculturally competent dialogues, these supervisors appeared to be ignorant of societal privileges and oppression. Constantine and Sue (2007) indicated that the supervisees felt mistrustful of these supervisors and that the supervisory alliances were marred. Participants reported that in these instances, the supervisors ignored the role that racism and discrimination played in the lives of clients. Each denial of the racial reality of a client or supervisee exemplifies a microinvalidation (Sue, 2010). Sue et al. (2007) and Sue (2010) identified this particular microinvalidation as the myth of meritocracy. This is the inaccurate belief that every person has equal access, opportunities, barriers, and advantages in life. It asserts that race

plays a minimal role in life successes (Sue et al., 2007). In essence, this perspective can be conceptualized as victim-blaming. Constantine and Sue (2007) indicated that the supervisors described in their study likely ascribed to beliefs in the myth of meritocracy. These faulty beliefs,

> fueled by the lack of awareness of their White privilege, clearly could cause them to misattribute the etiology of some clients' mental health concerns to factors that are individual or personal in nature rather than tied to structural or institutional discrimination. (Constantine & Sue, 2007, p. 149)

Constantine and Sue (2007) also uncovered a theme whereby supervisors offered culturally inappropriate or insensitive treatment recommendations to their supervisees.

> For example, as indicated by one of the trainees, a supervisor directed the supervisee to encourage his Black gay male client to disengage from his family of origin, which was viewed by the supervisee as a primary support system….Asking clients of color to disengage from a system that potentially provides vital support in the realm of race-related phenomena could prove to be damaging to their psychological well-being because it undermines their cultural matrix." (Constantine & Sue, 2007, p. 149)

The supervisor appeared to be viewing the client from a Eurocentric perspective that was biased and not culturally responsive or appropriate. These microinvalidations contributed to damaged supervisory alliances and even client outcomes (Constantine & Sue, 2007).

Contemporary Racism

For the majority of White Americans, being called a "racist" is an extreme personal affront – almost a slur in itself. President George W. Bush responded to popular

rap artist Kanye West who had stated that "George Bush doesn't care about Black people," by stating in a later interview that, "He called me a racist…I resent it. It's not true, and it was one of the most disgusting moments in my Presidency." ("Decision Points," 2010).

Whereas overt, blatant racism has become less socially acceptable and less legal over time, covert, insidious, subtle, ambiguous, and unconscious racism continues to thrive (Constantine & Sue, 2007; Gaertner & Dovidio, 1977; Pearson, Dovidio, & Gaertner, 2009; Solórzano, Ceja, & Yosso, 2000). Several constructs relate to this contemporary racism including prejudice, racial harassment, racial discrimination, symbolic racism, modern racism, and aversive racism. *Prejudice* includes positive or negative attitudes toward other races, often informed by stereotypes (Bryant-Davis & Ocampo, 2005). *Racial harassment* has a more overt and open quality and includes majority group hostility and denigration of other racial groups (Carter, 2007). *Racial discrimination* allows majority group members to distance, avoid, and ostracize minority group members, often in a covert manner (Carter, 2007). *Symbolic racism* (Kinder & Sears, 1981; Sears & Henry, 2003) includes a combination of racial anxiety and conservative values including individualism. *Modern racism* (McConahay, 1986) examines the belief system that holds that discrimination has ended, so any efforts to promote racial equality are too ambitious, unneeded, and unfair. *Aversive racism* embodies the discrepancy between White individuals' denial of overt prejudice and their actual, unconscious negative cognitions and emotions regarding racial and ethnic minority group members (Dovidio & Gaertner, 1986; Pearson et al., 2009). This type of racism includes layers of ambivalence. In essence, White individuals avow egalitarian

attitudes that favor equality while simultaneously harboring unconscious and negative attitudes and biases toward other racial, ethnic, and cultural groups. White people do not want to appear racist (they are averse to endorsing overt prejudice) and at the same time, they often exhibit discomfort and unease (averseness) around other racial groups.

Constantine and Sue (2007) found evidence of this double-edged ambivalence in cross-racial supervision. Several Black supervisees perceived their White supervisors as reluctant to give feedback for fears of being labeled as racist. Additionally, many supervisees reported that supervisors appeared to focus mostly on supervisee clinical weaknesses and not on existing strengths. These types of ambivalence exemplify the nature of aversive racism manifested through racial microaggressions, specifically microinvalidations. The supervisees experienced mistrust, discord, frustration, and disappointment in their supervision. Accurate, appropriate, and balanced feedback and evaluations are key components of ethical and competent supervision (Bernard & Goodyear, 2009). However, it appears that in the Constantine and Sue (2007) investigation, White supervisors were failing in their supervisory duties to the detriment of their supervisees and, by extension, the clientele.

Constantine and Sue (2007) also found evidence of supervisor prejudice toward Black people. Multiple participants reported that their White supervisors held racially stereotyped views of Black supervisees and Black clientele. These prejudices negatively impacted the supervisory alliance and quality of client care and can be classified as racial microinsults, given the Sue (2010) and Sue et al. (2007) taxonomy.

The Effects of Racial Microaggressions

The construct of racial microaggressions intersects and imbricates with other nuanced constructs such as race-related stress (Williams, Yu, Jackson, & Anderson, 1997), racial and ethnic discrimination (Fang & Myers, 2001; Williams et al., 1997), perceived racial and ethnic discrimination (Flores, Tschann, Dimas, Pasch, & de Groat, 2010; Moradi & Risco, 2006; Sellers & Shelton, 2003), race-based traumatic stress (Carter, 2007), racial battle fatigue (Smith, Allen, & Danley, 2007), and posttraumatic stress disorder (PTSD; Bryant-Davis & Ocampo, 2005; Helms et al., 2012). Numerous studies have demonstrated the link between factors of racism, racial discrimination, and racial microaggressions and adverse experiences and life outcomes. Constantine and Sue (2007) found results consistent with previous findings, specifically in supervisory relationships.

Regarding physical health outcomes, experiences of racial discrimination relate to high blood pressure (Harrel, Hall, & Taliaferro, 2003; Steffen, McNeilly, Anderson, & Sherwood, 2003) and sleep disturbance (Steffen & Bowden, 2006). Regarding mental health outcomes, experiences of racial discrimination relate to stress (Fang & Myers, 2001; Moradi & Risco, 2006; Solórzano et al., 2000; Sue, Capodilupo, & Holder, 2008), depression (Lambert, Herman, Bynum, & Ialongo, 2009; Santana, Almeida-Filho, Roberts, & Cooper, 2007), substance abuse (Wei, Alvarez, Ku, Russell, & Bonett, 2010), eating disorders (Mastria, 2002), and posttraumatic stress disorder (Flores et al., 2010; Pieterse, Carter, Evans, & Walter, 2010). Regarding educational outcomes, Solórzano et al. (2000) found that racial microaggressions created an adverse campus climate and resulted in both academic and social barriers as well as lowered academic achievement

among African American college students. In addition, according to Steele and Aronson (1995), stereotype threat is a major factor that undermines achievement, resulting in lowered scores on high-stakes standardized tests for African Americans. Nadal (2011) found that individuals who self-identify as racial and ethnic minorities can recognize racial microaggressions and do connect them to race and racism. Carter (2007) argued that based on their chronic nature and cumulative impact, racial microaggressions are stressors that can result in physical and mental harm.

Investigators have documented microaggressions in numerous formats and arenas of life such as graduate teaching assistantships (Gomez, Khurshid, Freitag, & Lachuk, 2011), college campuses (Solórzano et al., 2000), daily life (Ong, Burrow, Fuller-Rowell, Ja, & Sue, 2013), counseling (Constantine, 2007), and clinical supervision (Constantine & Sue, 2007). Therefore, for counselor educators, microaggressions in supervision is a pressing topic, and one not often addressed in either supervision or the literature (Bernard & Goodyear, 2009; Constantine & Sue, 2007; Utsey, Gernat, & Hammar, 2005). Despite receiving multicultural training, for example, White supervisors often demonstrate covert or unconscious racism (Constantine, 1997, 2003; Constantine & Sue, 2007; Utsey, Gernat, & Hammar, 2005), the results of which could cause harm to supervisees, the supervisory relationship, and clients (Helms & Cook, 1999). Furthermore, Helms and Cook (1999) argued that even though most White supervisors would not openly espouse or engage in overt racism, since racism permeates aspects of everyday life, then supervision is no more resistant than any other realm of life.

Because experiences of racism and microaggressions have the potential to be so harmful, some argue that microaggressions can become traumatic. Many scholars infer

that these types of oppressive experiences can be thought of as emotionally abusive, chronic, traumatic stressors (Bryant-Davis & Ocampo, 2005; Carter, 2007; Sanchez-Hucles, 1998; Helms et al., 2012). In order to understand how microaggressions may relate to trauma, the following section explores trauma and the connections between racial microaggressions and trauma.

Trauma

The word trauma comes from the Greek, *titrōskein*, meaning "to wound" (Trauma, n.d.). Medical and mental health professionals have agreed upon several key features to consider when diagnosing traumatic disorders. According to the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, the hallmark of PTSD is the development of a specific constellation of symptoms as responses to traumatic stressors or triggers (American Psychiatric Association [APA], 2013). Traumatic stressors are present when someone is exposed "to actual or threatened death, serious injury or sexual violence" (APA, 2013, p. 271). Additionally, exposure must follow at least one of the following scenarios:

> [d]irectly experiencing the traumatic event. Witnessing, in person, the event as it occurred to others. Learning that traumatic event(s) occurred to a close family member or close friend….Experiencing repeated or extreme exposure to aversive details of the traumatic event(s). (APA, 2013, p. 271)

Notably, the essential criteria focus on concrete, explicit, and recent physical danger to one's corporeal form and make no mention of threats to one's mental integrity or wellness. When considering the nature of trauma, it is important to note that not all traumatic stressors yield traumatic responses (or the same traumatic responses) in

individuals (Briere & Scott, 2006). In other words, people respond differently to trauma. According to Terr (1991), Type I traumas tend to be non-interpersonal, singular events (e.g., a hurricane), whereas Type II traumas tend to be prolonged, repeated, interpersonal experiences (e.g., chronic abuse). Given Terr's (1991) framework in the context of clinical supervision, it appears that Type II traumas would be the proper classification for supervisory microaggressions.

Precursors and Responses to Trauma

Many factors affect the likelihood of individuals developing traumatic responses, the intensity of the responses, and the complications associated with the responses (see Briere & Scott, 2006 for a review). One set of factors includes demographic and other characteristics that existed for the individual before or during the trauma (Briere & Scott, 2006). For example, individuals who were already experiencing heightened distress at or around the time of the traumatic stressor (*peritraumatic distress*) are more likely to develop posttraumatic stress symptoms (Brewin, Andrews, & Rose, 2000; Roemer, Orsillo, Borkovec, & Litz, 1998). In theory, for supervisees who are already experiencing stress prior to or during supervision, this may heighten the impact of negative supervision experiences.

In addition, race is a factor as people in the racial and ethnic minority are at a higher risk for developing traumatic symptomatology (Ruch & Chandler, 1983). Identifying as a woman or a racial or ethnic minority group member constitutes a risk factor for developing posttraumatic symptoms because these groups, in general, experience greater exposure to situations and incidents that produce traumatic responses including sexism and racism (Briere, 2004). This has substantial ramifications for

supervisees who identify as racial or ethnic minority group members. Another set of factors relates to the characteristics of the stressor itself. For instance, if the stressor is perceived as being unpredictable or uncontrollable, post-traumatic reactions may be more likely or more intense (Carlson & Dalenberg, 2000; Foa, Zinbarg, & Rothbaum, 1992). Finally, social support, societal response, and availability and access to resources can impact the level of intensity of the reaction. Reactions and communities that are accepting, respectful, compassionate, and validating are extremely helpful in mitigating traumatic effects (Briere & Scott, 2006). The inverse is true as well. For supervisees, if their supervisory relationships are already detrimental (as well as evaluative), then it follows that the clinical supervision experience may become oppressive and traumatic.

Racial Microaggressions as Traumatic Stressors

Traumatic sequelae can result from many stressors including interpersonal abuse (Briere & Scott, 2006). According to Lourie and Stefano (1978), emotional abuse is a "mental injury" (as cited in Sanchez-Hucles, 1998). Melchert (2000) defined emotional abuse as rejection and emotional neglect as non-responsiveness. The key to establishing the presence of emotional abuse is to determine whether the consequences of an act in question were detrimental (Sanchez-Hucles, 1998). Constantine and Sue (2007) "conclude that racial microaggressions take a psychological toll on Black trainees, and their effects cannot be considered minimally harmful" (p. 149).

According to Hart, Germain, and Brassard (1983), emotional abuse includes the commission and/or omission of actions that result in mental, physical, or emotional harm of the target (as cited in Sanchez-Hucles, 1998). Sanchez-Hucles (1998) also linked the concepts of racism and emotional abuse in the following passage:

> Garbarino and Vondra (1987) asserted that emotional abuse can be related to social and cultural contexts when groups or individuals perpetuate negative and rejecting messages towards other individuals and groups that can impede the development of positive self concepts. These negative and rejecting messages are clearly communicated in society, as in the case when people of color are depicted in stereotyped ways in the media, and in literature, when the cultures of these groups are ignored, disparaged or belittled, and perhaps most insidiously when society perpetuates the myth that fairness and opportunity are equally available to all (Jones & Jones, 1987). (Sanches-Hucles, 1998, p. 73)

Furthermore, "the trauma and emotional abusiveness of racism is as likely to be due to chronic, systemic and invisible assaults on the personhoods of ethnic minorities as a single catastrophic event" (Sanches-Hucles, 1998, p. 72). These passages are consistent with the theoretical and empirical works of Sue (2010), Sue et al. (2007), and Constantine and Sue (2007), the latter specifically regarding clinical supervision. Constantine and Sue (2007) found evidence of supervisor stereotyping of clients and supervisees, supervisor ignorance of minority cultures, supervisor multicultural insensitivity, and supervisor belief in the myth of meritocracy. These microaggressions served to undermine the self-esteem of supervisees and contribute to unhealthy supervisory relationships.

Trauma experts such as van der Kolk, Roth, Pelcovitz, Sunday, and Spinazzola (2005) and Herman (1992, 1997) have contributed to an understanding of traumatic stressors that transcends the limited notion that the stressor must be purely physical and concrete. For instance, although physically abusive and sexually abusive experiences are widely accepted as traumatic stressors, psychological injuries and emotionally abusive

experiences can yield the same types of traumatic responses in targets (Briere & Scott, 2006). In other words, not all of the traumatic stressors that are widely accepted by medical and mental health communities encompass the breadth of traumatic stressors (Briere & Scott, 2006; Carter, 2007). In fact, Herman (1992) and Carlson and Dalenberg (2000) argued that the diagnostic criteria for PTSD omit numerous events and circumstances – not related to injury or death – that may trigger posttraumatic responses. Carter (2007) proposed a new diagnostic category of *Race-Based Traumatic Stress* that would serve as a non-pathological model for understanding, preventing, and treating race-based injuries. Similarly, Franklin, Boyd-Franklin, and Kelly (2006) proposed a *Reactions to Racism-Related Trauma* diagnostic category that aims to recognize the link between racism and trauma in a way that does not pathologize targets of racism.

According to Briere and Scott (2006), " an event is traumatic if it is extremely upsetting and at least temporarily overwhelms the individual's internal resources" (p. 4). Many argue that oppressive experiences such as racism can be conceptualized as emotionally abusive, chronic traumatic stressors (Bryant-Davis & Ocampo, 2005; Carter, 2007; Sanchez-Hucles, 1998; Helms et al., 2012). Furthermore, Helms and colleagues (2012) reasoned that, "immediate or delayed PTSD symptoms may result from (a) direct cataclysmic racial or ethnic cultural events, (b) vicarious or witnessed cataclysmic events, and (c) racial and cultural microaggressions" (p. 68). Helms et al. (2012) further maintained that *"*racial/cultural microaggressions are discriminatory events that trigger memories of past personal or historical group trauma that are recalled as threatening to one's life or mental health" (p. 68). In this framework, the PTSD diagnosis may in fact be clinically indicated for microaggressions. According to Helms et al., microaggressions

are traumatic stressors as defined by the DSM because they serve as a conduit, linking the target of the microaggression to an event that involved physical injury or death.

Resistance and Resilience

Although racism and racial microaggressions are well-documented and pervasive, it is also noteworthy that resistance and resilience strategies are common as well. For example, according to Solórzano et al., 2000, African American college students create safer, affirmative spaces, both on-campus and off-campus, where they can develop a sense of community, support, and safety. To manage the chronic stressor of invisibility, target groups may engage in what Franklin and Boyd-Franklin (2000) termed, "microaggression repair" (p. 39). Constantine and Sue (2007) concluded that their participants (who were Black supervisees) were highly aware of and skilled at navigating contemporary forms of racism. Combining their "ability to distinguish between opposing racial realities, and ability to ward off implied racial deficiencies may have allowed the trainees in our investigation to better cope with incidents of racial microaggression" (pp. 149-150).

Conclusions and Implications for Counselor Educators

The term *microaggression* has been used since the 1970's. Scholars have recently investigated racial microaggressions and their effects on members of racial, cultural, and ethnic minority communities in a number of arenas of life, including counseling supervision. The literature and evidence discussed in this paper indicate that racial microaggressions (both inside and outside of counseling supervision) are pervasive, often obscured, and harmful. It is clear that further research is needed in the area of racial microaggressions.

The majority of studies on racial microaggressions have included qualitative methodologies, seeking the perspectives of those who are targets of the microaggressions. Two recent investigations have delved into scale development and validation in order to provide quantitative data regarding the experiences and classifications of racial microaggressions (Nadal, 2011; Torres-Harding et al., 2012). Future investigations (including qualitative, mixed-methods, and quantitative designs) should continue to examine and validate the classification systems of microaggressions proposed by Sue et al. (2007) and Sue (2010). These efforts could emphasize race, gender, sexual identity, and any other social identities with the potential of marginalization. In addition, researchers could explore the nuances and frequencies of different types of microaggressions in different populations in order to understand the dynamics involved.

Future investigations could also provide support and models for professional counselors and counselor educators to engage in advocacy, education, and prevention efforts. Such activities could intervene on the client level, the counselor level, and the supervisor/educator level. All of these investigations and pursuits would serve to advance multicultural competence in supervision, multicultural competence in professional counseling, and social justice for clients, counselors, and communities.

To date, no quantitative investigations have examined racial microaggressions in supervision from a supervisee perspective. Because the potential for harm is so potent with racial microaggression dynamics, and because wellness, prevention, development (Myers, 1992) and social justice (Chang et al., 2014) are foundations of professional counseling, it follows that further investigations will need to continue examining racial microaggressions in supervision and counseling. In particular, investigations could

analyze the relationships among the experiences of racial microaggressions in supervision, traumatic symptomatology, and assessments of the supervisory working alliance from a supervisee perspective.

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CHAPTER 2

THE RELATIONSHIPS AMONG THE EXPERIENCES OF RACIAL MICROAGGRESSIONS IN SUPERVISION, TRAUMATIC EXPERIENCES, AND THE SUPERVISORY WORKING ALLIANCE IN PROFESSIONAL COUNSELORS AND COUNSELORS-IN-TRAINING

According to Bernard & Goodyear (2009), supervision is one of the key underpinnings of preparation for professional counselors. As with any helping relationship, the supervisory working alliance is fiduciary in nature and should be built upon a foundation of mutual trust, respect, and security (Bernard & Goodyear, 2009). However, destructive interpersonal interactions known as microaggressions (Pierce, Carew, Pierce-Gonzalez, & Willis, 1978; Sue 2010; Sue et al., 2007) can damage supervision and counseling relationships (Constantine & Sue, 2007; Sue et al., 2007). Sue (2010) proposed a taxonomy that identifies, classifies, and explores microaggressions related to race, gender, and sexual identity. He noted that microaggressions may target other social identities as well.

Some scholars have argued that prolonged exposure to racial microaggressions has the potential to produce lasting damage and traumatic responses in recipients (Carter, 2007; Helms, Nicholas, & Green, 2012). Although counseling supervision should directly attend to issues of race in a supportive and productive manner (Constantine 1997; 2003; Hays & Chang, 2003), evidence suggests that racial microaggressions permeate supervision (Barnes, 2011; Constantine & Sue, 2007) as they likely permeate all cross-cultural interactions in life (Gomez, Khurshid, Freitag, & Lachuk, 2011; Ong, Burrow, Fuller-Rowell, Ja, & Sue, 2013; Solórzano, Ceja, & Yosso, 2000; Sue et al., 2007; Sue, Lin, Torino, Capodilupo, & Rivera, 2009). In order to promote counseling's wellness

perspective and to provide optimal preparation for professional counselors and supervisors, it is important to learn more about the intersections of the supervisory working alliance, racial microaggressions, and traumatic experiences.

Supervision and Microaggressions

Supervision of counseling involves a hierarchical relationship, continuing over a period of time, with the supervisor holding evaluative power over the supervisee (Bernard & Goodyear, 2009; Crook Lyon & Potkar, 2010). Bernard and Goodyear (2009) characterized the supervisory relationship as one that "has the simultaneous purposes of enhancing the professional functioning of the more junior person(s); monitoring the quality of professional services offered…; and serving as a gatekeeper for those who are to enter the particular profession" (p. 7). According to Constantine (1997) and Hays and Chang (2003), supervision should openly and directly address racial, cultural, and ethnic dynamics in order to encourage multicultural competence and social justice. Furthermore, the existence of racial microaggressions in supervision damages the supervisory alliance (Constantine & Sue, 2007; Helms & Cook, 1999). However, when open dialogues about race and culture occur in supervision, this serves to bolster alliances (Helms & Cook, 1999). Despite the importance of addressing these concerns in supervision, it appears that pain, taboos, and ignorance often sidetrack needed discussions around race, microaggressions, and privilege (Constantine & Sue, 2007; Sue et al., 2007; Utsey, Gernat, & Hammar, 2005; Utsey, Hammar, & Gernat, 2005). In order to understand the nature and dynamics of microaggressions more fully, the following section will explore details about what microaggressions are, how they operate, and their impact on counseling supervision.

Microaggressions and Racism

According to Pierce et al. (1978), microaggressions "are subtle, stunning, often automatic, and non-verbal exchanges which are 'put downs'" from those in the racial majority toward those in the racial minority (p. 66). Sue et al. (2007) elaborated that the potential to be part of a racial microaggression (transmitting or receiving) exists in any cross-cultural interpersonal exchange. "Racial microaggressions are brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults to the target person or group" (Sue et al., 2007, p. 273).

While the Pierce et al. (1978) definition focuses on race, Sue (2010) and Sue et al. (2007) have provided substantial contributions and a taxonomy for understanding microaggressions related not only to race, but also to gender and sexual identity. Other theoretical and empirical works have also broadened explorations of microaggressions to include race and ethnicity (Lewis, Mendenhall, Harwood, & Browne Huntt, 2013; Nadal, 2011; Torres-Harding, Andrade, & Romero Diaz, 2012), gender (Capodilupo et al., 2010; Lewis et al., 2013), gender identity (Nadal, 2013; Smith, Shin, & Officer, 2012), and sexual identity (Balsam, Molina, Beadnell, Simoni, & Walters, 2011; Shelton & Delgado-Romero, 2011; Smith et al., 2012).

Sue (2010) and Sue et al. (2007) established a classification system to aid in understanding the characteristics and components of microaggressions. Microaggressions are phenomena with two main facets (Sue, 2010). One facet is the delivery method for how microaggressions are transmitted. The other facet involves the forms of microaggressions.

Sue (2010) and Sue et al. (2007) proposed that there are three delivery methods of racial microaggressions including verbal, non-verbal, and environmental. Although the methods of communication may vary, the messages consistently convey threats, disapproval, suspicion, denial, disgust, scorn, and/or disrespect to the target. The other facet of racial microaggressions includes the forms of microaggressions – microassaults, microinsults, and microinvalidations. Sue (2010) and Sue et al. (2007) defined microassaults as open and direct attacks meant to harm the recipient. They defined microinsults as disrespectful, insensitive, or degrading communications that insult the target's racial, ethnic, or cultural heritage. Finally, they defined microinvalidations as communications that undermine the reality and lived experiences of people who are racial or ethnic minority group members. These three forms of racial microaggressions can be conceptualized on a continuum of awareness (consciousness) with microassaults tending to be the most intentional and microinvalidations tending to be the least intentional (Sue, 2010; Sue et al., 2007). This taxonomy holds that regardless of the method of delivery or the form, microaggressions are damaging.

Part of any discussion related to microaggressions must attend to privilege, oppression, and racism as these constructs are intertwined and related. Racism is a system of unearned advantages (privilege) and unearned disadvantages (oppression) that permeates US society and is rooted in the premise that race is a social construct (Chang, Gnilka, & O'Hara, 2014; Crethar, Torres Rivera, & Nash, 2008). Privilege and oppression dynamics exist in counseling and supervision as well as the population at large (Constantine & Sue, 2007; Hays & Chang, 2003; Sue & Sue, 2012). Often, these forces make it difficult to discuss and process cross-cultural issues in supervision

(Constantine & Sue, 2007; Hays & Chang, 2003). Part of what is so challenging is that the ways in which racism is expressed today, such as symbolic racism (Kinder & Sears, 1981; Sears & Henry, 2003), modern racism (McConahay, 1986), and aversive racism (Dovidio & Gaertner, 1986; Pearson, Dovidio, & Gaertner, 2009), are more subtle, ambiguous, and covert than racism in years past.

In an effort to explore the complicated dynamics of race, racism, and racial microaggressions in supervision, Constantine and Sue (2007) investigated cross-racial supervision dyads. They found evidence of racial microaggressions directed toward Black supervisees by White supervisors. Their results indicated the wide-spread presence of multiple microinsults and microinvalidations, which contributed to impaired supervisory alliances, mistrust, and harmful supervision. Because the impact of microaggressions can be harmful (Constantine & Sue, 2007; Sue 2010), and because experiences of racism can be conceptualized as chronic traumatic stressors (Bryant-Davis & Ocampo, 2005; Carter, 2007; Sanchez-Hucles, 1998; Helms et al., 2012), an exploration of racial microaggressions and trauma is warranted.

The Link to Trauma

The fifth edition of the *DSM* defines traumatic stressors as exposure "to actual or threatened death, serious injury or sexual violence" (APA, 2013, p. 271). One or more of the following situations qualifies:

> Directly experiencing the traumatic event. Witnessing, in person, the event as it occurred to others. Learning that traumatic event(s) occurred to a close family member or close friend….Experiencing repeated or extreme exposure to aversive details of the traumatic event(s). (APA, 2013, p. 271)

Although the DSM limits triggers to those that are direct life-threatening events, many experts maintain that traumatic responses occur from psychological and emotional abuse/injury (Briere & Scott, 2006; Bryant-Davis & Ocampo, 2005; Carter, 2007; Helms et al., 2012; Herman, 1992; 1997; Sanchez-Hucles, 1998; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). Helms et al. (2012) affirmed that racial microaggressions are traumatic triggers because they prompt recipients to remember years of intergenerational trauma and danger. Thus, microaggressions link the recipient to instances of injury, violation, or death.

Rationale for the Current Study

Although there have been multiple, consensual quantitative research studies conducted on microaggressions in various aspects of everyday life, and Constantine and Sue (2007) investigated microaggressions in cross-racial supervision, no quantitative studies have investigated microaggressions in supervision. In addition, there have been no investigations as to the relationship between trauma and racial microaggressions in supervision. As counseling is a profession built upon prevention and wellness (Myers, 1992), it follows that in order to provide quality supervision, and to promote multiculturally competent supervision and counseling, research must be conducted to investigate the potential impact of racial microaggressions as they relate to traumatic experiences and the quality of the supervisory alliance. Therefore, the purpose of this study is to explore the relationships among racial microaggressions, the supervisory alliance, and traumatic experiences in professional counselors or counselors-in-training. As a result, the following research questions were developed:

1) What are the relationships among the total scores of racial microaggressions in supervision, experiences of trauma, and supervisee assessment of the supervisory alliance?

    H1a: There will be a negative relationship between racial microaggressions and the supervisory alliance.

    H1b: There will be a negative relationship between experiences of trauma and the supervisory alliance.

    H1c: There will be a positive relationship between experiences of trauma and racial microaggressions.

2) Are experiences of the total scores of microaggressions in supervision and experiences of trauma predictive of the total score of the supervisory alliance from the supervisee's perspective?

    H2a: Racial microaggressions in supervision will predict ratings of the supervisory alliance.

    H2b: Experiences of trauma in supervision will significantly predict ratings of the supervisory alliance.

3) If both total scores of the experiences of microaggressions in supervision and experiences of trauma are significantly predictive of the total scores of the supervisory alliance alone, are both variables more predictive of the supervisory alliance than either variable alone?

    H3: Both experiences of microaggressions in supervision and experiences of trauma will be significantly more predictive of the supervisory alliance than either variable alone.

Method

Participants

The investigator utilized the online G*Power program, version 3.1.4, in order to estimate the sample size needed to conduct data analysis (Faul, Erdfelder, Buchner, & Lang, 2009). The observed power was greater than .80, which is supportive of an *a priori* power analysis of .80, and a sample size of 55. Therefore the sample size of this study was sufficient.

Eighty-six people participated in this study (age: $M = 36.38$, $SD = 10.11$, range 22-61 years). Participation was voluntary and each person consented to complete the online survey. The sample included 62 females (72.1%) and 14 males (16.3%) with no one self-identifying as transgender.

Participants self-identified with many different racial, ethnic, and cultural group identities. The items regarding racial, ethnic, and cultural identification were not forced-choice. Therefore, participants could select as many categories as they wanted that described them. These items also allotted an option for participants to specify other descriptions for how they self-identified. The sample was 30.2% (n = 26) African American / Black American, 20.9% (n = 18) European American / White American, 15.1% (n = 13) Latino/a or Hispanic American, 8.1% (n = 7) Asian or Pacific Islander American, 3.5% (n = 3) Multiracial American, and 2.3% (n = 2) Jewish American. A total of nine participants self-identified as another identity and responded in the following ways: “Afro Caribbean,” “Chinese,” “Caribbean,” “Bahamian American,” “Multiple heritage,” “Black (but not American),” “Middle Eastern,” “Russian American,” and “American of Polish Descent.”

Participants also identified the racial, ethnic, or cultural identity that others assumed them to be. Again, these items were not forced-choice, so participants could select as many options as they wanted. There was also an option for specifying other descriptions. In this sample, participants indicated that others assumed them to have the following breakdown of identities: 38.4% (n = 33) African American / Black American, 24.4% (n = 21) European American / White American, 18.6% (n = 16) Latino/a or Hispanic American, 12.8% (n = 11) Asian or Pacific Islander American, 7.0% (n = 6) Biracial American, 5.8% (n = 5) Middle Eastern American, 5.8% (n = 5) Multiracial American, and 3.5% (n = 3) Jewish American. A total of five participants stated that other people assumed them to be an identity not listed in this survey. They responded in the following ways: "Greek," "Native American," "They do not know," "I get everything," and "White/European."

Regarding sexual identity, 73.3% (n = 63) identified as heterosexual, 3.5% (n = 3) as gay, 3.5% (n = 3) as lesbian, 5.8% (n = 5) as bisexual, and 1.2% (n = 1) as queer. One participant self-identified as "questioning" through the write-in response option.

When asked about language use, 80.2% (n = 69) of participants indicated that they use English as their primary form of reading, writing, speaking, and/or communicating. The remaining participants 8.1% (n = 7) reported using another language. Participants also responded to an item requesting their generational and immigrant status in which 19.8% (n = 17) reported being first generation, 7.0% (n = 6) second generation, 12.8% (n = 11) third generation, and 47.7% (n = 41) responded that they were not recent immigrants.

Regarding relationship or marital status, 25.6% (n = 22) stated they were married, 8.1% (n = 7) were divorced, 2.3% (n = 2) were in a domestic partnership, 44.2% (n = 38) were single, 7.0% (n = 6) were unmarried and living in the same household, and 1.2% (n = 1) were widowed. With respect to religion, spirituality, and belief identification, 57.0% (n = 49) of the participants identified as Christian, 1.2% (n = 1) as Hindu, 1.2% (n = 1) as Jewish, 2.3% (n = 2) as Muslim, 3.5% (n = 3) as Buddhist, 10.5% (n = 9) as Agnostic, and 2.3% (n = 2) as Atheist. For the write-in option, eight participants wrote the following identities: "spiritual, not religious," "Spiritual," "none," "Missouri Synod Lutheran," "Animism," "Humanist," "Secular Humanist," and "Therapist." Participants indicated that 8.1% (n = 7) had a disability and 2.3% (n = 2) experienced limitations in functioning. In addition, 18.6% (n = 16) reported having a chronic health condition.

Regarding community and geography, 41.9% (n = 36) participants lived in urban or city areas, 29.1% (n = 25) lived in suburban areas, 11.6% (n = 10) lived in town or village, and 5.8% (n = 5) lived in rural areas. Participants also reported living in many areas of the US. 43.0% (n = 37) lived in the South, 22.1% (n = 19) lived in the Northeast, 11.6% (n = 10) lived in the Midwest, 2.3% (n = 2) lived in the Rocky Mountains, 5.8% (n = 5) lived on the West Coast, 1.2% (n = 1) lived in Alaska or Hawai'i, and 1.2% (n = 1) lived in another territory or protectorate.

With regards to formal education, 11.6% (n = 10) participants had attained degrees of Bachelors, 54.7% (n = 47) Masters, 4.7% (n = 4) Specialist, or 15.1% (n = 13) Doctoral in any field. Specific to professional counseling, 7.0% (n = 6) participants had attained degrees of Bachelors, 58.1% (n = 50) Masters, 4.7% (n = 4) Specialist, and 11.6% (n = 10) Doctoral. Participants reported engaging in various types of program

delivery including 75.5% (n = 65) traditional, 7.0% (n = 6) online, and 4.7% (n = 4) hybrid. Additionally, 76.7% (n = 66) of participants were enrolled in a program accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP), 4.7% (n = 4) were not, and 5.8% (n = 5) reported not knowing. Participants disclosed enrollment in the following CACREP specialty areas: 1.2% (n = 1) career, 26.7% (n = 23) clinical mental health, 1.2% (n = 1) college, 11.6% (n = 10) community, 25.6% (n = 22) counselor education, 2.3% (n = 2) marriage and family, 2.3% (n = 2) student affairs, and 9.3% (n = 8) school. Three participants shared other areas in the write-in option: "completed college counseling specialty and returned to complete community counseling," "with track in Play Therapy," "Counselor Education and Supervision." Regarding practicum and internship, 27.9% (n = 24) participants were currently enrolled and 60.5% (n = 52) had completed practicum/internship.

For the remainder of the demographic questions and the remaining survey instruments, participants answered questions directly geared toward describing supervision with one supervisor with whom they had experienced a racial/cultural microaggression in supervision. The type of supervisor in this sample was 27.9% (n = 24) on-site, 24.4% (n = 21) university-based, and 7.0% (n = 6) a community supervisor independent of practicum/internship. In addition, four participants reported other supervisor types including a "potential site supervisor," a "university career counseling center/assistant director," "postdoctoral fellowship," and "professor and chair." Furthermore, 11.6% (n = 10) of participants had no choice or control over this pairing and 52.3% (n = 45) did have some degree of choice or control.

Participants indicated a wide variety of previous experiences in supervision. This ranged from zero years (no supervision) to 16 years, with two years being the mode. In addition, 16 participants indicated having no prior supervision. Participants reported a wide range of the number of supervision sessions with the supervisor they identified. Example responses include "0 – got off to a bad start prior to beginning supervision," "more than 120 (in about three years)," and "weekly." The type of supervision reported was 34.9% (n = 30) individual (including triadic), 7.0% (n = 6) group, and 20.9% (n = 18) both individual and group. The settings reported included 16.3% (n = 14) community mental health agency, 1.2% (n = 1) faith-based agency, 4.7% (n = 4) hospital or medical setting, 3.5% (n = 3) private practice, 8.1% (n = 7) school (elementary or secondary), 16.3% (n = 14) university counseling center, and 8.1% (n = 7) university other. Five write-in responses included "non for profit specialty clinic," "university trauma agency," "university career counseling center," "non for profit," and "private nonprofit inpatient and outpatient."

Participants described the racial, ethnic, or cultural identity of the identified supervisor as being 5.8% (n = 5) African American / Black American, 2.3% (n = 2) Asian or Pacific Islander American, 46.5% (n = 40) European American / White American, 5.8% (n = 5) Jewish American, 1.2% (n = 1) Latino/a or Hispanic American, and 1.2% (n = 1) Middle Eastern American. Two participants provided write-in responses of "Afro Caribbean," and "European."

Participants characterized the professional identity of their supervisor to be 34.9% (n = 30) professional counselor, 12.8% (n = 11) psychologist, and 5.8% (n = 5) social worker. Nine participants offered write-in responses including "department head,"

"counselor educator," "principal," "academic advisor," "assistant dean," "department head," "principal," "rehab counselor," and "student." The degree level of this supervisor was 24.4% (n = 21) Masters, 4.7% (n = 4) Specialist, and 33.7% (n = 29) doctorate. If the identified supervisor had a professional counseling identity, participants reported the following specialty areas of the supervisor: 5.8% (n = 5) addictions, 2.3% (n = 2) career, 14.0% (n = 12) clinical mental health, 2.3% (n = 2) college, 4.7% (n = 4) community, 3.5% (n = 3) counselor education, 2.3% (n = 2) marriage and family, and 3.5% (n = 3) school. Additionally, four participants provided write-in answers indicating these areas of specialty: "child/adolescent," "children," "play therapy," and "interestingly, diversity." Finally, participants indicated this supervisor's years of experience providing supervision. 5.8% (n = 5) provided less than 12 months, 2.3% (n = 2) provided 1-2 years, 8.1% (n = 7) provided 3-4 years, 10.5% (n = 9) provided 5-7 years, 9.3% (n = 8) provided 8-10 years, 2.3% (n = 2) provided 11-15 years, 8.1% (n = 7) provided 16-20 years, and 1.2% (n = 1) provided 21 or more years of supervision.

Procedure

To request participation, the researchers sent emails to counselor education faculty, counseling students, and national email group mailing lists to which the primary investigator belongs (e.g., CESNET) whose members include counselors and counselor educators across the nation. The people asked to participate included diverse professional counselors and counselor educators with whom the primary investigator and her immediate colleagues have a professional connection. Recruitment also included requests to colleagues across the country via email, and requests to participate directed toward conference attendees at a national counseling conference (the Association for Assessment

and Research in Counseling) held in September, 2013. The investigators targeted training directors, program coordinators, and faculty in counselor education departments.

The invitation email included a link to an online survey for participants to complete through a survey system called Qualtrics (www.qualtrics.com). Participants were also encouraged to forward the survey link to others for participation, as they may have known of others who met the inclusion criteria for the small population to be studied (Heckathorn, 2002). This type of respondent-driven sampling is appropriate for "hidden" populations that may be difficult to study or in cases where privacy and stigma concerns exist (Heckathorn, 1997; 2002). The electronic survey link included an informed consent form and the actual survey itself. The link informed participants that their information would be kept confidential, that the data would be stored securely, and that the data would be password-protected. If participants agreed to participate, they completed the four measures described below.

Measures

Demographic questionnaire. The demographic questionnaire (see Appendix) requested information regarding participant age, race, ethnic identity, sex assigned at birth, gender, sexual identity, religious or spiritual affiliation, ability status, language preference, and other related demographic variables. Additionally, participants were asked to report the race and ethnicity that they believed others assumed them to be. The questionnaire also asked about geographic location (e.g., Southwestern US), residency location (e.g., urban, suburban, rural), level of formal education obtained in a counseling field, program details (e.g., degree program, specialty area), type of supervisor (e.g.,

university or on-site), supervisor background, type of internship setting (e.g., school, community mental health), and duration of experience as a supervisee.

Experiences of Black Supervisors Scale (EBSS; Barnes, 2011). The EBSS is a 16-item scale that measures microaggressions toward supervisors in supervision. For the purposes of this study, the items were adapted to direct attention toward racial or ethnic minority supervisees' perceptions of a supervisor. Each item requires a response of 0 (this never happened), 1 (this happened, but it did not bother me), or 2 (this happened and I was bothered by it). Example items include "My supervisee sometimes minimized the importance of racial or cultural issues in our supervision meetings" and "My supervisee sometimes seemed unaware of the realities of race and racism." For the purposes of this study, and with the original author's permission, the investigator changed the word *supervisee* to *supervisor*. In addition, the investigator removed two items that did not make sense given the targeted participant pool as per the original author's recommendation (R. Barnes, personal communication, June 20, 2013. Barnes (2011) reported a Cronbach's alpha of .92.

Trauma Symptom Check-list 40 (TSC-40; Elliot & Briere, 1992). The TSC-40 is a 40 item self-report instrument that assesses aspects of PTSD and related symptoms in adults. This measure is used exclusively for research (Briere & Runtz, n.d.). It measures symptoms that may have arisen from childhood or adult traumatic experiences. Each item consists of a 4-point Likert scale, which ranges from 0 (never) to 3 (often). Items measure the frequency of occurrence of specific symptoms over the last two months. The TSC-40 produces a total score as well as scores for the following six subscales: Anxiety, Depression, Dissociation, Sexual Abuse Trauma Index, Sexual Problems, and Sleep

Disturbances. Sample items include "Feelings that you are not always in your body," "Nightmares," and "Feelings of inferiority."

For the purposes of this study, the investigators will give specific instructions to participants to report only those symptoms that developed after the microaggressions were experienced in supervision. This study is not examining symptoms that are unrelated to microaggressions in supervision. According to Briere, since the TSC-40 is a publicly released instrument used widely for research, adaptations are acceptable (J. Briere, personal communication, March 9, 2013).

The TSC-33 is an earlier version of the TSC-40, which did not include the Sexual Problems or Sleep Disturbances scales (Briere & Runtz, 1989). By adding these scales, the researchers created an updated and revised instrument, the TSC-40 (Elliot & Briere, 1992). According to Elliot and Briere (1992), the TSC-40 is a valid and reliable instrument. Subscale Cronbach's alphas range from .66 to .77 and the full-scale Cronbach's alpha was .90. In general, full-scale Cronbach's alphas for the TSC-40 average around .89 to .91 (Briere & Runtz, n.d.). Zlotnick et al. (1996) established validity of the TSC-40. Elliot and Guy (1993) established reliability and internal consistency of the TSC-40.

Supervisory Working Alliance Inventory – Trainee Version (SWAI-T; Efstation, Patton, & Kardash, 1990). The SWAI-T is a popular instrument that measures the supervisory working alliance. There are two versions including one for supervisors and one for trainees (supervisees); the trainee version was used for this study. The SWAI-T consists of 19 items, each on a 7-point Likert scale (1 = almost never; 7 = almost always). The following statements are examples of some of the items: 1) "In

supervision, I am more curious than anxious when discussing my difficulties with clients," 2) "My supervisor stays in tune with me during supervision," and 3) "My supervisor treats me like a colleague in our supervisory sessions," and 4) "I feel free to mention to my supervisor any troublesome feelings I might have about him/her."

The SWAI-T yields a total full-scale score as well as two subscale scores. The Rapport subscale indicates the supervisor's effectiveness at developing bonds with supervisees. The Client Focus subscale indicates how much a supervisor emphasizes client concerns during supervision. Higher scores on the SWAI-T indicate the degree to which supervisees believe that their supervisory alliances embody these conditions. This measure demonstrates adequate reliability and validity (Efstation et al., 1990). The SWAI-T has high reported internal consistency scores of .95 (Wester, Vogal, & Archer, 2004) and .96 (Gnilka, Chang, & Dew, 2012; White & Queener, 2003).

Results

Table 1 displays the descriptive statistics for the full-scale scores of the three instruments.

Table 1

Descriptive Statistics for Full-Scale Scores

Measure	Minimum	Maximum	M	SD
SWAI-T	26	132	64.11	26.56
EBSS	0	28	15.61	7.181
TSC-40	0	75	24.20	18.86

Note. SWAI-T = Supervisory Working Alliance Inventory – Trainee Version; EBSS = Experiences of Black Supervisors Scale (adapted); TSC-40 = Trauma Symptom Checklist – 40.

The most frequent microaggressions that participants endorsed related to *denial*, *stereotyping*, and *distrust*. A total of 42 participants endorsed a "1" or "2" with the item, "My supervisor sometimes denied or minimized having racial or cultural biases or stereotypes." A total of 43 participants endorsed a "1" or "2" on the item, "My supervisor sometimes seemed to have unconscious racial or cultural stereotypes about me." A total of 40 participants endorsed a "1" or "2" on the item, "My supervisor sometimes minimized the importance of racial or cultural issues in our supervision meetings." A total of 43 participants indicated a "1" or "2" on the item, "In general, I felt some distrust of my supervisor due to his or her cultural biases or insensitivities."

Participants indicated that the most intense and troublesome microaggressions, as evidenced by a rating of "2," dealt with *insensitivity*, *denial*, *stereotyping* and *distrust*. Thirty-one participants endorsed a "2" on "At times, my supervisor was insensitive about racial or cultural background(s)." Thirty-one participants endorsed a "2" on the item, "My supervisor sometimes denied or minimized having racial or cultural biases or stereotypes." Thirty-four participants endorsed a "2" on the item, "My supervisor sometimes seemed to have unconscious racial or cultural stereotypes about me." Thirty-six participants endorsed a "2" for the item, "In general, I felt some distrust of my supervisor due to his or her cultural biases or insensitivities."

It was less frequent for participants to endorse the item, "At times my supervisor communicated that I was overly sensitive about racial or cultural issues." Thirty-four participants responded with a "0" indicating this did not happen to them in supervision. It was also rare that participants endorsed the item, "My supervisor sometimes seemed

hesitant to give me feedback about my work as a counselor, possibly for fear of being seen as racist." Forty-one participants responded with a "0" with this item as well.

Participants endorsed certain traumatic items frequently. The following items received a rating of "1," "2," or "3" from participants: feeling tense all the time (n = 37), spacing out (n = 36), sadness (n = 33), loneliness (n = 35), feeling isolated from others (n = 37), and headaches (n = 33). The most intense endorsements in the form of a "3" were for the following items: feeling isolated from others (n = 19), loneliness (n = 10), sadness (n = 12), not feeling rested in the morning (n = 10), feelings of inferiority (n =10), and feeling tense all the time (n = 12).

Certain traumatic items were not frequently endorsed by participants. The following items were most likely to receive a "0" from participants: desire to physically hurt self (n = 41), weight loss (n = 41), sexual problems (n = 45), sexual overactivity (n = 48); fear of men (n = 45), fear of women (n = 46), passing out (n = 47), unnecessary or overfrequent handwashing (n = 47), confused about sexual feelings (n = 47), and sexual feelings when you shouldn't have them (n = 45).

Several analyses were conducted including correlation and regression analysis. The EBSS (adapted) measures one construct and yields a full-scale score. Both the TSC-40 and the SWAI-T have subscale scores as well as full-scale scores. Therefore, full-scale scores were analyzed first.

Bivariate correlations demonstrated significant relationships among all three of this study's variables (see Table 2). The SWAI-T full-scale scores had a moderate negative correlation with the EBSS (adapted) full-scale scores ($r = -.637$, $p < .01$) with n = 53 and a moderate negative correlation with the TSC-40 full-scale scores ($r = -.372$, $p <$

.01) with n = 50. These results suggest that the more experiences of both microaggressions in supervision and experiences of trauma, the worse supervisees rated the supervisory working alliance. In addition, the EBSS (adapted) full-scale scores had a moderate positive correlation with the TSC-40 full-scale scores ($r = .513$, $p < .01$) with n = 50. This relationship indicates that the more participants experienced racial microaggressions in supervision, the more they experienced traumatic symptoms as well. Thus all three hypotheses for the first research question were confirmed.

Table 2

Correlations between Microaggressions, Trauma, and the Supervisory Alliance

Instrument	SWAI-T	EBSS (adapted)	TSC-40
SWAI-T	1		
EBSS (adapted)	-.637**	1	
TSC-40	-.372**	.513**	1

Note. Abbreviations: SWAI-T = Supervisor Working Alliance Inventory – Trainee Version; EBSS = Experiences of Black Supervisors Scale (adapted); TSC-40 = Trauma Symptom Checklist – 40.
** $p < .01$.

The second research question aimed to understand what factors predict ratings on the supervisory working alliance. Regression analysis was used to analyze the data. Full-scale scores of microaggressions (the adapted EBSS) were used as a predictor and full-scale scores of the supervisory alliance (the SWAI-T) were used as the dependent variable. The total number cases used included the following numbers of full-scale scores: SWAI-T n = 53, EBSS (adapted) n = 54, TSC-40 n = 50. This model found that 40.6% of the variation in the alliance can be explained by microaggressions in

supervision F (1, 48) = 32.752, $p < .01$ with an R^2 of .406. Furthermore, both microaggressions in supervision and experiences of trauma (related to that supervision) significantly predicted the ratings of the supervisory alliance. Thus, both hypotheses for the second research question were confirmed.

A hierarchical multiple regression analysis was utilized to determine if both microaggressions and trauma are more predictive of the supervisory alliance than either variable alone. The total number cases used included the following numbers of full-scale scores: SWAI-T n = 53, EBSS (adapted) n = 54, TSC-40 n = 50. This model was not significant F (2, 47) = 16.216, $p < .05$ with an R^2 of .408 and ΔR^2 of .003. Thus, trauma does not seem to add to the predictive capacity of the supervisory alliance in addition to what the presence of microaggressions already predicts. Therefore, results indicate that the presence of racial microaggressions is the only significant predictor of the supervisory alliance; the hypothesis for the third research question was not confirmed.

Because microaggressions significantly predicted the supervisory alliance, analysis proceeded by examining the correlations of the subscales of the SWAI-T (see Table 3). The EBSS (adapted) full-scale scores had a moderate negative correlation with both the SWAI-T Rapport subscale scores (r = -.627, $p < .01$) with n = 53 and the SWAI-T Client Focus subscale scores (r = -.577, $p < .01$) with n = 53. These relationships suggest that the more participants reported microaggressions, the lower they rated their supervisor in both Rapport and Client Focus, both of which relate to a poorer supervisory working alliance.

Table 3

Correlations between Microaggressions and Supervisory Alliance Subscales

Instrument	EBSS (adapted)	SWAI-T (Rapport Subscale)	SWAI-T (Client Focus Subscale)
EBSS (adapted)	1		
SWAI-T (Rapport Subscale)	-.627**	1	
SWAI-T (Client Focus Subscale)	-.577**	.813**	1

Note. EBSS = Experiences of Black Supervisors Scale (adapted); SWAI-T = Supervisor Working Alliance Inventory – Trainee Version.
** $p < .01$.

Discussion

This study examined the relationships among racial microaggressions, traumatic experiences, and the supervisory working alliance. Consistent with previous empirical and theoretical literature (Barnes, 2011; Constantine & Sue, 2007; Helms et al., 2012; Sue 2010; Sue et al., 2007), all three variables (as measured by instrument full-scale scores) significantly correlated with one another, which completely supported the first hypothesis. Higher reports of microaggressions were linked to a poorer supervisory alliance. Higher reports of microaggressions in supervision were linked to higher reports of trauma. Higher reports of trauma were linked to a poorer supervisory alliance. In sum, when participants reported more microaggressions in supervision, they also reported more traumatic experiences and a poorer supervisory working alliance.

This study also explored prediction among the three main variables. Analyses found that racial microaggressions in supervision accounted for approximately 41% of the variation in the supervisory working alliance. This is consistent with existing literature regarding microaggressions and interpersonal relationships including supervision (Barnes, 2011; Constantine & Sue, 2007; Sue 2010; Sue et al., 2007). Thus, results supported the second hypothesis as well. Furthermore, the most frequent and most intense responses dealt with issues of *insensitivity*, *stereotyping*, and *denial*. These types of microaggressions are consistent with the classifications of racial microinsults and racial microinvalidations according to the Sue et al. (2007) and Sue (2010) taxonomy.

In addition, results indicated that although microaggressions and trauma both significantly impacted the supervisory alliance, the combination of both together was not significant. Adding the trauma scores to the model did not increase the predictive capacity of the model beyond the inclusion of microaggressions scores alone. This was not expected based on the existing conceptual literature (Briere & Scott, 2006; Bryant-Davis & Ocampo, 2005; Carter, 2007; Helms et al., 2012). Therefore, results did not support the third hypothesis.

Because microaggressions scores significantly predicted supervisory working alliance scores, the researchers analyzed the EBSS (adapted) full-scale scores and the SWAI-T subscale scores. Results indicated that the presence of microaggressions predicts both the Client Focus subscale scores and Rapport subscale scores. This suggests that microaggressions in supervision negatively impact the supervisory alliance in terms of the relationship and in terms of client care.

Given that no quantitative studies have explored racial microaggressions in supervision from a supervisee perspective, these findings contribute meaningfully to the research bases related to both microaggressions and supervision. In addition, no studies have investigated the links with trauma and racial microaggressions in supervision. Since this study demonstrates significant correlations among racial microaggressions, trauma, and the supervisory working alliance, it also furthers the research bases in these areas as well. Furthermore, this study provides quantitative evidence that microaggressions negatively impact the supervisory alliance.

The most frequent microaggressions participants endorsed related to *denial*, *stereotyping*, and *distrust*. One item exemplifies the issue of *denial*: "My supervisor sometimes minimized the importance of racial or cultural issues in our supervision meetings." When supervisors minimize the importance of race or culture, they send the message that those aspects of life are not worthy of attention. It implies that the lived reality of people who are marginalized by race does not matter. This type of microaggression is classified a microinvalidation as defined by Sue et al. (2007). Furthermore, it is consistent with the findings of Constantine and Sue (2007), who found similar results. This can be highly destructive to the supervisory working alliance because supervisees may feel personally undermined. In addition, supervisees may not receive proper and culturally-relevant guidance from their supervisors if the supervisor minimizes the impact of race and culture on clients. Thus, this kind of microaggression harms not only the supervisee but also the supervisee's clients.

Regarding the frequent endorsement of items related to *stereotyping*, there are two aspects to explore. One aspect relates to the item, "My supervisor sometimes seemed to

have unconscious racial or cultural stereotypes about me." This is classified as a microinsult according to the Sue et al. (2007) rubric. By having and communicating racial or cultural stereotypes, supervisors can mar the supervisory alliance by unwittingly being disrespectful and demeaning to the supervisee. This is also analogous to the work of Constantine and Sue (2007). The other aspect included in the *stereotyping* area relates to the item, "My supervisor sometimes denied or minimized having racial or cultural biases or stereotypes." Although stereotypes themselves can be considered microinsults, the denial of bias actually makes this item a microinvalidation according to Sue et al. (2007). Again, when supervisors deny their role in oppressive systems and when they fail to take ownership of their privileges, they deny the racial realities of people who experience marginalization. This communicates that supervisee experiences and client experiences are not real and do not matter. It is highly destructive to supervision when a supervisor invalidates a supervisee's lived experience and it makes sense that it would damage rapport and the supervisory alliance. Again, these results are consistent with the findings of Sue and Constantine (2007).

Finally, and perhaps most blatantly, the issue of *distrust* warrants examination. The frequently-endorsed item, "In general, I felt some distrust of my supervisor due to his or her cultural biases or insensitivities" exemplifies this concern. This directly relates to the supervisory alliance in that this professional, fiduciary relationship is built upon trust. When supervisees feel skeptical, guarded, or wary because of what their supervisor is saying, doing, or conveying, this is highly detrimental to the supervisory alliance. Similar to the results of the Constantine and Sue (2007) investigation, when supervisees feel distrustful of their supervisors, this damages supervisory alliances.

It should be noted that data were missing for some of the participants. There are many reasons why this might have occurred. For example, some participants completed the demographic information but did not complete the three additional measures. It is possible that these participants may not have understood the nature of the survey. Furthermore, it is possible that some participants may not have fully understood what was meant by the term *microaggression* and found that once they began the survey that they could not continue because the items did not apply to them. In fact, this potential issue of participants' lack understanding of what a microaggression is may have contributed to this study's small number of participants, a limitation that will be discussed in the next section. Another explanation of the missing data could be that some participants felt uncomfortable disclosing sensitive information about their supervision histories, their experiences with microaggressions, or their trauma symptoms. It could be that this information was too uncomfortable or perhaps they feared that their supervisors would somehow obtain this information. That could be very threatening since supervisors hold power over their supervisees.

The participant pool had many notable characteristics including the racial, ethnic, and cultural composition of the respondents. Approximately 21% of participants self-identified as European American / White American. It could be that some of these individuals had a multiple heritage ancestry, but only 3.5% of the participants identified as Multiracial American and only one participant identified as "Multiple Heritage" through the write-in option. Two of the other write-in responses (i.e., "Russian American," and "American of Polish Descent") also included answers that could potentially be included in the European American / White American group. This suggests

that, for these individuals, their country of origin holds much salience, despite their potential to be classified as White. It is also possible that these individuals may have been recent immigrants as well and their acculturation processes may have played a role in their participation. This information is notable because according to current conceptualizations of microaggressions (Sue, 2010; Sue et al., 2007; Nadal, 2011; Torres-Harding, 2012), people of European ancestry or those who identify as White are not targets of racial microaggressions. Indeed, these issues exemplify some of the many challenges encountered when exploring and understanding the social construct of race.

Implications

Because microaggressions predicted poorer supervisory alliance ratings, it is clear that more prevention, education, and research are needed in this area. Examples include actions taken by training institutions (e.g., universities) and professional organizations (e.g., American Counseling Association, Association for Counselor Education and Supervision, National Board for Certified Counselors) in order to improve training regarding microaggressions in supervision. This could be in the form of curriculum and syllabus changes, availability of continuing education seminars, and changes to current professional preparation standards. The more that professional counselors and counselor educators can access and integrate meaningful information about microaggressions in supervision, the more they will be exposed to ideas that will facilitate changes in their awareness, knowledge, and skills. The goal is for counselor educators and supervisors to activate discussions about microaggressions with their supervisees and openly address such issues if they arise.

This study also confirms for those who are the targets of racial microaggressions in supervision that they are not alone. This is a common phenomenon that occurs across age, geography, and training background. It is imperative that individuals who are targeted know that there are resources available to them in the form of instrumental and emotional support. Thus, it is important that those working with supervisees provide access to resources for their supervisees including support networks and opportunities to redress concerns safely.

Approximately two-thirds of the participants' supervisors were European American or White American, after accounting for missing answers. This suggests that prevention, education, and remediation efforts around the experiences of racial microaggressions in supervision need to target these individuals and/or be tailored to suit these individuals. Likewise, participants indicated that most of their supervisors were not novice supervisors as they had been providing supervision for many years. This may reflect the increasing attention to multicultural competence and training that has occurred over time during the last decades. It is possible that newer generations of supervisors are somewhat more multiculturally competent than those trained in earlier generations. If this is true, then counselor preparation programs need to continue not only to maintain current levels of culturally-relevant training, but also to strive to improve it even further.

Limitations and Future Directions

The findings of this investigation provide useful insights into the experiences of supervisees who have experienced racial, ethnic, and cultural microaggressions in supervision. As with any study, there were several limitations that warrant further exploration. This study's limitations include the self-report nature of answers,

generalizability, and sample size. It is possible that participants under or over reported the number of answers or the intensity of their answers. In addition, the sample size was relatively small, but post-hoc analyses revealed that the sample size was adequate and could be interpreted with caution. The highly specific nature of the inclusion criteria made obtaining a large sample size challenging. Finally, it was difficult to control for additional or external traumatic factors that were outside of the traumatic experiences reported as a result of the supervisory relationship.

Future studies could examine microaggressions that target international supervisees or supervisees who are practicing in the US but are not citizens. These perspectives could be valuable in understanding the breadth and depth of microaggressions from other unique positionalities. In addition, future investigations could examine the perspectives of supervisees with other marginalized sociocultural identities that could make them targets for microaggressions (e.g., gender, gender identity, sexual identity, socioeconomic status, age, ability status, etc.). Future studies of various research designs could continue to explore and validate the taxonomy of microaggressions outlined by Sue et al. (2007) and Sue (2010). In addition, these efforts could examine the features of the various forms of microaggressions (i.e., microassaults, microinsults, microinvalidations) in diverse populations.

Additionally, in this study there was no way to compare participant responses with the responses their supervisor may have offered regarding their supervisory relationship. One of the fascinating aspects of microaggressions is their often covert nature. It is possible that many if not most or all of the supervisors who were identified in this study were unaware of their behaviors. Another idea would be to examine the

supervisory relationships that had processed the aftereffects of the microaggression occurring versus those relationships that had not processed the aftereffects.

Conclusion

Given the findings of this study, it remains imperative for professional counselors, counselor educators, and supervisors to incorporate information and dialogues about microaggressions into counselor preparation. This includes not only developing competencies in existing supervisors, but also developing competencies in future generations of counselors, as they are the future of supervision. Because the counseling profession is rooted in wellness, it is especially imperative that the profession recognizes, addresses, and prevents microaggressions from occurring. When microaggressions do occur, it is just as important for counseling professionals to know how to deal with them effectively, as supervisors and as supervisees. When supervisors foster validating and salubrious supervisory relationships, counseling supervisees have the opportunity to provide counseling services from a base of security and safety. This, in turn, allows professional counselors to serve their clients and communities with vitality.

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APPENDIX

Demographics Form

(Adapted, with permission, from Dispenza, 2010 and Gnilka, 2013)

1. Age in years: _____
2. Please identify your biological sex assigned at birth:
    a. Female
    b. Male
3. Do you identify as transgender?
    a. Yes
    b. No
4. Please identify your racial, ethnic, and/or cultural identity:
    a. African American / Black American
    b. Asian or Pacific Islander American
    c. Biracial American
    d. European American / White American
    e. Jewish American
    f. Latino/a or Hispanic American
    g. Middle Eastern American
    h. Multiracial American
    i. Other? Please identify: _____
5. Please identify the racial, ethnic, or cultural identity that you believe others assume you to be.
    a. African American / Black American

b. Asian or Pacific Islander American

c. Biracial American

d. European American / White American

e. Jewish American

f. Latino/a or Hispanic American

g. Middle Eastern American

h. Multiracial American

i. Other? Please identify: _____

6. Please identify your sexual orientation (identity):

a. Bisexual

b. Gay

c. Heterosexual

d. Lesbian

e. Queer

f. Other? Please identify: _____

7. Is English the primary language you use for reading, speaking, writing and/or communicating?

a. Yes

b. No

8. Please identify your relationship or marital status:

a. Civil Union

b. Divorced

c. Domestic Partnership

d. Married

e. Single

f. Unmarried and living in the same household

g. Widowed

9. Please indicate your religious, spiritual, or other belief identification:

a. Agnostic

b. Atheist

c. Buddhist

d. Christian

e. Hindu

f. Jewish

g. Muslim

h. Other? Please specify: _____

10. For the past six months, please select the kind of community where you live:

a. Urban / Metropolitan / City location

b. Suburban location outside of a Metropolitan location

c. Town or village location

d. Rural location

11. For the past six months, please indicate in which area of the US you live:

a. Northeast

b. South

c. Midwest

d. Rocky Mountains

e. West Coast

f. Alaska / Hawai'i

12. Do you have a chronic health condition?

    a. Yes

    b. No

13. Do you have a disability (e.g., hearing, seeing, moving, medical, psychological, learning)?

    a. Yes

    b. No

14. If you do have a disability, do you experience limitations in functioning (e.g., your ability to do work, your ability to get cleaned and dressed)?

    a. Yes

    b. No

    c. Not applicable

15. Please select one of the following regarding Practicum/Internship:

    a. Currently enrolled

    b. Finished

16. Please indicate the highest degree, of any kind, that you have attained:

    a. Bachelors

    b. Masters

    c. Specialist

    d. Doctorate

17. Please indicate the highest counseling degree that you currently hold:

a. Bachelors
b. Masters
c. Specialist
d. Doctorate

18. If you are currently a student, in what type of program are you currently enrolled? If you are not enrolled, please select "Not currently enrolled."
    a. Addiction Counseling
    b. Career Counseling
    c. Clinical Mental Health Counseling
    d. College Counseling
    e. Community Counseling
    f. Counselor Education
    g. Gerontological Counseling
    h. Marriage and Family Counseling
    i. Student Affairs
    j. School Counseling
    k. Not currently enrolled
    l. Other? Please specify: _____

When completing the rest of this survey, consider only one supervisor with whom you experienced racial/cultural microaggressions in your supervisory relationship. For the purposes of this study, if you experienced racial/cultural microaggressions with more

than one supervisor, please only consider the one supervisor where the microaggressions were the worst for you as you answer the remaining questions.

19. What type of supervisor was this person?
    a. Site supervisor
    b. University supervisor
    c. Community supervisor (independent of Practicum/Internship)
    d. Other? Please specify: _____
20. Did you have any choice or control over being paired with this supervisor?
    a. Yes
    b. No
21. How much supervision did you already have before you worked with this particular supervisor? Please indicate years and months (e.g., two years and six months). If this was your first supervisor, please indicate "zero." _____
22. How many sessions have you had (or did you have) with this particular supervisor? ___
23. What kind of supervision did you have with this particular supervisor?
    a. Individual (including triadic)
    b. Group
    c. Both individual and group
24. In what setting were you interning or working when you were the supervisee of this supervisor?
    a. Community mental health agency
    b. Faith-based agency

c. Hospital or medical setting

d. Private practice

e. School (elementary and secondary)

f. University counseling center

g. University other (e.g., supervision of supervision)

h. Other? Please specify: _____

25. To the best of your knowledge, what was the racial, ethnic, and/or cultural identity of this supervisor?

a. African American / Black American

b. Asian or Pacific Islander American

c. Biracial American

d. European American / White American

e. Jewish American

f. Latino/a or Hispanic American

g. Middle Eastern American

h. Multiracial American

i. I don't know

j. Other? Please identify: _____

26. To the best of your knowledge, what was the professional identity of this supervisor?

a. Faith Leader (e.g., religious studies, divinity, theology)

b. Physician

c. Professional Counselor

d. Psychiatrist

e. Psychologist

f. Social Worker

g. I don't know

h. Other? Please identify: _____

27. To the best of your knowledge, what degree level did this supervisor hold during your supervision?

a. Masters

b. Specialist

c. Doctorate

d. I don't know

e. Other? Please identify: _____

28. To the best of your knowledge, and only if this supervisor was a professional counselor, what was this supervisor's area of specialty? If this supervisor was not a professional counselor, please select "Not a professional counselor."

a. Addiction Counseling

b. Career Counseling

c. Clinical Mental Health Counseling

d. College Counseling

e. Community Counseling

f. Counselor Education

g. Gerontological Counseling

h. Marriage and Family Counseling

i. School Counseling

j. Student Affairs Counseling

k. Not a professional counselor

l. I don't know

m. Other? Please specify: _____

29. To the best of your knowledge, how many years of experience providing supervision did this supervisor have prior to your supervisory relationship?

a. Less than 12 months

b. 1-2 years

c. 3-4 years

d. 5-7 years

e. 8-10 years

f. 11-15 years

g. 16-20 years

h. 21 or more years

i. I don't know