Do the perceptions of supervisory working alliance mediate the relation between perceived supervisors' multicultural competence and trainees' multicultural counseling self-efficacy?

Arthur Ritmeester
University at Albany, State University of New York, arthurritmeester@gmail.com

The University at Albany community has made this article openly available. Please share how this access benefits you.

Follow this and additional works at: https://scholarsarchive.library.albany.edu/legacy- etd

Part of the Clinical Psychology Commons, and the Counseling Psychology Commons

Recommended Citation

This Dissertation is brought to you for free and open access by the The Graduate School at Scholars Archive. It has been accepted for inclusion in Legacy Theses & Dissertations (2009 - 2024) by an authorized administrator of Scholars Archive. Please see Terms of Use. For more information, please contact scholarsarchive@albany.edu.
DO THE PERCEPTIONS OF SUPERVISORY WORKING ALLIANCE MEDIATE THE
RELATION BETWEEN PERCEIVED SUPERVISORS’ MULTICULTURAL COMPETENCE
AND TRAINEES’ MULTICULTURAL COUNSELING SELF-EFFICACY?

by

Arthur H. Ritmeester

A Dissertation
Submitted to the University at Albany, State University of New York
in Partial Fulfillment of
the Requirements for the Degree of
Doctor of Philosophy

School of Education
Department of Educational and Counseling Psychology
2016
Do the Perceptions of Supervisory Working Alliance Mediate
the Relation between Perceived Supervisors’
Multicultural Competence and Trainees’ Multicultural
Counseling Self-Efficacy?

by

Arthur H. Ritmeester

Copyright 2016
Acknowledgments

This dissertation could not have been completed without the support and patience of my committee members, family, friends, supervisors, and colleagues. I would like to thank my advisor and chair Michael Ellis, Ph.D. for his guidance throughout this project, and challenging me to become a better researcher and professional. I also want to express much appreciation for Myrna Friedlander, Ph.D., my training director and committee member, for her unwavering support and encouragement throughout the doctoral enterprise. I would also like to express my deep gratitude to Alex Pieterse, Ph.D., who has served many roles throughout my training as instructor, supervisor, and committee member, to name but a few. I cherish his mentorship, wisdom, and friendship throughout this journey.

I am immensely grateful to my parents for their love, encouragement, and support over the years. My friends Bobby, Duane, Jeremy, and Laura hold a special place in my heart for their camaraderie, inspiration, and support. Thank you, especially, to Chris for his endless patience, and unrelenting encouragement.

I have tremendous gratitude for the supervisors I have been privileged to work with throughout my training: Alex, Andrea, Joe, Micki, Walt, Jason, Mike, Jerome, Warren, Dr. Sharp, Darren, Janet, Liz, Danny, and Juan, you inspired this project and ignited my passion for supervision. Finally, I am thankful to all the training directors who graciously forwarded my recruitment Emails and to all the participants that generously spent their time to provide the data that made this dissertation possible.
# Table of Contents

Acknowledgments iii  
Table of Contents iv  
Abstract vi  

## Chapter 1: Introduction 1  
Multicultural Counseling Self-Efficacy 3  
Supervisors’ Multicultural Competence 5  
Supervisory Working Alliance 7  
Problem Statement 9  

## Chapter 2: Method 10  
Participants 10  
  Power analysis 10  
  Inclusion and exclusion criteria 10  
  Sample characteristics 11  
Instruments 14  
  Supervisor Multicultural Competence 14  
  Supervisory Working Alliance 15  
  Multicultural Counseling Self-Efficacy 15  
  Social Desirability 16  
  Demographic Questionnaire 17  
Procedure 17  

## Chapter 3: Results 19  
Missing Data 19  
Preliminary Analyses 19
Major Analyses

Tests of Hypotheses

Chapter 4: Discussion

Descriptive Findings

Major Results

Limitations

Strengths

Practical Implications and Future Research Directions

Conclusion

References

List of Tables

Table 1: Sample Demographic Characteristics

Table 2: Reported Supervisor Characteristics

Table 3. Descriptive Data, Comparison Data, and Bivariate Correlations

Table 4: Regression Table

List of Figures

Figure 1. Hypothesized Mediation Model

Figure 2. Test of the mediated model with beta weights

Figure 3. Test of the mediated model with correlations

Appendix A. Demographics Questionnaire

Appendix B. Cover Letter

Appendix C. Informed Consent

Appendix D. Detailed Preliminary Analyses
Abstract

This study tested whether the relation between supervisory multicultural competence (SMC), as perceived by the supervisee, and multicultural counseling self-efficacy (MCSE) was partially mediated by the supervisory working alliance (SWA). This study was conducted in response to (a) a mismatch in previous research between the operationalization of MCSE and the underlying theorizing, and (b) inconsistent results in previous research about the relation between the SWA and counseling self-efficacy development. Participants were 182 health service psychologist trainees in the United States receiving supervision at the time of data collection.

The major results were as follows: SMC significantly predicted MCSE in a simple regression model; however, the effect size of this relation became trivial once the SWA was included in the mediated model. SMC had a strong direct relation with the SWA. The SWA had a significant direct relation with MCSE; however, in the tested mediation model this relation became nonsignificant. Thus, the SWA did not significantly mediate the relation between SMC and MCSE as hypothesized.

These findings might be explained by the relatively high experience level of the sample ($M = 36.51$ months, $SD = 22.58$) in comparison to prior studies. The relation of MCSE to previous training experiences was tested post hoc in an attempt to understand what might contribute to MCSE development. There was no significant relation between racial diversity in participants’ current caseload and MCSE. Furthermore, the months of prior supervised clinical experience had a trivial albeit significant effect size when predicting MCSE. This was inconsistent with Bandura’s (1977) theory, which suggests prior experience performing an activity is the primary contributor to self-efficacy development. The strong relation between SMC and SWA was discussed. The overreliance on supervisee self-report in studying these
aspects of supervision may paint an incomplete picture of what happens in supervision. In particular, the importance of the SWA to supervisees may overshadow their perceptions of other supervision factors. Future directions for research were also discussed.
Introduction

Therapists have been urged to be responsive to the needs of racially diverse clients (e.g., Sue, Arredondo, & McDavis, 1992), or “the category in which others assign individuals on the basis of physical characteristics, such as skin color or hair type” (American Psychological Association, 2003, p. 9). Therapists who are responsive to the needs of diverse clients can provide services leading to client satisfaction (Constantine, 2002; Fuertes & Brobst, 2002) and avoid providing sub-standard treatment to minority clients, as has historically been the case (Toldson & Toldson, 2001).

One way in which therapists’ preparedness to work with diverse clients has been assessed is through their self-reported multicultural counseling self-efficacy (MCSE; Sheu & Lent, 2007). Therapists’ MCSE is based on Bandura’s (1977, 1986) conceptualization of self-efficacy and refers to confidence in one’s ability to work with culturally diverse clients. According to Bandura’s (1977) conceptualization of self-efficacy, MCSE would predicate willingness to take on challenges, quality of performance, and persistence in the face of setbacks in the context of multicultural counseling. That is, theoretically self-efficacy is related directly to the ease with which learned skills are implemented (Chiaburu & Marinova, 2005) and performed (Larson et al., 1992; Munson, Stadulis, & Munson, 1986). The findings in these studies suggest that MCSE may be positively related to counselors’ performance when working with clients of diverse backgrounds.

Trainees may develop MCSE by training with supervisors who possess a high level of supervisory multicultural competence (SMC), defined as a supervisor who has the attitudes, knowledge, and skills needed to work effectively with diverse clients and supervisees, and explicitly addresses diversity in supervision (Inman, 2006). Because supervision is the primary
method of clinical training (Holloway, 1992), the present study explored MCSE development in that context.

This study focused on MCSE and SMC in relation to race because (a) a person’s racial group membership is one of the salient aspects of his or her identity (Killian, 2001), and (b) therapists are frequently faced with race-related issues in their clinical work because society is becoming increasingly racially diverse (Sue et al., 1992).

Little is known about factors that contribute to the development of MCSE due to two major problems in the literature. First, general counseling self-efficacy, rather than MCSE, has been assessed as a multicultural supervision outcome (e.g., Ng & Smith, 2012; Nilsson & Anderson, 2004). However, since self-efficacy in one area does not necessarily translate to self-efficacy in another (Bandura, 1986), SMC does not necessarily enhance a person’s self-efficacy in a domain other than MCSE. In previous research, general counseling self-efficacy may have been associated with SMC because counseling self-efficacy is associated with MCSE \((r = .79;\) Sheu & Lent, 2007); however, the relation between SMC and MCSE remains untested.

A second problem in the relevant literature is that multicultural competence is often confounded with MCSE (Sheu & Lent, 2007). Multicultural competence has frequently been assessed by self-report measures, which Constantine and Ladany (2000) suggested may be assessing MCSE rather than multicultural competence. Thus, evidence supporting relations between multicultural competence and other factors, such as SMC, may actually reflect relations between MCSE and SMC. Furthermore, some authors have intentionally measured MCSE using self-reports of multicultural competence (e.g., Constantine, 2001b). Thus multicultural competence measures have been used to measure multicultural competence as well as MCSE.

To identify what (if any) contribution SMC makes to MCSE, MCSE needs to be considered as a unique construct.
One factor that may elucidate the relation between SMC and MCSE is the supervisory working alliance (SWA), which refers to the supervisor and supervisee’s emotional bond, their agreement on supervision tasks, and agreement on supervision goals (Bordin, 1983): Supervisees have reported (a) a direct relation between their perceptions of SMC and the SWA (Inman, 2006), and (b) trust in their supervisor when discussing race explicitly (Burkard et al., 2006). It was reasoned that the SWA may mediate the relation between SMC and MCSE because, according to Bandura (1977), the degree of distress a person experiences when performing a target behavior (in this case, counseling racially diverse clients), is inversely related to the level of self-efficacy.

Although SWA is theoretically linked with counseling self-efficacy, empirical findings have been inconsistent. Whereas Efstation, Patton, and Kardash (1990) found a direct relation between SWA and general counseling self-efficacy, Ladany, Ellis, and Friedlander (1999) found no such relation. These inconsistencies obscure the extent to which the SWA may facilitate counselor self-efficacy development, either generally or in a specific context, such as multicultural counseling.

Identifying an antecedent to MCSE can help supervisors better facilitate supervisees’ MCSE development and supervisees’ subsequent ability to work with racially diverse clients. Hence, the purpose of the study was to address the confounds in the literature and to clarify our understanding of MCSE development.

**Multicultural Counseling Self-Efficacy**

Multicultural counseling self-efficacy refers to the belief that one can successfully perform the behaviors needed to provide multiculturally competent counseling (Sheu & Lent, 2007). Self-efficacy may provide an indication of how frequently and with how much effort therapists mobilize their abilities (Bandura, 1990). Thus, multicultural counseling self-efficacy
may be a component of multicultural competence (Constantine & Ladany, 2001) because, logically, counselors need to mobilize their multicultural knowledge, awareness, and skills in order to be multiculturally competent (Sue et al., 1992). However, two specific problems in the MCSE literature have limited our understanding of MCSE development.

First, general counseling self-efficacy has been used as an outcome variable of SMC (e.g., Ng & Smith, 2012; Nilsson & Anderson, 2004), thereby mismatching a general operationalization of self-efficacy to what conceptually is a more specific form of self-efficacy (i.e., multicultural counseling self-efficacy). Supervisors with high SMC can increase supervisees’ multicultural competence, which has been described as a unique subset of skills comprising general counseling competence (American Psychological Association, 2003; Fouad et al., 2009) because dialogue regarding race is explicitly addressed in clinical work (Sue & Sue 2003; Weinrach & Thomas, 1996).

Recall that MCSE refers to the counselor’s confidence in executing multicultural counseling skills; thus, MCSE is an appropriate measure of the contributions of SMC on supervisees’ self-efficacy. However, in several studies (Ng & Smith, 2012; Nilsson & Anderson, 2004) general counseling self-efficacy (i.e., counselors’ confidence in their ability to implement the larger set of skills comprising general counseling competence without attending to race per se; Sheu & Lent, 2007) was measured rather than MCSE, which may not reflect the effects of multicultural supervision because counseling self-efficacy is overly general in this context. This problem suggests that conclusions previously drawn about the relation between SMC and supervisees’ self-efficacy may be incongruent with underlying theory and not capture the full contribution of SMC on MCSE. Thus, prior research on the contributions of SMC should be replicated with MCSE.
The second problem in the MCSE literature is that many of the measures of multicultural counseling competence are self-report (e.g., D’Andrea, Daniels, & Heck, 1991; Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002; Sodowsky, Taffe, Gutkin, & Wise, 1994) which may reflect perceived ability (i.e., MCSE) rather than actual ability (Sheu, Rigali-Oiler, & Lent, 2012). That is, self-report ability is distinct from self-report competence. This distinction suggests that multicultural competence and MCSE have been confounded when self-report measures are used to assess multicultural competence. Researchers have found no significant association between scores on self-report multicultural competence measures and more objective measures of multicultural competence, such as case conceptualization ability as evaluated by external raters (Constantine & Ladany, 2000).

On the other hand, scores on self-report multicultural competence measures have been strongly and positively related to scores on a measure of MCSE ($r = .68$; Sheu & Lent, 2007). These findings suggest that constructs like SWA, identified as predictors of self-reported multicultural competence, may actually be closely related to MCSE. Therefore these relations need to be tested empirically. In order to do so effectively, the relation between MCSE and multicultural competence needs to be explicated theoretically.

**Supervisors’ Multicultural Competence**

Constantine and Ladany (2001) asserted that MCSE is a dimension of multicultural competence. Whereas multicultural competence refers to a counselor’s attitudes, knowledge, and skills (Sue et al., 1992), MCSE refers to beliefs a counselor has about his or her ability to use those skills (Lent & Sheu, 2007). The relation between these constructs is reasoned to be reciprocal. That is, as multicultural competence increases, so do supervisees’ beliefs about their abilities (i.e., MCSE); conversely, as MCSE increases, supervisees are more likely to practice their multicultural counseling skills and improve their competence. Thus, a direct relation is
posited between SMC and MCSE, because supervisors with high SMC can effectively train supervisees to enhance their multicultural attitudes, knowledge, and skills.

There is theoretical support for the relation between SMC and MCSE: People are said to develop self-efficacy from four sources (Bandura, 1977) which arguably is provided by effective supervision. The first source is supervisees’ experiences of successfully performing multiculturally competent counseling skills. Multiculturally competent supervisors are likely to provide supervisees the experience to integrate multicultural literature with the practice of multicultural counseling skills (Constantine, 2001b).

The second source of self-efficacy is vicarious learning and modeling, which may occur when supervisees observe their supervisors effectively addressing multicultural topics in supervision (Kaduvettoor, O’Shaughnessy, Mori, Beverly, Weatherford, & Ladany, 2009). Furthermore, supervisors may model taking risks when initiating multicultural discussions in the supervisory relationship, thereby increasing supervisees’ likelihood of discussing these issues in their own clinical work (Nelson, Oliver, & Capps, 2006). The third source of self-efficacy is verbal persuasion (Bandura, 1977), which may be provided via supervisors’ encouragement and support for supervisees’ counseling diverse clients.

The fourth source of self-efficacy is physiological and affective experience, such as the degree of anxiety and fear associated with a behavior (Bandura, 1977). In one study (Burkard et al., 2006), when supervisors addressed cultural concerns, supervisees reported feeling supported by their supervisors and reduced fear, a physiological and affective experience, about discussing race in both supervision and therapy. In other studies, when supervisors did not address culture, both white and racial minority supervisees reported feelings of powerlessness and mistrust (Daniels, D’Andrea, & Kim, 1999; Hird, Tao & Gloria, 2004). Thus, by discussing multicultural issues in supervision, supervisees’ perceptions of their multicultural competence (i.e., MCSE)
are reasoned to increase, as well as their actual multicultural competence (Constantine, 2001b; Hird et al., 2004).

The direct relation between supervision variables and self-efficacy has received empirical support in relation to general counseling self-efficacy (Larson et al., 1992). However, these relations have yet to be tested in the context of multicultural supervision. There has been indirect support for the relation between SMC and MCSE: Self-perceived multicultural competence has been directly related to the proportion of time spent discussing multicultural issues with a supervisor (Constantine, 2001b; Pope-Davis et al., 1994, 1995). Furthermore, Constantine (2001a) found that time spent addressing multicultural issues in supervision was a significant predictor of counselor trainees’ MCSE; however, these studies operationalized MCSE using self-report measures of multicultural competence. Although some evidence suggests that MCSE and self-reported multicultural counseling competence are closely related constructs (Sheu & Lent, 2007), this conceptual mismatch underscores the previously identified problem of confounding MCSE with other variables.

**Supervisory Working Alliance**

To further build a case for a relation between SMC and MCSE, let us consider a third construct, the supervisory working alliance (SWA, Bordin, 1983). The direct relation between SMC and the SWA, irrespective of the racial composition of the supervisory dyad, has received consistent quantitative and qualitative support (e.g., Burkard et al., 2006; Duan & Roehlke, 2001; Gatmon et al., 2001; Hird et al., 2004; Inman, 2006). Supervisors who are multiculturally competent are likely to engage their supervisees in multicultural discussions (Inman, 2006). These discussions may facilitate developing a strong SWA (e.g., Duan & Roehlke, 2001) because supervisees tend to trust supervisors who raise multicultural topics in supervision (Burkard et al., 2006).
The SWA, in turn, may be directly related to MCSE. One of eight outcomes that are expected from a strong SWA is the mastery of specific (e.g., multicultural) counseling skills (Bordin, 1983). Supervisees have reported that they feel respected, supported, and trusting when their supervisors are willing to discuss cultural differences (Duan & Roehlke, 2001). Thus it was reasoned that when the SWA is strong, the four sources of self-efficacy, performance accomplishments, vicarious experiences, verbal persuasion, and emotional arousal (Bandura, 1977), are likely to be present in supervision. Theoretically, a strong SWA may provide the encouragement (verbal persuasion) and sense of support (emotional arousal) needed for supervisees to practice their counseling skills and develop MCSE. Furthermore, negotiating goals and tasks in supervision may help supervisees identify priorities in their multicultural counseling, as well as take advantage of goal setting behaviors modeled by the supervisor (vicarious experiences). When the SWA is strong enough, supervisees may feel comfortable discussing their counseling sessions and receive feedback on their successes (performance accomplishments). Despite theoretical connections between SWA and MCSE, no studies have tested relations between these concepts.

Some studies have investigated the relation between the SWA and general counseling self-efficacy, although findings are mixed. Whereas some authors found no significant relation between SWA and general counseling self-efficacy (e.g., Ladany et al., 1999; Ng & Smith, 2012), other authors reported a significant direct relation (Efstation et al., 1990; Nilsson & Anderson, 2004). These inconsistent findings suggest the presence of confounding variables. A direct relation between the SWA and self-efficacy may occur in multicultural supervision because supervisees feel comfortable addressing diversity issues in this context (Burkard et al., 2006; Duan & Roehlke, 2001; Hird et al., 2004). Consequently, the frequency and quality of multicultural discussions needed to develop MCSE is likely directly related to the quality of the
SWA. Thus, although no consistent relation has been found between SWA and general counseling self-efficacy, there may be an association between SWA and MCSE, in particular due to the importance that supervisees tend to place on the supervisory relationship when discussing multicultural topics (Burkard et al. 2006; Hird et al., 2004).

**Problem Statement and Hypotheses**

In summary, SMC reflects the knowledge, awareness, and skills needed for supervisees to develop their multicultural competence, which theoretically includes MCSE. The development of MCSE is posited to be facilitated by the SWA, which likely contributes to the four sources of MCSE. Although SMC is directly related to SWA (Inman, 2006) and may be predictive of MCSE through the SWA, SMC may make a unique contribution to MCSE that is not explained by SWA. In other words, SWA may be a partial mediator rather than a full mediator of the relation between SMC and MCSE in that supervisees are receiving at least some multicultural knowledge, awareness, and skills in supervision even when the SWA is not strong.

The hypotheses were as follows H1: The SWA will at least partially mediate the relation between SMC and MCSE, such that there will be a direct relation between SMC and SWA, which in turn will be directly related to MCSE (see Fig. 1). If the mediated model is not supported, the following main effects are predicted. H2: SMC will directly predict MCSE. H3: SMC will directly predict the SWA. H4: The SWA will directly predict MCSE.
Method

Participants

**Power analysis.** An a priori power analysis was conducted to determine the sample size needed for a simultaneous multiple regression analysis to test the significance of the mediated effect with sufficient statistical power. An experiment-wise $\alpha = .05$ and desired statistical power of $.80$ were used. Effect sizes could not be estimated based on prior literature, because Multicultural Counseling Self-Efficacy (MCSE) has not been studied in relation to supervisors’ multicultural competence (SMC) or the supervisory working alliance (SWA).

The power analysis was based on a medium population effect size of $\hat{\rho}^2 = .05$ (Haase, Ellis, & Ladany, 1989), by convention (Cohen, 1988). It was determined that at least 180 participants would be needed. As the final sample was $N = 182$, this requirement was met. Furthermore, if the mediated model did not explain more than 5% of the variance in MCSE, it would be concluded that the mediated effects are trivial because the power is sufficient for detecting an effect of .05 or greater.

**Inclusion and exclusion criteria.** Students from master’s and doctoral level training programs in mental health related fields (i.e., counseling psychology, clinical psychology, mental health counseling, rehabilitation counseling, social work, marriage and family therapy, and school counseling) who held pre-licensure or pre-certification positions (e.g., practica, internship, post-doc, and pre-licensure employment) were eligible to participate. Since supervision practice is similar across professional backgrounds (Spence, Wilson, Kavanagh, Strong, & Worrall, 2001), a wide range of professions was sampled to allow the findings to be generalized to varied professions. Pre-licensure (including trainees in pre-certification) trainees were sampled because supervision is mandatory for credentialing and licensure. Thus it was reasoned that supervisor multicultural competence and SWA may show greater variability in a
pre-licensed sample than in a post-licensure one because supervision tends to be optional post-licensure (that is, supervisees are not likely to stay with a supervisor whom they perceive to be multiculturally incompetent if supervision is optional).

Only participants in the U.S. and Canada were included because the instruments were developed with North American samples due to similar supervision practices and cultural perceptions of race. Participants were eligible if they received individual supervision in the past year for their work with a client who was a different race than themselves. Supervisees were excluded if they had received supervision from their primary individual supervisor for less than 1 month, or were under 18 years of age.

**Sample characteristics.** Participants in the final sample were 182 clinical, counseling, or combined program (i.e., health service psychologists; HSP) doctoral students ranging in age from 22 to 44 years ($M = 28.76$, $SD = 4.07$, $Mdn = 28.0$). Although participants from fields other than counseling, clinical, and combined programs were initially sampled (e.g., social work), participants from each of these specialties comprised $< 10\%$ of the sample; since findings could not be generalized to these populations, these participants were excluded from the final sample.

The sample included $70.3\%$ White/Caucasian/Non-Latino(a), $9.3\%$ Asian/Asian American/Pacific Islander, $8.8\%$ Biracial/Multiracial, $6.0\%$ Latino(a)/Hispanic, $3.3\%$ African American/Black, and $1.1\%$ Middle Eastern participants. Participants were predominantly heterosexual ($87.4\%$) women ($79.1\%$) who had a master’s degree ($70.3\%$). Most participants were pursuing a doctorate in clinical psychology ($59.3\%$), followed by counseling psychology ($38.5\%$), and combined clinical/counseling psychology ($1.1\%$). The majority of participants ($59.3\%$) were in practicum at the time of data collection; others were pre-doctoral interns ($30.8\%$), post-doctoral trainees ($6.6\%$), pre-practicum students ($1.6\%$) and pre-licensure employees ($0.5\%$).
Cognitive/behavioral theoretical orientations (30.2%) and integrative/eclectic (27.9%) theoretical orientations had the most representation in the sample. Others identified their orientations as psychoanalytic/psychodynamic (16.8%), humanistic/client centered/gestalt/emotion focused (12.6%), feminist (3.8%), and family systems (1.7%). Some participants (6.1%) identified their orientation as other, specifying interpersonal therapy, or combinations of the other response options, with no single other response constituting > 1% of the sample.

In terms of training, participants reported receiving 2 to 120 months of supervised clinical supervision (M = 36.51, SD = 22.58, Mdn = 36.0), and 1 to 48 months of clinical supervision with their current supervisors (M = 7.04, SD = 5.75, Mdn = 7.0). Although participants reported a wide range of courses in which multicultural counseling was the focus (0 to 10) the means were modest (M = 2.19, SD = 1.90, Mdn = 2.0). Similarly, participants reported taking 0 to 45 courses in which multicultural topics were integrated (M = 9.30, SD = 7.86, Mdn = 7.0).

Participants reported attending 0 to 50 workshops and continuing education courses (M = 4.13, SD = 6.11, Mdn = 2.0). In terms of publications on multicultural topics, participants reported authoring and co-authoring 0 to 5 manuscripts (M = .84, SD = 1.18, Mdn = 0.0), 0 to 37 posters (M = 2.13, SD = 4.12, Mdn = 1.0), 0 to 5 roundtables (M = .41, SD = .96, Mdn = 0.0), 0 to 5 paper presentations (M = .47, SD = .92, Mdn = 0.0), and 0 to 5 panel participations (M = .38, SD = .95, Mdn = 0.0).

Participants reported that their current supervisors had supervised them with 0 to 75 African American/Black clients (M = 3.77, SD = 7.80, Mdn = 2.0), 0 to 50 Asian/Asian American/Pacific Islander clients (M = 1.75, SD = 4.85, Mdn = 1.0), 0 to 25 Latino(a)/Hispanic clients (M = 3.25, SD = 4.35, Mdn = 2.0), 0 to 3 Native American clients (M = .24, SD = .54, Mdn = 0.0), 0 to 70 Caucasian/White/Non-latino(a) clients (M = 9.73, SD = 10.72, Mdn = 6.0), 0 to 50 Biracial/Multiracial clients (M = 2.91, SD = 5.63, Mdn = 1.0), and 0 to 8 clients of another
race ($M = .50$, $SD = 1.20$, $Mdn = 0.0$). See Table 1 for more detailed participant demographic information.

Participants reported that their supervisors were predominantly women (61.0%), who were licensed in their respective field (91.2%). Although many participants responded that their supervisors had received formal training in supervision (51.1%) and multicultural counseling (46.2%), many participants did not know whether their supervisors had received any such training (42.9% and 50.0%, respectively). Supervisors were reported to be mostly Caucasian (73.6%); others were Latino(a)/Hispanic (7.7%), Asian/Asian American/Pacific Islander (6.6%), African American/Black (5.5%), unknown to the supervisee (2.2%), Biracial/Multiracial (1.1%), Middle Eastern (1.1%), and Native American (0.5%). Cognitive/behavioral theoretical orientations (36.8%) and psychoanalytic/psychodynamic (23.1%) theoretical orientations were most represented among supervisors. Other supervisors were identified as integrative/eclectic (14.3%), humanistic/client centered/gestalt/emotion focused (6.6%), unknown to the supervisee (6.6%), family systems (4.4%), and feminist (.5%). The “other” (6.0%) responses included interpersonal therapy (2.2%), acceptance and commitment therapy (1.6%), rational emotive behavior therapy, dialectical behavior therapy, narrative therapy, or were unspecified; none of the “other” responses constituted > 1% of the sample. Supervisors were reportedly primarily trained in clinical psychology (68.1%) and counseling psychology (19.2%), followed by unknown to the supervisee (2.7%), mental health counseling (2.2%), school counseling (1.1%), social work (1.1%), and marriage and family therapy (0.5%). Some supervisors were reported as having other training (3.3%), which included, psychiatry, combined counseling psychology and social work, forensic psychology, combined clinical psychology and neuropsychology, school psychology, and combined clinical psychology and marriage and family therapy, all of which
comprised < 1% of the total sample. See Table 2 for more detailed supervisor demographic information.

Participants were asked to rate their multicultural competence on a scale from 1 to 10 (with higher values reflecting more perceived multicultural competence); the range of responses was 3 to 9 ($M = 6.68, SD = 1.39, Mdn = 7.0$). Participants similarly rated their supervisors’ multicultural competence ranging from 1 to 10 ($M = 6.97, SD = 1.97, Mdn = 7.0$).

**Design**

The study used an *ex post facto* design consisting of a predictor variable, perceived supervisor multicultural competence (SMC; Inman, 2006); one mediator variable, supervisory working alliance (SWA; Bordin, 1983); and one criterion variable, multicultural counseling self-efficacy (MCSE; Sheu & Lent, 2007). The measures used to assess SMC, SWA, and MCSE were the Supervisor Multicultural Competence Inventory (Inman, 2005), the Supervisory Working Alliance Inventory – Trainee Form (Bahrick, 1990), Multicultural Counseling Self-Efficacy Scale – Racial Diversity form (Sheu & Lent, 2007), respectively. Social desirability (SD; Crowne & Marlowe, 1960) data were also collected using an abbreviated form of the Marlowe-Crowne Social Desirability Scale to account for a potential confound.

**Instruments**

**Supervisor Multicultural Competence.** The Supervisor Multicultural Competence Inventory (SMCI; Inman, 2005) is a 34-item self-report measure designed to assess supervisees’ perceptions of their supervisors’ multicultural competence based on themes identified in the literature as relevant to the supervisory relationship, clinical activities, and supervisors’ and supervisees’ personal development. Items are rated on a 6-point Likert-type scale (1 = *never*, 6 = *always*). Scores can range from 34 to 204. Sample items include “actively explores and challenges her or his own biases, values and worldview and how these issues relate to conducting
supervision,” and “facilitates supervisees’ understanding of both individual and contextual factors in clients’ lives.”

An exploratory factor analysis revealed a single underlying factor (Inman, 2005). The scale demonstrated strong $\alpha = .97$ in a sample of 147 marriage and family therapist trainees (Inman, 2006), which was identical to the internal consistency reliabilities found in the present sample ($\alpha = .97$). SMCI scores were found to be positively associated with scores on the Cross-Cultural Counseling Inventory-R (LaFromboise, Coleman, & Hernandez, 1991) as reported by Inman (2006), supporting its concurrent validity. The present sample rated their supervisors lower on multicultural competence ($M = 127.15, SD = 33.70$) than the comparison group of MFT trainees ($M = 144.84$; Inman, 2006), $t(181) = -7.08, p < .001, \hat{\rho}^2 = 0.21, 95\% \text{ CI} [0.12, 0.33]$.

**Supervisory Working Alliance.** The quality of the SWA was measured using the Supervisory Working Alliance Inventory – Trainee Form (SWAI-T; Bahrick, 1989) which was adapted from the Working Alliance Inventory developed by Horvath and Greenberg (1989) based on Bordin’s (1983) model of supervision. The SWAI-T is a 36-item measure consisting of 3 subscales: Agreement on Goals, Agreement on Tasks, and Emotional Bond. A confirmatory factor analysis (Ellis, Russin, & Deihl, 2003) found that the 3 subscales were highly intercorrelated, and highly correlated with the total score ($r > .92$). For this reason the total score of the SWAI-T was used for the present analysis. Items (14 of which are reverse scored) are rated on a 7-point Likert-type scale ($1 = never$ to $7 = always$). Full scale scores can range from 36 to 252, with higher scores indicating a stronger supervisory working alliance. Sample items include “We agree on what is important for me to work on,” and “I am frustrated by the things we are doing in supervision.”

The SWAI-T total score has been positively correlated with supervisory satisfaction ($r = .83$; Inman, 2006) and collaborative supervision ($r = 0.57$; Rousmaniere & Ellis, 2013), but not
significantly to the gender, race, or theoretical orientation of either the supervisee or the supervisor (Ellis et al., 2003). Ellis and colleagues also reported that the total SWAI-T $\alpha = .97$ in an aggregate sample of 656 supervisees, which was identical to the internal consistency reliabilities in the present sample ($\alpha = .97$). The sample in the present study showed no substantive differences in scores on the SWAI-T ($M = 197.58, SD = 34.49$) than participants in Ellis et al.’s comparison group of supervisees, $M = 197.06$, $t(181) = 0.20$, $p > .05$, $\hat{\beta}^2 < .001$, 95% CI [0.00, 0.02].

**Multicultural Counseling Self-Efficacy.** Supervisees’ perceived MCSE was measured using the Multicultural Counseling Self-Efficacy Scale – Racial Diversity form (MCSE-RD; Sheu & Lent, 2007), which was developed from Bandura’s (1977, 1986) social cognitive theory to assess supervisees’ perceived multicultural counseling skills. The 37-item MCSE-RD consists of 3 subscales: Multicultural Intervention (24 items), Multicultural Assessment (6 items), and Multicultural Counseling Session Management (7 items). Items are rated on a 10-point Likert-type scale (0 = *no confidence* to 9 = *complete confidence*). Sample items include “Encourage the client to express his or her negative feelings resulting from cross-cultural misunderstanding or impasses” and “Select culturally appropriate assessment tools according to the client’s cultural background.”

The overall scale score was used because a second-order factor analysis revealed a single multicultural counseling self-efficacy factor (Sheu & Lent, 2007). Full scale scores range from 0 to 333 with higher scores reflecting greater MCSE. The full scale reliability $\alpha = .98$ (Sheu & Lent, 2007), which is consistent with the internal consistency found in the present study ($\alpha = .97$). Discriminant validity was supported by a non-significant correlation between MCSE-RD scores and a measure of social desirability (Sheu & Lent, 2007). Convergent validity was supported by significant positive correlations between MCSE-RD scores and Counselor Activity
Self-Efficacy Scales, a general counseling self-efficacy scale (Lent, Hill, & Hoffman, 2003; \( r = .79 \)) and Multicultural Counseling Inventory scores, a multicultural counseling competence scale (Sodowsky, Taffe, Gutkin, & Wise, 1994; \( r = .68 \)). The comparison mean total score on the MCSE-RD was \( M = 199.43, SD = 58.09 \) in Sheu and Lent (2007); the present sample scored significantly higher on the measure, \( M = 234.52, SD = 46.43, t(181) = 10.20, p < .001, \hat{\rho}^2 = 0.36, 95\% CI [0.25, 0.47]. \)

**Social Desirability.** To assess participants’ response bias, participants completed an abbreviated form of the Marlowe-Crowne Social Desirability Scale, the M-C 1(10) (Strahan & Gerbasi, 1972). The M-C 1(10) is a 10-item Boolean scale, with 5 items keyed “true” and 5 keyed “false.” Full scale scores can range from 0 to 10. Sample items include “I'm always willing to admit it when I make a mistake,” and “I never resent being asked to return a favor.”

The original M-C SDS score was positively correlated with the lie scale on the Minnesota Multiphasic Personality Index \( (r = .54; \) Crowne & Marlowe, 1960) and inversely correlated with MMPI clinical scales \( (|r| > .36) \). The M-C 1(10) scores correlate strongly with the M-C SDS scores \( (r = .96; \) Fischer, 1993). Strahan and Gerbasi (1972) also reported that the M-C 1(10) had an internal consistency coefficient \( > .59 \) using the Kuder-Richardson formula 20, which is an equivalent of Cronbach’s alpha used for measures with dichotomous choices.

The sample in the present study scored significantly lower on the M-C 1(10) \( (M = 3.15, SD = 2.14) \) than the comparison group \( (Strahan & Gerbasi, 1972; M = 4.50), t(181) = -8.51, p < .001, \hat{\rho}^2 = 0.28, 95\% CI [0.18, 0.40]. \) In the present study the full-scale M-C 1(10) \( \alpha = .69. \)

**Demographic questionnaire.** A demographic questionnaire (see Appendix A) asked participants to provide information about their identity (e.g., age, gender, race/ethnicity, sexual orientation) and their training (i.e., level of education, field of training, amount of multicultural coursework, workshops, and presentations, amount of supervised clinical experience, theoretical
orientation, and amount of experience with relevant supervisor). Finally, asked about their supervisors’ demographic characteristics (i.e., gender, race/ethnicity, theoretical orientation, and the supervisor’s training).

**Procedure**

Participants were recruited via an email (see Appendix B) which was disseminated to training directors of master’s and doctoral training programs listed on the websites of various accrediting bodies (e.g., American Psychological Association), and internship program training directors. Furthermore, after completing the survey, participants were asked to forward the recruitment email to acquaintances who may be eligible and interested in participating in the study. The recruitment email stated that the purpose of the study is to explore “your training experiences in clinical supervision.” Participants were informed that they had the option to enter into a drawing for a $20 Amazon.com gift certificate, with 1 in 10 participants eligible to receive a gift card. The recruitment email contained a web link to the survey. After following this link, participants were informed their responses are confidential and that they may withdraw from the study at any time (See Appendix C). The data were collected through psychdata.com, a password-protected site. Participants were asked to respond to the measures in reference to their primary supervisor in the event that they have multiple supervisors. To minimize order effects the SMCI (Inman, 2005), SWAI-T (Bahrik, 1990), MCSE-RD (Sheu & Lent, 2007), and M-C1(10) (Strahan & Gerbasi, 1972) were counterbalanced, followed by the demographic questionnaire. Of the 24 possible orders of administration, 6 were randomly selected. Upon completion, participants were asked to forward the link to the study to acquaintances who may be eligible for participation in the study (i.e., snowball sampling). Finally, participants were redirected to another psychdata.com survey to provide contact information for the drawing. The response rate was indeterminable due to the sampling procedure.
Results

Missing Data

A total of 276 participants initiated the study. Participants who either omitted > 5% of the items on any single measure (n = 59), did not meet all inclusion criteria (n = 12), or whose field of study did not comprise enough of the sample to yield generalizable data (n = 23) were eliminated from the final analysis, resulting in a final N = 182. For these 182 cases, missing items were imputed (Tabachnick & Fidell, 2007) using deductive/logical imputation. Specifically, the average of the two items on the measure that were most similar content-wise to the item with the missing data was used to impute the missing value. Among the 182 participants, 62 (34.1%) had imputed data, resulting in < 1% (.42%) of the total data being imputed. Participants with imputed data did not differ significantly in their responses on any of the study variables from those without imputations (p ≥ .12).

Preliminary Analyses

The data were analyzed for counterbalancing effects, tests of assumptions for regression, and influences of social desirability. Appendix D shows that the tests for counterbalancing revealed no significant order effects on participants’ responses to the study variables.

The assumptions of linearity, normality, and homoscedasticity for a multiple regression analysis were tested as suggested by Cohen, Cohen, West, and Aiken (2003), and were all met. There was a moderate degree of multicollinearity between predictor variables. The data were examined for outliers, and although 12 response sets were identified as statistical outliers, there did not appear to be unusual response patterns and thus these sets were retained. Responses to the M-C 1(10) were not significantly related to responses on other measures, so social desirability was not included in the final model.
Major Analyses

Descriptive statistics were computed for the four study variables may be found in Table 1 along with the comparison to other samples data and bivariate correlations.

Tests of Hypotheses. Hypothesis 1 stated that the SWA would partially mediate the relation between SMC and MCSE, such that there would be a direct relation between SMC and SWA, which in turn will be directly related to MCSE. The most common method used for testing mediation was described by Frazier, Tix, and Barron (2004). Frazier et al. described a four step process using a series of regression equations to establish that a variable mediates the relation between a predictor variable and an outcome variable.

The first step is to regress MCSE onto SMC to test whether there is a relation to mediate (path c). The second step is to regress SWA onto SMC to test the first path in the mediation (path a). The third step is to regress MCSE onto both SMC and SWA to determine whether SWA is related to MCSE (path b), and estimate the unique relation between SMC and MCSE, i.e., controlling for SWA (path c’). If the relation between SMC and MCSE becomes nonsignificant in the full model, full mediation is indicated. If the relation decreases significantly, partial mediation is indicated. To test whether the indirect effect is significant, a bootstrapping approach is needed. A Bonferroni procedure (Holland & Copenhaver, 1988) was used to set the experimentwise Type I error rate at $a_{ew} = .05$, with a per-comparison Type I error rate set at $a_{pc} = .0125$, due to the four hypothesis tests. Recall that based on the a priori power analysis there is enough statistical power to test for an effect size of 0.05 or greater.

A significant direct relation emerged between SMC and MCSE $r = .31, \beta = .31, F(1,180) = 19.76, p < .001, \hat{\rho}^2 = .09, 95\% \text{ CI} [0.03, 0.18]$ (see Fig. 2, path c), supporting Hypothesis 2. There was also a significant direct relation between SMC and SWA $r = .70, \beta = .70, F(1,180) = 175.31, p < .001, \hat{\rho}^2 = 0.49, 95\% \text{ CI} [0.38, 0.59]$ (see Fig. 2, path a), supporting Hypothesis 3.
However, the unique relation between SWA and MCSE was nonsignificant in the full model $r_{MCSE(SWA \cdot SMC)} = .03, \beta = .05, p = .65$ (see Fig. 2, path b), thereby not supporting the hypothesized mediation effect (Hypothesis 1) of SWA on the relation between SMC and MCSE, despite the significance of path $c' r_{MCSE(SMC \cdot SWA)} = .20, \beta = .28, F(2, 179) = 9.94, p < .001, \hat{\rho}^2 = .04, 95\% CI [0.00, 0.11]$. Thus, SWA does not mediate the relation between SMC and MCSE, so Hypothesis 1 was rejected. In testing the direct effect from Hypothesis 4, SWA was found to be significantly and directly related to MCSE (not in the full model) $r = .24, \beta = .24, F(1,180) = 11.40, p = .001, \hat{\rho}^2 = 0.05, 95\% CI [0.01, 0.13]$, thereby supporting Hypothesis 4. See Figure 3 for a depiction of the model with correlations, and Table 4 for regression coefficients with confidence intervals.
Discussion

The general purpose of the present study was to test relations between supervisees’ perceptions of (a) their supervisor’s multicultural competence (SMC), (b) the supervisory working alliance (SWA), and (c) supervisees’ multicultural counseling self-efficacy (MCSE) using psychometrically robust measures that are operationally congruent with underlying theory. The major analyses revealed significant main effects among the three study variables; however, the hypothesized mediation model was not supported. Before discussing these findings further, the results of the study are placed in context by reviewing the descriptive results.

Descriptive Results

The final sample consisted exclusively of Health Service Psychologist (HSP) trainees who were relatively more experienced than samples used in other studies with similar constructs (e.g., Inman, 2006; Kaduvettoor et al., 2009; Sheu & Lent, 2007). The current sample had an average of 3 years of supervised clinical experience, and over 70% of participants had master’s degrees. Thus, the present results may allow us to gain more understanding about the experiences of more advanced trainees, which may differ from those in samples with less experience.

Specifically, the present sample reported significantly lower scores on the SMCI than the comparison group (Inman, 2006), with a moderate to large effect size ($\hat{\rho}^2 = 0.21$). Inman’s sample was comprised exclusively of marriage and family therapy trainees, who, on average, had fewer months of supervised individual therapy experience ($M = 30.01, SD = 32.94$) than the present sample ($M = 36.51, SD = 22.58$). However, in the present sample the months of supervised experience was not significantly related to SMCI scores ($r = .26, \hat{\rho}^2 = 0.00$). These between-sample differences may be explained by other variables such as discipline. Whereas Inman sampled MFT trainees, the present study sampled HSP trainees.
The present sample reported significantly higher scores (\(M = 234.52, SD = 46.43\)) on the MCSE, with a large effect size (\(\hat{\rho}^2 = 0.36, p < .001\)), than did the Sheu and Lent’s (2007) comparison group (\(M = 199.43, SD = 58.09\)), which was noticeably less experienced. To test whether experience might explain these between-sample differences, participants’ months of prior supervised experience was compared to MCSE scores. Although these variables were significantly related \(r = .20, F(1,175) = 7.02, p = .004, \hat{\rho}^2 = .03, 95\% \text{ CI} [.00, .10]\), the effect size was trivial. This result was consistent with a prior study (Ladany et al., 1999) that found no significant relation between supervised experience and general counseling self-efficacy. According to Bandura (1977), past performance is the greatest predictor of self-efficacy. However, the current participants’ numbers of racially diverse clients were not significantly related with MCSE (\(\hat{\rho}^2 = 0.00, p = .13\)), suggesting that MCSE was achieved through other experiences, such as earlier training experiences. Unfortunately, no data were collected about participants’ experience working with diverse clients prior to their current supervision experience.

Participants were asked to evaluate their supervisor’s SMC and their own multicultural competence through two questions in the demographic questionnaire to test whether SMCI and MCSE scores reflected participants’ perceptions. Perceived SMC was strongly related to SMCI scores, \(r = .80, F(1,176) = 309.24, p < .001, \hat{\rho}^2 = .64, 95\% \text{ CI} [0.55, 0.72]\), suggesting that SMCI scores reflected supervisees’ perceptions of their supervisors’ competence. Interestingly, self-reported multicultural competence, was not as strongly related with MCSE scores, \(r = .63, F(1,177) = 117.48, p < .001, \hat{\rho}^2 = .40, 95\% \text{ CI} [0.29, 0.51]\), suggesting that MCSE scores might not fully reflect supervisees’ perceptions of their own multicultural competence.

It should be noted that the wording of the demographic questions allowed for a more comprehensive definition of multicultural competence, and SMCI items explicitly include other
forms of diversity, whereas all of the MCSE items refer specifically to race. This discrepancy may help to explain the strength of the relationship between SMC and MCSE found in the present study. That is, a supervisor may be rated high on SMC for discussing aspects of diversity other than race, and subsequently SMC does not predict the supervisee’s MCSE scores.

Despite higher MCSE scores in the present study than in the comparison group (Sheu & Lent, 2007), and lower reported SMC than the comparison group, the present participants rated themselves \((M = 6.68, SD = 1.39)\) and their supervisors \((M = 6.97, SD = 1.97)\) similarly and favorably on the demographic items included in the present study, suggesting that although supervisees appeared to be more critical of their supervisors than in the comparison group, they nevertheless viewed their supervisors’ SMC positively overall.

The present study was on the low end of the range of white-identified participants (71.1%) compared to other supervision samples in the U.S., in which between 69.9% (e.g., Kaduvettoor et al., 2009) and 88.7% (e.g., Mehr, Ladany, & Caskie, 2010) of the supervisees self-identified as white. However, the present sample’s racial composition does not explain the higher MCSE scores relative to the comparison group \((\hat{\rho}^2 = 0.36)\), since the comparison group (Sheu & Lent, 2007) was more racially diverse (59% identified as White). Thus, participants’ minority racial status does not appear to predict MCSE at a cursory glance; however, this should be tested in future research.

The moderate to low internal consistency \((\alpha = .69)\) of the M-C 1(10) (Strahan & Gerbasi, 1972) scores in the present sample may suggest that the instrument does not yield reliable data for advanced HSP trainees. Participants in the present study had significantly lower M-C 1(10) scores (with a large effect size of \(\hat{\rho}^2 = 0.28\)) than a comparison group of undergraduates in an introductory psychology course (Strahan & Gerbasi), suggesting that the present participants may have been aware that the M-C 1(10) was a measure of social desirability and subsequently
were more truthful in their responses. Conversely, participants’ awareness of what constitutes socially desirable responses may cause them to provide more favorable responses on the MCSE measure.

Participants were asked to report their sexual orientation (88.3% were heterosexual) to further contextualize the findings of the present study; however, a cursory search of the supervision literature revealed that this information on participants is generally not reported, making comparisons to others’ findings difficult in this respect. Researchers may want to consider reporting this data in the future to further contextualize their findings, since our profession is calling for increased multicultural competence in research and practice (APA, 2003; Division 44/Committee on Lesbian, Gay, and Bisexual Concerns Joint Task Force on Guidelines for Psychotherapy With Lesbian, Gay, and Bisexual Clients, 2000), and this understudied demographic characteristic may help explain supervisees’ experiences in supervision. For example, Gatmon et al. (2001) found that supervisees reported greater supervisory satisfaction when sexual orientation was discussed. Thus it seems likely that other aspects of supervision variables may also be related to supervisees’ sexual orientation.

**Major Results**

The predicted main effects were statistically significant; however, the predicted mediated relation was not significant. The major findings were that (a) perceived SMC was a significant predictor of supervisees’ MCSE when controlling for SWA, (b) the SWA as perceived by the supervisee also significantly predicted supervisees’ MCSE, (c) perceived SMC was significantly related to the SWA, and (d) a mediated model was not supported perhaps because of the multicollinearity between SMC and SWA.

The first major finding provides direct empirical support for a relation between SMC and MCSE, which previously had received only indirect empirical support in the general counseling
self-efficacy literature (Efstation et al., 1990; Nilsson & Anderson, 2004) or in studies that used self-report multicultural competence measures (e.g., Constantine, 2001a). The direct relation between SMC and MCSE found in previous research (e.g., Constantine 2001a) was replicated in the present study using a theoretically grounded measure for MCSE, thereby addressing the problem in the literature created by the use of self-report measures of multicultural competence to test for MCSE.

Although a direct relation between SMC and MCSE was found, the relation between SMC and MCSE became trivial in the overall model, suggesting that the quality of the SWA may be overshadowing other aspects of supervision. This proposition is consistent with the strong relation between SMC and SWA.

Furthermore, previous evidence in support of a relation between clinical supervision variables and counselor self-efficacy development (Larson et al., 1992) has been in a general context with general self-efficacy. This study contributed some evidence supporting Bandura’s theory of self-efficacy (1977) in the context of multicultural supervision.

The second major finding supported the hypothesized relation between SWA and MCSE. This finding is (a) consistent with Efstation et al.’s (1990) study supporting a relation between SWA and general counseling self-efficacy, with calculated effect sizes ($\hat{\rho}^2 = 0.032$ and $\hat{\rho}^2 = 0.007$) based on their 2-factor model of SWA being slightly lower than the small effect size found in the present study ($\hat{\rho}^2 = 0.049$), (b) inconsistent with Ng and Smith’s (2012) findings that among international trainees a bivariate relation between SWA and general counseling self-efficacy was significant; however, a hierarchical regression analysis revealed that SWA did not uniquely contribute to predicting general counseling self-efficacy, and (c) also inconsistent with Ladany et al.’s (1999) study, in which no significant association between SWAI subscale scores and general counseling self-efficacy scores was found. Ng and Smith’s sample was comprised
exclusively of international students and Ladany et al.’s sample was less racially diverse, less experienced, and comprised of more counseling psychology trainees than the present participants. It is possible that the relation between counseling self-efficacy and SWA is moderated by demographic factors that thus far remain unidentified. Furthermore, all studies cited here used different measures to test the constructs; while this difference may not entirely explain between-sample differences, it makes comparisons difficult.

The third major finding, consistent with prior research (e.g., Inman 2006), was a significant relation between perceived SMC and SWA. However, Inman found an effect size of \( \hat{\rho}^2 = 0.37 \), which was lower than the one found in the present study \( \hat{\rho}^2 = 0.49 \). Inman used the same measures and analyses as those used in the present study, making these results comparable. The sample for the present study was noticeably more experienced than the one in the Inman study (\( M = 30.01 \) months, \( SD = 32.94 \)), suggesting that differences in supervisee experience level may explain the relation between these constructs. Thus far there does not appear to be other published research to support this explanation.

Finally, in the full model, where SWA was predicted to mediate the relation between SMC and MCSE, the relation between SMC and MCSE became trivial albeit significant. This may be in part explained by the previously discussed descriptive findings, which suggested that MCSE might have been developed prior to the supervision experience at the time of data collection: Because the current sample was a more circumscribed sample of advanced trainees, there may have been less variability in MCSE scores than in a sample of trainees where MCSE is in its formative stages. Furthermore, the strength of the relation between SMC and SWA in the overall model (\( r = .70, \hat{\rho}^2 = 0.49 \)) suggests that even for advanced trainees, these constructs seem to be closely related. Supervisees might be evaluating the SWAI on the basis of their supervisors’ SMC, since the relation between SWAI and MCSE was weak. That is, supervisees’
MCSE does not lead them to be more critical of their supervisor per se, but rather that SMC provides supervisees with a sense of safety in supervision as suggested in previous research (e.g., Burkard, Hird et al., 2001; Duan & Roehlke, 2001).

**Limitations**

The first limitation is that supervisees’ perceptions of their supervisor’s multicultural competence may not be consistent with a behavioral measure of SMC; thus this study relied exclusively on self-report. A second limitation is the use of a cross-sectional ex post facto design, so no temporal precedence could be established and thus no causal inferences could be made (Shadish, Cook, & Campbell, 2002). Thus, it remains unknown, for example, whether SMC actually facilitates supervisee MCSE development, or if MCSE affects perceptions of SMC. Furthermore, a snapshot of these variables may not capture the effects of day-to-day fluctuations in SMC and MCSE, or whether these variables change with time to begin with.

The third limitation was the use of self-selecting participants who may be personally invested in the topic and thus not represent the general population of supervisees. In fact, although the intent was to include all HSP trainees, the sample consisted of relatively experienced HSP trainees, who were primarily from clinical psychology programs. Furthermore, participants were recruited through training directors willing to forward recruitment information to their students, which may have led to systematically selecting participants attending programs where the training director valued multicultural or supervision research, which might also be the climate that leads to higher SMC. The findings may also not reflect the experiences of trainees who had too little time to participate in the study (e.g., less experienced trainees struggling to balance their responsibilities).
Strengths

The main strength of the study was the use of Bandura’s theory (1977) in designing the study and hypothesizing relations between MCSE and two other variables identified in the supervision literature. Furthermore, the present study used a theoretically grounded instrument to measure MCSE (Sheu & Lent, 2007) in an effort to ensure construct validity, contrasting this studies with previous studies’ use of self-report multicultural competence measures (e.g., Constantine, 2001b). Second, the variables selected for examination were chosen on the basis of existing empirical and theoretical support (e.g., Bordin, 1983; Inman, 2006) further ensuring construct validity. Third, this study’s design protected statistical conclusion validity by conducting an a-priori power analysis, controlling study-wise alpha levels by setting low per-comparison alpha levels, and testing all statistical assumptions to maximize overall statistical conclusion validity. Fourth, a social desirability scale (Strahan & Gerbasi, 1972) was included to verify whether participants provided intentionally socially desirable response sets, and this was subsequently ruled out as a non-significant relation. Finally, participants from both clinical and counseling psychology were included in the sample to make the results generalizable to both populations.

Practical Implications and Future Research Directions

The positive relation between SMC and MCSE suggests that supervisees’ perceptions of their supervisor’s SMC and how supervisees feel about themselves (i.e., MCSE) are related, which supports supervision as a relational process with the supervisor and supervisee mutually influencing one another. More specifically, supervision as a relational process is supported in a multicultural context, so supervisors may want to attend to their competency in addressing multicultural issues and how their supervisees are impacted by their interventions in this context. Although SMC in the present study was based exclusively on supervisees’ perceptions, these
perceptions are likely based partly on actual (i.e., objective) SMC. Thus supervisors may want to engage in ongoing training that increases knowledge, skills, and awareness to improve the quality of the supervision they are providing. Supervisors who are invested in their supervisees’ experiences and MCSE may want to invest in the SWA as well as their SMC, should future research reveal this relation to be causal.

Supervisees’ perceptions of their supervisor’s multicultural competence appeared to be related to their MCSE. Thus, supervisors may be able to improve their supervisees’ experiences in supervision by continuing to work on their own multicultural competence, and explicitly demonstrating their competence in supervision.

Future research can attempt to test for causal relations among the present variables by establishing temporal precedence to determine if, and to what extent, supervisors can actually influence a supervisee’s MCSE. Although there is theoretical support suggesting the MCSE might lead to multicultural competence (i.e., self-efficacy leads to competence; Bandura, 1977), and that MCSE is a component of multicultural competence (Constantine & Ladany, 2000), there is no empirical support to date. That is, SMC may improve supervisees’ MCSE, but does MCSE improve clinical outcomes? To justify a concerted effort to facilitate MCSE, however, evidence is needed to demonstrate that MCSE actually affects clinical outcomes. Although supervisors may be able to improve the subjective experience of the supervisee by facilitating MCSE, they may not want to invest limited resources on this if it does not lead to substantive improvements in competence or clinical outcomes.

The high correlation between SMCI scores and SWAI scores in the present study also warrants further investigation. It may have been difficult to determine the relation between MCSE and other study variables because the sample was relatively circumscribed; thus it remains unclear how MCSE relates to other supervision variables. Future researchers can
sample trainees who have a wider range of experience to elicit greater variability in MCSE, and collect detailed data on training history and personal demographics. Alternatively, SWA may be a core factor of supervisees’ experience in supervision to the point that it overshadows other aspects of the supervision. Future researchers may want to contrast supervisee report of their supervision experience with behavioral observations of what happens in supervision.

The present sample rated their supervisors more critically than the comparison group (Inman, 2006) on the SMCI, yet scores on the self-report demographic item indicated supervisees viewed their supervisors favorably. Even though the sample was circumscribed, SMC and SWA were highly related, suggesting that to advanced HSP trainees, SMC still matters despite the supervisees being more critical. Future researchers may want to investigate, explicitly, how more advanced trainees differ from more novice trainees in terms of the supervision factors that matter most to them.

Sheu and Lent (2007) reported a high correlation ($r = .79$) between general counseling self-efficacy and multicultural counseling self-efficacy scores. Future researchers may want to explore how these constructs are related to one another, since the high correlation suggests there may be some theoretical and practical overlap.

Finally, understanding to what extent self-report measures of SWA and SMC are consistent with objective (i.e., outside observer) assessments of SWA and SMC would allow us to know whether findings from previous and future studies reflect the relations between the underlying constructs. At present it remains unclear whether supervisors and supervisees actually discuss multicultural issues, or if, for example, supervisees are rating their supervisors on the basis of one salient discussion. Furthermore, understanding whether objective measures or supervisees’ perceptions are better predictors of outcome variables such as MCSE can help guide the focus of supervisory practice.
Conclusion

As HSPs’ contact with racially diverse clients becomes increasingly prevalent (Sue, Arredondo, & McDavis, 1992), it becomes increasingly important to understand how we can train health service psychologists to effectively work with racially diverse clients. As the findings of this and other studies suggest, clinical supervision is intrinsically tied to trainees’ development with regard to multicultural counseling (e.g., Inman, 2006; Ng & Smith, 2012). It is also clear that there is much about clinical supervision that is not yet understood. Hopefully this study contributes to a body of literature that will continue to grow and deepen our understanding of how we can better train supervisees, and thus better serve our clients.
References


measuring competence in professional psychology across training levels. *Training and Education in Professional Psychology, 3*, S5-S26. doi: 10.1037/a0015832


Table 1

*Sample Demographic Characteristics*

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>34</td>
<td>18.9</td>
</tr>
<tr>
<td>Female</td>
<td>144</td>
<td>80.0</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>1.1</td>
</tr>
<tr>
<td><strong>Race/Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American/Black</td>
<td>6</td>
<td>3.3</td>
</tr>
<tr>
<td>Asian/Asian American/Pacific Islander</td>
<td>17</td>
<td>9.4</td>
</tr>
<tr>
<td>Latino(a)/Hispanic</td>
<td>11</td>
<td>6.1</td>
</tr>
<tr>
<td>Caucasian/White/Non-Latino(a)</td>
<td>128</td>
<td>71.1</td>
</tr>
<tr>
<td>Biracial/Multiracial</td>
<td>16</td>
<td>8.9</td>
</tr>
<tr>
<td>Middle Eastern</td>
<td>2</td>
<td>1.1</td>
</tr>
<tr>
<td><strong>Sexual Orientation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Straight</td>
<td>159</td>
<td>88.3</td>
</tr>
<tr>
<td>Gay</td>
<td>3</td>
<td>1.7</td>
</tr>
<tr>
<td>Lesbian</td>
<td>5</td>
<td>2.8</td>
</tr>
<tr>
<td>Bisexual</td>
<td>10</td>
<td>5.6</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>1.7</td>
</tr>
<tr>
<td><strong>Field of Training</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counseling Psychology</td>
<td>70</td>
<td>38.9</td>
</tr>
</tbody>
</table>

Table continues
Table 1, continued

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Psychology</td>
<td>108</td>
<td>60.0</td>
</tr>
<tr>
<td>Combined Clinical/Counseling Psychology</td>
<td>2</td>
<td>1.1</td>
</tr>
<tr>
<td>Current Training Level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Practicum</td>
<td>3</td>
<td>1.7</td>
</tr>
<tr>
<td>Practicum</td>
<td>108</td>
<td>60.0</td>
</tr>
<tr>
<td>Internship</td>
<td>56</td>
<td>31.1</td>
</tr>
<tr>
<td>Post-doctoral residency</td>
<td>12</td>
<td>6.7</td>
</tr>
<tr>
<td>Employed (pre-licensure)</td>
<td>1</td>
<td>.6</td>
</tr>
<tr>
<td>Theoretical Orientation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychoanalytic/psychodynamic</td>
<td>30</td>
<td>16.8</td>
</tr>
<tr>
<td>Cognitive/behavioral</td>
<td>55</td>
<td>30.7</td>
</tr>
<tr>
<td>Humanistic/client centered/gestalt (emotion focused)</td>
<td>23</td>
<td>12.8</td>
</tr>
<tr>
<td>Integrative/eclectic</td>
<td>50</td>
<td>27.9</td>
</tr>
<tr>
<td>Family systems</td>
<td>3</td>
<td>1.7</td>
</tr>
<tr>
<td>Feminist</td>
<td>7</td>
<td>3.9</td>
</tr>
<tr>
<td>Other</td>
<td>11</td>
<td>6.1</td>
</tr>
</tbody>
</table>

*Note. N = 182.*
Table 2

*Reported Supervisor Characteristics*

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Supervisor Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>67</td>
<td>36.8</td>
</tr>
<tr>
<td>Female</td>
<td>111</td>
<td>61.0</td>
</tr>
<tr>
<td><strong>Supervisor’s Race/Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American/ Black</td>
<td>10</td>
<td>5.5</td>
</tr>
<tr>
<td>Asian/ Asian American/ Pacific Islander</td>
<td>12</td>
<td>6.6</td>
</tr>
<tr>
<td>Latino(a)/ Hispanic</td>
<td>14</td>
<td>7.7</td>
</tr>
<tr>
<td>Native American</td>
<td>1</td>
<td>.5</td>
</tr>
<tr>
<td>Caucasian/ White, Non-Latino(a)</td>
<td>134</td>
<td>73.6</td>
</tr>
<tr>
<td>Biracial/Multiracial</td>
<td>2</td>
<td>1.1</td>
</tr>
<tr>
<td>Middle Eastern</td>
<td>2</td>
<td>1.1</td>
</tr>
<tr>
<td>Unknown to supervisee</td>
<td>4</td>
<td>2.2</td>
</tr>
<tr>
<td><strong>Supervisor’s Theoretical Orientation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychoanalytic/psychodynamic</td>
<td>42</td>
<td>23.1</td>
</tr>
<tr>
<td>Cognitive/behavioral</td>
<td>67</td>
<td>36.8</td>
</tr>
<tr>
<td>Humanistic/client centered/gestalt (emotion focused)</td>
<td>12</td>
<td>6.6</td>
</tr>
<tr>
<td>Integrative/ eclectic</td>
<td>26</td>
<td>14.3</td>
</tr>
<tr>
<td>Family systems</td>
<td>8</td>
<td>4.4</td>
</tr>
<tr>
<td>Feminist</td>
<td>1</td>
<td>.5</td>
</tr>
</tbody>
</table>

Table continues
Table 2, continued

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unknown to supervisee</td>
<td>12</td>
<td>6.6</td>
</tr>
<tr>
<td>Other</td>
<td>11</td>
<td>6.0</td>
</tr>
<tr>
<td>Supervisor’s Field of Training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Counseling</td>
<td>4</td>
<td>2.2</td>
</tr>
<tr>
<td>School Counseling</td>
<td>2</td>
<td>1.1</td>
</tr>
<tr>
<td>Social Work</td>
<td>2</td>
<td>1.1</td>
</tr>
<tr>
<td>Marriage and Family Therapy</td>
<td>1</td>
<td>.5</td>
</tr>
<tr>
<td>Counseling Psychology</td>
<td>35</td>
<td>19.2</td>
</tr>
<tr>
<td>Clinical Psychology</td>
<td>124</td>
<td>68.1</td>
</tr>
<tr>
<td>Unknown to supervisee</td>
<td>5</td>
<td>2.7</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>3.3</td>
</tr>
<tr>
<td>Supervisor Licensure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Licensed</td>
<td>166</td>
<td>91.2</td>
</tr>
<tr>
<td>Unlicensed</td>
<td>13</td>
<td>7.1</td>
</tr>
<tr>
<td>Supervisor Formal Training – Supervision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>93</td>
<td>51.1</td>
</tr>
<tr>
<td>No</td>
<td>6</td>
<td>3.3</td>
</tr>
<tr>
<td>Don’t know</td>
<td>78</td>
<td>42.9</td>
</tr>
<tr>
<td>Supervisor Formal Training – Multicultural Counseling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>84</td>
<td>46.2</td>
</tr>
</tbody>
</table>

Table continues
Table 2, continued

<table>
<thead>
<tr>
<th>Variable</th>
<th>$n$</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>4</td>
<td>2.2</td>
</tr>
<tr>
<td>Don’t know</td>
<td>91</td>
<td>50.0</td>
</tr>
</tbody>
</table>

*Note. N = 182.*
Table 3

*Descriptive Data, Comparison Data, and Bivariate Correlations*

<table>
<thead>
<tr>
<th>Variable</th>
<th>M</th>
<th>SD</th>
<th>Comparison M</th>
<th>SMCI</th>
<th>SWAI</th>
<th>MCSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>SMCI</td>
<td>127.15*</td>
<td>33.70</td>
<td>144.84</td>
<td>--</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SWAI</td>
<td>197.58</td>
<td>34.49</td>
<td>197.06</td>
<td>.702*</td>
<td>--</td>
<td></td>
</tr>
<tr>
<td>MCSE</td>
<td>234.52**</td>
<td>46.43</td>
<td>199.43</td>
<td>.314*</td>
<td>.244*</td>
<td>--</td>
</tr>
<tr>
<td>M-C SDS(10)</td>
<td>3.15**</td>
<td>2.14</td>
<td>4.50</td>
<td>.169</td>
<td>.133</td>
<td>.115</td>
</tr>
</tbody>
</table>

*Note. N = 182. SMCI = Supervisor Multicultural Competence Inventory (Inman, 2006); SWAI = Supervisory Working Alliance Inventory (Bahrick, 1990); MCSE = Multicultural Counseling Self-Efficacy Scale – Racial Diversity Form (Sheu & Lent, 2007). For comparison group t test *p < .05. **p < .01. For the intercorrelations *p < .008 because a modified Bonferroni procedure (Holland & Copenhaver, 1988) was used due to the multiple statistical tests.*
Table 4

*Regression Coefficients and Confidence Intervals*

<table>
<thead>
<tr>
<th>Variable</th>
<th>SMC only</th>
<th>SWA only</th>
<th>Full model</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>CI</td>
<td>B</td>
</tr>
<tr>
<td>Constant</td>
<td>179.41</td>
<td>[154.11, 204.71]</td>
<td>169.6</td>
</tr>
<tr>
<td>SMC</td>
<td>.43</td>
<td>[.24, .63]</td>
<td></td>
</tr>
<tr>
<td>SWA</td>
<td></td>
<td></td>
<td>.33</td>
</tr>
</tbody>
</table>
Figure 1. Hypothesized model. SMC = Supervisor Multicultural Competence; SWA = Supervisory Working Alliance; MCSE = Multicultural Counseling Self-Efficacy. Path c is dotted to convey partial mediation.
Figure 2. Test of the mediated model with beta weights. Beta weights are reported for simple (pathways $a$, and $c$) and multiple (pathways $b$ and $c'$) regressions. *$p < .0125$. **$p < .0025$.

SMC = Supervisor Multicultural Competence; SWA = Supervisory Working Alliance; MCSE = Multicultural Counseling Self-Efficacy.
Figure 3. Test of the mediated model with correlations. Zero order correlations are reported for pathways $a$ and $c$. The semi partial correlation is reported for pathways $b$ and $c'$. *$p < .0125$.

**$p < .0025$.  SMC = Supervisor Multicultural Competence; SWA = Supervisory Working Alliance; MCSE = Multicultural Counseling Self-Efficacy.
Appendix A

Demographic Questionnaire

1. What is your age? ______________________

2. What is your gender?
   a. Male
   b. Female
   c. Other (please specify ______________________)

3. What is your race/ethnicity?
   a. African American/ Black
   b. Asian/ Asian American/Pacific Islander
   c. Latino(a)/ Hispanic
   d. Native American
   e. Caucasian/ White/ Non-latino(a)
   f. Biracial/ Multiracial
   g. Other (please specify ______________________)

4. What is your sexual orientation?
   a. Straight
   b. Gay
   c. Lesbian
   d. Bisexual
   e. Other (please specify ______________________)

5. What is your highest level of education?
   a. Bachelor’s degree
   b. Master’s degree
   c. Doctoral Degree (Ph.D., Psy. D. Ed.D.)
   d. Professional degree (e.g., MD, JD, etc.)
   e. Other (please specify ______________________)

6. What is your field of training?
   a. Mental Health Counseling
   b. Rehabilitation Counseling
   c. School Counseling
   d. Social Work
   e. Marriage and Family Therapy
   f. Counseling Psychology
   g. Clinical Psychology
   h. Other (please specify _____________)

7. What is your current clinical training level?
   a. Pre-practicum
b. Practicum
c. Internship
d. Post-doc
e. Employed (pre-licensure)
f. Licensed Employment
g. Other (please specify __________)

8. How much **supervised** clinical experience have you had?
   _____ Years, _____ Months

9. Where are you currently pursuing your degree?
   a. US
   b. Canada
   c. Other

10. Are you an international student (yes/no)
    If so, what is your country of origin? __________

11. How many graduate level courses have you taken where the focus of the course was multicultural counseling (estimate)? __________

12. How many courses have you taken in your graduate studies in which multicultural topics were an integral part of the course (estimate)? __________

13. How many multicultural workshops (e.g., continuing education, seminars, trainings) have you attended (estimate)? __________

14. How many publications on multicultural topics have you authored or co-authored?
   Manuscripts? __________
   Posters? __________
   Roundtables? __________
   Paper presentations? __________
   Panels participation? __________

15. Which best describes your theoretical orientation?
   a. Psychoanalytic/psychodynamic
   b. cognitive/behavioral
   c. humanistic/client centered/gestalt (emotion focused)
   d. integrative/eclectic
   e. family systems
   f. feminist
   g. other (please specify _______)

16. How long have you been receiving supervision from your current primary supervisor?
   ____________ Months
17. What is your supervisor’s gender?
   a. Male
   b. Female
   c. Other (please specify ________)

18. What is your supervisor’s race/ethnicity?
   a. African American/ Black
   b. Asian/ Asian American/Pacific Islander
   c. Latino(a)/ Hispanic
   d. Native American
   e. Caucasian/ White, Non-Latino(a)
   f. Biracial/ Multiracial
   g. Don’t know
   h. Other (please specify ______________________)

19. Which best describes your supervisor’s theoretical orientation?
   a. Psychoanalytic/psychodynamic
   b. Cognitive/behavioral
   c. Humanistic/client centered/gestalt (emotion focused)
   d. Integrative/eclectic
   e. Family systems
   f. Feminist
   g. Don’t know
   h. Other (please specify ________)

20. What is your supervisor’s field of training?
   a. Mental Health Counseling
   b. Rehabilitation Counseling
   c. School Counseling
   d. Social Work
   e. Marriage and Family Therapy
   f. Counseling Psychology
   g. Clinical Psychology
   h. Don’t know
   i. Other (please specify __________)

21. Is your primary supervisor licensed to work in his or her field of training?
   a. Yes
   b. No
   c. Don’t know

22. Has your supervisor received formal training (e.g., coursework, supervision) in clinical supervision?
   a. Yes
   b. No
   c. Don’t know
23. Has your supervisor received formal training (e.g., coursework, supervision) in addressing multicultural issues?
   a. Yes
   b. No
   c. Don’t know

24. Among the cases on which your supervisor has supervised you, how many are (please estimate)
   a. African American/ Black ________
   b. Asian/ Asian American/Pacific Islander ________
   c. Latino(a)/ Hispanic ________
   d. Native American ________
   e. Caucasian/ White/ Non-latino(a) ________
   f. Biracial/ Multiracial ________
   g. Other ________

25. How would you rate your supervisor’s overall multicultural competence (1 = not competent at all, 10 = completely competent)?
   1 2 3 4 5 6 7 8 9 10

26. How would you rate your own overall multicultural competence (1 = not competent at all, 10 = completely competent)?
   1 2 3 4 5 6 7 8 9 10
Appendix B

Cover Letter

Greetings,

My name is Arthur Ritmeester, and I am a doctoral candidate in the Department of Educational and Counseling Psychology at the University at Albany (UA). I am writing to ask you to please participate in a brief study about clinical supervision that has been approved by the UA Institutional Review Board. I am aware that you get many such requests, so I would appreciate any time you can donate to participate in my study.

The study involves clinical supervision. I am seeking pre-licensure counselors and trainees, who are currently seeing at least one client. Furthermore, to be eligible for participation you should be receiving individual clinical supervision from a supervisor whom has a) supervised you for at least one month, and b) within the past year supervised your work with a client racially different from you. The study, including the demographic questionnaire, takes approximately 25 minutes to complete.

Upon completion of the survey you have to option to enter into a drawing for $20 Amazon.com GIFT CARD. One in every 10 participants will receive a gift card.

In order to participate, please click on the following link:
https://www.psychdata.com/s.asp?SID=159728

Password: sup14

With many thanks,
Arthur Ritmeester, Doctoral Candidate
Department of Counseling Psychology
University at Albany
Albany, NY 12222
aritmeester@albany.edu
Appendix C

Informed Consent

One of the goals of clinical supervision is to teach supervisees multicultural counseling skills. However, there are still many gaps in our knowledge of how this occurs. The goal of this study is to learn how specific aspects of supervision, such as supervisees’ perceptions of their supervisors, contribute to supervisees’ sense of ability.

I am seeking supervised pre-licensure counselors and trainees who are currently providing services to at least one client. The survey, including the demographic questionnaire, takes approximately 25 minutes to complete. I appreciate your willingness to participate in my study, as a fellow counselor in training I can appreciate how valuable your time is.

Participation in the study is voluntary and your responses will be kept confidential. You may choose to withdraw from the study at any time without penalty. You may also omit responses to questions you prefer not to answer. Continuing to the online survey will indicate your consent to participate.

After responding to the online survey you will be asked to forward the study solicitation email to peers and colleagues who may be interested in participating in the study.

At the conclusion of the study you will have the opportunity to provide your contact information so you can be entered into a drawing for a $20 Amazon.com gift card. One out of every 10 participants will receive a gift card. Your contact information will be stored separately from survey responses.

As a participant in this research, you should read and understand the following statements:

- To be eligible to participate in this study, you must be at least 18 years of age and a practicing counselor-in-training or pre-licensure counselor in a mental health field (e.g., counseling psychology, clinical psychology, mental health counseling, rehabilitation counseling, social work, marriage and family therapy, school counseling). You must also be receiving individual clinical supervision from a supervisor whom has a) supervised you for at least one month, and b) within the past year supervised your work with a client racially different from you.
- Participation in this research is **VOLUNTARY**. You are free to withdraw from the study at any time without penalty.
- Your responses will be kept **CONFIDENTIAL** to the best extent possible.
  - To help protect your confidentiality, any information you provide will only be reported as grouped data with other participants’ responses.
  - None of the responses you provide or coding that is used in your responses will be able to identify you as an individual.
  - You should close your Internet browser after responding to the survey so that an outside party cannot press “back” and view your responses.
• You should not leave your computer until you have responded to the survey and closed the browser, or another party may be able to view your responses while your station is unattended.

• Anticipated risks associated with participation in this study are minimal. The only foreseeable risk is the unlikely event that you will experience minor psychological discomfort when recalling your experiences in supervision.

• Anticipated benefits of participation are minimal. The only foreseeable benefit is that this may be an opportunity for you to reflect on aspects of your supervision you have not previously considered.

DIRECTIONS:
Please complete the materials with your current clinical supervisory relationship in mind. If you currently have more than one clinical supervisor, please answer the questions with your primary clinical supervisor in mind.

With thanks,
Arthur Ritmeester, Doctoral Candidate
Division of Counseling Psychology
University at Albany
Albany, NY 12222
aritmeester@albany.edu

Contact Information
If you have any questions about this research, please contact me at 518-442-5040 or my faculty advisor, Michael Ellis, Ph.D., at 518-442-5050.

Your Rights as a Research Participant
If you have any questions concerning your rights as a research participant that have not been answered by the investigator or if you wish to report any concerns about the study, you may contact the University at Albany’s Office of Regulatory & Research Compliance at 1-866-857-5459 or hsconcerns@albany.edu.
Appendix D

Detailed Preliminary Analyses

**Counterbalancing effects.** Cell sizes for the six study orders were equivalent (31, 31, 30, 30, 30, and 30). A one-way multivariate analysis of variance (MANOVA) revealed no significant order effects on participants’ responses to the main measures, Pillai’s $V = .13$, $F(20,704) = 1.20, p = .247, \hat{\rho}^2 = .00, 95\%\ CI [0.00, 0.06]$.

**Outliers.** Univariate outliers were identified by examining $z$ scores on the measures. Only one participant was identified as a univariate outlier based on responses to the MCSE ($z = -3.18$). Examination of this participant’s responses revealed no discrepancies in the response set, and complete responses were provided to demographic questions. There was no evidence to suggest that this participant did not provide valid data, and outliers are to be expected in large data sets (Tabachnick & Fidell, 2007), so this participant remained in the data set for final analysis.

Multivariate outliers were identified by calculating influence, leverage, and discrepancy. Influence was calculated using Cooks Distance, which has a suggested cutoff point of $4/(n-k-1)$, or 1.0 (Cohen et al., 2003). Twelve (12) cases exceeded the calculated cutoff criterion of 0.02 with values ranging [0.025, 0.112]. No participants exceeded the second cutoff of 1.0. The responses of the 12 participants who surpassed the cutoff were examined for irregularities, and their response sets appeared valid. To determine if any outliers influenced the regression coefficients $dfBETAs$ were calculated (cutoff criterion = $|1.0|$; Cohen et al., 2003). No $dfBETAs$ surpassed the cutoff value.

Leverage was calculated to determine if a data point alters the overall model to an excessive degree. The suggested cutoff criterion of $2k/n$ can yield too many outliers in large samples, so a stricter cutoff of $3k/n$ was used (Cohen et al., 2003). One (1) case exceeded the
calculated cutoff criterion (0.049) with a value of 0.060. This participant’s responses were examined for irregularities, and a full set of demographic information was provided, there was no missing data, and responses to the primary measures did not suggest that the response set was invalid, so this participant’s data was retained for the major analysis.

Discrepancy was calculated using studentized deleted residuals (criterion = |3.0|; Cohen et al., 2003). Two cases were identified that exceeded the cutoff value at 3.06 and 3.17. Responses for these cases appeared to be valid and were retained for the major analyses.

Two cases exceeded criteria on more than one index of multivariate outliers. Both cases surpassed the Cook’s criterion value (.02) for influence at 0.11 and 0.06 as well as the criterion for studentized deleted residuals (|3.0|) at -3.06 and -3.17 respectively. Examination of these participants’ data sets suggested a valid set of responses and both response sets were thus retained for analysis. No other participants exceeded cutoff criteria on more than one index of multivariate outliers.

**Normality.** Normal probability plots (i.e., q-q plots) and histograms were constructed for each variable in the model (SMC, MCSE, and SWA). Skewness and kurtosis values were also calculated for each variable in the model. Examination of the q-q plots and histograms suggested that the data were normally distributed. The kurtosis (peakedness) and skewness (symmetry) did not exceed a cutoff of |1.0|, so the distribution was concluded to be normal (Tabachnick & Fidell, 2007).

Additionally, normal probability plots, and scatterplots of standardized residuals plotted against standardized predicted values were examined. These plots suggested a normal distribution of the residuals, so the assumption of normality appeared to be met for the data.

**Linearity and homoscedasticity.** To test the assumption of linearity, scatterplots of the predicted residuals against observed residuals were constructed for the independent (SMC),
dependent (MCSE), and mediator (SWA) variables in the model. The distribution of residuals did not suggest that either assumption was violated. Furthermore, each variable was plotted against each other variable in bivariate scatter plots. The data were distributed in a pattern consistent with the assumption of linearity. Finally, residuals were plotted against the predictor variables and the pattern of residuals was consistent with the assumption of homoscedasticity. Thus all assumptions underlying the major analysis were satisfied.

**Multicollinearity.** There was a moderate degree of multicollinearity between SMC and SWA as evidenced by $VIF = 1.97$ and tolerance $= .051$ (much less than the ideal of 1). However, the tolerance cutoff for severe multicollinearity of .5 was not reached. The sum of zero order correlations in the overall model (.56) exceeded the model correlation coefficient ($r = .32$).

**Social desirability.** Participants completed the M-C 1(10) to assess for social desirability as a potential confound. M-C 1(10) scores were found to be related neither significantly nor substantively, all $F$s(1, 180) $\leq$ 3.25, $p$s $\geq$ .023 (recall that because a Bonferroni procedure was used $\alpha_{pc} = .0083 = .05/6$), $rs \leq .169$, $\hat{\rho}^2 s \leq .02$, 95% CI [0.00, 0.08] to responses on other measures. Thus, social desirability scores were omitted from the final regression model.