Multicultural Competence, White Privilege Attitudes and the Working Alliance in Clinical Supervision

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MULTICULTURAL COMPETENCE, WHITE PRIVILEGE ATTITUDES
AND THE WORKING ALLIANCE IN CLINICAL SUPERVISION

by

Michelle A. Stahl

A dissertation submitted to the Graduate College
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MULTICULTURAL COMPETENCE, WHITE PRIVILEGE ATTITUDES AND THE WORKING ALLIANCE IN CLINICAL SUPERVISION

Michelle A. Stahl, Ph.D.
Western Michigan University, 2020

Research indicates that White supervisors have difficulty facilitating and integrating multicultural issues in supervision (Fong & Lease, 1997; Hird, Tao, & Gloria, 2004). A factor that interferes with a multicultural focus in supervision is the multicultural competence of the supervisor (Miville, Rosa, & Constantine, 2005). Moreover, as a result of White privilege, White supervisors may also be less aware of their cultural selves and subsequently less inclined to discuss multicultural issues in supervision (Hird et al., 2004). Lack of attention to important multicultural issues, such as White privilege, can interfere with the development of an effective supervisory alliance (Constantine & Sue, 2007; Crockett & Hays, 2015; Hays & Chang, 2003). Despite the theoretical impact of White privilege on the supervision process and outcomes, there is a paucity of literature on this topic. Therefore, the purpose of the present study was to examine the nature of the relationship between supervisor multicultural competence, White privilege attitudes, and the supervisory working alliance within the context of clinical supervision.

Participants were recruited from e-mail listservs and graduate programs in counselor education and counseling psychology. A total of 38 White clinical supervisors participated. Data were collected using online password protected survey software. The survey contained a demographic questionnaire and measures of multicultural competence, White privilege attitudes,
and the supervisory working alliance. Primary analyses were simultaneous and hierarchical regressions.

Findings indicate that White privilege awareness is positively associated with supervisor multicultural competence. Other findings revealed a significant positive relationship between multicultural competence and supervisors’ perceptions of the supervisory working alliance. Overall, findings support limited available research indicating a positive relationship between supervisor multicultural competence and the supervisory working alliance (e.g., Crockett & Hays, 2015; Inman, 2006). Findings also provide support for the commonly held assumption that White privilege awareness is associated with the development of multicultural competence (Imig, 2018; Mindrup, Spray, & Lamberghini-West, 2011). Limitations of the study are discussed and implications for future research and practice are recommended. Results of this investigation can be used to inform supervision practices related to multicultural issues and to enhance supervision outcomes.
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CHAPTER I
INTRODUCTION

Over the next 50 years, the population of the United States is expected to become increasingly more diverse. Moreover, it is predicted that this diversity will be reflected in individuals served by mental health professionals as well (American Psychological Association [APA], 2017; Estrada, Frame, & Williams, 2004; Sue, Sue, Neville, & Smith, 2019). In accordance with the changing demographics of the country, there has been an increased emphasis on incorporating multicultural skill development into mental health training programs (APA, 2017; Pederson, 1990; Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2016; Sue et al., 2019). In addition, numerous professional associations, such as the American Counseling Association (ACA), American Psychological Association, and National Association of Social Workers (NASW) have issued calls to increase the multicultural competence of all mental health professionals, arguing that it is an ethical imperative for counselor skill development, research, and practice to be grounded in cultural sensitivity (APA 2017; NASW, 2015; Ratts et al., 2016).

Clinical Supervision

Clinical supervision is a central aspect of counselor training that can be used to provide further training and development of multicultural counseling skills to mental health professionals (APA, 2015; Bernard & Goodyear, 2018; Constantine, 2001; Soheilian, Inman, Klinger, Isenberg, & Kulp, 2014; Tummala-Nara, 2004). During supervision, knowledge, wisdom, experiences, and insight are passed from one professional generation to the next (Bernard & Goodyear, 2018; Neufeldt, 2007; Tohidian & Quek, 2017). Supervisors are ultimately
responsible for ensuring that multicultural issues are raised and discussed in supervision given their position of power and the implications for counselor training and client service delivery (Ancis & Marshall, 2010; Bernard & Goodyear, 2018; Estrada et al., 2004; Hird, Cavalieri, Dulko, Felice, & Ho, 2001; Hird, Tao, and Gloria, 2004; Taylor, Hernández, Deri, Rankin, & Siegel, 2006). However, supervisors continue to face challenges when addressing, facilitating, and integrating dialogues about multicultural issues into their supervision practices (Burkard et al., 2006; Constantine & Sue, 2007; Tohidian & Quek, 2017).

A lack of attention to culturally relevant issues in supervision may negatively affect the supervision process and outcomes (Burkard et al., 2006; Dressel, Consoli, Kim, & Atkinson, 2007; Hays & Chang, 2003; Hird et al., 2004; Phillips, Parent, Dozier, & Jackson, 2017; Soheilian et al., 2014; Tohidian & Quek, 2017). Several studies highlight the low frequency with which discussions about cultural variables occur during supervision, despite previous research findings that stress the importance of supervisors initiating these discussions (e.g., Constantine, 1997; Gatmon et al., 2001; Gloria, Hird, & Tao, 2008; Imig, 2018). There is also a growing body of research evidence suggesting that supervisors report more efforts to initiate discussions about cultural considerations than supervisees perceive (e.g., Duan & Roehlke, 2001; Green & Dekkers, 2010). Barriers to effective multicultural supervision practice include the belief that cultural issues are unimportant, worry about making mistakes in front of supervisees, fear of being perceived as racist, or feeling inadequately trained (Constantine & Sue, 2007; Hird et al., 2004).

**Supervisor Multicultural Competence and White Privilege**

A factor that interferes with a multicultural focus in supervision is the competence of the supervisor (Miville, Rosa, & Constantine, 2005). Supervisor multicultural competence is
defined as a supervisor’s awareness, knowledge, and skills with regard to working with culturally diverse supervisees and their clients (Crockett & Hays, 2015). The multicultural competence of clinical supervisors may not be as advanced as that of their supervisees (Constantine, 2001; D’Andrea & Daniels, 1997; Miville et al., 2005). This dynamic is problematic because the effectiveness of multicultural supervision is ultimately influenced by what supervisors do and do not do in supervision (Miville et al., 2005). Furthermore, the supervisor’s multicultural competence and openness dictate whether the supervisee’s experience will be positive (Bernard & Goodyear, 2018). Ancis and Ladany (2010) posited that it is likely that supervisors believe they are more multiculturally competent than they actually are.

White supervisors have been shown to have the most difficulty with facilitating and integrating conversations about multicultural issues in supervision (Fong & Lease, 1997; Hird et al., 2004). There is some evidence suggesting that White supervisors report less multicultural supervision competence and spend less time talking about cultural issues in supervision than racial/ethnic minority supervisors (Gloria et al., 2008; Hird et al., 2004). Furthermore, because of White privilege, White supervisors may be less aware of their cultural selves and subsequently less likely to discuss multicultural issues in supervision (Hird et al., 2004). The invisibility of White privilege permeates the systems within which counseling and psychotherapy training must function (Bartoli, Bentley-Edwards, Garcia, Michael, & Ervin, 2015). Unexamined White privilege can result in the acceptance of mainstream White culture as the standard for evaluating behaviors and a disregard for the experience of individuals from racial/ethnic minority backgrounds (Fong & Lease, 1997). These behaviors contribute to mistrust in the supervisory relationship (Constantine & Sue, 2007).
Supervisory Working Alliance

The supervisory working alliance has emerged as an essential component of effective supervision and there is a growing body of research evidence suggesting that processing multicultural issues in supervision is related to an effective supervisory working alliance (Bernard & Goodyear, 2018; Crockett & Hays 2015; Falender & Shafranske, 2004, 2017; Phillips et al., 2017; Tohidian & Quek, 2017; Watkins, 2014b). There must be a reasonably positive working alliance between the supervisor and supervisee for any supervisory intervention to be effective (Ancis & Ladany, 2010; Toporek, Ortega-Villalobos, & Pope-Davis, 2004; Watkins, 2014b). The supervisory working alliance does not instantaneously occur; rather, it is a co-construction that is built through sustained interaction and developed over time (Watkins, 2014b). When supervisors react to cultural issues in a responsive manner, a more positive working alliance develops and the supervisory relationship can be strengthened (Schroeder, Andrews, & Hindes, 2009). In contrast, a lack of attention to important racial and multicultural dynamics can block or interfere with the development of a positive supervisory alliance (Burkard et al., 2006; Hays & Chang, 2003).

Problem Statement

Little empirical research to date has examined the multicultural experiences, practices, and competence of supervisors in general, and White supervisors in particular (Gloria et al., 2008; Imig, 2018). Furthermore, despite the theoretical impact of White privilege on the supervision process, there is a dearth of literature on this topic and most of the extant literature has been conceptual in nature (e.g., Fong & Lease, 1997; Hays & Chang, 2003). While many authors have written about how White privilege may affect the supervision process (e.g., Fong & Lease, 1997; Hays & Chang, 2003; Nilsson & Duan, 2007), these claims have not been
empirically tested. In fact, there are a limited number of empirical studies that examine White privilege within the context of clinical supervision. Furthermore, there are a lack of studies that have explored the nature of the relationship between supervisor multicultural competence, White privilege attitudes, and the supervisory working alliance. There is a clear need for additional research in this area.

**Statement of Purpose**

The present study examined the nature of the relationship between supervisor multicultural competence, White privilege attitudes, and the supervisory working alliance within the context of clinical supervision. This study was guided by Sue, Arredondo, and McDavis’s (1992) seminal framework on multicultural competence. The purpose of this study was threefold. First, this study examined the relationship between supervisor multicultural competence and White privilege attitudes. Second, because most clinical supervisors are White (Association for Counselor Education and Supervision, 2016; Fong & Lease, 1997; Green & Dekkers, 2010), a related purpose of this study was to contribute to the dearth of literature on the impact of supervisor White privilege attitudes on the supervision process. Finally, this study explored the nature of the relationship between supervisor multicultural competence and White privilege attitudes on supervisors’ perceptions of the supervisory working alliance.

**Research Questions**

This study will address the following research questions:

1. What is the nature of the relationship between the multicultural competence and White privilege attitudes of clinical supervisors?

2. How will the White privilege attitudes of clinical supervisors relate to their perception of the supervisory working alliance?
3. What is the nature of the relationship between the multicultural competence and White privilege attitudes of clinical supervisors and their perception of the supervisory working alliance?

**Hypotheses**

The following research hypotheses will be tested:

*Hypothesis 1a:* Supervisors with high multicultural competence will be more aware of White privilege than supervisors with low multicultural competence.

*Hypothesis 1b:* Supervisors with high multicultural competence will be more willing to confront White privilege than supervisors with low multicultural competence.

*Hypothesis 1c:* Supervisors with high multicultural competence will be more remorseful about White privilege than supervisors with low multicultural competence.

*Hypothesis 1d:* Supervisors with high multicultural competence will be less concerned about the anticipated costs of addressing White privilege than supervisors with low multicultural competence.

*Hypothesis 2a:* Supervisors with high White privilege awareness, high White privilege remorse, high willingness to confront White privilege, and low anticipated costs of addressing White privilege will make a greater effort to facilitate supervisees’ understanding of clients than supervisors with low White privilege awareness, low White privilege remorse, low willingness to confront White privilege, and high anticipated costs of addressing White privilege.

*Hypothesis 2b:* Supervisors with high White privilege awareness, high White privilege remorse, high willingness to confront White privilege, and low anticipated costs of addressing White privilege will make a greater effort to build a positive supervisory
working alliance with supervisees than supervisors with low White privilege awareness, low White privilege remorse, low willingness to confront White privilege, and high anticipated costs of addressing White privilege.

Hypothesis 2c: Supervisors with high White privilege awareness, high White privilege remorse, high willingness to confront White privilege, and low anticipated costs of addressing White privilege will have a greater perception of supervisees’ identification with the supervisor than supervisors with low White privilege awareness, low White privilege remorse, low willingness to confront White privilege, and high anticipated costs of addressing White privilege.

Hypothesis 3a: Above and beyond supervisor multicultural competence, White privilege attitudes will have an influence on supervisors’ efforts to facilitate supervisees’ understanding of clients.

Hypothesis 3b: Above and beyond supervisor multicultural competence, White privilege attitudes will have an influence on supervisors’ efforts to build a positive supervisory working alliance with supervisees.

Hypothesis 3c: Above and beyond supervisor multicultural competence, White privilege attitudes will have an influence on supervisees’ identification with the supervisor.

**Definition of Terms**

This section provides definitions for specific terms used in this paper. Although the terms are defined throughout the paper, they are organized in this section for simplicity.

- **Clinical supervision**: “An intervention provided by a more senior member of a profession to a more junior colleague or colleagues who typically (but not always) are members of that same profession. This relationship is evaluative and hierarchical,
extends over time, and has the simultaneous purposes of enhancing the professional functioning of the more junior person(s); monitoring the quality of professional services offered to the clients that she, he, or they see; and serving as a gatekeeper for the particular profession the supervisee seeks to enter” (Bernard & Goodyear, 2018, p. 9).

− **Multicultural competence:** Beliefs and attitudes, knowledge, and skills with regard to working with culturally diverse clients (Sue et al., 1992).

− **Multicultural supervision competence:** A supervisor’s awareness, knowledge, and skills with regard to working with culturally diverse supervisees and clients (Crockett & Hays, 2015).

− **Supervisory working alliance:** The extent to which the supervisor and supervisee agree on goals, the extent to which they agree on tasks necessary to reach those goals, and the affective bond that develops between them (Bordin, 1983).

− **White privilege:** “An expression of power arising from receipt of benefits, rights, and immunities and is characterized by unearned advantages and a sense of entitlement that results in both societal and material dominance by Whites over people of color. These unearned advantages are invisible and often unacknowledged by those who benefit.” (Neville, Worthington, & Spanierman, 2001, p. 262).

− **White privilege attitudes:** Strong affective, cognitive, and behavioral reactions that result from awareness of White privilege (Pinterits, Poteat, & Spanierman, 2009).

**Summary**

This chapter began with a brief overview of the historical background for this research and was followed by a statement of the problem, description of the study, specific research
questions to be answered, and research hypotheses. The remainder of the dissertation will be organized in the following manner: Chapter II reviews the extant related literature on the nature of the relationship between multicultural competence, White privilege attitudes, and the supervisory working alliance within the context of clinical supervision. Chapter III describes the method and procedures used to conduct the study. Chapter IV presents the findings of the study. Finally, Chapter V includes a summary of the study and discussion of the findings. Limitations of the study, implications for practice, and recommendations for future research are also discussed.
CHAPTER II

REVIEW OF RELATED LITERATURE

In this review of related literature, the nature of the relationship between multicultural competence, White privilege attitudes, and the supervisory working alliance will be examined within the context of clinical supervision. The review will begin with an overview of clinical supervision, including a discussion of core supervisory behaviors and best practices. Next, the definitions of multicultural competence and multicultural supervision competence are provided. These constructs serve as the theoretical underpinnings for the study. Then, best practices in multicultural supervision will be identified, followed by barriers to effective multicultural supervision practices. Because White supervisors have been shown to have the most difficulty with facilitating and integrating conversations about multicultural issues in supervision (Fong & Lease, 1997; Hird et al., 2004), specific challenges for White supervisors will be identified. Next, the definition of White privilege will be provided, followed by a discussion of the theoretical impact of White privilege on supervisory processes and outcomes. Finally, the importance of the supervisory working alliance will be highlighted, followed by an overview of the demonstrated relationship between effective multicultural supervision practices and the supervisory working alliance. The review of related literature will end with a brief summary of this section.

Clinical Supervision

Clinical supervision is the “signature pedagogy of the mental health professions” (Bernard & Goodyear, 2018, p. 2) and a mandatory component of all mental health training
programs (Bernard & Goodyear, 2018; Falender & Shafranske, 2017; Neufeldt, 2007). Clinical supervision has two central purposes: (a) to ensure client welfare and (b) to promote the personal and professional growth and development of supervisees (APA, 2015; Bernard & Goodyear, 2018). Clinical supervision is a distinct professional competency that requires formal education and training (APA, 2015) and is essential for monitoring, improving, and advancing mental health professions (Bernard & Goodyear, 2018; Overholser, 2004). During supervision, knowledge, wisdom, experiences, and insight are passed from one professional generation to the next (Bernard & Goodyear, 2018; Neufeldt, 2007; Tohidian & Quek, 2017). The definition of clinical supervision is as follows:

- an intervention provided by a more senior member of a profession to a more junior colleague or colleagues who typically (but not always) are members of that same profession. This relationship is evaluative and hierarchical, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the more junior person(s); monitoring the quality of professional services offered to the clients that she, he, or they see; and serving as a gatekeeper for the particular profession the supervisee seeks to enter. (Bernard & Goodyear, 2018, p. 9)

In summary, supervision has both facilitative and evaluative components (APA, 2015; Bernard & Goodyear, 2018; Neufeldt, 2007).

**Roles and Responsibilities of Supervisors**

Clinical supervision is a complex process that requires supervisors to perform multiple roles, incorporate specific skills, and balance competing demands (Bernard & Goodyear, 2018). Responsibilities of supervisors include, but are not limited to, monitoring the quality of services provided by the supervisee, evaluating the supervisee’s performance, providing ongoing
feedback, and enhancing the supervisee’s professional competence (APA, 2015; Bernard & Goodyear, 2018). Falender, Shafranske, and Ofek (2014) outlined effective practices of competent clinical supervisors. Some of these practices are as follows: (a) clarifying and ensuring understanding of supervisee roles and supervisor expectations; (b) remaining mindful and attuned to ethical and legal aspects of supervision and clinical practice; (c) monitoring and assessing the supervisee’s competencies by providing ongoing feedback; and (d) seeking, reflecting on, and incorporating feedback from the supervisee on the supervision process.

Supervisors often utilize an array of supervision modalities, such as individual supervision, group supervision, or triadic supervision, to offer a comprehensive supervision experience (Bernard & Goodyear, 2018). Borders and Brown (2005) authored a list of six reasons for choosing specific supervisory methods and interventions, which are as follows: (a) supervisor preference, (b) developmental level of the supervisee, (c) supervisee’s goals for supervision, (d) supervisor’s goals for the supervisee, (e) supervisor’s own learning goals as a supervisor, and (f) contextual factors.

**Best Practices in Clinical Supervision**

During the past decade, several efforts were made to establish competencies and guidelines to direct supervision education and practice (Watkins, 2014a). For example, training in the provision of supervision has become a required component of most academic programs. In addition, several competency frameworks have been published (e.g., Falender & Shafranske, 2004; Falender, Shafranske, & Falicov, 2014; Roth & Pilling, 2008) that provide structures and processes to enhance the effectiveness of supervision practice (Watkins, 2014a). Furthermore, in 2015, the American Psychological Association published the *Guidelines for Clinical Supervision in Health Service Psychology* (APA, 2015). This publication was developed to establish a set of
agreed upon guidelines to inform the practice of supervision in the field of psychology. Prior to the publication of these documents, there were few guidelines that directed the provision of supervision in the mental health disciplines (Watkins, 2014a).

The competency frameworks and *Guidelines for Supervision Practice* (APA, 2015) identify knowledge, skills, and attitudes that are required for effective supervision practice. They also provide information about essential supervision processes (e.g., ongoing discussions about expectations for supervision, establishing goals for supervision, formative and summative evaluation, hierarchical nature of the supervisory relationship). Some of the more specific supervision competencies are as follows: the ability to form and maintain a strong supervisory working alliance, regularly monitoring and providing feedback on supervisee performance, ongoing enhancement of multicultural competence, and regularly attending to diversity and its impact in supervision (APA, 2015; Bernard & Goodyear, 2018; Falender & Shafranske, 2017; Falender et al., 2014). The importance of supervisor accountability is also emphasized. To be a competent supervisor, supervisors must possess competence in the provision of clinical supervision and competence in all areas of clinical practice supervised (APA, 2015; Fouad et al., 2009).

Furthermore, many authors argue that because clinical supervisors are gatekeepers to the profession (APA, 2015; Bernard & Goodyear, 2018), they are responsible for addressing multicultural issues in supervision in order to meet the needs of an increasingly diverse client population and further develop the multicultural competence of the individuals they supervise (APA, 2015; Falender et al., 2014; Hays & Chang, 2003; Tohidian & Quek, 2017; Tummala-Nara, 2004). According to APA (2015), “diversity competence is an inseparable and essential component of supervision competence” (p. 11). Ancis and Ladany (2010) argued that
multicultural competence is an integral component of supervision, just as it is an integral component of therapy. However, relatively little attention has been paid to the process by which multicultural issues are addressed in supervision (Ancis & Marshall, 2010).

**Multicultural Competence**

Multicultural competence, the “fourth force” in counseling and psychotherapy (Pederson, 1990), is a critical component of therapy and supervision (Bernard & Goodyear, 2018; Inman & Ladany, 2014; Sue, 2001; Sue et al., 1992; U.S. Department of Health and Human Services, 2014; Worthington, Soth-McNett, & Moreno, 2007). Sue and colleagues (1992) authored one of the most widely recognized theoretical frameworks of multicultural competency. This theory provides the framework for the present study. Sue and colleagues proposed the following definition of multicultural competence: beliefs and attitudes, knowledge, and skills with regard to working with culturally diverse clients. Beliefs and attitudes refer to awareness of one’s own assumptions, values, and biases (Worthington et al., 2007). Knowledge refers to a general understanding of cultures at the individual, group, and systemic levels (Inman & Ladany, 2014). Skills refer to developing culturally appropriate intervention strategies and techniques (Sue et al., 1992; Worthington et al., 2007).

The development of multicultural competence is a lifelong process that begins with awareness and commitment and evolves into increased knowledge, skill building, and culturally responsive behavior (U.S. Department of Health and Human Services, 2014). The first step in developing multicultural competence is for counselors to become aware of their own cultural group membership(s), personal values, assumptions, and biases and how these influence their perceptions of clients (Sue, 2001; U.S. Department of Health and Human Services, 2014). Counselors must also have knowledge about client’s cultural backgrounds, worldviews, and
expectations for therapy. In addition, they must be aware of potential bias in assessment and testing instruments (Sue et al., 1992). Finally, providers are responsible for developing and implementing interventions that are culturally relevant and appropriate (Sue et al., 1992; U.S. Department of Health and Human Services, 2014). Providers are recommended to seek out educational, consultative, and training experiences to increase their understanding and effectiveness in working with culturally different populations (Sue et al., 1992).

Several authors have argued that sociopolitical awareness and social justice advocacy are also important components of multicultural competence (e.g., Crether, Torres Rivera, & Nash, 2008; Ratts et al., 2016; Sue, 2001). The profession of counseling oftentimes reflects the values of larger society (Sue et al., 1992). Therefore, multicultural counseling competence must also be about social justice, which means providing equal access and opportunity, being inclusive, and removing individual and systemic barriers to quality mental health services (Sue, 2001). Clients exist within and are constantly affected by environmental systems and contexts (Crether et al., 2008). Therefore, counselors are recommended to take a more contextual approach to working with clients and communities, recognizing that clients are part of a larger system (Ratts et al., 2016). To be effective helpers, mental health professionals must increase their awareness and knowledge of ways that experiences of injustice, oppression, discrimination, and marginalization adversely affect the lives of clients (Crether et al., 2008). Mental health professionals should also strive to ameliorate social injustices that adversely affect the mental health of those who are oppressed and marginalized.

Multicultural Supervision Competence

It is widely agreed upon that multicultural competence is also a critical component of clinical supervision (e.g., APA, 2015; Ancis & Ladany, 2010; Bernard & Goodyear, 2018;
Falender et al., 2014; Hird et al., 2001; Inman & Ladany, 2014; Miville et al., 2005; Tohidian & Quek, 2017). According to Pederson (1990), all supervision can be viewed as multicultural just as all therapy can be viewed as multicultural. Multicultural supervision competence is defined as the supervisor’s awareness, knowledge, and skills with regard to working with culturally diverse supervisees and clients (Crockett & Hays, 2015). Multicultural supervision competence also involves “developing an in-depth understanding and assessment of how larger systemic issues (e.g., nation, community) influence the experience and competence (knowledge, self-awareness, and skills) of the individuals in the client-counselor-supervisor triad, whether they are from the same or different cultures, at both an intrapersonal and interpersonal level, and affecting the process and outcome of supervision and counseling” (Inman & Ladany, 2014, p. 648). The most competent supervisors strive to be multiculturally skilled and learn from mistakes along the way (Inman & Ladany, 2014). However, it is likely that supervisors believe they are more multiculturally competent than they actually are (Ancis & Ladany, 2010).

**Model of Multicultural Supervision Competence**

Although the literature base regarding the multicultural competence of supervisors has grown over the past decade, this research is still in its infancy and there is a dearth of theoretical models that guide the provision of multiculturally informed supervision (Tohidian & Quek, 2017). Several scholars have suggested that multicultural issues can be incorporated into existing supervision theories and approaches; however, a problem with this method is that existing approaches lack emphasis on the cultural dynamics of the individuals involved in the supervisory triad (Ancis & Ladany, 2010; Miville et al., 2005). The lack of models that guide the provision of supervision makes it more difficult to develop supervisors who are multiculturally aware, knowledgeable, and responsive (Tohidian & Quek, 2017).
Ancis and Ladany’s (2001, 2010) framework for multicultural supervision competence is one of the leading models of multicultural supervision. According to these authors, multicultural supervision competence consists of three interrelated subconstructs: (a) multicultural knowledge, (b) multicultural self-awareness, and (c) multicultural skills. Ancis and Ladany’s definition of multicultural supervision competence is similar to the definitions offered by other authors (e.g., Crockett & Hays, 2015; Inman & Ladany, 2014). Ancis and Ladany’s (2001, 2010) framework builds on the extant definitions of multicultural supervision competence by highlighting ways that multicultural competencies can be manifested in supervision. In addition, this framework holds supervisors accountable for providing supervision that is effective, ethical, and culturally responsive.

Ancis and Ladany (2010) established guidelines for developing multicultural supervision competence across six domains: (a) supervisor-focused personal development, (b) supervisee-focused personal development, (c) conceptualization, (d) interventions, (e) process, and (f) evaluation. Supervisor-focused personal development refers to the supervisor’s self-exploration regarding their own values, biases, and limitations. Supervisee-focused personal development refers to the process of fostering self-exploration, awareness, and knowledge of supervisees. Conceptualization refers to promoting an understanding of the impact of sociopolitical and other contextual factors on the lives of clients. The skills dimension refers to practicing relevant and sensitive interventions when working with diverse clients and encouraging flexibility. The process dimension refers to developing a strong working relationship between supervisor and supervisee that is characterized by respect and open communication. Finally, evaluation refers to the notion that the primary goal of supervision is to
be aware of any personal or professional limitations of supervisees that are likely to impede their practice.

Several supervisory behaviors are recommended to facilitate the development of multicultural competence across each of the six domains. These recommendations include, but are not limited to, exploring personal values, biases, and limitations and facilitate the supervisee’s exploration of biases that may impede clinical practice (Ancis & Ladany, 2010). Supervisors are also encouraged to promote an understanding of the impact of individual and contextual factors on clients’ lives, practice relevant and sensitive interventions when working with diverse clients, develop a relationship with the supervisee that is characterized by respect and open communication, and ensure that the supervisee provides multiculturally sensitive counseling services. Finally, supervisors must be able to identify supervisees’ personal and professional strengths and weaknesses regarding multicultural counseling. They must also provide ongoing evaluation of supervisees to ensure multicultural competence.

As can be seen, multicultural supervision competence is an ongoing pursuit that requires continuous work and attention (APA, 2015; Bernard & Goodyear, 2018; Tohidian & Quek, 2017). Like the development of multicultural competence, the development of multicultural supervision competence begins with the supervisor’s awareness of beliefs, biases, and assumptions that may impede their clinical practice (Ancis & Ladany, 2010; Miville et al., 2005). Researchers have shown that previous multicultural training and the number of interns supervised may contribute to the development of multicultural supervision competence. In their study of 211 White supervisors, Gloria and colleagues (2008) found that the number of supervisees supervised was the strongest predictor of multicultural supervision competence. Therefore, these authors hypothesized that multicultural supervision competence may develop as
supervisors gain more experiencing providing supervision. Furthermore, Constantine (2001) found that previous training and coursework related to multicultural counseling was significantly predictive of counseling graduate students’ multicultural counseling competence. This finding indicates that multicultural counseling training may help counselors feel more self-efficacious about responding to the mental health needs of diverse clients.

**Best Practices in Multicultural Supervision**

Although core supervisory behaviors, such as empathic listening and ongoing support, may contribute to successful multicultural supervision, specific multicultural issues must be addressed if multicultural supervision is to be effective (Dressel et al., 2007; Phillips et al., 2017). The explicit discussion by supervisors of the diverse and intersecting identities of the supervisory dyad is a recommended best practice in the multicultural supervision literature (Phillips et al., 2017). In addition, supervisors should be able to address multicultural issues affecting supervisees’ relationships with clients (Schroeder et al., 2009). Supervisors must also possess in-depth knowledge of ways that larger systemic issues influence the experiences of all individuals in the supervisory triad, regardless of each person’s cultural background (Inman & Ladany, 2014). These behaviors have been shown to positively impact supervisees. Phillips and colleagues (2017) surveyed 132 doctoral student supervisees to investigate whether the depth of exploration of multicultural identities in supervision was associated with positive supervisory outcomes. They found that more depth of discussion was correlated with a stronger working alliance, supervisees’ general counseling self-efficacy, and multicultural intervention self-efficacy.

There is strong support for the notion that it is the supervisor’s responsibility to initiate discussions about cultural issues in supervision, and, such discussions should begin early on in
the supervisory relationship (Ancis & Marshall, 2010; Bernard & Goodyear, 2018; Estrada et al., 2004; Hird et al., 2001; Hird et al., 2004; Taylor et al., 2006). In addition, supervisors are ethically responsible for initiating cultural discussions given their position of power and the implications of supervision for counselor training and client service delivery (APA, 2015; Hird et al., 2004). To begin these discussions, supervisors are encouraged to state their willingness to talk about cultural factors and how they may influence the process and outcome of counseling and supervision (Bernard & Goodyear, 2018; Toporek et al., 2004). Initiating these discussions early-on in the supervisory relationship provides an opportunity for the supervisor to assess the supervisee’s comfort with discussing diversity variables in therapy and supervision (Taylor et al., 2006).

Miville and colleagues (2005) recommended that supervisors serve as models for supervisees by sharing their own experiences and anxieties around attending to racial and cultural biases in counseling and supervision. In a qualitative study with four psychologists in training who were involved in multicultural supervision relationships, Hird and colleagues (2001) found that when supervisors openly evaluated their own cultural background and biases in supervision, supervisees felt more comfortable to disclose and evaluate their own values and assumptions as well. This finding was echoed by Tohidian and Quek (2017), who found that supervisees benefited when their supervisor was self-reflective and actively explored their personal biases and assumptions in supervision. Ancis and Marshall (2010) found that the comfort level and amount of self-disclosure of supervisees increased when supervisors shared aspects of their own cultural background, biases, and values in supervision. Supervision was therefore viewed as a comfortable place to take risks and be vulnerable to promote learning.
In addition, it is recommended that supervisors discuss the power differential inherent in the hierarchical nature of the supervisory relationship (Bernard & Goodyear, 2018; Estrada et al., 2004; Fong & Lease, 1997). One approach to attending to the power differential is prioritizing respect and reciprocity, asking questions, and seeking feedback from supervisees about the quality of the supervisory relationship (Green & Dekkers, 2010). A second approach is for supervisors to be deliberate and intentional about initiating conversations about race with their supervisees (Pieterse, 2018). Harrell (2014) warned that it is critical to avoid the assumption that race-related multicultural competences are only relevant in cross-racial encounters. In a study of 59 cross-racial supervisory dyads in university counseling center settings, Duan and Roehlke (2001) found that the supervisor’s willingness to discuss racial similarities and differences with supervisees was more important for effective supervision than matching supervisees with supervisors of the same race. To begin these discussions, supervisors are encouraged to engage in self-reflection guided by the following questions: (a) How has my racial background influenced my life experiences? and (b) What beliefs do I have about myself and others based on my racial group membership? (Pieterse, 2018). These questions may also be asked of supervisees to facilitate dialogue and promote self-awareness.

Supervisors are also encouraged to provide frequent and ongoing support to supervisees throughout the duration of the supervisory relationship. Dressel and colleagues (2007) surveyed 21 supervisors involved in cross-cultural supervisory relationships to identify behaviors that are conducive to successful multicultural supervision practice. Findings indicated that the most important component of successful multicultural supervision was facilitating a supportive environment to discuss multicultural issues. In addition, offering support to supervisees was also a crucial component of the supervision process. These findings were echoed by Tohidian and
Quek (2017), who found that supervisees reported positive supervision outcomes when they felt validated and supported, were empowered to take risks, and were able to enhance their own multicultural competence. As a result, it is important for supervisors to help manage supervisees’ feelings of discomfort when discussing multicultural issues, challenge supervisees to consider how the client’s cultural background may be influencing their presenting problem, and encourage supervisees to continuously explore their own identity development (Burkard et al., 2006; Dressel et al., 2007).

Ancis and Marshall (2010) conducted semi-structured interviews with four graduate students from counseling and clinical psychology programs to learn about the behaviors and practices of supervisors who they perceived as multiculturally competent. Participants were instructed to think of a past or current clinical supervisor who demonstrated a high degree of interest in multicultural issues. Results indicated that supervisees appreciated when supervisors disclosed the limits of their knowledge. Supervisees also valued conversations in which they were encouraged to explore ways that their own cultural lens may inform their work with clients and reactions to clients. Finally, supervisees reported that their supervisor encouraged them to increase their multicultural awareness by participating in discussions and/or activities outside of supervision that would expose them to information about different cultures. The results of this study provide additional insight into interventions that supervisors can use to guide the provision of culturally responsive supervision.

Supervisors demonstrating multicultural competence in supervision may help supervisees become more confident in their ability to effectively counsel a client (Crockett & Hays, 2015; Soheilian et al., 2014). When conversations about culture are an integral component of the supervision process, supervisees are more able to understand how culture influences their clinical
practice, their perceptions of clients, and their clients’ perceptions of them (Hird et al., 2004). In their study of 102 supervisees, Soheilian and colleagues (2014) found that the supervisee’s counseling effectiveness was enhanced when supervisors facilitated exploration or provided education about specific cultural issues, discussed culturally appropriate therapeutic skills and interventions, and facilitated the supervisee’s self-awareness. Furthermore, empirical evidence suggests that increased cultural awareness and skill development of supervisees may be contingent on clinical supervisors who regularly attend to issues of diversity and consistently model culturally sensitive behavior (Butler, 2003; Estrada et al., 2004; Soheilian et al., 2014; Toporek et al., 2004). This continuous modeling ultimately contributes to the multicultural development of both the supervisor and the supervisee (Butler, 2003).

**Barriers to Multicultural Supervision**

In spite of the aforementioned findings and recommendations, supervisors continue to face challenges when addressing, facilitating, and integrating dialogues about multicultural issues into their supervision practices (Tohidian & Quek, 2017). A lack of attention to culturally relevant issues in supervision may negatively affect the process and outcome of supervision (Burkard et al., 2006; Dressel et al., 2007; Hays & Chang, 2003; Hird et al., 2004; Phillips et al., 2017; Soheilian et al., 2014; Tohidian & Quek, 2017). For example, supervisors sometimes fail to acknowledge that supervision must include conversations about race and culture, regardless of the client’s cultural background (Tummala-Narra, 2004). Failure to address the cultural biases and assumptions of each supervisee may result in ineffective learning opportunities, lack of skill attainment, and lack of awareness of the salience of cultural variables when working with clients (Hird et al., 2004). There is also some evidence that suggests that supervisors report more effort to address multicultural issues in supervision than supervisees perceive (Duan & Roehlke, 2001).
There is a paucity of literature that explores the experiences and perceptions of supervisees in multicultural supervision relationships (Ancis & Marshall, 2010); however, several researchers (e.g., Burkard et al., 2006; Constantine & Sue, 2007; Dressel et al., 2007; Soheilian et al., 2014) have begun to fill this gap. Dressel and colleagues (2007) identified behaviors that characterized successful and unsuccessful multicultural supervision experiences. The most frequently cited behavior associated with unsuccessful multicultural supervision was the supervisors’ lack of awareness of their own racial, ethnic, and cultural biases. Without this awareness, supervisors may run the risk of engaging in ineffective supervisory behaviors. For example, supervisors who do not feel comfortable discussing issues related to race may bypass, ignore, or minimize discussions about racially or culturally relevant material in supervision (Chang, Hays, & Shoffner, 2004; Fong & Lease, 1997; Tummala-Narra, 2004). These behaviors may be due to the supervisor’s discomfort with their own participation in a racialized society (Pieterese, 2018). In addition, supervisors and supervisees may collude to avoid race-related conversations to guard against perceptions of being racist and/or other unwanted attributes (Harrell, 2014). This supervisory encounter may lend to racial enactments, which can silence both the supervisee and client in their inquiry of the impact of race- and culture-related material on lived experiences and presenting concerns (Tummala-Narra, 2004).

Burkard and colleagues (2006) interviewed 26 female doctoral students regarding their experiences in a cross-cultural supervisory relationship. Participants were encouraged to identify instances in which supervisors intentionally dismissed the relevance of culture or intentional or unintentional acts of omission regarding cultural issues. Examples of these events were as follows: the supervisor verbally dismissing the cultural concerns of client cases, the supervisor actively worked to discredit the importance of cultural issues in therapy, and the supervisor...
criticized supervisees when they showed interest in cultural issues. Supervisees indicated that the culturally unresponsive supervision event(s) had a negative effect on the supervision relationship. Furthermore, supervisees experienced negative feelings toward their supervisors and became guarded in supervision after the culturally unresponsive supervision event occurred. Other culturally unresponsive supervision events that have been identified in prior research include negative stereotyping, racial microaggressions, and offering culturally insensitive treatment recommendations, among others (e.g., Burkard et al., 2006; Constantine & Sue, 2007; Dressel et al., 2007).

Several studies highlight the low frequency with which discussions about cultural variables occur during supervision, despite previous research findings that stress the importance of supervisors initiating these discussions. In a quantitative study with 289 doctoral psychology interns, Gatmon et al. (2001) found that supervisors infrequently initiated discussions about ethnicity, gender, and sexual orientation in supervision. Furthermore, these authors found that discussions about cultural variables occurred more frequently in supervisory dyads composed of supervisors and supervisees who were culturally different. This finding was echoed by Constantine (1997), who found that predoctoral psychology interns and their supervisors spent approximately 15% of their time (less than 10 minutes of a supervision hour) discussing multicultural issues in supervision. Because more time discussing multicultural issues in supervision has been shown to yield a supervisory benefit, Gloria and colleagues reported that more time discussing multicultural dynamics within supervision is warranted. However, recommending a specific amount of time per session to address cultural issues would be “impractical and impose rigidity to the dynamic flow of supervision” (Gloria et al., 2008, p. 133).
There is also a growing body of research evidence suggesting that supervisors report more efforts to initiate discussions about cultural considerations than supervisees perceive (e.g., Duan & Roehlke, 2001; Green & Dekkers, 2010). In a study of 43 supervisory dyads (60 predoctoral interns and 58 clinical supervisors), Duan and Roehlke (2001) found that over 93% of supervisors reported that they acknowledged their lack of cross-cultural supervision experience with their supervisee; however, only 50% of supervisees reported that they received this acknowledgement. These authors hypothesized that supervisors may have overreported their efforts due to the social desirability of such responses. Furthermore, in a study of 42 supervisees and 22 supervisors from marriage and family therapy programs, Green and Dekkers (2010) found that supervisors reported that they regularly attended to power issues in supervision; however, supervisees did not perceive the same level of effort.

One factor that interferes with a multicultural focus in supervision is the multicultural competence of the supervisor (Miville et al., 2005). The multicultural competence of supervisees may be more advanced than the supervisor (Constantine, 2001; D’Andrea & Daniels, 1997; Miville et al., 2005). Many current supervisors were trained prior to the focus on multicultural issues that now exists in most counselor training programs and, as a result, may not have had opportunities or formal training to develop multicultural supervision competence (Constantine, 2001; D’Andrea & Daniels, 1997). supervisees may therefore be better trained to address cultural issues in the supervisory relationship (Gatmon et al., 2001). They may also have more theoretical, conceptual, and practical experiences because of the improvement of training requirements in graduate programs (Gloria et al., 2008). This dynamic is problematic because the effectiveness of multicultural supervision is ultimately influenced by what supervisors do and by what they do not do (Miville et al., 2005). Furthermore, the supervisor’s multicultural
competence and openness dictates whether the supervisee’s experience will be positive (Bernard & Goodyear, 2018). However, a supervisor’s willingness to discuss cultural differences may be more important than their level of multicultural competence (Schroeder et al., 2009).

Although culturally unresponsive supervision events yield negative outcomes for all supervisees, racial/ethnic minority supervisees may be more adversely affected than White supervisees. Burkard and colleagues (2006) hypothesized that these differential effects may occur because racial/ethnic minority supervisees may be more aware of culturally unresponsive events due to lived experiences of racism and oppression. White supervisees, on the other hand, may overlook or more easily dismiss supervision events that are not culturally responsive due to their limited exposure to issues related to race. Furthermore, racial/ethnic minority supervisees may be further harmed by White supervisors’ dual power due to the to the combined impact of their privileged identity and the hierarchical nature of the supervisory relationship (Constantine & Sue, 2007; Nilsson & Duan, 2007). In their study of 69 racial/ethnic minority supervisees, Nilsson and Duan (2007) found that previous experiences of prejudice increased racial/ethnic minority supervisees’ uncertainty about how to relate to White supervisors and manage the different roles, expectations, and conflicts inherent in the supervisory relationship.

**Challenges for White Supervisors**

Little empirical research to date has examined the multicultural experiences, practices, and competence of supervisors in general, and White supervisors in particular (Gloria et al., 2008; Imig, 2018). The majority of clinical supervisors and mental health professionals today are White (Ancis & Szymanski, 2001; Association for Counselor Education and Supervision, 2016; Fong & Lease, 1997; Green & Dekkers, 2010) and many began their careers and counseling practices using predominately Western models for therapy, resulting in a significant
learning curve (Tohidian & Quek, 2017). In the field of Counselor Education, approximately 81.1% of counselor supervisors and educators identity as White (Association for Counselor Education and Supervision, 2016). Furthermore, racial/ethnic minority supervisees are much more likely to have a supervisor who is White than a supervisor who is a member of a racial/ethnic minority group (Fong & Lease, 1997; Hipolito-Delgado, Estrada, & Garcia, 2017; Pieterse, 2018). It is therefore important to study the unique characteristics and challenges of this population because White supervisors are largely responsible for educating and training emerging mental health professionals and overseeing client care.

Conversations about race and culture may be especially difficult for White supervisors (Fong & Lease, 1997). Acknowledging personal biases is difficult because most people perceive themselves to be moral, decent, and fair (Sue, 2001). In addition, some White supervisors were trained at a time when multiculturalism was not emphasized as part of their curriculum (D’Andrea & Daniels, 1997). Therefore, they may not have had opportunities or formal training to develop multicultural supervision competence. Because of these factors, White supervisors may lack multicultural competence, be less likely to engage in conversations about cultural issues in supervision, or avoid these discussions altogether (Constantine & Sue, 2007; Fong & Lease, 1997; Hird et al., 2004; Gloria et al., 2008). They may also believe that cultural issues are unimportant, feel inadequately trained, worry they will make mistakes in front of supervisees, or fear that they will be perceived as racist (Constantine & Sue, 2007; Hird et al., 2004). Constantine and Sue (2007) interviewed 10 Black supervisees to examine their experiences in supervision with a White clinical supervisor. They found that many of the participants reported that their White supervisors tended to minimize, dismiss, or avoid discussing racial-cultural issues in supervision. Similarly, Burkard et al. (2006) found that White supervisors verbally
dismissed the cultural concerns of client cases, which resulted in negative feelings toward the supervisor.

There is some evidence suggesting that White supervisors report less multicultural supervision competence than racial/ethnic minority supervisors; however, this research is in its infancy and results have been mixed (Hird et al., 2004). Hird and colleagues conducted a quantitative study of 442 supervisory dyads to examine the self-reported multicultural supervision competence of White supervisors and racial/ethnic minority supervisors. Most of the supervisors who participated in the study were White ($n = 390$). The authors found that White supervisors reported less multicultural supervision competence than racial/ethnic minority supervisors. Conversely, in their study of 211 White doctoral intern supervisors, Gloria and colleagues (2008) found that supervisors self-reported above average multicultural competence. Gloria and colleagues hypothesized that participants may have overreported their multicultural supervision competence as a function of social desirability or ideal versus actual behaviors and attitudes.

There is also some evidence suggesting that White supervisors may spend less time talking about cultural issues in supervision than racial/ethnic minority supervisors (Hird et al., 2004). Furthermore, they may also spend more time talking about cultural issues in cross-cultural supervision relationships (Gatmon et al., 2001; Gloria et al., 2008; Hird et al., 2004). Cary and Marques (2007) reported that students in their social work graduate program did not frequently discuss cultural issues or values with their White supervisors during their field practice experiences. Hird and colleagues (2004) found that White supervisors spent approximately 6.36 minutes of their most recent supervision session discussing cultural issues. Similarly, Gloria and colleagues (2008) found that supervisory dyads with a White supervisor
spent approximately 5.53 minutes of their most recent supervision session discussing cultural dynamics in counseling and supervision. On the other hand, racial/ethnic minority supervisors reported spending approximately 10.55 minutes discussing cultural issues during their most recent supervision session (Hird et al., 2004). Hird and colleagues also found that White supervisors spent more time talking about cultural issues with racial/ethnic minority supervisees than White supervisees. This finding was echoed by Gatmon et al. (2001), who found that supervisors spent more time talking about cultural issues when there were cultural differences between the supervisor and supervisee.

As can be seen, White supervisors may be more likely to discuss multicultural issues with racially different supervisees than with White supervisees (Gatmon et al., 2001; Gloria et al., 2008; Hird et al., 2004). Gloria and colleagues (2008) found that White supervisors in same-race supervision dyads discussed multicultural issues less frequently than White supervisors in mixed-race supervision dyads. This finding is especially problematic because opportunities to model cultural sensitivity for White supervisees are missed when conversations about race and culture do not occur (Hird et al., 2004). Without these dialogues, White supervisees may not have an opportunity to understand how their cultural identity (e.g., Whiteness), biases, and beliefs impact their professional practice. Ancis and Syzmanski (2001) found that some White counselor trainees deny and dismiss the concept of White privilege. It is therefore important for supervisors to encourage their supervisees to consider how White privilege affects their counseling and supervisory relationships (Hays & Chang, 2003). Hird and colleagues posed the following question: “If White supervisors are not providing the space or time for supervisees to process culture, then where and when will White supervisees receive the formalized training experiences to hone these counseling skills?” (p. 118).
White Privilege

White privilege is a construct that is conceptually related to multicultural counseling competence (Mindrup, Spray, & Lamberghini-West, 2011; Neville et al., 2001) and multicultural supervision competence (Imig, 2018). White privilege is defined as “an expression of power arising from receipt of benefits, rights, and immunities and is characterized by unearned advantages and a sense of entitlement that results in both societal and material dominance by Whites over people of color” (Neville et al., 2001, p. 262). White privilege is an invisible and overlooked condition; therefore, most White people tend to be unaware that they possess it or benefit from its existence (Hays & Chang, 2003; McIntosh, 1989). It remains invisible to many because addressing racial issues is challenging (Hays & Shillingford-Butler, 2017). Moreover, those who do acknowledge the existence of White privilege have difficulty confronting it because they may view it as a problem with a larger system that is outside of their control (Hays & Chang, 2003). The impact of race and the unearned benefits that accompany Whiteness have several implications for clinical work (Fong & Lease, 1997).

McIntosh (1989) authored a seminal essay on White privilege in which she described 46 unearned advantages of being White. Her essay provided a language for social scientists to use when discussing the advantages associated with being White (Neville et al., 2001). According to McIntosh, White people are taught not to recognize White privilege. McIntosh described White privilege as “an invisible package of unearned assets that I can count on cashing in every day, but about which I was meant to remain oblivious” (p. 10). Some of these advantages include: “If a traffic cop pulls me over or if the IRS audits my tax return, I can be sure I haven’t been singled out because of my race” (p. 11); “I can be sure that if I need legal or medical help, my race will not work against me” (p. 11); and “I can be sure that my children will be given curricular
materials that testify to the existence of their race” (p. 11). McIntosh challenged readers to increase their awareness of the privilege afforded to White people that is not afforded to members of racial/ethnic minority groups.

The racial hierarchy and societal value system of the United States favors Whiteness (DiAngelo, 2016; Neville et al., 2001), thereby providing unfair advantages to Whites and disadvantages to people from racial/ethnic minority groups (DiAngelo, 2016; McIntosh, 1989). Neville and colleagues (2001) developed a comprehensive model that identifies and describes seven components and processes of White privilege. According to these authors, White privilege: (a) differentially benefits Whites, (b) embodies both macro- and micro-level expressions, (c) consists of unearned advantages, (d) offers immunity to selected social ills, (e) embodies an expression of power, (f) is largely invisible and unacknowledged, and (g) contains costs to Whites. White privilege serves to maintain the privileged status of Whites and increase access to desired goals. It is important to note that no one was born into our society with the desire or intention to be biased or prejudiced (Sue, 2001). However, individuals acquire misinformation about culturally different groups through social conditioning, which results in inheriting biases of forebears (DiAngelo, 2016; Sue, 2001).

The invisibility of White privilege permeates the systems within which counseling and psychotherapy training must function (Bartoli et al., 2015; Sue et al., 2019). Several researchers have found that White counselors and supervisors lack awareness of their White privilege (e.g., Ancis & Szymanski, 2001; Burkard et al., 2006; Constantine & Sue, 2007; Fong & Lease, 1997; Neville et al., 2001), which hinders the development of multicultural counseling competence (Bartoli et al., 2015; Mindrup et al., 2011). Unexamined White privilege can lead to several negative consequences, such as accepting mainstream White culture as the standard for
evaluating behaviors and a disregard for the experience of individuals from other racial and cultural backgrounds (Fong & Lease, 1997). Moreover, as a result of White privilege, White supervisors may be less aware of their cultural selves and subsequently less inclined to discuss multicultural issues in supervision (Hird et al., 2004). Constantine and Sue (2007) found that Black supervisees reported that their White supervisors were unaware of their White privilege and were also unaware of the impact of racism on the lives of individuals from racial/ethnic minority groups. These behaviors contributed to mistrust in the supervisory relationship.

The White privilege of clinical supervisors can add to the power hierarchy of the supervision process (Fong & Lease, 1997). White supervisors, who hold the power of White privilege, can control the supervision process by choosing to minimize racial issues, ignoring alternative cultural perspectives, unconditionally applying a Eurocentric approach, and pathologizing differences (Fong & Lease, 1997; Harrell, 2014). Because of these issues, it is especially important for White supervisors to take responsibility for their privilege and encourage discourse related to racial identities, privilege, and oppression in supervisory relationships (Phillips et al., 2017). Counselors who examine their White privilege and its influence on the therapeutic relationship are less likely to allow racial stereotypes and ethnocentric values to guide their work with clients (Hays, Chang, & Havice, 2008). Therefore, supervisors must strive to increase their awareness of White privilege.

**White Privilege and Multicultural Competence**

White privilege is conceptually related to multicultural counseling competence (Mindrup et al., 2011; Neville et al., 2001) and multicultural supervision competence (Imig, 2018). The first domain of multicultural competence, awareness of biases and assumptions, highlights the need for White mental health professionals to examine their race-based privilege and become
more aware of their social impact on others (Arredondo, Tovar-Blank, & Parham, 2008; Pinterits, 2004). This step must be taken before delving into action (Pinterits, 2004). Awareness of White privilege ranges from denial to critical consciousness (Pinterits et al., 2009). Moreover, it can result in strong affective, cognitive, and behavioral reactions (DiAngelo, 2016; Pinterits et al., 2009). Knowledge about White privilege is also a critical component of the knowledge dimension of multicultural competence (Neville et al., 2001). Individuals with a more critical consciousness of White privilege often accept responsibility for change at both personal and institutional levels (Pinterits et al., 2009).

To date, there are a limited number of empirical studies that have explored the association between White privilege attitudes and multicultural competence. Mindrup and colleagues (2011) examined the nature of the relationship between White privilege attitudes and multicultural counseling competence among 298 White graduate students in the fields of clinical psychology and social work. Results indicated that White privilege awareness was positively correlated with multicultural awareness and multicultural knowledge. Furthermore, greater levels of exposure to members of racial/ethnic minority groups was positively associated with White privilege awareness. The results of this study provide empirical support for the commonly held assumption that White privilege awareness is associated with the development of multicultural competence (e.g., Constantine, 2001; Neville et al., 2001; Pinterits, 2004). Mindrup and colleagues concluded that, although White privilege awareness and multicultural competence were moderately correlated, they appear to be different constructs. Therefore, it is likely that White privilege awareness is one component of multicultural competence.
White Privilege and Multicultural Supervision Competence

Most of the extant literature on White privilege and clinical supervision has been conceptual in nature (e.g., Fong & Lease, 1997; Hays & Chang, 2003). There is a paucity of empirical studies that have explored the nature of the relationship between White privilege attitudes and multicultural competence among White clinical supervisors. In a doctoral dissertation, Imig (2018) surveyed 74 White clinical supervisors (56 female, 16 male) regarding their perceptions of their White privilege attitudes and multicultural competence. Results indicated that greater multicultural awareness predicted greater White privilege awareness. In addition, greater multicultural knowledge predicted greater willingness to address White privilege and greater White privilege awareness. According to Imig, these results align with previous research findings that identified a statistically significant positive relationship between White privilege awareness and multicultural competence (e.g., Mindrup et al., 2011).

In addition, Imig (2018) found statistically significant relationships between some professional characteristics (e.g., number of multicultural counseling courses taken) and White privilege awareness. Interestingly, she found that more multicultural counseling courses predicted less awareness of White privilege. Imig therefore questioned the effectiveness of the way information about White privilege is presented in multicultural counseling courses. Furthermore, Imig did not find a statistically significant relationship between years of supervision experience and White privilege awareness. She therefore hypothesized that White privilege awareness may be connected to cultural experiences that are more personal versus professional in nature. In sum, several questions remain regarding the impact of professional characteristics on White privilege awareness.
Supervisory Working Alliance

The supervisory working alliance has emerged as an essential component of effective supervision (Bernard & Goodyear, 2018; Falender & Shafranske, 2004, 2017). According to Watkins (2014b), the supervisory working alliance “has been increasingly embraced as the very heart and soul of supervision, and its potential impact on the supervisee change process and supervision outcome has generally come to be regarded as affecting and far reaching” (p. 20). There must be a reasonably positive working alliance between the supervisor and supervisee for any supervisory intervention to be effective (Ancis & Ladany, 2010; Toporek et al., 2004; Watkins, 2014b). The supervisory working alliance does not instantaneously occur; rather, it is a co-construction that is built through sustained interaction and developed over time (Watkins, 2014b). In his comprehensive literature review of 20 years of research on the supervisory working alliance, Watkins found that a positive supervisory working alliance was linked to more satisfaction with supervision, greater perceived effectiveness of supervision, more favorable perceptions of supervisor ethical behaviors, and more discussions about multicultural issues in supervision. In contrast, an unfavorably rated supervisory working alliance was related to a higher degree of perceived stress, more exhaustion and burnout, and more frequently perceived occurrences of negative supervision events.

Bordin (1983) developed a model of the supervisory working alliance that is composed of three core elements: (a) the extent to which the supervisor and supervisee agree on goals, (b) the extent to which they agree on tasks necessary to reach those goals, and (c) the affective bond that develops between the supervisor and supervisee. More specifically, the development of a positive working alliance involves agreeing on objectives for supervisee growth and supervision outcomes (Wood, 2005). Furthermore, it is recommended that supervisors seek mutual
agreement with the supervisee on tasks they will engage in to reach their goals for supervision. Finally, bond refers to the extent to which the supervisor and supervisee trust, respect, and care for each other. It is hypothesized that the bond is enhanced when supervisors and supervisees share the experience of supervision and mutually agree upon goals and tasks for supervision. Bordin (1983) identified eight goals that could be used to guide the supervision process: (a) mastery of specific skills, (b) enlarging one’s understanding of clients, (c) enlarging one’s awareness of process issues, (d) increasing awareness of self and impact on process, (e) overcoming personal and intellectual obstacles toward learning and mastery, (f) deepening one’s understanding of concepts and theory, (g) providing a stimulus to research, and (h) maintaining standards of service (p. 37-38).

**Multicultural Supervision and the Supervisory Alliance**

There is a positive relationship between multicultural supervision events and the supervisory working alliance (e.g., Crockett & Hays, 2015; Phillips et al., 2017; Tohidian & Quek, 2017; Watkins, 2014b). The key to creating an effective supervisory working alliance is acknowledging cultural differences and contextual factors that may influence the nature and quality of the supervisory relationship (Harrell, 2014; Pieterse, 2018; Schroeder et al., 2009). Gatmon and colleagues (2001) found that supervisors who provided an atmosphere of safety, depth of dialogue, and frequent opportunities to discuss cultural variables in supervision significantly contributed to a positive working alliance and supervisees’ satisfaction with supervision. When supervisors react to cultural issues in a responsive manner, a more positive working alliance develops and the supervisory relationship can be enhanced (Schroeder et al., 2009). In contrast, a lack of attention to important racial and multicultural dynamics can block
or interfere with the development of a positive supervisory alliance (Burkard et al., 2006; Hays & Chang, 2003).

**Supervisor Multicultural Competence and the Supervisory Alliance**

Research evidence has increasingly revealed that there is a positive association between discussing multicultural issues and the development of an effective supervisory working alliance; however, there is a dearth of literature on this topic and some of the findings have been inconsistent. Inman (2006) investigated 147 marriage and family therapy trainees’ perceptions of their supervisor’s multicultural competence, quality of the supervisory working alliance, and satisfaction with supervision. Results indicated that supervisor multicultural competence was positively associated with the working alliance and satisfaction with supervision. Based on these findings, Inman hypothesized that the supervisory working alliance may be a “significant common factor” (p. 83) in multicultural supervision and should be integrated into the conceptualization of multicultural supervision competence.

In a doctoral dissertation, Riley (2004) investigated the nature of the relationship between supervisor multicultural competence and supervisors’ and supervisees’ perceptions of the supervisory working alliance. Riley surveyed the members of 79 mixed-race supervision dyads, which consisted of 79 White clinical supervisors and 79 racial/ethnic minority supervisees (63 African Americans, 13 Hispanic/Latino(a)s, and 3 Asian Americans). Riley did not find a statistically significant relationship between supervisor multicultural competence and the supervisor’s perception of the supervisory alliance. However, she did find a statistically significant inverse relationship between supervisor multicultural competence and the supervisee’s perception of the supervisory alliance. The presence of the inverse relationship indicates that there is an incongruence between White supervisors’ perceptions of their
multicultural competence and supervisees’ perceptions of the quality of the supervisory relationship. Therefore, White supervisors may not be as skilled at developing the working alliance as they perceive.

More recently, Crockett and Hays (2015) conducted a study with 221 supervisees to examine how supervisor multicultural competence influences the supervisory working alliance, supervisee self-efficacy, and supervisee satisfaction with supervision. They found that supervisees who perceived their supervisor to be more multiculturally competent reported a more positive supervisory working alliance. They also found that a more positive supervisory working alliance led to increased satisfaction with supervision. Based on these findings, the authors concluded that the multicultural competence of the supervisor does not directly contribute to satisfaction with supervision. Rather, demonstrating multicultural competence assists the supervisor in building a positive working alliance with the supervisee. Then, a positive working alliance facilitates increased satisfaction with supervision. This finding was echoed by Burkard, Knox, Hess, and Schultz (2009) in their study of 17 LGB-identified doctoral student supervisees. They found that the multicultural competence of supervisors enhanced the supervisory working alliance and satisfaction with supervision. Therefore, the supervisory working alliance may be a pivotal component of multicultural supervision that moderates how all other experiences are perceived (Toporek et al., 2004).

**Summary**

Little empirical research to date has examined the multicultural experiences, practices, and competence of supervisors in general, and White supervisors in particular (Gloria et al., 2008). Further impeding efforts to enhance multicultural competence is the paucity of empirical studies of White privilege (Neville et al., 2001; Pinterits, 2004). Despite the theoretical impact
of White privilege on the supervision process and outcomes, there is a dearth of literature on this topic. Moreover, most of the extant literature has been conceptual in nature (e.g., Fong & Lease, 1997; Hays & Chang, 2003). While many authors have written about how White privilege may affect the supervision process (e.g., Fong & Lease, 1997; Hays & Chang, 2003; Nilsson & Duan, 2007), these claims have not been empirically tested. In fact, there are a limited number of empirical studies to date that examine White privilege attitudes within the context of clinical supervision (Imig, 2018). Furthermore, there is a paucity of studies that have explored the nature of the relationship between supervisor multicultural competence, White privilege attitudes, and the supervisory working alliance. Because the supervisory working alliance has been shown to partially mediate the relationship between supervisor multicultural competence and other outcome variables (e.g., satisfaction with supervision; Crockett & Hays, 2015), it seems important to examine how the White privilege attitudes of clinical supervisors affect the development of the supervisory working alliance. There is therefore a demonstrable need for additional research in this area.
CHAPTER III

METHOD

Participants

Participants initially consisted of 51 clinical supervisors who provided supervision within the past two years. Thirteen cases were removed for the following reasons: (a) the participant did not identify as White \( n = 3 \) or (b) the participant opened the survey link, consented to participate, but did not respond to any of the remaining survey items \( n = 10 \). The final sample size was 38 participants. Participant demographic characteristics are summarized in Table 1.

Table 1

*Participant Characteristics*

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<thead>
<tr>
<th>Category</th>
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<td>School</td>
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<tr>
<td>40 and above</td>
<td>6</td>
<td>15.8</td>
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</tbody>
</table>
Of the 38 participants, 30 (44.8%) identified as female, 5 (7.5%) identified as male, 1 (1.5%) identified as transgender male, 1 (1.5%) identified as nonbinary, and 1 (1.5%) did not specify a gender identity. All participants identified as White. Participants ranged in age from 23 to 63 years old, with a mean age of 37.84 (\(Mdn = 35; SD = 10.69\)). Most participants worked in a university counseling center (\(n = 23; 34.3\%\)), followed by private practice (\(n = 4; 6\%\)); hospital (\(n = 3; 4.5\%\)), community mental health agency (\(n = 2; 3\%\)), department training clinic (\(n = 2; 3\%\)), school (\(n = 2; 3\%\)), and other (\(n = 2; 3\%\)). In terms of education, 11 (16.4%) reported that they were currently in graduate school, 19 (28.4%) earned a master’s degree, and 8 (11.9%) earned a doctoral degree. Most participants reported their academic program as counseling psychology (\(n = 13; 19.4\%\)), followed by clinical psychology (\(n = 9; 13.4\%\)), social work (\(n = 6; 9\%\)), counselor education (\(n = 4; 6\%\)), clinical mental health (\(n = 3; 4.5\%\)), community counseling (\(n = 1; 1.5\%\)), and 2 (3%) studied a specialty that was not listed. During their training, 18 (47.4%) participants took three or more courses related to multicultural issues/competencies, 11 (28.9%) took two or more courses, and 9 (23.7%) took one course.

In terms of their clinical practice, participants provided counseling services for an average of 10.16 years (\(Mdn = 6.66; SD = 8.75\)) and clinical supervision for an average of 5.55 years (\(Mdn = 3.75; SD = 6.96\)). The percentage of clientele served over the course of their careers who were members of racial/ethnic minority groups ranged from 5% to 80% (\(M = 29.34; SD = 18.89\)). Thirty-two participants (47.8%) were currently providing supervision, 1 (1.5%) provided supervision within the past month, 2 (3%) provided supervision within the past six months, 2 (3%) provided supervision within the past year, and 1 (1.5%) provided supervision within the past two years. Participants have provided supervision to a range of 1 to 100 supervisees (\(M = 16.16; Mdn = 6; SD = 22.28\)). The percentage of supervisees supervised over
the course of their careers who were members of racial/ethnic minority groups ranged from 0% to 50% \( (M = 16.42; \text{Md}n = 10; SD = 17.54) \). Finally, the average amount of time spent discussing multicultural issues during each supervision session was 13.82 minutes \( (SD = 8.08) \).

**Measures**

**Demographic Questionnaire**

Participants completed a demographic questionnaire (Appendix D) in which they were asked to indicate their age, gender identity, race, setting in which they currently work, amount of counseling experience, percentage of clients served who were members of racial/ethnic minority groups, amount of supervision experience, number of supervisees supervised, percentage of supervisees who were members of racial/ethnic minority groups, average amount of time spent discussing multicultural issues per supervision session, professional background, and number of courses completed in multicultural issues/competencies.

**Multicultural Counseling Knowledge and Awareness Scale**

The Multicultural Counseling Knowledge and Awareness Scale (MCKAS; Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002) is a 32-item measure of multicultural counseling competence. There are two subscales: Knowledge and Awareness. The Knowledge subscale includes 20 items that measure general knowledge of basic multicultural counseling issues. The Awareness subscale includes 12 items that measure a subtle Eurocentric worldview bias. Respondents are asked to rate the truth of each item as it applies to them using a 7-point Likert scale anchored from 1 \( (\text{not at all true}) \) to 7 \( (\text{totally true}) \). Scores in the Knowledge subscale are summed and averaged to calculate the subscale score. Scores in this subscale range from 1 to 7, with higher scores indicating a higher perceived knowledge of multicultural issues. Ten of the 12 Awareness subscale items are negatively worded and are therefore reverse scored. Scores are
then summed and averaged to calculate the subscale score. Scores in this subscale range from 1 to 7, with higher scores indicating a higher perceived awareness of multicultural counseling issues.

In the validation sample (525 students and professionals in counseling and counseling psychology), internal consistency reliability estimates of the scores (Cronbach’s alpha) were .85 for Knowledge and .85 for Awareness (Ponterotto et al., 2002). The two-factor structure of the MCKAS has been supported using an exploratory principle component analysis and a confirmatory factor analysis. Correlations between the MCKAS and the Multicultural Counseling Inventory (MCI; Sodowsky, Taffe, Gutkin, & Wise, 1994) provided support for the convergent validity of the MCKAS subscale scores. Correlations between the Knowledge subscale of the MCKAS and the subscales of the MCI ranged from .43 to .49. Correlations between the Awareness subscale of the MCKAS and the subscales of the MCI ranged from -.06 to .74. The Awareness subscales of each instrument were not correlated ($r = -.06$) because the items in the MCKAS Awareness subscale focus on subtle Eurocentric bias, whereas the items in the MCI Awareness subscale focus on the counselor’s understanding/knowledge of issues outside of the counseling relationship. Correlations between the MCKAS and the Multigroup Ethnic Identity Measure (MEIM; Phinney, 1992) provided preliminary support for criterion-related validity of the MCKAS subscale scores. Correlations between the Knowledge and Awareness subscales of the MCKAS and the MEIM were .31 and .20, respectively. Furthermore, discriminant validity tests yielded no statistically significant correlations between scores on the Marlowe Crowne Social Desirability Scale (MCSDS; Crowne & Marlowe, 1960) and the Awareness subscale of the MCKAS, although a statistically significant correlation was found between the MCSDS and the Knowledge subscale of the MCKAS ($r = -.39$).
White Privilege Attitudes Scale

The White Privilege Attitudes Scale (WPAS; Pinterits et al., 2009) is a 28-item measure of White privilege attitudes. White privilege attitudes consist of strong affective, behavioral, and cognitive reactions that result from awareness of White privilege (Pinterits et al., 2009). Affective reactions include, but are not limited to, fear, guilt, and anger. Behavioral reactions range from avoidance or unwillingness to discuss the existence of White privilege to intentions and actions to dismantle it. Cognitive reactions are a continuum of White privilege awareness, which range from denial to critical consciousness. There are four subscales: Willingness to Confront White Privilege, Anticipated Costs of Addressing White Privilege, White Privilege Awareness, and White Privilege Remorse. The Willingness to Confront White Privilege subscale includes 12 items that reflect a behavioral dimension of intentions or plans to address White privilege. The Anticipated Costs of Addressing White Privilege subscale includes six items that reflect affective dimensions that are linked to assessment of anxiety and fear about addressing White privilege or losing White privilege. The White Privilege Awareness subscale includes four items that reflect a cognitive dimension of having a conscious understanding of White privilege. The White Privilege Remorse subscale includes six items that reflect a second affective dimension in the assessment of feelings, such as anger and shame, about the existence of White privilege. Respondents are asked to rate the degree to which they personally agree or disagree with each statement using a 6-point Likert scale anchored from 1 (strongly disagree) to 6 (strongly agree).

Two of the items in the Willingness to Confront White Privilege subscale are negatively worded and are therefore reverse scored. Scores are then summed and averaged to calculate the subscale score. Scores in this subscale range from 1 to 6, with higher scores indicating a greater
likelihood of confronting White privilege. Scores in the Anticipated Costs of Addressing White Privilege subscale are summed and averaged to calculate the subscale score. Scores in this subscale range from 1 to 6, with higher scores indicating greater concern for the anticipated costs of addressing White privilege. Two of the items in the White Privilege Awareness subscale are negatively worded and are therefore reverse scored. Scores are then summed and averaged to calculate the subscale score. Scores in this subscale range from 1 to 6, with higher scores indicating greater awareness of White privilege. Scores in the White Privilege Remorse subscale are summed and averaged to calculate the subscale score. Scores in this subscale range from 1 to 6, with higher scores indicating greater remorse for having race-based privilege.

In the validation sample (250 undergraduate and graduate students), internal consistency reliability estimates of the scores (Cronbach’s alpha) were .95 for Willingness to Confront White Privilege, .81 for Anticipated Costs of Addressing White Privilege, .84 for White Privilege Awareness, and .91 for White Privilege Remorse (Pinterits et al., 2009). Pinterits and colleagues also conducted a confirmatory factor analysis using a sample of 251 undergraduate and graduate students in which they found Cronbach’s alphas of .93 for Willingness to Confront White Privilege, .78 for Anticipated Costs of Addressing White Privilege, .84 for White Privilege Awareness, and .89 for White Privilege Remorse. The 2-week test-retest reliability estimates of the scores on the WPAS subscales were as follows: Willingness to Confront White Privilege ($r = .83$), Anticipated Costs of Addressing White Privilege ($r = .70$), White Privilege Awareness ($r = .87$), and White Privilege Remorse ($r = .78$). These results suggest that the WPAS subscales demonstrated adequate temporal stability. The four-factor structure of the WPAS has been supported using exploratory and confirmatory factor analyses (Pinterits et al., 2009). Convergent validity analyses with the Color-Blind Racial Attitudes Scale (CoBRAS; Neville, Lilly, Duran,
Lee, & Browne, 2000), the Modern Racism Scale (MRS, McConahay, 1986) and the Social Dominance Orientation (SDO; Pratto, Sidanius, Stallworth, & Malle, 1994) have provided support for the construct validity of WPAS scores. Furthermore, discriminant validity tests yielded no statistically significant correlations between scores on the Marlowe-Crowne Social Desirability Scale-Form A (MCSDS-A; Reynolds, 1982) and the WPAS subscales.

**Supervisory Working Alliance Inventory – Supervisor Version**

The Supervisory Working Alliance Inventory – Supervisor Version (SWAI-S; Efstation, Patton, & Kardash, 1990) is a 23-item measure of the supervisor’s perception of the supervisory working alliance. Efstation and colleagues conceptualized the supervisory working alliance as “a set of actions interactively used by supervisors and trainees to facilitate the learning of the trainee” (p. 323). The development of this measure was based conceptually on Bordin’s (1983) model of the supervisory working alliance, along with the works of several other authors. There are three subscales: Client Focus, Rapport, and Identification. The Client Focus subscale consists of nine items that measure the supervisor’s emphasis on promoting the supervisee’s understanding of the client. The Rapport subscale consists of seven items that measure the supervisor’s effort to build rapport with the supervisee. The Identification subscale consists of seven items that measure the supervisor’s perception of the supervisee’s identification with the supervisor. Respondents are asked to rate the frequency with which the behavior described in each item seems characteristic of their work with their supervisee using a 7-point Likert scale anchored from 1 (*almost never*) to 7 (*almost always*). Scores on each subscale are summed and averaged to calculate the subscale score. Scores on the Client Focus subscale range from 1 to 7, with higher scores indicating a greater effort to facilitate the supervisee’s understanding of the client. Scores on the Rapport subscale range from 1 to 7, with higher scores indicating a greater
effort to establish rapport with the supervisee. Scores on the Identification subscale range from 1 to 7, with higher scores indicating a greater perceived identification of the supervisee with the supervisor.

In the validation sample (185 clinical supervisors), internal consistency reliability estimates of the scores (Cronbach’s alpha) were .71 for Client Focus, .73 for Rapport, and .77 for Identification (Efstation et al., 1990). Patton, Brossart, Gehlert, Gold, and Jackson (1992) also conducted a validation study with 90 clinical supervisors and found that the reliability estimates of the scores were .67 for Client Focus, .64 for Rapport, and .79 for Identification. The three-factor structure of the SWAI-S has been supported using factor analyses. Correlations between the SWAI-S and the Supervisory Styles Inventory (SSI; Friedlander & Ward, 1984) have provided preliminary support for the convergent and discriminant validity of SWAI-S subscale scores. Correlations between the subscales of the SWAI-S and the SSI ranged from -.06 to .50.

**Procedures**

This study was approved by the Human Subjects Institutional Review Board at Western Michigan University (Appendix A). A correlational research design was used to guide this study (Heppner, Wampold, Owen, Thompson, & Wang, 2016). Purposive and snowball sampling techniques were used to recruit participants. Participants were recruited via e-mail (Appendix B) from APA accredited doctoral programs in counseling and clinical psychology, CACREP accredited doctoral programs in counselor education, and listservs, such as the Association for University and College Counseling Center Directors (AUCCCD) and the Association for University and College Counseling Center Training Directors (AACTA). This recruitment strategy was selected because it has been used in previous studies of multicultural supervision (e.g., Gloria et al., 2008; Hird et al., 2004).
To recruit, an e-mail was sent to all directors and training directors who subscribed to the listservs. An e-mail was also sent to faculty members of the APA accredited doctoral programs in counseling psychology, clinical psychology, and counselor education. The e-mail asked each individual to please consider forwarding the recruitment information to those who provide clinical supervision at their respective organizations. In addition, the recruitment e-mail provided information about the nature of the study, requirements to participate, and a link to the survey. In order to be included in the study, participants had to meet the following criteria: (a) must have been 18 years of age or older, (b) identify as White, and (c) must have provided clinical supervision within the past two years. Participants who did not meet the inclusionary criteria were excluded from the study.

All data were collected online using SurveyMonkey (http://www.surveymonkey.com), which is a password protected online survey platform. The survey was electronic. Data were collected from March 2018 to June 2019. Participants visited the survey link provided in the recruitment e-mail to participate. Prior to beginning the survey, participants read the informed consent document (Appendix C) and acknowledged their agreement to participate in the study. Participants were informed that their responses would be anonymous and kept confidential, that they could choose not to respond to any survey item for any reason, and that they could exit the survey at any time without consequence. After consenting to participate, participants completed the following measures: (a) demographic survey, (b) MCKAS, (c) WPAS, and (d) SWAI-S. The demographic survey was presented first. To minimize sequence effects, the remaining measures were presented in a random order. Completion times ranged from 7 minutes to 2 hours and 7 minutes ($M = 25.84$, $Mdn = 15$, $SD = 26.86$). At the end of the survey, participants had the opportunity to enter a random drawing to earn an incentive for their participation (one of four
$25 gift cards to Amazon.com). To protect confidentiality, a link to a separate SurveyMonkey (http://www.surveymonkey.com) form was provided at the end of the survey. After clicking the link, participants were instructed to enter their e-mail addresses separately from their responses.

A series of *a priori* power analyses were conducted using G*Power 3.1 (Faul, Erdfelder, Buchner, & Lang, 2009) to estimate the sample size necessary to detect any effects that may exist in the population (Field, 2013). First, two power analyses were conducted based on a medium effect size. The first power analysis was conducted for a multiple regression with two predictors using an alpha of 0.05, a power of 0.80, and a medium effect size ($f^2 = 0.15$). The desired sample size was 68. The second power analysis was conducted for a multiple regression with four predictors using an alpha of 0.05, a power of 0.80, and a medium effect size ($f^2 = 0.15$). The desired sample size was 85. Next, two power analyses were conducted based on a large effect size. The first power analysis was conducted for a multiple regression with two predictors using an alpha of 0.05, a power of 0.80, and a large effect size ($f^2 = 0.35$). The desired sample size was 31. The second power analysis was conducted for a multiple regression with four predictors using an alpha of 0.05, a power of 0.80, and a large effect size ($f^2 = 0.35$). The desired sample size was 40.
CHAPTER IV

RESULTS

The results of this study are presented in four sections: (a) preliminary analyses, (b) descriptive analyses, (c) inferential analyses, and (d) supplemental analyses. The findings of the three hypotheses are reported in the inferential analyses section.

Preliminary Analyses

Prior to testing the hypotheses, several analyses were conducted to ensure the accuracy of the data. First, a series of steps were followed to identify potential data entry and/or score calculation errors. Data were examined using frequency distributions to ensure that no cases had values outside of the range of possible values (Mertler & Reinhart, 2016). Categorical variables were also assessed to ensure that all cases had values that corresponded to the coded values for the possible categories. Next, the accuracy of data entry was double-checked by comparing each participant’s responses to the data entered into IBM SPSS Statistics for Windows, Version 26.0. No discrepancies were identified. Then, the data were screened at the univariate level, assessed for missing values and outliers, and the assumptions of linear regression were tested.

Data Screening

The data were screened at the univariate level to assess for univariate normality and univariate outliers. Univariate normality was assessed by examining the skewness and kurtosis values of each variable. Variables with skewness values greater than ±2 were considered skewed and variables with kurtosis values equal greater than ±7 were considered kurtotic (Fabrigar, Wegener, MacCallum, & Strahan, 1999). The skewness and kurtosis values fell within the
normal to moderate range for all variables except one (Amount of Supervision Experience); however, this variable was used only for the purposes of describing the sample and was not included in subsequent analyses. Then, the data were assessed for univariate outliers by examining frequency distributions and histograms (Mertler & Reinhart, 2016). No unusual values were identified.

**Missing Values**

The data were assessed for missing values. When the data suggested that a participant exited the survey prior to completion (e.g., missing values for all remaining survey items after the last response), those cases were removed from the sample ($n = 10$). Next, an analysis of missing data was conducted on each study variable. The percentage of missing data for each variable did not exceed 5%. Furthermore, there were no identifiable trends in the missing data. The percentage of missing data for the MCKAS was .41%, the percentage of missing data for the WPAS was 1.69%, and the percentage of missing data for the SWAI-S was .23%. Because the percentage of missing data for each variable did not exceed 5%, data were not imputed for missing values.

The Little’s Missing Completely at Random (MCAR; Little, 1988) test was conducted on the MCKAS, WPAS, and SWAI-S to determine the likelihood that missing values were missing completely at random, meaning that missingness did not depend on the observed data nor on the missing data in the dataset (Dong & Peng, 2013). The results of the MCAR were not statistically significant for the MCKAS [$\chi^2 (123, N = 38) = 122.361, p > .05$], SWAI-S [$\chi^2 (33, N = 38) = 47.141, p > .05$], or the WPAS [$\chi^2 (66, N = 38) = 62.131, p > .05$], indicating that the data were likely missing at random. Therefore, no additional cases were removed.
Outliers

The data were assessed for multivariate outliers using the Mahalanobis distance test (Tabachnick & Fidell, 2007). None of the cases exceeded the critical chi-square value of 27.877 ($df = 9$). Therefore, no additional cases were removed.

Assumptions of Linear Regression

Regression diagnostics were conducted to test the following assumptions of linear regression: (a) normality, (b) linearity, (c) homoscedasticity, and (d) multicollinearity (Keith, 2006; Mertler & Reinhart, 2016). The assumptions of linearity, homoscedasticity, and normality were tested via visual inspection of scatterplot matrices and scatterplots of the residuals for the MCKAS, WPAS, and SWAI-S. The assumption of normality was supported because the lowess line came close to the regression line in the scatterplots of the residuals (Keith, 2006; Mertler & Reinhart, 2016). The assumptions of linearity and homoscedasticity were supported because the values of the residuals were consistently spread out in the scatterplot (Mertler & Reinhart, 2016). Finally, multicollinearity was assessed by examining Tolerance and Variance Inflation Factor (VIF) values for the predictor variables. Variables were considered multicollinear if they had values that fell below .10 for Tolerance and above 10 for VIF (Field, 2013; Mertler & Reinhart, 2016). Tolerance values ranged from .219 to .847. VIF values ranged from 1.18 to 4.57. Therefore, the absence of multicollinearity was supported.

Descriptive Analyses

Descriptive statistics including means, standard deviations, and bivariate correlations for the MCKAS, WPAS, SWAI-S are presented in Table 2. Multicultural competence was measured using the MCKAS. The MCKAS consists of two subscales: Multicultural Awareness and Multicultural Knowledge. Subscale scores range from 1 (not at all true) to 7 (totally true).
The mean score for Multicultural Awareness was 6.12 ($SD = .56$), which indicates that participants reported a higher perceived awareness of multicultural issues. The mean score for Multicultural Knowledge was 5.59 ($SD = .64$), which indicates that participants reported a higher perceived knowledge of multicultural issues.

Table 2

*Descriptive Statistics for MCKAS, WPAS, and SWAI-S*

<table>
<thead>
<tr>
<th>Variable</th>
<th>1</th>
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<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
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<td>.66*</td>
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<td>7. Client Focus</td>
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<td>—</td>
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<td>8. Rapport</td>
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<td>.18</td>
<td>-.07</td>
<td>.43*</td>
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<tr>
<td>9. Identification</td>
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<td>.29</td>
<td>-.15</td>
<td>-.04</td>
<td>-.15</td>
<td>-.33*</td>
<td>.43*</td>
<td>.72*</td>
<td>—</td>
</tr>
<tr>
<td>M</td>
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<td>3.77</td>
<td>5.53</td>
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<td>.74</td>
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<td>-.34</td>
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<td>4.78</td>
<td>.03</td>
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<td>-.80</td>
<td>-.20</td>
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</tbody>
</table>

*Note.* MC Awareness = Multicultural Awareness; MC Knowledge = Multicultural Knowledge; Confront WP = Willingness to Confront White privilege; Costs WP = Costs Associated with Addressing White Privilege; WP Awareness = White Privilege Awareness; WP Remorse = White Privilege Remorse. MCKAS ranges from 1 to 7. WPAS ranges from 1 to 6. SWAI-S ranges from 1 to 7. *$p < .05$.

White privilege attitudes were measured using the WPAS. The WPAS consists of four subscales: White Privilege Awareness, White Privilege Remorse, Willingness to Confront White Privilege, and Anticipated Costs of Addressing White Privilege. Subscale scores range from 1
(strongly disagree) to 6 (strongly agree). The mean score for White Privilege Awareness was 5.31 (SD = 1.15), which indicates that participants reported a higher awareness of White privilege. The mean score for White Privilege Remorse was 3.77 (SD = 1.25), which indicates that participants reported feeling impartial about having race-based privilege. The mean score for Willingness to Confront White Privilege was 4.89 (SD = .97), which indicates that participants reported they are somewhat more likely to have a plan to explore or address White privilege. The mean score for Anticipated Costs of Addressing White Privilege was 2.57 (SD = 1.15), which indicates that participants endorsed little concern about potential costs associated with addressing White privilege (e.g., loss of relationships with family/friends).

The supervisory working alliance was measured using the SWAI-S. The SWAI-S consists of three subscales: Rapport, Client Focus, and Identification. Subscale scores range from 1 (almost never) to 7 (almost always). The mean score for Rapport was 6.14 (SD = .63), which indicates that participants reported making more effort to build rapport with supervisees. The mean score for the Client Focus subscale was 5.53 (SD = .59), which indicates that participants reported making more effort to facilitate supervisees’ understanding of clients. The mean score for the Identification subscale was 5.50 (SD = .74), which indicates that participants perceived a stronger identification of the supervisee with the supervisor (e.g., supervisee conceptualizes clients in a similar manner as the supervisor, supervisee identifies with supervisor in the way they think and talk about clients).

Correlations

Bivariate correlation analyses were conducted to explore the strength and direction of the relationships between variables. A statistically significant positive correlation was found between the MCKAS subscales (Multicultural Awareness and Multicultural Knowledge; r =
Therefore, participants who endorsed more multicultural awareness also endorsed more multicultural knowledge. In addition, a statistically significant positive correlation was found between Multicultural Awareness and Willingness to Confront White Privilege ($r = .76$), Multicultural Awareness and White Privilege Awareness ($r = .77$), and Multicultural Awareness and White Privilege Remorse ($r = .50$). Therefore, participants who endorsed more multicultural awareness also endorsed more willingness to address White privilege, more awareness of White privilege, and more shame and anger about having race-based privilege. Finally, a statistically significant positive correlation was found between Multicultural Knowledge and Willingness to Confront White Privilege ($r = .36$), Multicultural Knowledge and Client Focus ($r = .41$), and Multicultural Knowledge and Rapport ($r = .36$). Therefore, participants who endorsed more multicultural knowledge endorsed more willingness to address White privilege, reported making a greater effort to build rapport with supervisees, and reported making a greater effort to facilitate supervisees’ understanding of clients.

Correlations among the WPAS subscales ranged from -0.09 to 0.81 ($Mdn = .38$). A statistically significant positive correlation was found between Willingness to Confront White Privilege and White Privilege Awareness ($r = .81$) and Willingness to Confront White Privilege and White Privilege Remorse ($r = .63$). Therefore, participants who endorsed more willingness to confront White privilege endorsed more awareness of White privilege and more shame and anger about having race-based privilege. A statistically significant positive correlation was also found between White Privilege Awareness and White Privilege Remorse ($r = .66$). Therefore, participants who endorsed more awareness of White privilege endorsed more shame and anger about having race-based privilege. Next, a statistically significant negative correlation was found between White Privilege Remorse and Identification ($r = -.33$). Therefore, participants
who endorsed more remorse for having race-based privilege endorsed a weaker perceived identification of the supervisee with the supervisor.

Correlations among the SWAI-S subscales ranged from .43 to .72 (Mdn = .43). There was a statistically significant positive correlation among all three of the SWAI-S subscales (Client Focus, Rapport, and Identification). Therefore, participants who endorsed making a greater effort to facilitate supervisees’ understanding of clients also endorsed making a greater effort to build rapport with supervisees and a greater perceived identification of the supervisee with the supervisor.

**Reliability Estimates of the Scores**

Reliability estimates of the scores for the MCKAS, WPAS, and SWAI-S are presented in Table 3. Scores for the MCKAS and WPAS subscales met the standard cutoff score of .70 (Nunnally, 1978). Scores for the Rapport and Identification subscales of the SWAI-S also met the standard cutoff score. The reliability estimate of the scores for the Client Focus subscale of the SWAI-S did not meet the standard cutoff score (Cronbach’s $\alpha = .66$). Patton and colleagues (1992) reported similar results in their validation study of the SWAI-S. They found that the reliability estimate of the scores for the Client Focus subscale was .64. As a result, analyses using the Client Focus subscale of the SWAI-S should be interpreted with caution.
Table 3

**Reliability Estimates (Cronbach’s α) of Subscale Scores**

<table>
<thead>
<tr>
<th>Scale</th>
<th>Cronbach’s α</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCKAS Multicultural Awareness</td>
<td>.72</td>
<td>37</td>
</tr>
<tr>
<td>MCKAS Multicultural Knowledge</td>
<td>.83</td>
<td>35</td>
</tr>
<tr>
<td>WPAS Willingness to Confront White Privilege</td>
<td>.94</td>
<td>35</td>
</tr>
<tr>
<td>WPAS Anticipated Costs of Addressing White Privilege</td>
<td>.83</td>
<td>37</td>
</tr>
<tr>
<td>WPAS White Privilege Awareness</td>
<td>.92</td>
<td>37</td>
</tr>
<tr>
<td>WPAS White Privilege Remorse</td>
<td>.92</td>
<td>36</td>
</tr>
<tr>
<td>SWAI-S Client Focus</td>
<td>.66</td>
<td>38</td>
</tr>
<tr>
<td>SWAI-S Rapport</td>
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<td>37</td>
</tr>
<tr>
<td>SWAI-S Identification</td>
<td>.83</td>
<td>37</td>
</tr>
</tbody>
</table>

*Note.* Reliability estimates in bold did not meet the standard cutoff criteria of .70.

**Overview of Multiple Regression**

The present study utilizes simultaneous regression and hierarchical regression analyses to test the research hypotheses. Regression analyses have two primary purposes: (a) developing an equation that can be used for predicting values on an outcome variable or (b) explaining variation (Keith, 2006; Field, 2013; Mertler & Reinhart, 2016). When regression analyses are conducted for the purpose of prediction, a regression equation is developed to predict outcome values for individuals in a population (Mertler & Reinhart, 2016). When regression analyses are conducted for the purpose of explanation, the variation in one variable is explained by the variation in another variable (Keith, 2006). More specifically, each predictor variable is evaluated by the proportion of variance accounted for in the outcome variable. The present study will use regression analyses for the purpose of explanation.
There are several methods in which predictor variables can be entered into a regression analysis. These methods are as follows: simultaneous regression, hierarchical regression, and stepwise regression (Keith, 2006; Mertler & Reinhart, 2016). With simultaneous regression, all predictor variables are entered into the regression equation at the same time. Simultaneous regression is primarily used for explanatory research to determine the extent of the influence of one or more predictor variables on the outcome variable (Keith, 2006). Simultaneous regression is also useful for determining the relative influence of each of the variables studied because it estimates the direct effects of each predictor variable on the outcome variable. Simultaneous regression analyses will be conducted to answer the first and second research questions. With hierarchical regression, on the other hand, the predictor variables are entered into the regression equation one at a time, in an order determined in advance by the researcher (Keith, 2006; Mertler & Reinhart, 2016). The primary focus of hierarchical regression is on the change in the variance accounted for by each predictor variable after it is entered into the regression model. Similar to simultaneous regression analyses, hierarchical regression analyses are also typically used for the purposes of explanation (Keith, 2006). Hierarchical regression analyses will be conducted to address the third research question.

**Inferential Analyses**

**Research Question 1**

*What is the nature of the relationship between the multicultural competence and White privilege attitudes of clinical supervisors?*

*Hypothesis 1a:* Supervisors with high multicultural competence will be more aware of White privilege than supervisors with low multicultural competence.
A simultaneous regression was conducted with White privilege awareness as the outcome variable with two predictors: multicultural awareness [MC Awareness] and multicultural knowledge [MC Knowledge]. The overall regression equation was statistically significant, $F(2, 35) = 26.53, p = .00, R^2 = .60$ (see Table 4). Approximately 60% of the variance in White privilege awareness was accounted for by the two predictors. An examination of the individual predictors revealed that multicultural awareness was statistically significant ($b = 1.67, \beta = .81, p = .00$). Therefore, participants who endorsed more multicultural awareness also endorsed more awareness of White privilege. There was not a statistically significant relationship between multicultural knowledge and White privilege awareness. A post hoc power analysis was conducted using G*Power (Faul et al., 2009). The power achieved was .99.

### Table 4

<table>
<thead>
<tr>
<th>Variable</th>
<th>$B$</th>
<th>SE $B$</th>
<th>$\beta$</th>
<th>$t$</th>
<th>$p$</th>
<th>$sr$</th>
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<tr>
<td>Power</td>
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<td>.99</td>
</tr>
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</table>

*Note. MC Awareness = Multicultural Awareness; MC Knowledge = Multicultural Knowledge. $sr = semi$-partial correlation.  

* $p < .05.$

**Hypothesis 1b:** Supervisors with high multicultural competence will be more willing to confront White privilege than supervisors with low multicultural competence.
A simultaneous regression was conducted with willingness to confront White privilege as the outcome variable with two predictors: multicultural awareness [MC Awareness] and multicultural knowledge [MC Knowledge]. The overall regression equation was statistically significant, $F(2, 35) = 24.93, p = .00, R^2 = .59$ (see Table 5). Approximately 58% of the variance in willingness to confront White privilege was accounted for by the two predictors. An examination of the individual predictors revealed that multicultural awareness was statistically significant ($b = 1.33, \beta = .77, p = .00$). Therefore, participants who endorsed more multicultural awareness also endorsed more intentions or plans to address White privilege. There was not a statistically significant relationship between multicultural knowledge and willingness to confront White privilege. A post hoc power analysis was conducted using G*Power (Faul et al., 2009). The power achieved was .99.

Table 5

<table>
<thead>
<tr>
<th>Variable</th>
<th>$B$</th>
<th>SE $B$</th>
<th>$\beta$</th>
<th>$t$</th>
<th>$p$</th>
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<td>Power</td>
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<td>.99</td>
</tr>
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</table>

Note. MC Awareness = Multicultural Awareness; MC Knowledge = Multicultural Knowledge. $sr$ = semi-partial correlation.

* $p < .05.$

**Hypothesis 1c:** Supervisors with high multicultural competence will be more remorseful about White privilege than supervisors with low multicultural competence.
A simultaneous regression was conducted with White privilege remorse as the outcome variable with two predictors: multicultural awareness [MC Awareness] and multicultural knowledge [MC Knowledge]. The overall regression equation was statistically significant, $F(2, 35) = 8.75, p = .001, R^2 = .33$ (see Table 6). Approximately 33% of the variance in White privilege remorse was accounted for by the two predictors. An examination of the individual predictors revealed that multicultural awareness ($b = 1.49, \beta = .35, p = .00$) and multicultural knowledge ($b = -.63, \beta = -.32, p = .048$) were statistically significant. Therefore, participants who endorsed more multicultural awareness endorsed more remorse about their race-based privilege. However, participants who endorsed more multicultural knowledge endorsed less remorse about their race-based privilege. A post hoc power analysis was conducted using G*Power (Faul et al., 2009). The power achieved was .96.

Table 6

<table>
<thead>
<tr>
<th>Variable</th>
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<td></td>
</tr>
</tbody>
</table>

*Note.* MC Awareness = Multicultural Awareness; MC Knowledge = Multicultural Knowledge. $sr$ = semi-partial correlation. $^*p < .05$. 
Hypothesis 1d: Supervisors with high multicultural competence will be less concerned about the anticipated costs of addressing White privilege than supervisors with low multicultural competence.

A simultaneous regression was conducted with anticipated costs of addressing White privilege as the outcome variable with two predictors: multicultural awareness [MC Awareness] and multicultural knowledge [MC Knowledge]. The overall regression equation was not statistically significant, $F(2, 35) = 24.93, p > .05, R^2 = .00$ (see Table 7). A post hoc power analysis was conducted using G*Power (Faul et al., 2009). The power achieved was .05.

Table 7

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
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<th>$\beta$</th>
<th>$t$</th>
<th>$p$</th>
<th>$sr$</th>
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<td>.05</td>
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<td></td>
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<td></td>
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<td>.05</td>
</tr>
</tbody>
</table>

Note. MC Awareness = Multicultural Awareness; MC Knowledge = Multicultural Knowledge. $sr$ = semi-partial correlation.

Research Question 2

How will the White privilege attitudes of clinical supervisors relate to their perception of the supervisory working alliance?

Hypothesis 2a: Supervisors with high White privilege awareness, high White privilege remorse, high willingness to confront White privilege, and low anticipated costs of
addressing White privilege will make a greater effort to facilitate supervisees’ understanding of clients than supervisors with low White privilege awareness, low White privilege remorse, low willingness to confront White privilege, and high anticipated costs of addressing White privilege.

A simultaneous regression was conducted with client focus as the outcome variable with four predictors: White privilege awareness [WP Awareness], White privilege remorse [WP Remorse], willingness to confront White privilege [Confront WP], and anticipated costs of addressing White privilege [Costs WP]. The overall regression equation was not statistically significant, $F(4, 33) = .69, p > .05, R^2 = .07$ (see Table 8). A post hoc power analysis was conducted using G*Power (Faul et al., 2009). The power achieved was .20.

Table 8

*Simultaneous Regression of Client Focus by White Privilege Attitudes*

<table>
<thead>
<tr>
<th>Variable</th>
<th>$B$</th>
<th>SE $B$</th>
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<td>–.19</td>
<td>–.63</td>
<td>.54</td>
<td>–.11</td>
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<tr>
<td>Costs WP</td>
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<td>.16</td>
<td>.89</td>
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<td>.15</td>
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<td>.31</td>
<td>.93</td>
<td>.36</td>
<td>.16</td>
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<td>–.15</td>
<td>–.66</td>
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<td>–.11</td>
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<tr>
<td>$R^2$</td>
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<td></td>
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<td>.20</td>
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</table>

*Note. Confront WP = Willingness to Confront White privilege; Costs WP = Costs Associated with Addressing White Privilege; WP Awareness = White Privilege Awareness; WP Remorse = White Privilege Remorse. $sr$ = semi-partial correlation. $*p < .05.$*
**Hypothesis 2b:** Supervisors with high White privilege awareness, high White privilege remorse, high willingness to confront White privilege, and low anticipated costs of addressing White privilege will make a greater effort to build a positive supervisory working alliance with supervisees than supervisors with low White privilege awareness, low White privilege remorse, low willingness to confront White privilege, and high anticipated costs of addressing White privilege.

A second simultaneous regression was conducted with rapport as the outcome variable with four predictors: White privilege awareness [WP Awareness], White privilege remorse [WP Remorse], willingness to confront White privilege [Confront WP], and anticipated costs of addressing White privilege [Costs WP]. The overall regression equation was not statistically significant, \( F(4, 33) = 1.19, p > .05, R^2 = .12 \) (see Table 9). A *post hoc* power analysis was conducted using G*Power (Faul et al., 2009). The power achieved was .35.

**Table 9**

*Simultaneous Regression of Rapport by White Privilege Attitudes*

<table>
<thead>
<tr>
<th>Variable</th>
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<th>( SE ) ( B )</th>
<th>( \beta )</th>
<th>( t )</th>
<th>( p )</th>
<th>( sr )</th>
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<td>.91</td>
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<tr>
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<td>.10</td>
<td>-.17</td>
<td>-.97</td>
<td>.34</td>
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<td>.18</td>
<td>.48</td>
<td>1.49</td>
<td>.15</td>
<td>.25</td>
</tr>
<tr>
<td>WP Remorse</td>
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<td>-.37</td>
<td>-1.66</td>
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<tr>
<td>Power</td>
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<td></td>
<td></td>
<td>.35</td>
</tr>
</tbody>
</table>

*Note.* Confront WP = Willingness to Confront White privilege; Costs WP = Costs Associated with Addressing White Privilege; WP Awareness = White Privilege Awareness; WP Remorse = White Privilege Remorse. \( sr \) = semi-partial correlation.

*\( p < .05 \).
Hypothesis 2c: Supervisors with high White privilege awareness, high White privilege remorse, high willingness to confront White privilege, and low anticipated costs of addressing White privilege will have a greater perception of supervisees’ identification with the supervisor than supervisors with low White privilege awareness, low White privilege remorse, low willingness to confront White privilege, and high anticipated costs of addressing White privilege.

A third simultaneous regression was conducted with identification as the outcome variable with four predictors: White privilege awareness [WP Awareness], White privilege remorse [WP Remorse], willingness to confront White privilege [Confront WP], and anticipated costs of addressing White privilege [Costs WP]. The overall regression equation was not statistically significant, $F(4, 33) = 1.17, p > .05, R^2 = .12$ (see Table 10). A post hoc power analysis was conducted using G*Power (Faul et al., 2009). The power achieved was .35.

Table 10

Simultaneous Regression of Identification by White Privilege Attitudes

<table>
<thead>
<tr>
<th>Variable</th>
<th>$B$</th>
<th>SE $B$</th>
<th>$\beta$</th>
<th>$t$</th>
<th>$p$</th>
<th>sr</th>
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<tr>
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<td>.00</td>
<td>.99</td>
<td>.00</td>
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<tr>
<td>Costs WP</td>
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<td>.75</td>
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<td>WP Awareness</td>
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<td>.14</td>
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<td>.67</td>
<td>.08</td>
</tr>
<tr>
<td>WP Remorse</td>
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<td>.13</td>
<td>-.43</td>
<td>-1.91</td>
<td>.07</td>
<td>-.32</td>
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<tr>
<td>$R^2$</td>
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<td></td>
<td></td>
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<td>.12</td>
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<tr>
<td>Power</td>
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<td></td>
<td>.35</td>
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</tr>
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</table>

Note. Confront WP = Willingness to Confront White privilege; Costs WP = Costs Associated with Addressing White Privilege; WP Awareness = White Privilege Awareness; WP Remorse = White Privilege Remorse. sr = semi-partial correlation. *$p < .05$. 
Research Question 3

What is the nature of the relationship between the multicultural competence and White privilege attitudes of clinical supervisors and their perception of the supervisory working alliance?

Hypothesis 3a: Above and beyond supervisor multicultural competence, White privilege attitudes will have an influence on supervisors’ efforts to facilitate supervisees’ understanding of clients.

A hierarchical regression was conducted with client focus as the outcome variable. Predictor variables were entered across two steps: (a) multicultural awareness [MC Awareness] and multicultural knowledge [MC Knowledge] in step 1 and (b) White privilege awareness [WP Awareness], White privilege remorse [WP Remorse], willingness to confront White privilege [Confront WP], and anticipated costs of addressing White privilege [Costs WP] in step 2. The primary focus was on the change in $R^2$ from the main effects to the full model. The findings are reported in Table 11. The omnibus test was statistically significant at step 1 ($F[2, 35] = 3.62, p = .03$), but not at step 2 ($F[6, 31] = 2.04, p = .08$). Examining the individual variables in the models revealed that the main effect for multicultural knowledge was statistically significant in all steps: Final Step – Constant = 2.831; $B = .444; \beta = -.32, sr = .418$). Therefore, supervisors with more multicultural knowledge placed more emphasis on facilitating supervisees’ understanding of clients. A post hoc power analysis was conducted using G*Power (Faul et al., 2009). The power achieved was .43.
Table 11

Hierarchical Regression of Client Focus by Multicultural Competence and White Privilege Attitudes

<table>
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<th>Variable</th>
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<th></th>
<th>Model 2</th>
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</thead>
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<td>SE B</td>
<td>β</td>
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<td>.19</td>
<td>-.06</td>
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<td>.16</td>
<td>.44</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
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<td>MC Knowledge</td>
<td></td>
<td>.44</td>
<td>.17</td>
<td>.48</td>
</tr>
<tr>
<td>Confront WP</td>
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<td>-.29</td>
<td>.19</td>
<td>-.49</td>
</tr>
<tr>
<td>Costs WP</td>
<td></td>
<td>.08</td>
<td>.09</td>
<td>.15</td>
</tr>
<tr>
<td>WP Awareness</td>
<td></td>
<td>.07</td>
<td>.17</td>
<td>.13</td>
</tr>
<tr>
<td>WP Remorse</td>
<td></td>
<td>.04</td>
<td>.11</td>
<td>.08</td>
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<td>Total R²</td>
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</tr>
<tr>
<td>Power</td>
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<td>.43</td>
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<td></td>
</tr>
</tbody>
</table>

Note. MC Awareness = Multicultural Awareness; MC Knowledge = Multicultural Knowledge; Confront WP = Willingness to Confront White privilege; Costs WP = Costs Associated with Addressing White Privilege; WP Awareness = White Privilege Awareness; WP Remorse = White Privilege Remorse. sr = semi-partial correlation.

* p < .05.

Hypothesis 3b: Above and beyond supervisor multicultural competence, White privilege attitudes will have an influence on supervisors’ efforts to build a positive supervisory working alliance with supervisees.

A hierarchical regression was conducted with rapport as the outcome variable. Predictor variables were entered across two steps: (a) multicultural awareness [MC Awareness] and multicultural knowledge [MC Knowledge] in step 1 and (b) White privilege awareness [WP
Awareness], White privilege remorse [WP Remorse], willingness to confront White privilege [Confront WP], and anticipated costs of addressing White privilege [Costs WP] in step 2. The primary focus was on the change in $R^2$ from the main effects to the full model. The findings are reported in Table 12. The omnibus test was not statistically significant at step 1 ($F[2, 35] = 2.84, p > .05$) or step 2 ($F[6, 31] = 1.31, p > .05$). A *post hoc* power analysis was conducted using G*Power (Faul et al., 2009). The power achieved was .34.

Table 12

*Hierarchical Regression of Rapport by Multicultural Competence and White Privilege Attitudes*

<table>
<thead>
<tr>
<th>Variable</th>
<th>$B$</th>
<th>SE $B$</th>
<th>$\beta$</th>
<th>$t$</th>
<th>$p$</th>
<th>sr</th>
<th>$\Delta R^2$</th>
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<td><strong>Model 1</strong></td>
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<td>.14</td>
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<tr>
<td>MC Awareness</td>
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<td>.11</td>
<td>.63</td>
<td>.53</td>
<td>.11</td>
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<td>.22</td>
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<tr>
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<td>−.23</td>
<td>−.71</td>
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<td>−.13</td>
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<tr>
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<td>−.17</td>
<td>−1.01</td>
<td>.32</td>
<td>−.18</td>
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<td>.98</td>
<td>.34</td>
<td>.17</td>
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<td>WP Remorse</td>
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<td>.12</td>
<td>−.24</td>
<td>−1.01</td>
<td>.32</td>
<td>−.18</td>
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<tr>
<td>Power</td>
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</tbody>
</table>

*Note.* MC Awareness = Multicultural Awareness; MC Knowledge = Multicultural Knowledge; Confront WP = Willingness to Confront White privilege; Costs WP = Costs Associated with Addressing White Privilege; WP Awareness = White Privilege Awareness; WP Remorse = White Privilege Remorse. $sr$ = semi-partial correlation.

*p < .05.*
Hypothesis 3c: Above and beyond supervisor multicultural competence, White privilege attitudes will have an influence on supervisees’ identification with the supervisor.

A hierarchical regression was conducted with identification as the outcome variable. Predictor variables were entered across two steps: (a) multicultural awareness [MC Awareness] and multicultural knowledge [MC Knowledge] in step 1 and (b) White privilege awareness [WP Awareness], White privilege remorse [WP Remorse], willingness to confront White privilege [Confront WP], and anticipated costs of addressing White privilege [Costs WP] in step 2. The primary focus was on the change in $R^2$ from the main effects to the full model. The findings are reported in Table 13. The omnibus test was not statistically significant at step 1 ($F[2,35] = 2.29, p > .05$) or step 2 ($F[6,31] = 1.45, p > .05$). A post hoc power analysis was conducted using G*Power (Faul et al., 2009). The power achieved was .27.
### Table 13

**Hierarchical Regression of Identification by Multicultural Competence and White Privilege Attitudes**

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE B</th>
<th>β</th>
<th>t</th>
<th>p</th>
<th>sr</th>
<th>ΔR²</th>
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<td>–.19</td>
<td>–1.02</td>
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<td>–.17</td>
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<td>.18</td>
<td>.61</td>
<td>.55</td>
<td>.11</td>
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<tr>
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<td>.29</td>
<td>1.51</td>
<td>.14</td>
<td>.26</td>
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<tr>
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<td>–.21</td>
<td>–.66</td>
<td>.51</td>
<td>–.12</td>
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</tr>
<tr>
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<td>–.06</td>
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<td>–.07</td>
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<td>–.01</td>
<td>–.03</td>
<td>.98</td>
<td>–.00</td>
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<tr>
<td>WP Remorse</td>
<td>–.17</td>
<td>.14</td>
<td>–.28</td>
<td>–1.20</td>
<td>.24</td>
<td>–.21</td>
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<tr>
<td><strong>Total R²</strong></td>
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<td></td>
<td>.21</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Power</strong></td>
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<td></td>
<td></td>
<td></td>
<td>.27</td>
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</tbody>
</table>

*Note.* MC Awareness = Multicultural Awareness; MC Knowledge = Multicultural Knowledge; Confront WP = Willingness to Confront White privilege; Costs WP = Costs Associated with Addressing White Privilege; WP Awareness = White Privilege Awareness; WP Remorse = White Privilege Remorse. sr = semi-partial correlation.

*p < .05.

### Supplemental Analyses

Although not the primary focus of this study, several supplemental analyses were conducted to examine the nature of the relationship between personal and professional characteristics of supervisors, multicultural competence, and White privilege attitudes for the purpose of generating future hypotheses. The following variables were examined: number of courses completed in multicultural competencies and the amount of time spent discussing
multicultural issues during each supervision session. Analyses of variance (ANOVA) were conducted on the number of courses completed in multicultural competences to assess for the presence of statistically significant mean differences. Regression analyses were conducted on the amount of time spent discussing multicultural issues during each supervision session to explore the amount of variance accounted for in the outcome variable by the predictor variables in the model. The results of the analyses are presented below.

**Multicultural Competence**

Researchers have begun to identify factors that facilitate the development of multicultural competence among clinical supervisors; however, there are a limited number of studies that have explored the impact of the personal and professional characteristics of supervisors on this process. Two one-way ANOVAS were conducted to examine mean group differences for the number of courses completed regarding multicultural issues/competencies on multicultural competence. The first one-way ANOVA was conducted on multicultural awareness [MC Awareness], with coursework completed in multicultural issues/competencies as the grouping variable with three groups: one course, two courses, and three or more courses. The assumption of homogeneity of variance was supported. The results were not statistically significant, $F(2, 35) = 1.125, p > .05$ (see Table 14). The second one-way ANOVA was conducted on multicultural knowledge [MC Knowledge], with coursework completed in multicultural issues/competencies as the grouping variable with three groups: one course, two courses, and three or more courses. The assumption of homogeneity of variance was supported. The results were not statistically significant, $F(2, 35) = 1.581, p > .05$ (see Table 14). Therefore, participants endorsed similar levels of multicultural awareness and knowledge regardless of the number of multicultural courses completed.
Table 1

One-Way Analyses of Variance in Number of Courses Completed Regarding Multicultural Issues/Competencies and Multicultural Competence

<table>
<thead>
<tr>
<th>Measure</th>
<th>One Course</th>
<th></th>
<th>Two Courses</th>
<th></th>
<th>Three or More</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
<td>F(2, 35)</td>
</tr>
<tr>
<td>MC Awareness</td>
<td>6.35</td>
<td>.29</td>
<td>5.98</td>
<td>.60</td>
<td>6.09</td>
<td>.63</td>
</tr>
<tr>
<td>MC Knowledge</td>
<td>5.44</td>
<td>.72</td>
<td>5.42</td>
<td>.44</td>
<td>5.79</td>
<td>.68</td>
</tr>
</tbody>
</table>

Note. MC Awareness = Multicultural Awareness; MC Knowledge = Multicultural Knowledge.

Because specific multicultural issues must be addressed if multicultural supervision is to be effective (Dressel et al., 2007; Phillips et al., 2017), a simultaneous regression was conducted to explore the extent to which supervisor multicultural competence contributes to the amount of time spent discussing multicultural issues during each supervision session. The amount of time spent discussing multicultural issues during each supervision session was the outcome variable with two predictors: multicultural awareness [MC Awareness] and multicultural knowledge [MC Knowledge]. The overall regression equation was statistically significant, $F(2, 33) = 4.77$, $p = .01$, $R^2 = .22$ (see Table 15). Approximately 22% of the variance in the amount of time spent discussing multicultural issues during each supervision session was accounted for by the two predictors. An examination of the individual predictors revealed that multicultural knowledge was statistically significant ($b = 6.33$, $\beta = .51$, $p = .007$). Therefore, participants who endorsed more multicultural knowledge also endorsed spending more time discussing multicultural issues during each supervision session. A post hoc power analysis was conducted using G*Power (Faul et al., 2009). The power achieved was .80.
Table 15

Simultaneous Regression of Time Spent Discussing Multicultural Issues by Multicultural Competence

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE B</th>
<th>β</th>
<th>t</th>
<th>p</th>
<th>sr</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Constant)</td>
<td>-14.37</td>
<td>14.25</td>
<td>-1.01</td>
<td>.32</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MC Awareness</td>
<td>-1.19</td>
<td>2.50</td>
<td>-.08</td>
<td>-.48</td>
<td>.64</td>
<td>-.07</td>
</tr>
<tr>
<td>MC Knowledge</td>
<td>6.33</td>
<td>2.19</td>
<td>.51</td>
<td>2.89</td>
<td>.01*</td>
<td>.44</td>
</tr>
<tr>
<td>( R^2 )</td>
<td>.22</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Power</td>
<td>.80</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. MC Awareness = Multicultural Awareness, MC Knowledge = Multicultural Knowledge. \( sr \) = semi-partial correlation.
*\( p < .05 \).

White Privilege Attitudes

There is a paucity of studies that have explored the impact of multicultural coursework on White clinical supervisors’ awareness of White privilege. Four one-way ANOVAs were conducted to examine mean group differences for the number of courses completed regarding multicultural issues/competencies on White privilege attitudes. The first one-way ANOVA was conducted on White privilege awareness [WP Awareness], with coursework completed in multicultural issues/competencies as the grouping variable with three groups: one course, two courses, and three or more courses. The assumption of homogeneity of variance was supported. The results were not statistically significant, \( F(2, 35) = 1.589, p > .05 \) (see Table 16). The second one-way ANOVA was conducted on White privilege remorse [WP Remorse], with coursework completed in multicultural issues/competencies as the grouping variable with three groups: one course, two courses, and three or more courses. The assumption of homogeneity of variance was supported. The results were not statistically significant, \( F(2, 35) = .68, p > .05 \) (see
The third one-way ANOVA was conducted on willingness to confront White privilege [Confront WP], with coursework completed in multicultural issues/competencies as the grouping variable with three groups: one course, two courses, and three or more courses. The assumption of homogeneity of variance was supported. The results were not statistically significant, $F(2, 35) = .812, p > .05$ (see Table 16). The fourth one-way ANOVA was conducted on anticipated costs of addressing White privilege [Costs WP], with coursework completed in multicultural issues/competencies as the grouping variable with three groups: one course, two courses, and three or more courses. The assumption of homogeneity of variance was supported. The results were not statistically significant, $F(2, 35) = 1.551, p > .05$ (see Table 16). Therefore, participants endorsed similar White privilege attitudes regardless of the number of courses completed.

Table 16

<table>
<thead>
<tr>
<th>Measure</th>
<th>One Course</th>
<th></th>
<th>Two Courses</th>
<th></th>
<th>Three or More</th>
<th></th>
<th>$F(2, 35)$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$M$</td>
<td>$SD$</td>
<td>$M$</td>
<td>$SD$</td>
<td>$M$</td>
<td>$SD$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WP Awareness</td>
<td>5.78</td>
<td>.42</td>
<td>5.48</td>
<td>.76</td>
<td>4.99</td>
<td>1.50</td>
<td>1.59</td>
<td>.22</td>
</tr>
<tr>
<td>WP Remorse</td>
<td>4.02</td>
<td>.89</td>
<td>3.98</td>
<td>.92</td>
<td>3.52</td>
<td>1.56</td>
<td>.69</td>
<td>.51</td>
</tr>
<tr>
<td>Confront WP</td>
<td>5.23</td>
<td>.31</td>
<td>4.92</td>
<td>.73</td>
<td>4.72</td>
<td>1.27</td>
<td>.81</td>
<td>.45</td>
</tr>
<tr>
<td>Costs WP</td>
<td>2.69</td>
<td>.90</td>
<td>3.00</td>
<td>.97</td>
<td>2.25</td>
<td>1.31</td>
<td>1.55</td>
<td>.23</td>
</tr>
</tbody>
</table>

*Note.* WP Awareness = White Privilege Awareness; WP Remorse = White Privilege Remorse; Confront WP = Willingness to Confront White privilege; Costs WP = Costs Associated with Addressing White Privilege.
CHAPTER V

DISCUSSION

The purpose of the current study was to explore the nature of the relationship between multicultural competence, White privilege attitudes, and perceptions of the supervisory working alliance among White clinical supervisors. Three hypotheses were tested. Two hypotheses were partially supported, and one hypothesis was not supported. More specifically, Hypothesis 1, which explored the nature of the relationship between multicultural competence and White privilege attitudes, was partially supported. Hypothesis 2, which examined the nature of the relationship between White privilege attitudes and the supervisory working alliance, was not supported. Hypotheses 3, which examined the nature of the relationship between multicultural competence, White privilege attitudes, and the supervisory working alliance, was not supported. A discussion of the findings, limitations of the current study, implications for practice, and directions for future research follow.

Supervisor Multicultural Competence and White Privilege Attitudes

The findings of the current study indicated that there was a statistically significant positive relationship between multicultural awareness and White privilege awareness, multicultural awareness and willingness to confront White privilege, and multicultural awareness and White privilege remorse. Therefore, participants who endorsed more multicultural awareness also endorsed a more conscious understanding of White privilege, more plans to address or explore White privilege, and more emotional responses, such as shame and anger about having race-based privilege. These results are consistent with the findings of previous
researchers (e.g., Imig, 2018; Mindrup et al., 2011). Mindrup and colleagues (2011) identified a statistically significant positive relationship between multicultural awareness and White privilege awareness, multicultural awareness and willingness to confront White privilege, and multicultural awareness and White privilege remorse. Imig (2018) also found a statistically significant positive relationship between multicultural awareness and White privilege awareness, multicultural awareness and willingness to confront White privilege, and multicultural awareness and White privilege remorse. Therefore, the findings of these authors mirror the findings of the present study.

The results of the present study provide additional empirical support for the commonly held assumption that White privilege awareness is associated with the development of multicultural competence (e.g., Constantine, 2001; Imig, 2018; Mindrup et al., 2011; Neville et al., 2001; Pinterits, 2004). Increased multicultural awareness likely results in more critical consciousness about the deleterious effects of White privilege. It is critical to understand how privilege has contributed to the creation and maintenance of systemic barriers and societal inequities. In addition, Pinterits and colleagues (2009) reported that individuals who have a greater critical consciousness of White privilege often accept responsibility for change at both personal and institutional levels. Feelings of guilt, shame, or remorse about White privilege may also lead to increased intentions to act against White privilege. Higher levels of multicultural awareness may therefore increase one’s willingness to confront White privilege (i.e., interrupting racist jokes, continuing to gain education about the dynamics of privilege and oppression, initiating conversations with supervisees about White privilege, etc.).

Interestingly, the findings of the current study indicated that there was a statistically significant inverse relationship between multicultural knowledge and White privilege remorse.
Therefore, participants who endorsed more multicultural knowledge endorsed less remorse about their race-based privilege. This finding is not consistent with the results of previous research; however, the results of previous studies are mixed. Mindrup and colleagues (2011) found a statistically significant positive relationship between multicultural knowledge and White privilege remorse. Conversely, Imig (2018) did not find a statistically significant relationship between multicultural knowledge and White privilege remorse. One possible explanation for the finding of the current study is participants who have more knowledge about multicultural issues may have a more intellectualized instead of affective understanding of White privilege; therefore, they may have difficulty accepting responsibility for their role in perpetuating racism and oppression. A second possible explanation for this finding is that in learning that emotional responses may impede one’s ability to create change, individuals with more multicultural knowledge may accept responsibility for creating change without experiencing shame or anger. Hays and Shillingford-Butler (2017) reported that the emotions that arise for White people when they learn about racism and White privilege may make it even more difficult for them to take ownership for perpetuating them. In addition, many individuals are willing to acknowledge that racism must be addressed at institutional and societal levels; however, they often avoid addressing it on a personal level (Sue, 2001).

**White Privilege Attitudes and the Supervisory Working Alliance**

There is a dearth of empirical studies that have explored the nature of the relationship between White privilege attitudes and supervisors’ perceptions of the supervisory working alliance. Interestingly, the findings of the current study indicated that there was not a statistically significant relationship between White privilege attitudes and supervisors’ perceptions of the supervisory working alliance. These findings were not expected. Because the supervisory
working alliance is an essential component of effective supervision (Bernard & Goodyear, 2018; Watkins, 2014b), it is possible that supervisors perceive that they make substantial efforts to build positive working relationships with supervisees regardless of their White privilege attitudes. Another possible explanation for these findings is supervisors could have reported on their anticipated behaviors and attitudes instead of actual attitudes, which could have biased results.

Furthermore, there is evidence to suggest that the predicted strength and direction of the relationships between White privilege attitudes and the supervisory working alliance may not be accurate. More specifically, the bivariate correlations between the WPAS and SWAI-S subscales did not correlate as expected. There was a statistically significant negative correlation between White Privilege Remorse and Identification ($r = -.33$). Therefore, supervisors who endorsed more remorse about their race-based privilege perceived that the supervisee had a weaker identification with the supervisor. It is possible that supervisors perceived that their supervisees did not share the same anti-racist beliefs and attitudes. Furthermore, it is possible that the presence of an interaction effect (i.e., race of supervisee) may better explain this finding. The bivariate correlations between the remaining subscales were not statistically significant.

**Supervisor Multicultural Competence, White Privilege Attitudes, and the Supervisory Working Alliance**

The findings of the current study indicated that there was a statistically significant positive relationship between multicultural knowledge and the Client Focus subscale of the SWAI-S. Therefore, supervisors who endorsed more multicultural knowledge perceived that they placed more emphasis on facilitating supervisees’ understanding of clients. This finding adds to the growing body of research evidence that demonstrates the positive relationship
between supervisor multicultural competence and the supervisory working alliance (Crockett & Hays, 2015; Inman, 2006). It is likely that supervisors who have more multicultural knowledge are more aware of cultural issues and sociopolitical concerns (e.g., experiences of racism or discrimination, the client’s worldview, cultural beliefs and practices, etc.) that impact clients’ lived experiences and/or presenting concerns. Moreover, they may be eager to share this information with supervisees to enhance client service delivery and facilitate supervisees’ professional development. Supervisors may also possess specialized knowledge that can assist supervisees with integrating various dimensions of culture into their assessments, case conceptualizations, and treatment interventions (Warner, 2015).

Interestingly, there was not a statistically significant relationship between multicultural competence, White privilege attitudes, and the Rapport subscale of the SWAI-S. Furthermore, there was not a statistically significant relationship between multicultural competence, White privilege attitudes, and the Identification subscale of the SWAI-S. Therefore, supervisors perceived that they made the same amount of effort to develop rapport and facilitate supervisees’ identification with the supervisor regardless of their level of multicultural competence and White privilege attitudes. Because the supervisory working alliance is an essential component of effective supervision (Bernard & Goodyear, 2018; Inman, 2006; Watkins, 2014b), it is possible that supervisors consistently prioritize the development of a positive supervisory working alliance, regardless of the influence of other variables.

Furthermore, there is additional evidence to support the accuracy of the predicted strength and direction of the relationships between multicultural competence and the supervisory working alliance and the inaccuracy of the predicted strength and direction of the relationships between White privilege attitudes and the supervisory working alliance. Some of the bivariate
correlations between the MCKAS subscales and SWAI-S subscales correlated as expected. There was a statistically significant positive relationship between Multicultural Knowledge and Rapport \((r = .36)\) and Multicultural Knowledge and Client Focus \((r = .41)\). Therefore, participants who endorsed more multicultural knowledge reported making a greater effort to build a positive working alliance with supervisees and placed more emphasis on facilitating supervisees’ understanding of clients. Conversely, the bivariate correlations between Multicultural Awareness and the SWAI-S subscales were not statistically significant. Therefore, increased multicultural awareness alone may not translate into changed supervisory behaviors.

As previously discussed, the bivariate correlations between the WPAS and SWAI-S subscales did not correlate as expected. Only one correlation, White Privilege Remorse and Identification \((r = -.33)\), was statistically significant. Therefore, it appears that White privilege attitudes may not influence the supervisory working alliance above and beyond multicultural competence. Because White privilege awareness is thought to be one component of the much broader framework of multicultural competence (Mindrup et al., 2011), it is possible that the influence of White privilege attitudes is subsumed under multicultural competence and therefore does not add any unique variance to the supervisory working alliance. For example, supervisees who do not believe that their supervisor is unaware of their White privilege may conclude that the supervisor lacks multicultural competence. Demonstrating multicultural competence assists the supervisor in building a positive working alliance with supervisees (Crockett & Hays, 2015; Inman, 2006). Therefore, multicultural competence may be more predictive of the supervisory working alliance than White privilege attitudes.
Statistical Power

Due to the present study’s limited sample size ($n = 38$), *post hoc* power analyses ($1 – \beta$) were conducted for each statistical analysis to comment on the confidence in the conclusions drawn from the results. Statistical power is the probability that a test will detect an effect assuming that one exists in the population (Field, 2013). In the behavioral sciences, a value of .80 is recommended (Cohen, 1988; Field, 2013), which means that there is an 80% chance of detecting an effect if one exists. If the value of the post hoc power analysis is .80 or more, it can be concluded that sufficient power was achieved to detect any effects that may have existed in the population (Field, 2013). Conversely, low statistical power may lead to invalid conclusions about the meaning of the results. For example, it can be difficult to determine whether statistically nonsignificant results were found because of insufficient statistical power or because an effect does not exist in the population.

The results of the *post hoc* power analyses ($1 – \beta$) ranged from .05 to .99 for research question 1, .20 to .35 for research question 2, and .27 to .43 for research question 3. Because a value of .80 was not achieved for any of the hypotheses in research questions 2 or 3, findings that were not statistically significant may have been caused by insufficient statistical power.

In order to determine whether the nonsignificant findings were caused by insufficient statistical power, this study should be replicated with a larger sample size. Additional information about the potential implications of low statistical power is provided in the Discussion section.

Furthermore, there is evidence to suggest that the predicted strength and direction of the relationships between some of the study variables may not be accurate. The bivariate correlations between the WPAS and SWAI-S did not correlate as expected. There was a
statistically significant negative correlation between White Privilege Remorse and Identification; however, the bivariate correlations among the remaining subscales were not statistically significant. Conversely, some of the bivariate correlations between the MCKAS subscales and SWAI-S subscales did correlate as expected. There was a statistically significant positive relationship between Multicultural Knowledge and Rapport and Multicultural Knowledge and Client Focus. These findings suggest that White privilege attitudes may not influence the supervisory working alliance above and beyond multicultural competence.

Limitations

As is the case with all studies, the present study contained several limitations. One limitation is the small sample size \((n = 38)\) and low response rate. Small sample sizes lead to low statistical power, which increases the probability of committing a Type II error (failing to detect a true effect; Shen et al., 2011). Furthermore, larger samples more closely approximate the population. Regarding the low response rate, there is unfortunately no way to know whether the individuals who were contacted via the listservs forwarded the recruitment information to the clinical supervisors at their respective organizations. Low response rates appear to be common in the supervision literature, as several other researchers reported low response rates in their studies (e.g., Green & Dekkers, 2010; Hird et al., 2004; Nilsson & Duan, 2007; Schroeder et al., 2009). Furthermore, supervision research is replete with studies utilizing small samples (Bernard & Goodyear, 2018).

Second, participants had to self-select into the survey (i.e., self-selection bias); therefore, there may have been differences between those who chose to participate and those who did not. Participants who declined to respond to the survey may have provided different views than those who chose to participate (Schroeder et al., 2009), which could have influenced results. For
example, participants may have perceived themselves to be more multiculturally competent and more aware of their White privilege than those who did not participate in the study.

Finally, all measures used were self-report and only supervisors’ perceptions were assessed (i.e., method bias). There are several disadvantages of self-report instruments that can impact the reliability and validity of the findings. First, participants may be inclined to respond in a socially desirable manner. Social desirability bias is the tendency of respondents to answer questions in a manner that will be viewed favorably by others (Crowne & Marlow, 1960). Therefore, responses may have reflected anticipated behaviors and attitudes versus actual behaviors and attitudes. Social desirability bias can also take the form of over-reporting desirable behavior or under-reporting undesirable behavior. Self-reporting multicultural competence is often prone to social desirability (Constantine & Ladany, 2000); however, previous research has demonstrated that neither the MCKAS nor the WPAS were correlated with social desirability measures (Pinterits et al., 2009; Ponterotto et al., 2002). Furthermore, because only supervisors were surveyed, supervisees’ perspectives were not included in the study. Supervisees’ perceptions may have differed from those of their supervisors. For example, supervisees may have had a different perception of their supervisor’s multicultural competence and/or the quality of the supervision relationship.

Implications for Practice

Despite the aforementioned limitations, the findings of the current study have several important implications for supervision practice. First, an implication emerges to provide training experiences for all White clinical supervisors to further develop their multicultural supervision competence and awareness of White privilege, regardless of perceived experience levels (Gloria et al., 2008). Supervisor self-awareness is a critical component of multicultural supervision
competence (Ancis & Ladany, 2010). Therefore, supervision training should incorporate information about how to detect biases (e.g., White privilege), as biases can unknowingly impact the provision of mental health services. For example, supervisors may benefit from participating in implicit bias activities to increase awareness of subconscious biases that may be attributed to stereotypes (Jones, Sander, & Booker, 2013). Supervisors may also benefit from furthering their understanding of ways their affective, cognitive, and behavioral reactions to White privilege may maintain systemic oppression and impede the development of their multicultural competence (Mindrup et al., 2011). Increased awareness of White privilege will likely increase supervisor multicultural competence.

Next, supervisors are recommended to continuously evaluate their multicultural supervision practices and identify areas for growth. Supervisors should reflect on their practice of initiating and discussing multicultural issues in supervision and consider whether they may be giving less attention to these issues than is warranted (Phillips et al., 2017). This recommendation is consistent with best practice guidelines (e.g., APA, 2015). Supervisors should also identify barriers that may impede the provision of culturally responsive supervision (e.g., perceived lack of competence, fear of making mistakes, belief that cultural issues are unimportant) and seek opportunities to remediate these barriers. This process may enhance the supervisory working alliance, as supervisors may subsequently be more willing to engage in discussions about multicultural issues with supervisees.

Finally, supervisors may benefit from supervision training that focuses on establishing and assessing the supervisory relationship in conjunction with addressing multicultural issues (Toporek et al., 2004). This training must include information about the importance of initiating discussions about multicultural issues in supervision and specific examples of how to do so.
Supervisors would also benefit from learning strategies to engage supervisees in difficult conversations while maintaining the supervisory relationship (DiAngelo, 2016; Sue, 2015). Supervisors would also benefit from reading the relevant literature on best practices in multicultural supervision, watching demonstrations of multicultural supervision, and supervised experiences with providing supervision to supervisees who hold marginalized identities. It is also recommended that supervisors seek ongoing feedback from supervisees regarding their experiences in supervision and use this feedback to inform their supervision practices.

In addition, supervisor training experiences should occur in a sequential manner to maximize the development of supervisors’ awareness, knowledge, and skills. More specifically, multicultural supervision training should not occur until students have completed coursework related to multicultural issues/competencies and the importance of considering diversity in all aspects of psychological practice (e.g., psychological assessment, research methods, counseling theories, group work, career development, etc.; Sue et al., 2018). Coursework related to multicultural issues/competencies should emphasize self-awareness, especially White privilege awareness (Jones et al., 2013; Sue et al., 2019) and awareness of White privilege attitudes (Pinterits et al., 2009). If this sequence is followed, students will be familiar with information about multicultural issues and White privilege prior to beginning supervision training. Furthermore, students will have had opportunities to increase self-awareness, consider the relevance of diversity issues in all aspects of psychological practice, and apply multicultural awareness and knowledge to assessments, therapy, and case conceptualizations. Ancis and Ladany (2010) argued that a supervisor’s first task is to understand and assess the multicultural competence of the supervisee; however, supervisors must have a higher level of multicultural
competence in order to conduct such an assessment. Therefore, these training experiences will enable supervisors to better assess the skill development of supervisees and increase comfort with initiating dialogues about multicultural issues in supervision.

**Future Research**

While the findings of the current study contribute to our knowledge about the relationship between multicultural competence, White privilege attitudes, and the supervisory working alliance, additional information is needed prior to drawing conclusions about the impact of White privilege on the supervision process. There is a dearth of empirical studies that have explored the nature of the relationship between supervisor multicultural competence and White privilege attitudes. Moreover, there is a dearth of empirical studies that have explored the impact of supervisor multicultural competence and White privilege attitudes on the supervisory working alliance. Therefore, we are only beginning to understand the influence of White privilege attitudes on the supervision process. Although literature on supervisor multicultural competence has flourished during the last decade, it is still in its early stages (Tohidian & Quek, 2017). To increase validity, the current study should be replicated with a larger sample size.

Furthermore, additional information is needed to continue to inform our understanding of the factors that influence the development of multicultural competence and White privilege attitudes among White clinical supervisors. More specifically, it is recommended that future researchers explore the impact of personal and professional characteristics (e.g., the impact of the amount, frequency, and depth of contact with racial/ethnic minority groups through lived experiences, the ages of supervisors and supervisees, years of experience providing clinical services to racially different groups) on the multicultural competence and White privilege attitudes of supervisors. It may also be beneficial to study the multicultural competence and
White privilege attitudes of more experienced supervisors (e.g., supervisors who have provided supervision for 10 years or more; Bernard & Goodyear, 2018) compared to supervisors who have less experience (e.g., supervisors who have provided supervision for less than 10 years). This information should then be used to enhance supervision training.

Finally, because the methodology of the present study limited data collection to only one member of the supervisory dyad (i.e., the supervisor), it is recommended that future research incorporate the perspectives of both supervisors and supervisees. Incorporating perspectives from both members of the supervisory dyad will allow for the investigation of interaction effects and increase the validity of findings (Schroeder et al., 2009). Most studies of clinical supervision have collected responses from only the supervisor or supervisee (Ancis & Marshall, 2010; Watkins, 2014b). Watkins (2014b) found that supervisees’ perspectives have been the subject of interest in most studies of the supervisory working alliance. However, Ancis and Marshall (2010) found that the experiences and perceptions of supervisees in multicultural supervision relationships have been largely unexplored. Because the supervisory working alliance is co-constructed, it seems important to examine the perspectives of both members of the supervisory dyad (Watkins, 2014b). Furthermore, previous research has shown that the perspectives of supervisors and supervisees regarding their experiences in supervision may differ (e.g., Riley, 2004; Duan & Roehlke, 2001; Green & Dekkers, 2010). Therefore, including the perspectives of supervisors and supervisees will enable comparisons and provide important contributions to our knowledge about clinical supervision.
REFERENCES


Appendix A

Human Subjects Institutional Review Board
Letter of Approval
Date: December 19, 2018

To: Joseph Morris, Principal Investigator
   Michelle Stahl, Student Investigator for dissertation

From: Amy Naugle, Ph.D., Chair

Re: IRB Project Number 18-03-09

This letter will serve as confirmation that the changes to your research project titled “The Influence of White Privilege Attitudes and Multicultural Competence on Supervisors' Perception of the Supervisory Working Alliance” requested in your memo received December 12, 2018 (to change project title to, “The Influence of White Privilege Attitudes and Multicultural Competence on Supervisors' Perception of the Supervisory Working Alliance”; to revise recruitment procedures; to remove three instruments; to revise demographic questionnaire; to modify recruitment script and consent document to reflect these changes) have been approved by the WMU Institutional Review Board.

The conditions and the duration of this approval are specified in the Policies of Western Michigan University.

Please note that you may only conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the IRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: March 27, 2019
Appendix B

Recruitment Script
Dear Colleague:

My name is Michelle Stahl and I am a doctoral candidate in the counseling psychology program at Western Michigan University. I am contacting you because I am currently recruiting participants for a research project that explores the extent to which various social attitudes relate to the supervisory working alliance. This research is being conducted as a part of my dissertation requirements. I would very much appreciate if you would consider forwarding the following recruitment letter to the clinical supervisors at your agency. I greatly appreciate your time and consideration.

Sincerely,

Michelle Stahl

---------------------------------------------------------------------------------------------------------------------

Dear Colleagues:

My name is Michelle Stahl and I am a doctoral candidate in the counseling psychology program at Western Michigan University. I am contacting you to invite you to participate in a research project that explores the extent to which various social attitudes relate to the supervisory working alliance. This research is being conducted as a part of my dissertation requirements. My doctoral chairperson is Dr. Joseph R. Morris, a professor in the Department of Counselor Education and Counseling Psychology at Western Michigan University.

It is estimated to take 15 to 20 minutes to participate in this study. All data collection will occur online. Your responses will be completely anonymous. At the end of the survey, you will have an opportunity to enter a drawing for one of four $25.00 gift cards to Amazon.com. You are eligible to participate in this study if:

1. You are 18 years of age or older
2. You are a White clinical supervisor
3. You have provided supervision within the past two years

You may access the survey by clicking on the following link:
When you begin the survey, you are consenting to participate in the study. If you decide that you do not wish to continue after beginning the survey, you may stop at any time. You may choose not to answer any question for any reason.

If you have questions prior to or during the study, you may contact Joseph R. Morris at joseph.morris@wmich.edu or Michelle A. Stahl at michelle.a.stahl@wmich.edu.

Sincerely,

Michelle Stahl
Appendix C

Informed Consent Document
Western Michigan University  
Department of Counselor Education and Counseling Psychology

Principal Investigator: Joseph R. Morris, Ph.D.  
Student Investigator: Michelle A. Stahl, M.A.

You have been invited to participate in a research project that explores the extent to which various social attitudes relate to the supervisory working alliance. This study is being conducted by Michelle A. Stahl, a doctoral student in counseling psychology, under the supervision of Dr. Joseph R. Morris, a professor in the Department of Counselor Education and Counseling Psychology at Western Michigan University. This research is being conducted as part of the dissertation requirements for Michelle Stahl.

This consent document will explain the purpose of this research project and will go over all of the time commitments, procedures used in the study, and risks and benefits of participating in this research project. Please read this consent form carefully and completely and ask any questions if you need more clarification before you begin the survey.

What are we trying to find out in this study?  
The purpose of this study is to better understand how various social attitudes relate to the supervisory working alliance.

Who can participate in this study?  
All clinical supervisors who are (a) White and (b) have provided clinical supervision within the past two years are eligible to participate. In addition, all participants must be 18 years of age or older.

Where will this study take place?  
Data will be collected using online survey software at a location determined by the participant.

What is the time commitment for participating in this study?  
Participation in this study is expected to take approximately 15 to 20 minutes.

What will you be asked to do if you choose to participate in this study?  
If you choose to participate in this study, you will be asked to respond to a series of questions about yourself and your experiences in one of your supervisory relationships.

What information is being measured during the study?  
Information about yourself and your experiences in one of your supervisory relationships will be collected.

What are the risks of participating in this study and how will these risks be minimized?  
There are no known risks for participating in this study. A code number will be used to label your data, not your name. Data will only be accessed by the research team.
What are the benefits of participating in this study?
Your participation in this study will increase our understanding of the ways in which various social attitudes relate to the supervisory working alliance. Participating in this study will also provide an opportunity for you to reflect on your experiences in one of your supervisory relationships.

Are there any costs associated with participating in this study?
There are no costs associated with participating in this study.

Is there any compensation for participating in this study?
At the end of the survey, you will have an opportunity to enter your name into a drawing for one of four $25.00 gift cards to Amazon.com.

Who will have access to the information collected during this study?
All data collection will be anonymous. Your name will not appear on the data. Only the principal and student investigator will have access to the information collected during this study. All data will be secure, in accordance with the standards of Western Michigan University, federal regulations, and the American Psychological Association.

What if you want to stop participating in this study?
You can choose to stop participating in the study at any time for any reason. You will not suffer any prejudice or penalty by your decision to stop your participation. You will experience NO consequences either academically or personally if you choose to withdraw from this study.

When you begin the survey, you are consenting to participate in the study. If you do not agree to participate in this research project simply exit now. If, after beginning the survey, you decide that you do not wish to continue, you may stop at any time.

Should you have any questions prior to or during the study, you can contact the primary investigator, Joseph R. Morris at (269) 387-5112 or joseph.morris@wmich.edu or the student investigator, Michelle Stahl, at michelle.a.stahl@wmich.edu. You may also contact the Chair, Human Subjects Institutional Review Board at (269) 387-8293 or the Vice President for Research at (269) 387-8298 if questions arise during the course of the study.

This consent document has been approved for use for one year by the Human Subjects Institutional Review Board (HSIRB) on March 25, 2020. Do not participate after March 24, 2020.

Participating in this online survey indicates your consent for the use of the answers you supply.

I agree to participate in this research study.
I do not agree to participate in this research study.
Appendix D

Demographic Questionnaire
Demographic Questionnaire

1. Age:

2. Gender:
   A. Male
   B. Female
   C. Transgender
   D. Not listed, please specify:

3. Race/Ethnicity:
   A. American Indian or Alaskan Native
   B. Asian or Pacific Islander
   C. Black or African American
   D. Hispanic/Latino(a)
   E. White
   F. Bi-racial/Multi-racial
   G. Not listed, please specify:

4. Describe the setting in which you currently work:
   A. Community Mental Health Agency
   B. Department Training Clinic
   C. Hospital
   D. Private Practice
   E. School
   F. University Counseling Center
   G. VA
   H. Not listed, please specify:

5. How long have you provided counseling services:
   A. _______ years
   B. _______ months

6. What percentage of your clients have been racial/ethnic minorities (e.g., African American, Asian American, Latino/a, Native American):

7. How long have you been a supervisor:
   A. _______ years
   B. _______ months

8. How frequently do you provide supervision:
   A. Daily
   B. Weekly
   C. Bi-weekly
   D. Monthly
9. How recently have you supervised someone:
   A. I am currently supervising someone
   B. I supervised someone within the past month
   C. I supervised someone within the past 6 months
   D. I supervised someone within the past year
   E. I supervised someone within the past 2 years

10. Total number of supervisees supervised:

11. What percentage of your supervisees have been racial/ethnic minorities (e.g., African American, Asian American, Latino/a, Native American):

12. Average amount of time (in minutes) spent discussing multicultural issues during each supervision session:

13. Describe your training:
   A. Currently in graduate school
   B. Completed Master’s degree
   C. Completed doctoral degree

14. Major/area of concentration (e.g., clinical psychology, counseling psychology, social work, etc.):

15. Coursework completed in multicultural issues/competencies:
   A. I have not completed a course covering these topics
   B. I have completed one course
   C. I have completed two courses
   D. I have completed three or more courses