The Role of Counseling Trainee Adversity, Attachment Style, and Trauma-Informed Principles in Clinical Supervision

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The Role of Counseling Trainee Adversity, Attachment Style, and Trauma-Informed Principles in Clinical Supervision

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A Dissertation Submitted to The Graduate School at the University of Missouri-St. Louis
in partial fulfillment of the requirements for the degree
Doctor of Philosophy in Education with an emphasis in Counseling

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Abstract

Current supervision literature suggests that supervisees with insecure attachment styles may perceive a poorer relationship with their supervisor and feel less satisfied with supervision. Studies across disciplines indicate a relationship between traumatic and/or adverse experiences and insecure attachment; however, this association has not been studied within the context of supervision. This dissertation explores a structural equation model assessing the associations between student’s adverse experiences, insecure attachment, and quality of the supervision relationship. It was hypothesized that greater prevalence of adverse experiences would negatively relate to supervision relationship quality, and this relationship would be mediated by insecure attachment. The results of study 1 indicate that student experiences of adversity are related to perceptions of lower supervision relationship quality, but this relationship was not mediated by participant’s attachment to their supervisor. This suggests a need for supervisors to account for their supervisee’s past experiences with adversity as they relate to the supervision process.

Additionally, trauma-informed principles and practices have been offered as a potential foundation for relationship-focused supervision, but many publications calling for the application of trauma-informed principles are largely theoretical. To begin to establish an evidence base for the application of trauma-informed principles in counseling training programs, the second study of this dissertation explored the relationship between student perceptions of their supervisor’s adherence to trauma-informed principles and the supervision working alliance, satisfaction with supervision, and how effectively the supervisor meets the supervisee’s needs. The results of hierarchical regression models from study 2 indicate that student’s perceptions of their
supervisor’s adherence to trauma-informed principles predicted supervision relationship outcomes above and beyond demographic variables. Trauma-informed principles may serve as a foundation for supervisor training which promotes positive supervision outcomes from the perspective of the student. Results, limitations, and implications for research and practice are provided for each manuscript.

*Keywords:* Supervision, Adversity, Attachment, Trauma-informed
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Section 1

Introduction

The following studies broadly investigate the relationship between adversity and relationship factors in supervision, as well as the utility of trauma-informed principles in supervision. Trauma, traumatic stress, and adverse experiences are so prevalent they have been considered a public health crisis (Felitti et al., 1998). It stands to reason that such a widespread societal issue would also be a factor in counseling, counselor education, and supervision. Furthermore, there is a significant body of research establishing a connection between adversity and relationship challenges. The counseling profession relies heavily on relationships—between peers, between counselor and client, between student and instructor, and between supervisee and supervisor. Theoretically, these relationships, like other relationships, are also susceptible to the effects of trauma. A goal of these studies is to explore the specific ways that adversity and trauma-informed principles relate to the supervision relationship in particular.

In this research I define adversity and trauma broadly, going beyond the criteria outlined in the DSM-5 (American Psychiatric Association, 2013). This was an intentional choice because adverse experiences that do not qualify as a traumatic event according to DSM-5 Criterion A may still have implications for social and emotional functioning. For example, researchers have shown individuals report more severe mental health symptoms and/or greater attachment insecurity if they have experienced teasing (McCabe et al., 2010), racial discrimination (Sibrava et al., 2019), and adverse childhood experiences (Murphy et al., 2014; Thomson & Jaque, 2017). I wanted to take a broad approach to
defining adversity in order to capture a wide range of experiences that counseling trainees may be bringing with them to their training program.

Given high rates of mental health providers with traumatic histories (Elliot & Guy, 1993; Follette, Polusny, & Milbeck, 1994), in addition to the potential for vicarious traumatization in new counselors (Sommer, 2008), counselor educators must understand the impact of trauma in students’ lives, just as we do in clients’ lives. In 2014, the Substance Abuse and Mental Health Services Administration (SAMHSA) outlined six trauma-informed principles (TIP): safety, trustworthiness, and transparency, peer support, collaboration and mutuality, empowerment, and cultural issues (SAMHSA, 2014). These principles were developed for application in behavioral healthcare settings, but recently practitioners and authors have begun to apply the principles to counseling and supervision. Recently, some authors have called for increased application of trauma-informed principles to supervision and counselor training (e.g., Berger & Quiros, 2014; Copeland et al., 2019; Knight, 2018), but most of these publications have been driven by the potential for vicarious traumatization in counselors rather than the counselor’s own traumatic history. There is still a considerable lack of evidence behind trauma-informed principles, including in a supervision setting, so another goal of this dissertation is to address that gap.

The goals of TIP are to maximize the efficacy of mental health treatment, reduce an institution’s exacerbation of client or customer stress, and create a common framework among service delivery systems. Counselor education programs deliver the service of specialized training and supervision in preparation for professional counseling careers, and some have suggested graduate training in human services may be a traumatic
experience for students (Carello & Butler, 2014; Copeland et al., 2019; Zosky, 2013). For example, in a qualitative study of social work students, Zosky (2013) found that participants experienced emotional challenges during class discussions of traumatic experiences such as intimate partner violence. Additionally, in clinical settings, graduate students are at risk for developing secondary traumatic stress, or vicarious trauma, when working with client survivors of trauma (Knight, 2018). Considering this, TIP may be a useful tool in furthering counselor training processes in order to maximize the efficacy of supervision and reduce harm to students under supervision. Supervisors who operate within TIP may meet their student’s needs more effectively, form stronger working alliances with trainees, and have greater overall satisfaction with supervision. If TIP are related to these positive supervision outcomes, TIP could be a potentially beneficial area of counselor education and supervision research and training. Applying TIP could provide a common supervision framework for the practice and teaching of supervision practices, which would further ground supervision in evidence beyond theory alone (Watkins, 2020).

Furthermore, in recent years greater attention has been given to the harmful practices of graduate education and the relationship of these practices to poorer student mental health (Evans et al., 2018). In their study of over 2,000 graduate student participants, these researchers found that the sample was over 6 times more likely to report depression and anxiety than the general population (Evans, et al., 2018). Furthermore, participants experiencing anxiety and depression were more likely to report a poor work-life balance in their program, low supervisor support and mentorship, and a perception of not being valued by their mentor. These results highlight the importance of
student-mentor relationships during graduate training in supporting student mental health. A student’s relationship with their supervisor may be a protective factor against mental health challenges experienced in graduate training, and also a protection against a student’s past adverse experiences affecting their professional development. A student-centered training approach which understands each student’s unique experiences and needs could be provided through a trauma-informed framework. Through this research I intend to draw attention to the epidemic of adverse experiences in counseling trainees and encourage training programs to take responsibility for understanding and navigating these dynamics to ensure effective professional development for students. Adverse experiences may contribute to challenges in supervision, and uncovering causes of student behaviors may help instructors and supervisors address student needs more effectively rather than removing these students from training. Recommendations for student development and remediation could differ depending on the student’s unique history and the reasons behind their clinical struggles. This could have implications for counseling gatekeeping in training programs. Perhaps programs are removing students from the field due to problematic behaviors without fully investigating the source and changeability of those behaviors, which may be due to adverse experiences rather than characterological deficits (Watkins, 2010a). Students who experience challenges in their training program related to personal history may benefit from a trauma-informed approach to supervision and teaching which acknowledges the role of trauma in their professional development and seeks to minimize the effects of traumatization on the student as they learn. Minimizing harm could also translate to improved learning outcomes and therefore more effective and competent counselors. However, before these principles can be widely applied to
counselor education, there is a need to examine outcomes related to these principles (Berliner & Kolko, 2016).

Finally, I intend to submit these manuscripts for publication in Counselor Education and Supervision under the topic of supervision (page requirements are 20-25 pages double spaced, including all references, tables, and appendices). I believe publishing in this journal will produce the largest impact on the field of counselor education.
Section 2 - Articles

Introduction: Study 1

Supervision is a core professional area of doctoral professional identity according to the Council for Accreditation of Counseling and Related Educational Programs (CACREP; 2016) standards for CES doctoral study. For example, standard B.2 requires CES programs to document how doctoral students are taught supervision theory, skills, gatekeeping methods, assessments, and more (CACREP, 2016). CACREP (2016) Standard B.2.c in particular focuses on the roles and relationships of clinical supervision, which encompass relationship dynamics between supervisee and supervisor. Supervision can improve supervisee’s competence (Alfonsson et al., 2018; Kühne et al., 2019), is best when attending to the relationship between supervisor and supervisee (Carpenter et al., 2013), can mitigate supervisee stress (O’Donoghue & Tsui, 2015), and may have some impact on supervisee skill development and self-efficacy (Wheeler & Richards, 2007). Alternatively, many researchers who have reviewed the supervision literature have found no conclusive evidence for a positive effect of supervision on supervisee or client outcomes (Bogo & McKnight, 2006; Reiser & Milne, 2014; Simpson-Southward, et al., 2017; Watkins, 2011). Although the empirical evidence in this area is limited and some suggest the importance of supervision is overblown (Watkins, 2020), researchers have shown that supervisees and supervisors believe supervision is important and beneficial to both supervisee and client growth outcomes (Rast et al., 2017). Therefore, although there is a lack of clear understanding of supervisee’s experiences of supervision and variables that affect perceptions of supervision, supervisees still place value on the experience and thus this area of training deserves further attention and development. The purpose of the
current study is to explore how student experiences with adversity and attachment style affect supervision variables.

There is mixed evidence of the role of student adversity and attachment in the supervision relationship and how they may be affected by the multiple personal qualities and experiences each individual brings to the relationship. Some researchers have investigated the role of supervisee and supervisor factors in supervision, including how a supervisee’s personal experiences and qualities relate to elements of the supervision relationship (see Dickson, Moberly, Marshall, and Reilly, 2011). Additionally, researchers examining the intersection of traumatic stress and supervision have explored how supervisees manage vicarious traumatization through clinical work, but these studies largely ignore the role of the supervisee’s personal experience with traumatic stress and how it may affect professional relationships (Berger & Quiros, 2014; Copeland et al., 2019; Jones & Branco, 2020; Knight, 2018).

Traumatic stress and adversity can affect emotional functioning (Wojcik et al., 2019), relationships (Barazzone et al., 2019), and physical and mental health (Sachs-Ericsson et al., 2017), all of which potentially play a role in a therapist’s approach to interventions and presence in the therapy room (Bennett-Levy, 2019; Bernard & Goodyear, 2018; Gelso & Perez-Rojas, 2017). Because a therapist’s inner experiences in sessions with clients can impact what interventions are chosen and how they are applied, counselor educators should be aware of factors affecting trainee’s inner experiences, including traumatic stress and adversity.

It is also plausible that a student’s personal experience with traumatic stress and adversity may impact their progression through a counseling training program. Students
may experience compounding traumatization through their clinical work, disengage from
courses, or otherwise behave in ways that may necessitate a referral to the program’s
review board. Such behaviors may be due to adverse experiences or insecure attachment
rather than an inability to succeed in the field. Uncovering causes of student behaviors
may help instructors and supervisors address student needs more effectively, and
recommendations for student development would differ depending on the student’s
unique history and the reasons behind their clinical struggles. This could have
implications for counseling gatekeeping in training programs (Carello, 2018). In
supervision specifically, addressing individual students’ need may look different
depending on the experiences the student brings to the supervision relationship. For
example, disengagement or over-independence may be a sign of challenging personality
variables that can affect student’s relationships with clients (Kaslow et al., 2007) or could
be due to insecure attachment resulting from trauma. Perhaps programs are removing
students from the field due to problematic behaviors without fully investigating the
source and changeability of those behaviors, which may be due to adverse experiences
rather than characterological deficits (Watkins, 2010a).

In addition to the effect of traumatic stress and attachment in the therapist-client
relationship, these factors are also potential barriers to effective supervision. Researchers
have shown that attachment, or psychological and emotional connectedness between
people, may affect the bond between supervisor and supervisees. For example,
supervisees with insecure attachment style (e.g., attachment anxiety and avoidance)
report lower ratings of the working alliance in supervision (e.g., Bennett et al., 2008;
Gunn & Pistole, 2012). Relatedly, traumatic stress has been shown to relate to attachment
style and interpersonal dynamics (e.g., Bachem, et al., 2019; DePrince et al., 2011; Wojcik et al., 2019), and these relationship dynamics would theoretically extend to the supervision relationship. John Bowlby, the father of attachment theory, originally theorized that while attachment style was stable across the lifespan, negative experiences (i.e., adversities) have the potential to disturb attachment stability, including the death of a parent, foster care, parental divorce, and child physical or sexual abuse (Bowlby, 1953). Although attachment has generally been understood in relation to a primary caregiver in childhood, there is evidence that adverse events across the lifespan can alter attachment style to multiple types of significant relationships including parents and romantic partners (Bachem et al., 2019; Cooper, 2006; Huth-Bocks, et al., 2004; Mikulincer et al., 2011; Murphy et al, 2014; Rumstein-McKean & Hunsley, 2011; Thomson & Jaque, 2017). Therefore, in theory, adversity across the lifespan has the potential to affect the supervision relationship.

In two known studies, researchers have explored the role of childhood experiences on attachment and the supervision relationship (see Dickson, et al., 2011; Riggs & Bretz, 2006). In a sample of 259 British clinical doctoral trainees, Dickson and colleagues (2011) found no direct association between trainee’s experience of maladaptive parenting styles and the supervision working alliance, although their path analysis suggested an indirect relationship between parental indifference and working alliance variables similar to results from Riggs and Bretz (2006) with their sample of 87 psychology doctoral students in the United States. These studies focused on a single type of adversity (parenting styles), and there is a need to examine the role of supervisee’s
personal experiences (e.g., traumatic stress and adversity broadly) in the supervision relationship.

Additionally, adverse experiences that do not qualify as a traumatic event according to DSM-5 Criterion A may still have implications for social and emotional functioning. For example, researchers have shown individuals report more severe mental health symptoms and/or greater attachment insecurity if they have experienced teasing (McCabe et al., 2010), racial discrimination (Sibrava et al., 2019), and adverse childhood experiences (Murphy et al., 2014; Thomson & Jaque, 2017). Therefore, it is theoretically possible that supervisee’s history of broadly adverse experiences and attachment style could impact the supervision relationship. This study includes both Criterion A and non-Criterion A events in the definition of adversity because of the potential for both types of events to affect the victim. Because supervision is a crucial piece of counselor training (CACREP, 2016), it is necessary to explore and understand these barriers. To understand supervisee’s needs and effectively meet those needs, supervisors may require a deeper understanding of the ways the supervisee’s personal experiences manifest in supervision.

**Current Study**

The purpose of this study was to examine the relationships between supervisees’ experiences with trauma and adversity, their attachment style, and their perceptions of the quality of the relationship with their supervisor. In particular, the study tested whether supervisee attachment to their supervisor mediated the relationship between adversity and supervision quality.

I hypothesized that higher rates of adverse experiences would correlate with lower perceived quality in the supervision relationship (hypothesis 1), and that this relationship
would be mediated by supervisee attachment style (hypothesis 2, see Figure 1). In other words, greater adversity would predict greater insecure attachment to the supervisor, which would then predict lower quality in the supervision relationship. Researchers have shown that adverse experience predicts insecure attachment (Bachem et al., 2019; Murphy et al., 2014; Thomson & Jaque, 2017), and insecure attachment style is related to a poorer supervision working alliance and lower satisfaction with supervision (Bennett et al., 2008; Renfro-Michel & Sheperis, 2009). This model explores these relationships simultaneously, which no other study was found to have done previously.

Additionally, I hypothesized that greater adversity would predict general insecure attachment style, and this variable would also predict greater insecure attachment to the supervisor and lower supervision relationship quality (hypothesis 3). While there is substantial evidence that adversity and attachment style are reciprocally related (Franz et al., 2014; Lieberman & Amaya-Jackson, 2005), there is some literature demonstrating that general attachment and attachment to a supervisor are separate but related constructs. Bennett and colleagues (2008) found that participants with higher levels of general attachment avoidance were more likely to display insecure attachment behaviors with their supervisors, and supervisor-specific attachment style was associated with stronger supervisory alliance while general attachment style was not. Furthermore, Wrape and colleagues (2017) found that while the two attachment constructs were positively correlated with each other, supervisor-specific attachment was a stronger predictor of the supervision working alliance than general attachment style. These results support Fraley’s (2007) theory of attachment which suggests a general, overarching attachment style predicts relationship quality, in addition to context-specific attachment styles which
may differ across relationship types (e.g., peers, parents, significant others). Thus, the overall model of the current study is grounded in theory and empirical evidence.

Method

Participants

The sample of 228 participants (mean age = 30.15, SD = 5.67) was 50% women, 48.7% men, and 1.3% a third gender or nonbinary. Approximately 17% of the sample identified as African American or Black, 15% Hispanic or Latino/a/x, 4% Native American, 61% White, and 3% Asian or Asian American. Most (55%) of the participants were enrolled in a clinical mental health counseling (CMHC) program; others were enrolled in school counseling (23%), counselor education and supervision (9%), marriage and family therapy (6%), and rehabilitation counseling (6%). The remaining participants were receiving a dual degree or were in other types of training programs (e.g., clinical psychology). The mean number of adverse childhood experiences in the sample was 10.32 (SD = 6.44; range 0 - 22). The expanded ACES measure assesses the frequency of 31 different adverse experiences (Karatekin & Hill, 2019). Approximately 6% of the sample experienced zero ACES, 2.6% experienced 1 ACE, 4.8% experienced 2 ACES, and 82% reported experiencing 4 or more ACES.

Measures

Adverse Childhood Experiences- Expanded (ACE-E)

Karatekin and Hill (2019) developed a measure of Adverse Childhood Experiences (ACEs) that expanded on the original ACEs survey developed by Felitti and colleagues in 1998. The authors theorized that expanding the ACEs scale to include adversities outside the home would more effectively capture the experiences of diverse
populations and encourage advocacy efforts to address community issues in addition to individual and family issues. Karatekin and Hill (2019) combined the original ACEs (Felitti, et al., 1998) questionnaire items with the Juvenile Victimization Questionnaire (Finkelhor, et al., 2005). Factor analysis of the expanded 31-item scale revealed a four-factor structure: maltreatment, household dysfunction, community dysfunction, and peer dysfunction/property victimization. Although four factors did emerge, the authors recommend using the ACE-E as a unitary scale. Participants respond to each item with a “yes” or “no” to indicate if they experienced each type of adversity before the age of 18. Responses are summed to yield a total ACE-E score ranging from 0-31, with higher scores indicating greater experience with childhood adversity.

In a sample of 75 predominantly White female students (79% White, 84% female), internal consistency of this expanded scale was good (Cronbach’s α = .84), and test-retest reliability (r (67) = .77) over the course of a semester (average interval between administrations was 48.8 days) was adequate. Assessment of concurrent validity revealed the expanded ACEs scale was moderately correlated with other measures of stressful events and trauma: the Stressful Life Events Screening Questionnaire—Revised (SLESQ; Green & Green 2006), $t = .43, p < .001$, and the Childhood Trauma Questionnaire (CTQ; Bernstein et al., 2003), $t = .54, p < .001$. The expanded ACEs scale was also predictive of more severe mental health symptoms measured by the Short Form-36 (Ware et al., 1993), Hopkins Symptom Checklist-10 (HSCL; Syed et al., 2008), and the Perceived Stress Scale (PSS; Cohen & Williamson, 1988). This scale was chosen to capture participants’ experiences of adversity before the age of 18, which may have
implications for attachment style (Barazzone et al., 2019). The scale’s Cronbach alpha for the current sample was .87.

*Adverse Adult Experiences (AAE)*

To capture adverse experiences after the age of 18, the instructions from the ACE-E were modified to pertain to adulthood rather than childhood. Some items were eliminated from the AAE due to irrelevance in adulthood (e.g., *Were you sent away or taken away from a parent or your family for any reason [not including voluntary separations, such as going to summer camp]*). Items referring to “other kids, your sibling, or your boyfriend or girlfriend” were modified to refer to “peers, friends, siblings, or significant others.” After these modifications were made, the final scale contained 26 items that paralleled items on the ACE-E. Participants respond to each item with a “yes” or “no” to indicate if they experienced each type of adversity after the age of 18. Other researchers have used this method (i.e., modifying an adverse childhood experiences scale) to assess adult adverse experiences (see Borja et al., 2019 and Stumbo et al., 2015); however, this modified scale has not been psychometrically validated to date. Scoring was similar to the ACE-E (Karatekin & Hill, 2018); all items were summed to create a total score ranging 0-26, with higher scores indicating greater experience with adulthood adversity. This scale was chosen to capture participant’s experiences with adversity after age 18, which may also have implications for attachment style, as attachment style is still vulnerable to change after an adverse event in adulthood (Bachem et al., 2019). Cronbach’s alpha for the current study was .87.
The Everyday Discrimination Scale (Williams et al., 1997) is a 9-item scale measuring frequency of discriminatory experiences in day-to-day life (e.g., “You receive poorer service than other people at restaurants or stores”). It was originally developed to study racial discrimination in Detroit (items were created based on previous qualitative research on discrimination) but has since been used in diverse populations. The EDS has shown good internal consistency in diverse samples including Black adolescents (alpha = .87; Clark et al., 2004), American Indian and Alaskan Natives (alpha = .92; Gonzalez et al., 2016), and a national racial and gender diverse sample (alpha = .93; Kessler et al., 1999). Scores on the EDS have also been correlated with physical and mental health outcomes (e.g., depression, anxiety, stress, substance misuse, decreased cardiovascular health, fatigue) in multiple studies (Paradies, 2006; Taylor et al., 2004; Williams & Mohammed, 2009), providing evidence of criterion validity. This scale was chosen for the current study to supplement the measurement of adversity in adulthood. The scale’s Cronbach’s alpha was .90 for the current study.

Participants respond to the EDS on a Likert scale ranging from 1 (Never) to 6 (Almost everyday). Total scores are calculated by summing ratings for all items and may range from 9-54 with higher scores indicative of more frequent experiences of discrimination. Participants who respond to any of the initial nine items with “a few times a year” or more are directed to follow-up questions assessing participants’ perceptions of the main or most common reason for their experience (e.g., gender, race, weight, education). This additional data is typically kept separate from the quantitative ratings of discrimination frequency and can be used to categorize participants into groups. This data
may provide descriptive information on how participants perceive discrimination in various settings.

**Experiences in Supervision Scale (ESS)**

The Experiences in Supervision Scale (ESS; Gunn & Pistole, 2012) is a 36-item scale assessing supervisee attachment to a supervisor. Because there is currently no supervisor-specific attachment measure in the literature, the ESS was created by Gunn (2008) through modification of the Experiences in Close Relationships Scale (ECR; Brennan, Clark, & Shaver, 1998). The original authors further modified the scale by changing the language in each item to reflect supervisee interactions with supervisors, and new items were then reviewed by eight counseling graduate students and one faculty member with expertise in attachment theory. Items referring to a “partner” or “others” were modified to refer to the “supervisor.” Finalized items were entered into a principal factor analysis with promax rotation. Results showed Factor 1 explained 40.76% of the variance and Factor 2 explained 11.16% of the variance (Gunn & Pistole, 2012). Internal consistencies were .89 for the anxiety factor and .91 for the avoidance factor. In the current study, Cronbach’s alpha was .86 for the anxiety factor and .82 for the avoidance factor.

The final version of the ESS produces scores on two subscales: attachment anxiety (18 items) and attachment avoidance (18 items). Participants rate items on a 7-point Likert scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). Attachment anxiety scores are generated by averaging ratings on items 1-18, and attachment avoidance scores are created by averaging ratings on items 19-36. Higher scores on each dimension indicate low anxiety and low avoidance, which interpreted together, but not
summed, reflect greater attachment security. This scale was chosen to measure supervision-specific attachment because it provides dimensional attachment scores on anxious and avoidant attachment beliefs and behaviors. Researchers have demonstrated attachment style may be more appropriate measured dimensionally than categorically (Fraley, 2007). Additionally, as noted by Gunn (2007), the ECR was created using the “gold standard” of scale development: all previously published instruments measuring both romantic and non-romantic relationships were entered into a factor analysis, resulting in the final ECR. Although the final version refers to romantic partners and measures perceptions of close relationships, this dynamic may also apply to the supervision relationship given that effective supervision requires trust, communication, encouragement, reliability, and other elements of close relationships (Berger & Quiros, 2014).

Measure of Attachment Qualities (MAQ)

The Measure of Attachment Qualities (Carver, 1997) is a 14-item measure assessing level of attachment avoidance, anxiety, and security within adult relationships. An initial item set was created by compiling multiple attachment measures and modified to reflect avoidant, anxious, or secure beliefs about relationships. After two sets of revisions the final scale was administered to a sample of 807 undergraduates (452 female; additional sample demographics not reported) at a university in the southern United States. Principal components analysis revealed a four-factor structure all with adequate or above internal consistency and test-retest reliability: Avoidance (α = .76, 6-week test-retest r = .80), Ambivalence-Worry (α = .69, 6-week test-retest r = .69), Ambivalence-Merger (α = .73, 6-week test-retest r = .69), and Security (α = .72, 6-week test-retest r =
The Ambivalence-Worry subscale items appeared to pertain to a sense of worry over potential abandonment by significant others, while the Ambivalence-Merger scale items focused on a desire to approach or merge with a significant other. To assess convergent validity, a subsample of 576 were administered a single item measure of attachment by Hazan and Shaver (1987), yielding three groups based on attachment style: avoidance, ambivalence, and secure. Participants in the avoidant group reported higher levels of MAQ Avoidance and lower levels of MAQ Security than the ambivalent and secure groups, and the ambivalent group scored significantly higher on the MAQ Ambivalence-Worry and Ambivalence-Merger scales than the avoidant or secure groups, supporting the construct validity of the MAQ.

Participants rate each item on a 4-point Likert scale ranging from 1 (I disagree with the statement a lot) to 4 (I agree with the statement a lot). Item ratings are summed to produce four subscale scores of Security, Avoidance, Ambivalence-Worry, and Ambivalence-Merger. Items 4, 8, and 9 are reverse coded. The two subscales Avoidance and Ambivalence-Merger (8 items total) was used to measure participant’s anxious and avoidant attachment to attachment figures in general, rather than within a specific relationship. This decision is based on research showing attachment style has both general and relationship-specific qualities. The Avoidance scale on the MAQ is complementary to the ESS subscale of avoidance, and the Ambivalence-Merger subscale on the MAQ is complementary to the ESS subscale of anxiety. Of the Ambivalence scales, the Ambivalence Merger scale displayed marginally higher internal consistency and was chosen over the Ambivalence-Worry subscale. Cronbach’s alpha was .45 for the
Avoidance subscale and .50 for the Ambivalence-Merger subscale indicating insufficient reliability.

**Supervisory Working Alliance Inventory-Trainee Version (SWAI-T)**

The Supervisory Working Alliance Inventory-Trainee version (SWAI–T; Efstation et al., 1990) is a 19-item measures based on Bordin’s (1983) theory of the supervisory working alliance and consists of two subscales: Rapport (12 items; e.g., “I feel comfortable working with my supervisor”) assesses the supervision relationship and perceived supervisor support; Client Focus (seven items; e.g., “My supervisor encourages me to take time to understand what the client is saying and doing”) assesses the client-focused tasks/ goals of supervision including help with understanding clients and determining effective counseling interventions. In a validation sample of 178 doctoral interns in counseling and clinical psychology training programs (57.8% female, mean age = 29.95, no other participant characteristics were reported), alpha coefficients for the SWAI-T were .90 for Rapport and .77 for Client Focus. The Client Focus subscale was moderately correlated with Supervisor’s (.50) and Trainee’s (.52) versions of the Task-Orientated scale from the Supervisory Styles Inventory (SSI; Friedlander & Ward, 1984), suggesting good convergent validity. The Rapport subscale displayed low correlations with the Task-Oriented scales of the SSI, also suggesting good convergent validity. Both Rapport and Client Focus subscales were significantly correlated with the Self-Efficacy Inventory (SEI; Friedlander & Snyder, 1983), with correlation coefficients of .22 and .15, respectively, providing support for the SWAI-T’s discriminant validity. In this study, only the Rapport subscale was used because Rapport refers to the quality of the bond between supervisor and supervisee and therefore is theoretically more relevant to
supervisee attachment to their supervisor. Additionally, the Rapport subscale has emerged most “strongly and consistently across studies” (Watkins, 2014, p. 42).

Items are rated on a 7-point Likert scale ranging from 1 (*almost never*) to 7 (*almost always*). For a total Rapport score, items 1-12 are summed then divided by 12. Higher scores reflect greater rapport and client focus, and therefore a stronger supervision working alliance. Working alliance has emerged as an important factor in supervision in several studies (Bernard & Goodyear, 2018). The SWAIT-R also displays solid psychometric properties; therefore, it was chosen to measure this construct for the current study. Cronbach’s alpha was .92 in the current sample.

**Supervisee Needs Index (SNI)**

The Supervisee Needs Index (SNI; Muse-Burke & Tyson, 2010) is a 48-item measure assessing trainee’s perceptions of their supervisor’s ability to meet their needs in supervision. Items are rated on a 7-point Likert scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*) and include “My supervisor makes our relationship a priority” and “My supervisor helps me feel self-assured in my clinical work.” Total scores range from 48- 336, with higher scores indicating the supervisor is more effectively meeting the supervisee’s needs. A total of 24 items are reverse scored. The SNI is an unpublished measure and therefore information on reliability and validity of the scale could not be found. Despite this, based on the face validity of the scale’s items, it measures a construct that is relevant to the supervision relationship and was therefore included. In the current study, Cronbach’s alpha for the SNI was .95.
The Supervisory Satisfaction Questionnaire (SSQ)

The Supervisory Satisfaction Questionnaire (SSQ; Ladany et al., 1996) is an 8-item scale examining supervisee’s perceptions of the quality of supervision. The SSQ is a modified version of the Client Satisfaction Questionnaire (CSQ; Larsen et al., 1979). Language referring to counseling services was replaced with terms referring to supervision and supervisors. Internal consistency was .93 in the original scale (unknown sample characteristics) and .96 in the modified scale (in a sample of 108 counseling and clinical psychology doctoral trainees, 79.6% female, 80.5% White, mean age = 30.47). The CSQ has demonstrated positive correlations with self-reported client improvement \( r = .53, p < .001 \) and lower client dropout \( r = .37, p < .01 \), indicating the CSQ relates to other variables in theoretically predictable ways. Satisfaction was included as a variable in this study due to its relationship to supervisee attachment style and the supervision working alliance (Bennett et al., 2008; Renfro-Michel & Sheperis, 2009).

Items (e.g., How satisfied are you with the amount of supervision you have received?) are rated on a 4-point Likert scale \( 1 = \text{Excellent}, 2 = \text{Good}, 3 = \text{Fair}, 4 = \text{Poor} \). A total satisfaction score is created by summing ratings for each item, with a possible score ranging from 8-32 and higher scores indicating greater satisfaction with supervision. Cronbach’s alpha was .90 for the current study.

Demographics

Supervisee demographic variables were also measured, including type of program of graduate study, level of training (i.e., masters or doctoral), number of supervision sessions with current supervisor, trainee age, racial/ethnic background, gender, and months/years of counseling experience.
Procedure

After gaining IRB approval, participants were recruited in multiple ways: a) emailing recruitment ads to faculty in CACREP-accredited and non-accredited counseling programs in the United States, b) regular social media postings on Twitter and Facebook, and c) posts on counseling professional listservs including CES-NET, COUNSGRADS, and DIVERSEGRAD-L. CACREP provides a list of accredited programs and their faculty contacts, and this list was used to contact accredited programs. A total of 402 were contacted based on this information. Additionally, an internet search and conducted to locate non-CACREP accredited programs in the United States, and programs with public email addresses of faculty were contacted. A total of 128 programs were contacted from this search. For social media recruitment, a page for the study was created on Facebook and the author paid to advertise the study to targeted groups of counseling students. Mental health, psychology, counseling, and school counseling pages encouraging diversity in membership were also contacted via Twitter. Contacts of the author were also encouraged to share the study information on their personal social media pages.

All measures were completed by participants online using the survey platform Qualtrics. Additionally, participants were encouraged to share the study information on their own social media platforms (a method of snowball sampling). Inclusion criteria were counseling trainees over the age of 18, currently enrolled in a counseling or mental health related program, and currently receiving individual clinical supervision. Data collection was anonymous. Participants had the option of entering a randomized raffle to
win one of forty $30 Amazon gift cards. This part of the survey was not linked to participant’s survey data.

Initially, 366 participants joined the study. Eleven participants failed the three validity checks embedded in the surveys, and another 109 participants were omitted due to missing data. Three univariate (data with Z scores ± 3.29) and 15 multivariate (data with Mahalanobis distance scores above 29.59) outliers were also removed, for a final sample size of 228.

**Latent Variables**

Latent variables were used in the structural equation model to minimize measurement error. The current study’s latent constructs were originally measured with at least three manifest or observed indicators representing each one, according to recommendations from Kline (2005). However, the goodness of fit data for the measurement model indicated insufficient model fit, so the SNI was removed from the model and insecure attachment construct was split into general and supervisor-specific attachment. This left the latent constructs of Insecure Attachment Style, Insecure Attachment to Supervisor, and Supervision Relationship Quality with only two indicator variables.

The latent variable of Adversity was comprised of adverse experiences from both childhood and adulthood, as well as a measure of discrimination experiences that may not traditionally be considered traumatic. The latent variable Perceived Supervision Quality encompassed interrelated factors of the supervision relationship including the working alliance and overall satisfaction with supervision. Because a goal of supervision is the development of the student, the student’s perceptions of the supervision process are
relevant to assessing its quality. Other variables affecting supervision (i.e., supervisor theory and qualities) are outside the scope of this project. Finally, attachment style may be conceptualized as having both generalized and relationship-specific qualities (Fraley, 2007); therefore, general and supervisor-specific attachment were used as distinct latent variables.

**Results**

**Preliminary Analysis**

As noted previously, the data were cleaned for missing data and failures of embedded validity checks. Additionally, tests for violations of normality, linearity, multicollinearity, and homoscedasticity were conducted. None of the main variables displayed substantial skewness (± 2) or kurtosis (± 7; Field, 2009). Based on variance inflation factor (VIF) values and tolerance values, there was no evidence of multicollinearity between independent variables. A curve estimation was conducted in SPSS (IBM, 2019) to assess for linear relationships between main study variables; several of these relationships were not sufficiently linear, and this assumption was violated. The non-linear relationships were attributed to both subscales on the Experiences in Supervision (ESS) scale. Additionally, homoscedasticity of the main variables was assessed through a visual inspection of scatterplots of the variable residual values. The residual plots did not reveal significant dispersion; however, the results of Breusch-Pagan tests for homoscedasticity indicated that SSQ and SNI were heteroscedastic. Violation of the homoscedasticity assumption increases risk of bias in the parameter estimates in linear regression analyses; however, there is little information
on how this violation affects SEM analyses (Deng et al., 2018). The decision was made to proceed, keeping in mind the potential limitations.

Correlations were conducted to determine if any continuous demographic variables were related to the main variables of interest. Additionally, ANOVAs were conducted for the categorical demographic variables. Several of these variables were significant correlated ($p < .001$) with supervision quality. However, many of these variables (e.g., gender, age) were not theoretically relevant to the constructs of interest and were therefore not included in the final model. Because of their relevance to the supervision-related latent constructs (i.e., Insecure Attachment to Supervisor and Supervision Relationship Quality), the number of supervision sessions completed with a trainee’s current supervisor and the trainee’s expectation of receiving a passing or failing grade in their training course were included in the model.

Table 1 displays means, standard deviations, and correlations for the main study variables. Adverse childhood and adult experiences were significantly positively correlated. Mean scores on these scales suggest high prevalence of adverse experiences among participants; in the development of the expanded ACES scale, Karatekin and Hill (2019) reported a mean ACEs of 4.3 for their sample. Some older publications have indicated that mental health professionals report higher frequency of traumatic experience than other professions (Elliot & Guy, 1993; Follette, Polusny, & Milbeck, 1994), and this newer data corroborates those previous findings. Variables measuring general insecure attachment were correlated with measures of adversity, which is in line with previous research exploring the reciprocal relationship between trauma/aversity and attachment (Franz, et al., 2014; Lieberman & Amaya-Jackson, 2005). However, variables measuring
insecure attachment to the supervisor were not correlated with adversity measures. Finally, greater rapport in the supervision working alliance was negatively correlated with measures of adversity and general insecure attachment, which is consistent with previous literature and theoretical understandings of adversity, attachment, and relationship quality (Campbell & Renshaw, 2018; Collins & Read, 1994; Dickson, et al., 2011; Riggs & Bretz, 2006).

**Testing the Structural Equation Model**

The hypothesized relationships between adversity, attachment, and supervision quality were tested using Amos version 26. Prior to testing the structural model, the measurement model was tested using confirmatory factor analysis (CFA). Model fit was evaluated based on the comparative fit index (CFI), the incremental fit index (IFI), and Tucker-Lewis index (TLI), standardized root mean residual (SRMR), and the root mean square of approximation (RMSEA). The chi squared statistic was not used to assess model fit because of its oversensitivity to larger sample sizes (Kline, 2016). Instead, the SRMR was substituted because it is not overly sensitive to sample size. The recommended cutoff for the SRMR is .08 for adequate fit, and below .05 for good fit (Hu & Bentler, 1999). It has been asserted that CFI, IFI, and TLI values above .95 and RMSEA values below .08 indicate acceptable fit (Hu & Bentler, 1999); however, other literature is mixed on the utility of adhering to these specific cutoff points on fit indices. Studies examining complex constructs with lower expected factor loadings (i.e., between 0.40 and 0.90) may not achieve adequate model fit by these standards despite reliable measurement and analysis procedures (McNeish, An, & Hancock, 2018). Therefore, the
following fit indices should be interpreted with caution given the complexity of the latent variables in the current study.

Results of the CFA indicated poor model fit based on the previously listed standards: CFI = .88, TLI = .81, IFI = .88, SRMR = .099, and RMSEA = .170 (90% CI [.15, .19]). All the observed variables were significant at $p < .001$, suggesting the latent variables were well defined by the observed variables; individual factor loadings can be found in Table 2. Modification indices suggested that the SNI loaded onto two latent variables- Insecure Attachment to Supervisor and Supervision Relationship Quality. Due to this cross loading, the SNI was removed to simplify the model. Results indicated the fit of the measurement model was improved from the originally hypothesized model, but still insufficient overall: CFI = .96, TLI = .92, IFI = .96, SRMR = .0720, and RMSEA = .104 (90% CI [.08, .13]). Again, all observed variables were significant at $p < .001$.

Factor loadings ranged from .52 to .96, with one loading not meeting the minimum standard of .60 (Awang, 2015).

Next, the structural model was created and the covariates of number of supervision sessions and the supervisee’s expectation of a passing or failing grade were included in the model. These covariates were allowed to correlate with each other and predicted the endogenous variables that were theoretically relevant (i.e., insecure attachment to supervisor and supervision relationship quality). Results indicated an insufficient model fit: CFI = .922, IFI = .923, TLI = .877, SRMR = .093, RMSEA = .111 (95% CI [.079, .131]). Modification indices were not used to guide improving the model fit because none were theoretically justifiable. Only two paths in the model were not significant (see Figure 2). Hypothesis 1 was supported because there was a significant
negative relationship between Adversity and Supervision Relationship Quality ($\beta = -.53$, $p < .001$). The structural model was also tested without covariates to see if any results changed: including covariates did not change the main findings but worsened the model fit.

To test hypothesis two, that the relationship between adversity and perceptions of supervision relationship quality would be mediated by supervisee attachment style, bootstrapping in AMOS was used. One thousand bootstrap samples were constructed with bias-corrected 95% confidence intervals. An indirect effect between variables is significant if the confidence interval does not include zero (Shrout & Bolger, 2002). The indirect effect of adversity on supervision relationship quality through insecure attachment to supervisor was not significant ($b = -.029$, BC 95% CI [-.48, .25], $\beta = -.37 X -.08 = .029$), so hypothesis 2 was not supported.

The direct effect of Adversity on General Insecure Attachment was significant ($\beta = -.48$, $p < .001$). Interestingly, the indirect effect of adversity and insecure attachment to the supervisor was also significant ($b = .39$, BC 95% CI [.19, .62], $\beta = .44 X .9 = .39$), suggesting the relationship between adversity and insecure attachment to the supervisor was mediated by general insecure attachment, which aligns with theories of attachment style (Bennett, et al., 2008; Fraley, 2007). Alternatively, Adversity had a significant negative relationship with Insecure Attachment to the Supervisor, suggesting greater adversity experiences led to lower attachment insecurity, or greater attachment security with the supervisor. Finally, Adversity was significantly related to lower Supervision Quality. Thus, hypothesis 3 was partially supported.
**Discussion**

The purpose of this study was to simultaneously measure the relationship between adversity, insecure attachment, and perceptions of the supervision relationship in counseling trainees. Understanding how students’ personal history and attachment style relate to the supervision relationship may be useful in improving supervision in training programs. Previous researchers have examined relationships between adversity and attachment, and attachment and supervision separately, and this study sought to integrate those bodies of work into a comprehensive model.

The first hypothesis that higher rates of adverse experiences would correlate with lower perceived quality of the supervision relationship was supported. In their 2011 study, Dickson and colleagues reported that clinical psychology students with higher levels of parental indifference from childhood also endorsed lower ratings of the working alliance with their supervisors. In their study, the direct path between maladaptive parenting and the working alliance was not significant, and the authors suggested this may be due to early experiences not playing a significant role in current relationship functioning. In the current study, both childhood and adulthood adversity were included in the model, and this combination of adversity across the lifespan was correlated with lower supervision relationship quality. This provides some evidence that a trauma-informed perspective of supervision is a useful framework for understanding these relationship dynamics (Knight, 2018). Researchers have shown trauma and adversity affect relationship satisfaction (Hardy & Barkman, 1994; Riggs & Bretz, 2006), and these factors may also be important in navigating the supervision relationship. This finding supports approaching supervision from a trauma-informed lens for the support of the
counseling trainee (Berger & Quiros, 2014; Copeland et al., 2019). Not only can adversity increase a risk for vicarious traumatization in clinical work (Berger & Quiros, 2014; Jones & Branco, 2020), but according to the current study, adversity may also increase the risk for a subpar supervision relationship, which in turn can affect how a student progresses through a training program. As counselor educators we are tasked with providing quality training and education to our students (CACREP, 2016; Urofsky, 2012), and this task may be more challenging if a student’s personal history of adversity and relationship functioning are not considered.

The second hypothesis that insecure attachment to the supervisor would mediate the relationships between adversity and supervision relationship quality was not supported. Contrary to other research on attachment and supervision, neither general insecure attachment nor insecure attachment specific to the supervisor were significantly related to supervision relationship quality. Attachment to the supervisor was measured with the Experiences in Supervision Scale (ESS) which did not meet the linearity assumption for SEM. Since Amos only measures linear relationships between variables, this may have led to insignificant relationships between the ESS and supervision quality. Additionally, general attachment was measured with the Measure of Attachment Quality (MAQ) scale, which demonstrated low reliability in the current sample based on Cronbach’s alpha. However, these measures were related to each other and to the construct of adversity in expected ways, which suggests the reliability of the measures was adequate. An additional explanation is that there may be variables important to the model that were unmeasured. For example, Riggs and Bretz (2006) found that specific attachment behaviors such as compulsive self-reliance are relevant in how attachment
affects the supervision relationship. Future research in this area may explore specific attachment styles and behaviors in relationship to supervision quality to further understand the role of attachment in supervision.

Additional findings include the significant positive relationship between adversity and general insecure attachment style, which partially supported hypothesis 3. This corroborates a large body of research indicating greater adverse and traumatic experiences correlate with insecure attachment style (Bachem, et al., 2019; Barazzone et al., 2019; DePrince et al., 2011; Wojcik et al., 2019). General insecure attachment and supervisor-specific insecure attachment were also highly correlated, which supports tenets of attachment theory positing that general and specific attachment styles are interrelated (Fraley, 2007). Surprisingly, adversity was negatively correlated with insecure attachment to the supervisor, suggesting greater adversity was related to secure attachment to the supervisor. This is contrary to previous research which demonstrates a positive relationship between adversity and attachment insecurity (Bachem et al., 2019; Murphy et al, 2014; Thomson & Jaque, 2017), although it is possible this relationship does not apply to attachment to the supervisor. Because general and relationship-specific attachment styles are separate but related constructs (Bennett et al., 2008; Wrape et al., 2017), adversity may differentially affect the supervision relationship. Most research conducted on adversity and attachment style has focused on general attachment style; therefore, additional investigation is warranted to clarify the association of adversity with different types of relationships, including the supervision relationship.
Implications for Supervision Practice

Adverse experiences affect relationship functioning (Bachem et al., 2019; Mikulincer et al., 2011; Murphy et al., 2014; Rumstein-McKean & Hunsley, 2011; Thomson & Jaque, 2017), and the current study suggests this extends to the supervision relationship. If, due to experiences of adversity, supervisees struggle to form working bonds with their supervisors, that may impact their clinical skill development and progress through their training program (Ladany et al., 1999). Furthermore, Kemer and Borders’ (2017) review of expert supervisors’ descriptions of challenging supervisees notes that participants described trainees with “personal issues (trauma history) override ability to connect with client and supervisor” (p. 13). Thus, attending to these personal histories as they arise in supervision may be a component of expert supervisors’ conceptualizations of supervisees.

Attending to the trauma need not be an explicit piece of supervision in which both parties openly discuss the student’s experiences, but the supervisor may wish to broach the topic as needed, or simply include adverse experiences in conceptualization of their supervisees. In more significant instances of student challenges stemming from trauma and attachment, supervisors may wish to refer to additional counseling outside of the program’s required sessions, academic advising to discuss reducing course load or credit hours, training in bracketing techniques, or other remedial solutions unique to the university.

Attending to supervision relationship dynamics may involve addressing power dynamics, broaching cultural differences, discussing expectations for the relationship, and using here-and-now skills to discuss parallel processes and countertransference
To create a safe space for students to process vulnerable topics such as past adversity and functioning within the supervision relationship, supervisors may wish to apply Relational Cultural Theory (Jordan, 2017) to supervision. This humanistic approach may encourage disclosure and deeper processing of the ways the student’s adversity is contributing to their professional relationships (Stargell et al., 2020).

Given the potential impact of trainee’s adverse experiences on supervision, supervisors should be comfortable broaching these topics with their supervisees. Upon noticing a student’s relational difficulties, supervisors may gently suggest the possible impact of adverse experiences on the supervisee’s work, without requiring the student to further disclose or discuss with the supervisor on the topic. The supervisor may simply plant a seed for the student and make suggestions for how the student may navigate the challenges observed by the supervisor. Also, students from marginalized groups may not feel comfortable disclosing such information for fear of negative consequence or retaliation from the supervisor. The supervisor should respect this without requiring a student to disclose; additional multiculturally competent resources outside of supervision (e.g., consultation, counseling, training opportunities) should be provided to the student should they wish to explore these dynamics further. Psychoeducation may also be a gentle approach in which the supervisor speaks generally about the impact of trauma and adversity on clinical work and professional relationships (e.g., countertransference, attachment, working alliance). The supervisor, given their position of power over the supervisee, should broach the topic first to demonstrate attunement to the supervisee’s
needs (Nelson & Friedlander, 2001); however, the student should be empowered to make their own decision about if and when to share more personally and specifically.

Supervisors can guide the supervisee through the process of self-insight appropriate to the developmental level of the supervisee to successfully navigate any challenges. Trainees can be encouraged to self-reflect and explore their past experiences as they may surface in supervision and clinical work. Supervisors may focus on the *counselor* role within Bernard’s Discrimination Model of supervision, which aims to address the trainee’s emotional and psychological reactions to clients and the supervisor (Bernard, 1997). Supervisors may wish to address these reactions (which may stem from adversity and/or attachment style) to minimize their effect on the trainee’s relationships with clients and the supervisor.

Supervisors may also find it beneficial to apply the Person of the Therapist (POTT) training model to allow space for students to process their experiences in a supportive space (Aponte & Carlsen, 2009). The POTT model encourages students to explore their *signature theme*, or a psychological issue stemming from “woundedness” (Niño et al., 2016, p. 608). This model does not pathologize the signature theme, or wound, but encourages students to utilize it as a strength in building empathy for clients and developing a person-to-person connection. Students can be guided with the POTT model in reflecting and understanding their adversity in ways to best connect with clients in therapeutically appropriate ways. The POTT model is pan theoretical; however, many supervisors may choose to navigate student adversity and relationship challenges in different ways based on their theoretical orientation.
Additionally, this study provides some evidence that a trauma-informed approach to supervision may be valuable. Given the role of adversity/trauma in the supervision relationship, supervisors who are sensitive to these dynamics in trauma-informed ways may more effectively meet their supervisee’s needs and form a stronger working alliance. Supervisors operating from a trauma-informed lens understand the impact of trauma on service users (i.e., counseling trainees) and seek to mitigate that negative impact (SAMSHA, 2014). As some publications have called for, a trauma-informed approach may benefit supervisees by mitigating the harmful effects of trauma as they surface in training programs (Berliner & Kolko, 2016; Knight, 2018). For example, Knight (2018; 2019) suggests normalizing trainees’ experiences, attending to the unique needs of each trainee, transparently naming and respecting boundaries, attuning to parallel process, and offering choices to the trainee whenever possible.

Finally, although it was not a main purpose of this study, the results indicated alarmingly high rates of childhood and adulthood adverse experiences in this sample. As mentioned previously, a few older publications have indicated mental health professionals report higher rates of trauma and adversity than other professions (Elliot & Guy, 1993; Follette et al., 1994). The results of this study suggest that a significant portion of counseling students have experienced adversity, and therefore a significant portion of students may experience challenging supervision relationships. Counselor educators should be mindful of this when evaluating students and structuring training programs; this study suggests relationship difficulties may not be a characterological issue, but rather a common experience among trainees that informs how they form relationships. Trainees should have the chance to reflect on and address these challenges.
via trauma-informed remediation before they are removed from counseling programs. It may be beneficial for programs to train supervisors in the dynamics of trauma/adversity and relationships to better prepare supervisors for guiding trainees through potential challenges.

**Implications for Research and Future Directions**

Future researchers examining adversity, attachment and supervision should continue exploring the model from the current study to determine if other variables or covariates are relevant. Despite significant factor loadings of the measured variables onto the latent constructs, the overall model fit was not fully adequate. Additionally, the mediation hypothesis was not supported. Future researchers could explore alternative model structures and measurements of the latent constructs to continue exploring and refining the relationships between variables.

Also, researchers could explore if the model is moderated by different attachment style groups. For example, in this study, the avoidant and anxious types of insecure attachment were combined to create a broad construct of attachment insecurity. However, there is some evidence that suggests these insecure types are not related to poorer ratings of the supervision working alliance in similar ways (Renfro-Michel & Sheperis, 2009), and this may have contributed to the lack of significant relationships between insure attachment to the supervisor and supervision relationship quality in the current study. Future researchers can explore how attachment styles relate to supervision outcomes in different ways.

Finally, the role of attachment and adversity may function differently in supervision depending on the developmental level of the supervisor. At the master’s
level, much of supervision is devoted to skills training and the supervisor often occupies the teaching role (Bernard & Goodyear, 2016). As the supervisee gains experience and foundational skills, more time can be devoted to more complex supervision issues such as trainee adversity, relationship dynamics and attachment, and countertransference. Attachment may play a larger role in the supervision relationship as the goals of supervision change (Bernard & Goodyear, 2016). Future studies should examine how these dynamics change over time as supervisees becomes more therapeutically competent, more effective, and more self-aware.

**Limitations**

There are several limitations to this study that should be noted. First, some measures did not meet assumptions of linearity and homoscedasticity, which may have affected the regression weights in the model so the results should be interpreted with caution. It is possible there are other unmeasured variables affecting the data and contributing to inconsistent error with the variables of interest. Next, the reliability for the MAQ was low, which suggests another, longer measure may have been more appropriate for measuring general attachment style.

The model fit was questionable at multiple stages of the analysis; however, there is considerable debate about the utility of cutoff scores for fit indices in SEM (McNeish, et al., 2018). Thus, the standardized factor loadings of the model were provided in Table 2 to offer a clearer picture of the findings beyond fit indices alone. As noted by McNeish and colleagues, “low” factor loadings may affect fit indices especially in complex models with less clearly defined constructs (i.e., relationship dynamics such as attachment).
Thus, despite insufficient fit by the common cutoff points, the model from this study may still provide useful information.

According to Byrne (2013), it is recommended that at least three observed variables should indicate each latent variable included in a SEM. In the current study, three latent variables only had two indicators, thus not meeting this standard. Creating parcels from measure items in these latent constructs worsened the model fit, so the decision was made to maintain the original two subscale structure for the insecure attachment latent variables. Furthermore, removing the SNI from the supervision relationship quality latent variable left only two indicators (i.e., the SSQ and the SWAI-T-R) but improved the model fit considerably. Future research testing this model should include at least three indicators per latent construct to account for more measurement error in the model.

Finally, all data were self-report and may be subject to biased self-perceptions. Also, the sample was majority White, which reflects the current racial composition of the counseling profession, but findings may not generalize to students of other racial and ethnic identities. More research is needed on the role of adversity and attachment in supervision in students of color.

**Conclusion**

This study provides evidence that more frequent experiences with adversity relate to lower perceived quality of the supervision relationship, according to counseling trainees. Although this study presents with several methodological issues, it nevertheless points to the importance of understanding counseling trainees’ personal experiences and how they might affect a student’s experiences in training. Counseling programs may
benefit from training clinical supervisors on trauma-informed supervision and the impact of adversity on relationships in order to more effectively help their students navigate potential challenges in supervision and in relationship with clients.
Introduction: Study 2

Given high rates of mental health providers with traumatic histories (Elliot & Guy, 1993; Follette, Polusny, & Milbeck, 1994), in addition to the potential for vicarious traumatization in new counselors (Sommer, 2008), counselor educators must understand the impact of trauma in students’ lives just as counselors do in clients’ lives. In the past 20 years, some authors have called for increased application of trauma-informed principles (TIP) to supervision and counselor training (e.g., Berger & Quiros, 2014; Copeland et al., 2019; Knight, 2018), but most of these publications have been driven by the potential for vicarious traumatization in counselors rather than the counselor’s personal traumatic history. Researchers (Barazzone et al., 2019; Nelson & Wampler, 2000) have demonstrated relationships between adverse and traumatic experiences and relationship variables (e.g., satisfaction, attachment style), and these findings have implications for a counselor’s relationships with clients, peers, and supervisors. Some conceptual pieces have been published in this area (e.g., Berger & Quiros, 2016; Knight, 2018), but they come primarily from the field of social work. If helping professionals are taking note of this training need for a trauma-informed approach to clinical work and training, developing evidence-based trauma-informed practices is warranted.

In 2014, the Substance Abuse and Mental Health Services Administration (SAMHSA) outlined six TIP: safety, trustworthiness, and transparency, peer support, collaboration and mutuality, empowerment, and cultural issues (SAMHSA, 2014). These principles were developed for application in behavioral healthcare settings, but more recently researchers and practitioners have applied them to areas such as child welfare (Connors-Burrow et al., 2013), reproductive healthcare (Decker et al., 2017), and primary
education (Báez et al., 2019). In these settings, researchers have found mixed results in the utility of TIP. Child welfare employees reported greater knowledge of trauma-informed practices after a trauma-informed training session (Connors-Burrow et al., 2013). After receiving trauma-informed mental health and educational support overseen by community social workers, students in a low-income school in New York City reported improvements in social skills after a year of support, but students with higher rates of trauma compared to other students reported decreases in social skills (Báez et al., 2019). After an education intervention for staff at a family planning clinic, patients reported greater confidence in their providers’ ability to respond to abusive relationships and a higher perceived compassion from providers (Decker et al., 2017).

These mixed results suggest there may be positive outcomes related to application of TIP in service industries; however, more investigation is needed. As these researchers have illustrated, despite the increased attention to trauma-informed principles in service-oriented fields, very little is known about the effectiveness of application of these principles (Berliner & Kolko, 2016). In recent years, some authors have called for application of trauma-informed principles to supervision (e.g., Knight, 2018). Before these principles are widely used in counseling training programs, there is a need to determine if trauma-informed principles (SAMHSA, 2014) are being utilized by counselor educators and if they are related to positive supervision outcomes.

The goals of TIP are to maximize the efficacy of mental health treatment, reduce an institution’s exacerbation of client or customer stress, and create a common framework among service delivery systems. Counselor education programs deliver the service of specialized training and supervision in preparation for professional counseling
careers, and some have suggested graduate training in human services may be a traumatic experience for students (Carelllo & Butler, 2014; Copeland et al., 2019; Zosky, 2013). Considering this, TIP may be a useful tool in furthering counselor training processes in order to maximize the efficacy of supervision and reduce harm to students under supervision. Supervisors who operate within TIP may meet their student’s needs more effectively, form stronger working alliances with trainees, and have greater overall satisfaction with supervision. If TIP are related to these positive supervision outcomes, TIP could be a potentially beneficial area of counselor education and supervision research and training. Applying TIP could provide a common supervision framework for the practice and teaching of supervision practices, which would ground supervision in evidence beyond theory alone (Watkins, 2020).

Furthermore, multiple researchers have investigated the negative effects of harmful supervision on supervisees (Ellis et al., 2014; Nelson & Friedlander, 2001). Estimates of harmful supervision range from 20% to 40% of study samples, which is a significant portion of supervisees reporting negative supervision experiences (Bang & Goodyear, 2014; Ellis, 2001; Ellis et al., 2014; Ellis et al., 2015; Hendricks & Cartwright, 2018; Nelson & Friedlander, 2001; Ramos-Sanchez et al., 2002). Through trauma-informed supervision, harm to supervisees could be minimized and the associated negative outcomes (e.g., psychological trauma, functional impairment, decline in mental health) of this harm would theoretically be reduced. Several studies have shown participants value trauma-informed principles and see the utility in application of such principles to different human service fields (Kerns, et al., 2016; Sullivan et al., 2016), including counseling and supervision (Jones & Branco, 2020). Theoretically, a trauma-
informed approach to counseling programs would benefit students by reducing these potential barriers to success in their graduate programs. Furthermore, there are significant inconsistencies between state requirements for supervisor training and qualifications; TIP may serve as a foundation for supervision training to improve supervision quality and competency, and provide consistent standards of practice (Nate & Haddock, 2014). If students’ negative experiences in supervision are reduced with the application of TIP, students may find they are better equipped to focus on their counseling training and practice, ultimately leading to more effective counselors and improved client care. However, before these principles can be widely applied to counselor education, there is a need to examine outcomes related to these principles (Berliner & Kolko, 2016).

The purpose of the current study was to examine the utilization of TIP by counselor education supervisors from the perspective of supervisees using the Trauma-Informed Practice Scales (Goodman et al., 2016), and explore outcomes related to the supervision relationship such as working alliance ratings and trainee satisfaction with supervision.

Current Study

Because the supervision relationship has been viewed as a cornerstone of supervision practice (Watkins, 2020), it is useful to examine TIP in relation to this backbone of supervisory work. If student perceptions of TIP are related to important practical supervision factors such as the working alliance and trainee satisfaction, this could provide support for the application of TIP within counselor education and supervision. Specifically, this study examined how perceived utilization of TIP predicted the supervision working alliance, trainee satisfaction with supervision, and the ability of
the supervisor to meet their supervisee’s needs. I hypothesized that perceptions of greater adherence to TIP would predict a stronger supervision working alliance, greater satisfaction with supervision, and a greater meeting of the supervisee’s needs. This is the first study the author is aware of to assess the relationship between perceived TIP and relevant supervision outcomes.

**Method**

**Participants and Procedure**

The final sample size was 226 participants. Mean age of the sample was 30.19 (SD = 5.70) and participants reported attending an average of 11.58 (SD = 16.13) supervision sessions with their current individual clinical supervisor. About 49.6% of the sample identified as women. In terms of ethnicity, 60.6% of participants identified as white or European American, 16.4% as Black or African American, 15.4% as Hispanic or Latino/a/x, 4.0% as Native American, 3.1% as Asian or Asian American, and the remaining .4% identified as biracial. The majority (85.7%) of participants were master’s students in either practicum or internship, and most participants (87.5%) expected to receive a passing grade in their current clinical course. Participants were mostly students in clinical mental health counseling (CMHC) programs (54.46%), followed by school counseling at 23.65%, counselor education and supervision at 8.48%, marriage and family therapy at 6.70%, rehabilitation counseling at 5.80%, and the remaining .9% reporting other types of training programs (e.g., clinical psychology).

After gaining IRB approval, participants were recruited in multiple ways: a) emailing recruitment ads to faculty in CACREP-accredited and non-accredited counseling programs in the United States, b) regular social media postings on Twitter and
Facebook, and c) posts on counseling professional listservs including CES-NET, COUNSGRADS, and DIVERSEGRAD-L. All measures were completed online using the survey platform Qualtrics. Additionally, participants were encouraged to share the study information on their own social media platforms (a method of snowball sampling).

Inclusion criteria were counseling trainees over the age of 18, currently in a counseling or mental health related program, and currently receiving individual clinical supervision. Data collection was anonymous. Participants had the option of entering a randomized raffle to win one of forty $30 Amazon gift cards. This part of the survey was not linked to participant’s survey data.

Measures

**Supervisee Needs Index (SNI)**

The Supervisee Needs Index (SNI; Muse-Burke & Tyson, 2010) is a 48-item measure assessing trainee’s perceptions of their supervisor’s ability to meet their needs in supervision. Items are rated on a 7-point Likert scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*) and include “My supervisor makes our relationship a priority” and “My supervisor helps me feel self-assured in my clinical work.” Total scores range from 48- 336, with higher scores indicating the supervisor is more effectively meeting the supervisee’s needs. A total of 24 items are reverse scored. In the current study, Cronbach’s alpha for the SNI was .95.

**The Supervisory Satisfaction Questionnaire (SSQ)**

The Supervisory Satisfaction Questionnaire (SSQ; Ladany et al., 1996) is an 8-item scale examining supervisee’s perceptions of the quality of supervision. The SSQ is a modified version of the Client Satisfaction Questionnaire (CSQ; Larsen et al., 1979).
Language referring to counseling services was replaced with terms referring to supervision and supervisors. Internal consistency was .93 in the original scale (unknown sample characteristics) and .96 in the modified scale (in a sample of 108 counseling and clinical psychology doctoral trainees, 79.6% female, 80.5% White, mean age = 30.47). The CSQ has demonstrated positive correlations with self-reported client improvement ($r = .53, p < .001$) and lower client dropout ($r = .37, p < .01$), indicating the CSQ relates to other variables in theoretically predictable ways.

Items (e.g., How satisfied are you with the amount of supervision you have received?) are rated on a 4-point Likert scale (1 = Excellent, 2 = Good, 3 = Fair, 4 = Poor). A total satisfaction score is created by summing ratings for each item, with a possible score ranging from 8-32 and higher scores indicating greater satisfaction with supervision. Cronbach’s alpha was .90 for the current study.

**Supervisory Working Alliance Inventory-Trainee Version (SWAI–T)**

The Supervisory Working Alliance Inventory-Trainee version (SWAI–T; Efstation et al., 1990) is a 19-item measures based on Bordin’s (1983) theory of the supervisory working alliance and consists of two subscales: Rapport (12 items; e.g., “I feel comfortable working with my supervisor”) assesses the supervision relationship and perceived supervisor support; Client Focus (seven items; e.g., “My supervisor encourages me to take time to understand what the client is saying and doing”) assesses the client-focused tasks/ goals of supervision including help with understanding clients and determining effective counseling interventions. In a validation sample of 178 doctoral interns in counseling and clinical psychology training programs (57.8% female, mean age = 29.95, no other participant characteristics were reported), alpha coefficients for the
SWAI-T were .90 for Rapport and .77 for Client Focus. The Client Focus subscale was moderately correlated with Supervisor’s (.50) and Trainee’s (.52) versions of the Task-Orientated scale from the Supervisory Styles Inventory (SSI; Friedlander & Ward, 1984), suggesting good convergent validity. The Rapport subscale displayed low correlations with the Task-Oriented scales of the SSI, also suggesting good convergent validity. Both Rapport and Client Focus subscales were significantly correlated with the Self-Efficacy Inventory (SEI; Friedlander & Snyder, 1983), with correlation coefficients of .22 and .15, respectively), providing support for the SWAI-T’s discriminant validity. In this study, only the Rapport subscale was used because Rapport refers to the quality of the bond between supervisor and supervisee and therefore is theoretically more relevant to supervisee attachment to their supervisor. Additionally, the Rapport subscale has emerged most “strongly and consistently across studies” (Watkins, 2014, p. 42).

Items are rated on a 7-point Likert scale ranging from 1 (almost never) to 7 (almost always). For a total Rapport score, items 1-12 are summed then divided by 12. Higher scores reflect greater rapport and client focus, and therefore a stronger supervision working alliance. Cronbach’s alpha was .92 in the current sample.

*Trauma-Informed Practice Scales (TIP)*

The Trauma-Informed Practice Scales (Goodman et al., 2016) are a set of scales (33 items total) developed to assess how programs are implementing trauma-informed practices from the perspective of those receiving services. The scale items are based on qualitative analysis of relevant publications on trauma-informed care, in addition to results from a focus group of trauma survivors and advocates which contributed additional items to the initial pool. In a racially and socioeconomically diverse sample of
370 domestic violence survivors (39.1% White, 24.4% African American/Black, 23.8% Hispanic/Latino, mean age = 36.4, gender statistics not reported), the authors tested the final set of items. Results of a factor analysis revealed four factors researchers labeled Environment of Agency and Mutual Respect (i.e., Agency), Access to Information on Trauma (i.e., Information), Opportunities for Connection (i.e., Connection), and Emphasis on Strengths (i.e., Strengths). Additional analysis on items related to cultural responsivity and parenting support produced 8 items on the Cultural Responsiveness and Inclusivity (i.e., Inclusivity) Factor and 5 items on the Support for Parenting factor. Cronbach’s alpha for the full scale (6 factors) was .92.

Goodman and colleagues (2016) also examined the convergent validity of the TIP and found that scores on the Working Alliance Inventory, Short-Revised (WAI-SR; Hatcher & Gillaspy, 2006) were strongly correlated with the TIP subscales of Agency ($r = .77$), Information ($r = .57$), Connection ($r = .50$), Strengths ($r = .65$), Inclusivity ($r = .73$), and Parenting ($r = .52$) Additionally, scores on the Client Satisfaction Questionnaire (CSQ; Larsen et al., 1979) were associated with TIP subscales of Agency ($r = .76$), Information ($r = .62$), Connection ($r = .51$), Strengths ($r = .62$), Inclusivity ($r = .72$), and Parenting ($r = .54$). Data on discriminant validity was not reported.

This scale was modified to apply to counseling trainee’s supervisors. For example, the item “staff understand when I’m feeling stressed out or overwhelmed” was modified to “my supervisor understands when I’m feeling stressed out or overwhelmed.” The Connection (3 items) and Parenting (item count) subscales were removed due to lack of applicability to the supervision relationship (i.e., “In this program, I have the opportunity to connect with others”; “I am learning more about how my own experience
of abuse can influence my relationships with my children”). Participants responded to each item using a 4-point Likert scale ranging from 0 (not true at all) to 4 (very true) to indicate perceptions of their supervisor. Not all the measure’s subscales were used in this study, therefore an overall TIP score cannot be calculated. Only the subscales of Agency, Information, Strengths, and Inclusivity were administered to participants for a total of 25 items. These subscales measured supervisee’s perceptions of their sense of self-determination, amount of trauma-related information and education provided by the supervisor, the supervisor’s focus on and validation of the supervisee’s strengths, and the supervisor’s attention to culture.

Originally, the Trauma-Informed Practice (TIP) subscales of Agency, Information, Strengths, Inclusivity (Goodman, et al., 2016) were to be included in the regression analyses as separate predictor variables. However, these subscales were all highly correlated with each other, indicating an issue with multicollinearity. To address this, the four subscales were combined to create a single mean score on the TIP. Cronbach’s alpha for the shorted (25 item) scale was .94, indicating good reliability for the overall shortened measure.

**Demographics**

Supervisee demographic variables were also measured, including type of program of graduate study, level of training (i.e., masters or doctoral), number of supervision sessions with current supervisor, trainee age, racial/ethnic background, gender, and months/years of counseling experience.
Results

Data Screening and Preliminary Analysis

Initially, 366 participants joined the study. Eleven participants failed the three validity checks embedded in the surveys, and another 109 participants were omitted due to missing data. Three univariate (data with Z scores ± 3.29) and 17 multivariate (data with Mahalanobis distance scores above 29.59) outliers were also removed, for a final sample size of 226.

None of the main variables displayed substantial skewness (± 2) or kurtosis (± 7; Field, 2009). Next, the assumption of linearity was assessed using scatterplots of the relationships between independent and dependent variables in the study; visual inspection of the scatterplots indicated the linearity assumption was met.

The main predictor variable of trauma-informed practice was significantly correlated with the outcome variables (SWAIT rapport: \( r = .84, p < .001 \); SSQ: \( R = .67, p < .001 \); SNI: \( R = .71, p < .001 \)), indicating the three multiple regression analyses could be reliably performed. For all dependent variables, the sum of the residuals (e.g., error terms) was zero. To assess for heteroscedasticity, the standardized residuals were plotted against the standardized predicted values. These plots revealed no obvious funneling for the SWAIT, the SSQ, and the SNI. However, Breusch-Pagan tests were significant for the SNI (\( p < .001 \)) and the SSQ (\( p < .05 \)), indicating heteroscedasticity for these variables which should be noted as a limitation of this study.

Based on PP-plots for the dependent variables, the values of the residuals were normally distributed, suggesting this assumption was met. However, for the Supervisee Needs Index and the SWAI-T-R, the tests of normality of the residuals were statistically
significant \((p < .001)\), indicating the residuals for these variables were not normally distributed. To address this, a Log10 transformation of the SNI was conducted. The test of normality of the residuals was not significant, indicating the transformed SNI displayed normality. Log transformation did not affect the normality of the SWAI-T-R, which should be noted as another limitation.

Tolerance and variance inflation factor (VIF) values did not indicate multicollinearity between independent variables and covariates. Finally, correlations between predictor variables were all below \(r = .39, p < .001\) (see Table 1), indicating that multicollinearity was unlikely to be a concern (Tabachnick & Fidell, 2007).

Using SPSS (IBM, 2019), Pearson correlations and a series of regression models were conducted to determine the relationship between trauma-informed principles (TIP) and other relevant supervision outcomes including the Supervisory Working Alliance Inventory-Trainee (SWAIT-T; Efstation et al., 1990), the Supervisee Needs Index (Muse-Burke & Tyson, 2010), and the Supervisory Satisfaction Questionnaire (SSQ; Ladany et al., 1996).

Because the scores on these outcome measures are treated as continuous variables, a linear regression model is appropriate. Hierarchical regression allows researchers to enter variables in multiple steps of the regression analysis in order to determine the individual contributions of the independent variables while removing the influence of variables entered into the model previously (Tabachnick & Fidell, 2007). In the current study, demographics variables were entered into each regression at step one to account for them as covariates. Three demographic variables were eliminated from the regression analyses due to insignificant correlations with the dependent variables (Race,
type of training program [CMHC, CES, etc], and program level [doctoral or masters]).
TIP scores were entered as a predictor in the second step.

**Regression Analyses**

**Hypothesis 1**

Hypothesis 1 stated that greater perceptions of supervisor adherence to trauma-
inform ed principles would correlate positively with working alliance ratings. Hierarchical
multiple regression was performed to investigate the ability of trauma-informed practice
to predict levels of rapport within the supervision working alliance on the SWAI-T
Rapport subscale (Efstation et al., 1990), after controlling for age, gender, number of
supervision sessions completed, and whether the student expected to receive a passing
grade in their training course.

In the first step of the hierarchical multiple regression, the previously listed
covariates were entered. This step was statistically significant: $F(4, 221) = 9.60, p < .001$
and explained 14.8% of the variance in rapport. See Table 2 for each covariate’s unique
contribution to the model. Age and passing grade both significantly positively predicted
SWAI-T-R scores, indicating older participants and those expecting to receive a passing
grade in their clinical course rated the supervision working alliance higher.

In step 2, trauma-informed practice (TIP) was entered as a predictor. This model
was statistically significant ($F (5, 220) = 110.61, p < .001$) and explained 71.5% of the
variance. Age and gender emerged as significant positive predictors of the SWAI-T-R,
indicating that older participants and woman participants rated the supervision working
alliance higher, although these effects were very small. The introduction of the trauma-
inform ed practice variable explained an additional 56.7% of variance in the SWAIT-R
($R^2$ change = .56; $F (1, 220) = 438.61, p < .001$). This indicated that when controlling for
the covariates, 56.7% of the variance in the Supervisory Working Alliance rapport scores was explained by scores on the trauma-informed practices scales. This suggests that perceptions of greater adherence to trauma-informed principles is related to greater rapport within the supervisory relationship above and beyond demographic variables, thus supporting hypothesis 1.

**Hypothesis 2**

Hypothesis 2 stated that perceptions of greater adherence to trauma-informed principles would positively correlate with satisfaction in supervision ratings (measured by the Supervisory Satisfaction Questionnaire (SSQ; Ladany et al., 1996)). Hierarchical multiple regression was performed to investigate the ability of trauma-informed practice to predict levels of satisfaction with supervision after controlling for age, gender, number of supervision sessions completed, and whether the student expected to receive a passing grade in their training course.

In the first step of the hierarchical multiple regression, the same covariates from the previous model were entered. This model was statistically significant ($F(4, 221) = 14.85, p < .001$ and explained 21.2% of the variance in the dependent variable. Age, number of supervision sessions, gender, and expectation of a passing grade were all significant positive predictors of supervision satisfaction. This indicates that women and participants expecting to receive a passing grade were more satisfied with supervision than men and participants who expected to fail their clinical course. Additionally, the greater number of supervision sessions, the higher the satisfaction with supervision. See Table 3 for each covariate’s unique contribution to the model.
In step 2, the main predictor of trauma-informed practice was included in the model. This model was also statistically significant \(F(5, 220) = 51.14, p < .001\) and explained a total of 53.8% of the variance in the SSQ. Including the trauma-informed practice variable in the model accounted for an additional 32.6% of the variance in the dependent variable \(R^2 \text{ change} = .326; F(1, 220) = 154.95, p < .001\). This suggests that perceptions of greater supervisor adherence to trauma-informed principles related to higher supervisee satisfaction with the supervision relationship, above and beyond demographic factors; thus, hypothesis two was supported. Also in step 2, the only significant demographic predictor was gender, with women rated their satisfaction with supervision higher than men \(\beta = .23, p < .001\).

**Hypothesis 3**

Hypothesis 3 stated that perceptions of greater adherence to trauma-informed principles would positively correlate with higher scores on the Supervisee Needs Index (Muse-Burke & Tyson, 2010), or greater support for supervisee’s needs. Hierarchical multiple regression was performed to investigate the ability of trauma-informed practice to predict levels of satisfaction with supervision after controlling for age, gender, number of supervision sessions completed, and whether the student expected to receive a passing grade in their training course.

In the first step of the hierarchical multiple regression, the same covariates from the previous models were entered. This model was statistically significant \(F(4, 221) = 12.81, p < .001\) and explained 18.8% of the variance in the dependent variable. Gender was a significant predictor of the SNI, with women reporting their needs were more effectively met \(\beta = .25, p < .001\). Supervision sessions also predicted the SNI \(\beta = .27, p\)
< .001); a greater number of sessions related to students reporting their supervisors met their needs more effectively. Table 4 shows each covariates’ unique contribution to the model in step 1.

In step 2, the main predictor of trauma-informed practice was included in the model. This model was also statistically significant ($F(5, 220) = 68.81, p < .001$) and explained a total of 61.0% of the variance in the dependent variable. The TIP variable accounted for an additional 42.2% of the variance in the SNI ($R^2$ change = .422, $F(1, 220) = 237.87, p < .001$). This suggests that greater perceptions of supervisor adherence to trauma-informed principles was related to a greater sense that supervisees had their needs met by their supervisor, above and beyond demographic factors. Thus, hypothesis three was supported. In this step, gender also emerged as a significant predictor of the dependent variable, with women reporting their supervision needs were more effectively met ($\beta = .24, p < .001$). A greater number of supervision sessions ($\beta = .13, p < .001$) was also positively related to greater meeting of the supervisee’s needs. Finally, age was a negative predictor of SNI scores, suggesting younger participants found their needs met more effectively than older participants, although this effect was small ($\beta = -.10, p < .05$).

**Discussion**

The purpose of this study was to investigate if greater perceptions of utilization of TIP predicted relevant supervision variables including supervision satisfaction, the supervision working alliance, and the ability of the supervisor to meet supervisee’s needs. It was hypothesized that greater perception of adherence to trauma-informed practice would positively predict each of these supervision variables, and these three hypotheses were supported. Specifically, perceptions of higher trauma-informed practice positively
predicted higher supervision satisfaction, greater supervision working alliance, and higher ratings of supervisee’s needs being met by their supervisor.

These findings are supported by limited research on the TIP scales. When developing the scale, Goodman and colleagues (2016) found that all TIP subscales were significantly positively correlated with the Working Alliance Inventory, short form revised (WAI-SR; Hatcher & Gillaspy, 2006). The authors also found the TIP scales were significantly positively correlated with a measure of client satisfaction with services: the Client Satisfaction Questionnaire-8 (CSQ-8; Larsen, Attkisson, Hargreaves, & Nguyen, 1979). Although clients and supervisees are different types of “service-users,” there may be parallels between these roles. Clients look to the counselor and the counseling relationship for support and guidance just as supervisees look to the supervisor and the supervisory relationship for these things, and similar relational dynamics may affect both types of relationships (Friedlander et al., 1989). Similar to the findings of Goodman and colleagues (2016) on client satisfaction, TIP significantly predicted greater supervisee satisfaction with supervision in the current study.

Trauma-informed practice has become a significant movement in the field of mental health. The American Counseling Association recently approved a new organization affiliate, the International Association for Resilience and Trauma Counseling, in July 2021. The organization’s mission is:

To enhance the quality of life for people and communities worldwide by promoting the development of professional counselors, advancing ACA, the counseling profession, and the ethical practice of counseling through trauma-
informed practices, respect for human dignity, cultural inclusivity, and resilience

(https://www.iartc.org/)

Additionally, CACREP (2016) requires that master’s students in accredited programs receive education on the impact of trauma on various client populations, although this is not consistent across all program types. The field of counseling and counselor education is moving towards greater recognition of trauma and adversity within the profession, and the results of this study support that trajectory. Given that TIP are relevant in positive supervision outcomes (as demonstrated by the current study), programs and individual supervisors may wish to implement TIP to partially meet CACREP standards requiring education in this area.

This study is the first to demonstrate that supervisors who are perceived to utilize trauma-informed practice, according to their supervisees, may form stronger working alliances with their supervisees, more effectively meet their supervisee’s needs, and contribute to greater overall satisfaction with clinical supervision. Thus, counseling programs may benefit from training clinical supervisors (at the faculty and doctoral student level) in trauma-informed principles and strategies. Higher working alliance with a supervisor has been correlated with lower supervisee burnout (Livni et al., 2012), more counselor self-efficacy (Marmarosh et al., 2013), greater supervisee disclosure which is important for effective therapeutic development (Mehr, et al., 2015), and greater multicultural competency such as racial identity development (Bhat & Davis, 2007). Implementing trauma-informed training may indirectly contribute to these positive supervision outcomes and help supervisors more effectively support their supervisees.
There is a considerable lack of empirical research on the application of trauma-informed principles to supervision. Berliner and Kolko (2016) critiqued the broad application of trauma-informed care principles due to a lack of evidence supporting their utility, which is evident in clinical supervision practice. As some authors have noted, the principles of trauma-informed care can theoretically provide a safe, trustworthy, open, and validating space for supervisees (Knight, 2019; Berger, et al. 2018). Trauma-informed principles can also aid supervisors in navigating power differentials and intersecting cultural identities with their supervisees. This study is unique because it begins to provide an evidence base supporting the relationship between TIP and supervision outcomes. For concrete strategies for providing trauma-informed supervision, readers can reference publications from Knight (2018), Berger and Quiros (2014), and Berger, Quiros, and Benavidez-Hatzis (2017).

Although not part of the initial study hypotheses, the role of gender as a predictor of supervision outcomes was also investigated. Participant gender identity was related to all supervision outcome variables; that is, women participants reported greater satisfaction, stronger working alliance, and greater meeting of their needs, although these effect sizes were low-moderate to weak (β < .25; Acock (2014). In a review of gender in the supervisory relationship, Hindes and Andrew (2011) found that gender relates to the openness and affiliation of the supervisee, and women supervisees are more relationship-focused than men. This may help explain the current study’s findings that women reported higher scores on relational variables. It should be noted that gender has been critiqued as a measure of differences because of its intersection with other cultural identities (Peters, 2017). Additionally, gender is a social construct which falls on a
spectrum, and many studies on the role of gender in supervision operationalize gender as a binary variable for ease of categorizing participants (this study included). Researchers interested in studying the role of gender in supervision should be transparent about their measurement and analytical procedures and note the limitations of operationally defining gender as categorical (Shannon, 2019).

Additionally, in some of the models, participant age emerged as a significant predictor of supervision outcomes, although these results were inconsistent across models. Age positively predicted SWAIT-R scores and negatively predicted SNI scores, and the effect sizes for these results were small. Deriving meaning from these results should be done cautiously; more research is needed to examine the nuanced relationship between age, trauma-informed practice, and supervision outcomes.

Implications for Supervision Practice

Supervisors working towards trauma-informed supervision can reference SAMHSA’s (2014) six original principles of trauma-informed care: trustworthiness, and transparency, peer support, collaboration and mutuality, empowerment, and cultural issues. Supervisors can build trust through consistency in communication and action, respecting boundaries of time and disclosure, and with transparency and compassion surrounding supervision procedures such as evaluation. Supervisors may also encourage connection between peers through triadic or group supervision modalities when developmentally appropriate, and when group norms and guidelines have been mutually established among members. Supervisors can work to empower supervisees by offering choices of intervention with clients, recognizing the existing strengths of supervisees, and positioning themselves as collaborators with the
supervisee rather than a clinical expert to dispense knowledge. Supervisors should also be *multiculturally competent* and broach important cultural topics with supervisees as they apply to clinical as well as supervision dynamics. Additional strategies on trauma-informed supervision can be found in Knight (2018) and Berger and Quiros (2014).

In a recent survey of expert supervisors, Kemer (2020) found that highly skilled and experienced supervisors regularly attended to relationship and working alliance factors including “safety, trust, collaboration” (Kemer, 2020, p. 89). These factors map onto trauma-informed principles originally outlined by SAMHSA (2014); this provides further support for the application of TIP in effective supervision. Kemer and Borders (2017) also emphasized the importance of attending to the supervision relationship, particularly with challenging supervisees, as a source of reflection and self-awareness. Thus, if expert supervisors are already attending to trauma-informed principles as a foundation for effective supervision, training programs could benefit from intentionally implementing TIP-based training for supervisors. Supervisors can assess their utilization of TIP through regular measurement using tools such as the Trauma-Informed Practice Scales (Goodman et al., 2016). Programs may wish to assess supervisor’s self-reported and supervisee-reported utilization of TIP to avoid biases in supervisor’s self-perceptions. Based on results of these measurements, supervisors can obtain additional training in TIP, consult with other practitioners and supervisors in developing trauma-informed approaches, or consult with the supervisees themselves to determine how best to meet their needs.
Research Implications and Future Directions

This study was cross-sectional; therefore, causal conclusions cannot be drawn. Future research should implement experimental designs testing the effect of trauma-informed supervision practices and training on supervisor, counseling trainee, and client outcomes. Additionally, more research is needed on the specific aspects of trauma-informed practice (i.e., empowerment, transparency, creating safety) and their relevance in supervision and counselor training. In the current study, the components of trauma-informed practice were combined to avoid multicollinearity among predictors. Understanding the specific components of TIP that contribute to improved supervision outcomes would help training programs most effectively provide supervision and train their supervisors.

Furthermore, this study focused on the experiences of master’s students’ experiences with their supervisors in counseling and mental health training programs. Future research should also explore how post-graduates perceive their supervised hours for obtaining state licensure. If TIP are related to positive supervision outcomes for post-graduate counselors, TIP may provide a helpful training framework for supervisors outside of training programs. Many master’s level clinicians provide supervision to recent post-graduates; however, states are inconsistent in their training requirements for supervisors (Nate & Haddock, 2014). Many supervisors may not have received any formal supervision training before taking on supervisees, which may result in inconsistent, unhelpful, and even harmful supervision practices. More research is needed on the supervision practices of practitioners outside the academy in order to determine best-practices and effective training strategies for licensure supervisors. Qualitative
studies in particular may be useful in exploring specific impacts of TIP on supervisors and supervisees. Qualitative studies aim to assess participant’s lived experiences with a construct and would therefore be appropriate in exploring how TIP impact student and supervisee growth and development (Prosek & Gibson, 2021).

**Limitations**

There are limitations to this study that should be noted. Some dependent variables violated the assumption of homoscedasticity, suggesting the possibility of other unmeasured variables affecting the data and contributing to inconsistent error values. Only linear relationships between variables were examined, and therefore this analysis may have ignored the existence of other types of interactions between variables (i.e., curvilinear). Additionally, participants were 61% White; although this is reflective of current demographics in the counseling profession, these results may not generalize to people of other races and ethnicities. Finally, the data were cross-sectional in nature and therefore causal relationships between the independent and dependent variables cannot be made. Nevertheless, this study is a novel examination of the relevance of trauma-informed principles in supervision and provides support for applying TIP to supervision practice and training.

**Conclusion**

Despite the limitations, this study provides evidence that trauma-informed principles are related to some positive supervision outcomes. From the perspective of counseling trainees, supervisors who adhere more strongly to trauma-informed principles in their supervision practices may foster stronger working alliances with supervisees, contribute to greater supervisee satisfaction with the supervision process, and more
successfully meet their supervisee’s needs. As calls for the application of TIP to
counseling and counselor education increase, it is necessary to develop a body of
evidence for the utility of these principles in supervision. This study provides a launching
point for further investigation into TIP in supervision and mental health training
programs.
Section 3 – Conclusion

Collectively, these studies present findings which support the relationship between adversity and perceived quality of the supervision relationship, as well as the utility of applying trauma-informed principles as a framework for effective supervision. Previous research on supervision and attachment style has suggested that insecure attachment styles are related to poorer working alliance and lower supervision satisfaction. This finding was not corroborated by the current study; however, the relationship between adversity and supervision relationship quality was significant. Higher frequency of adversity experiences was related to lower quality of the supervision relationship, although this relationship was not mediated by supervisor insecure attachment. No other studies that the author is aware of have simultaneously explored the role of adversity and attachment as they both relate to supervision outcomes. There is some literature demonstrating that mental health professionals may experience higher rates of adversity and trauma than other professionals. The current study establishes that adversity may correlate with supervision outcomes, and thus this area warrants attention from counselors and counselor educators. If mental health professionals experience high rates of adversity, and adversity relates to poorer supervision outcomes, training programs should explore strategies to mitigate the potentially harmful effects of trainee’s history of adverse experiences on their professional development.

The second study in this dissertation provides a potential solution to the harmful effects of students’ trauma history on the supervision relationship: application of trauma-informed principles to the supervision process. In this study, student perceptions of adherence to trauma-informed principles were significantly positively related to better
supervision outcomes including stronger working alliance, greater satisfaction with supervisor, and a greater ability of the supervisor to meet the supervisee’s needs. Given the role of students’ history of adversity in the supervision relationship, supervisors who adopt a trauma-informed approach to supervision may improve supervision outcomes for students who have experienced trauma. These students may display challenging characteristics and behaviors due to their history that make it difficult to form relationships with peers, instructors, supervisors, and clients. Despite this challenge, such students should not automatically be removed from the profession. In a trauma-informed approach, provider of the service (i.e., counseling, education, supervision, etc.) seeks to meet the client or student where they are and maximize the amount of support in order to best serve them. In trauma-informed supervision, the supervisor understands the impact of the student’s trauma history and works to guide the student through relational or professional challenges through a compassionate lens.

Of course, students are ultimately responsible for their development in a training program, and there are instances where gatekeeping is warranted. However, a trauma-informed approach may improve supervision outcomes across the student body, not just for those students who appear challenging. It should also be noted that some behaviors that result from adversity are also developmentally appropriate for counselors in training (e.g., anxiety, fear of disclosure, difficulty naming emotions, low self-efficacy; Whittaker, 2004); therefore, remedial decisions about student’s clinical and supervision challenges should not be made without multiple assessments over time by multiple supervisors or faculty.
The overarching connection between these studies is the role of student trauma, adversity, and related variables in supervision. These studies explore how trainee’s experiences may affect their relationship with their supervisor, and how a trauma-informed approach to supervision could be a potential solution to navigating student's challenges in the supervision relationship. Considering the high rates of adversity experienced by students, and the potential impact on supervision, counseling training programs may reconsider how students are supervised and how supervisors are trained. A trauma-informed lens to supervision could help programs structure their training and gatekeeping practices centered on the individual needs of the student, which may help students with a history of adversity experience greater supervision quality.

Due to the limitations of the structural equation model in study 1, a future direction for this research could be to further refine this model and collect more data. I would use different measures for insecure attachment and preferably the new data would meet all analytic assumptions of SEM. This may also improve the model fit and thus provide stronger evidence for the relationships among the study variables. Although the relationship between insecure attachment to the supervisor was not a significant factor in supervision outcomes in this study, other research has established evidence for that relationship. For expanding on the regression results in study 2, I plan to develop a trauma-informed training intervention for supervisors and measure the effect of this intervention on supervision and supervisee outcomes including the working alliance, satisfaction with supervision, and counselor self-efficacy. Through an experimental design, I hope to establish a causal relationship between trauma-informed principles and
positive training outcomes to provide further evidence that TIP are useful in counselor education and supervision practices.
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https://doi.org/10.4324/9781410600219


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**Author.**


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https://doi.org/10.1016/j.chiabu.2019.104233


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Appendix A: IRB Materials

February 15, 2021
Principal Investigator: Nicole Hurless
Department: Educ Research & External Funds

Your IRB Application to project entitled Investigating Variables Related to Counseling Supervision was reviewed and approved by the UMSL Institutional Review Board according to the terms and conditions described below:

<table>
<thead>
<tr>
<th>IRB Project Number</th>
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<tr>
<td>IRB Review Number</td>
<td>281307</td>
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<td>Initial Application Approval Date</td>
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<td>Updated study information sheet/consent to be posted to Qualtrics.</td>
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<td>Updated version of study protocol with consistent compensation information</td>
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The principal investigator (PI) is responsible for all aspects and conduct of this study. The PI must comply with the following conditions of the approval:

1. Enrollment and study related procedures must remain in compliance with the University of Missouri regulations related to interaction with human participants following guidance at http://www.umsl.edu/recd/compliance/umsl-guidance-covid19-restart-6.25.2020.pdf

2. No subjects may be involved in any study procedure prior to the IRB approval date or after the expiration date.

3. All unanticipated problems must be reported to the IRB on the Event Report within 5 business days of becoming aware of the problem. Unanticipated problems are defined as events that are unexpected, related or possibly related to the research, and suggests the research places subjects or others at a greater risk of harm than was previously known or recognized. If the unanticipated problem was a death, this is reportable to the IRB within 24 hours on the Death Report.

4. On-site deaths that are not unanticipated problems must be reported within 5 days of awareness on the Death Report, unless the study is such that you have no way of knowing a death has occurred, or an individual dies more than 30 days after s/he has stopped or completed all study procedures/interventions and required follow-up.

5. All deviations (non-compliance) must be reported to the IRB on the Event Report within 5 business days of becoming aware of the deviation.

6. All changes must be IRB approved prior to implementation unless they are intended to reduce immediate risk. All changes must be submitted on the Amendment Form.

7. All recruitment materials and methods must be approved by the IRB prior to being used.

8. The project-generated annual report must be submitted to the IRB for review and approval at least 30 days prior to the project expiration date. If the study is complete, the Completion/Withdrawal Form may be submitted in lieu of the annual report.

9. Securely maintain all research records for a period of seven years from the project completion date or longer depending on the sponsor’s record keeping requirements.

10. Utilize the IRB stamped consent documents and other approved research documents located within the document storage section of eCompliance. These documents are highlighted green.

If you are offering subject payments and would like more information about research participant payments, please click here to view the UM Policy: https://www.umsystem.edu/ums/policies/finance/payments_to_research_study_participants

If you have any questions, please contact the IRB Office at 314-516-6489 or irb@umsl.edu.

Thank you,
UMSL Institutional Review Board
SOCIAL/BEHAVIORAL/EDUCATIONAL RESEARCH PROTOCOL
University of Missouri–St. Louis

Project Title: Investigating Variables Related to Counseling Supervision
IRB Number: 2034724 SL
Version Number: 1
Version Date: 12/7/20
Principal Investigator: Nicole Hurless
Funding Source: N/A

I. Research Objectives/Background

The practice of clinical supervision in counselor education is largely unsupported by empirical evidence (Watkins Jr., 2020). In order to support quality supervision within counseling training programs, research should explore what factors relate to quality supervision and ways supervisors can support the learning and growth of trainees. There is a body of research establishing relationships between traumatic stress and attachment but no studies to date have applied these variables within the supervision relationship (see Bennett et al., 2008; Dickson, et al., 2011; Gunn & Pistole, 2012; Riggs & Bretz, 2006). This study will test a model examining the relationships between traumatic experiences, attachment style, and supervision variables (i.e., supervision quality, the supervision working alliance, and satisfaction with supervision) in counseling trainees. Understanding factors affecting supervision will help counselor educators better understand relationships with their supervisees and improve supervision practices and training.

Additionally, there is a high prevalence of graduate students with personal trauma histories and mental health challenges which often go unsupported by their graduate programs (Evans, et al., 2018). Some authors have called for increased application of trauma-informed principles to supervision and counselor training, but most of these publications have been driven by the potential for vicarious traumatization in counselors rather than the counselor’s own traumatic history (Knight, 2018; Quiros & Berger, 2014). The call for application of trauma-informed supervision, regardless of the reason, has been recent and there is a need to determine if these trauma-informed principles (TIP) and related strategies are being utilized by counselor educators. Therefore, this study will also examine the utilization of TIP by counselor education supervisors and explore related supervision outcomes such as working alliance ratings and trainee satisfaction with supervision. There is a need to determine the utility of TIP before counselor education programs can effectively apply TIP.

Exploring the impact of traumatic stress and trauma-informed principles on supervision will provide an empirical foundation for the development of trauma-informed supervision practices. Understanding the factors affecting the supervision relationship will help counselor education programs develop evidence-based practices in further refining supervision procedures based on the needs of their students. Finally, there is a need to establish valid and reliable assessments of supervision variables. This study will also assess the psychometric properties of a measure that may be useful in assessing supervision quality, the Supervisee Needs Index (Muse-Burke & Tyson, 2010).

The following research questions will be explored:

1. How does personal history of traumatic stress affect counseling trainee’s attachment style and their perceptions of the supervision relationship?
2. How does greater adherence to trauma-informed principles relate to the supervision working alliance, trainee satisfaction in supervision, and supervision quality variables?
3. What are the psychometric properties of the Supervisee Needs Index?

II. Recruitment Process

Participants
Participants must be adults over the age of 18 currently enrolled in a counseling or counseling-related graduate program (masters or doctoral level) and receiving individual clinical supervision. Counselors who have already graduated from their training program will be excluded. A maximum of 800 participants will be sought.

Procedure
Study measures will be formatted for online use and posted on Qualtrics and distributed via counselor education and supervision program email listservs and social media platforms (including Facebook, Twitter, and Reddit) with emphasis on online groups supporting racial, ethnic, and gender diverse counselors. Participants may click on the Qualtrics link to access the online surveys and only participants who indicate their consent to participate will be given full access to the measures.

Participation is expected to last between 25-35 minutes. Participants may decline to answer any survey question or discontinue participation without penalty. Following completion of the surveys, participants may opt to enter their email address in a drawing for one of forty $30 Amazon gift cards. Email addresses will be collected and saved using a Google form separate from the Qualtrics survey data to minimize risk of loss of anonymity. If participants choose to opt into the gift card drawing, they will click on a link redirecting them to the Google form where they may enter their email to join the drawing. The email addresses will be stored on a password protected computer in a locked office accessible only by the principal investigator. Email addresses will be stored in this manner for 5 years after completion of the study.

III. Consent Process

When a person clicks the Qualtrics survey link, they will be provided information on the study including types of surveys in the study, risks and benefits to participation, anticipated time of participation, and contact information for the principal investigator and UMSL IRB. Participants may then consent to participate or not consent to participate by clicking either option on a survey question at the bottom of the screen. This will replace the written informed consent document. Written consent is waived because of the anonymous nature of data collection; the consent signature would be the only personal identifier linked to a participant’s survey data. This will be eliminated to minimize risk of loss of anonymity.

IV. Inclusion/Exclusion Criteria

Participants must be adults over the age of 18 currently enrolled in a counseling graduate program (masters or doctoral level) and receiving individual clinical supervision. These survey questions will be provided at the beginning of the survey and any participant not meeting full criteria will not proceed with further survey questions.

V. Number of Subjects
A maximum of 800 participants will be sought. This number is based on recommendations for structural equation modeling which is the statistical method that will be used to test the proposed theoretical model of relationships between this study’s variables of interest (MacCallum & Austin, 2000; Wolf, et al., 2013).

VI. Study Procedures/Study Design

This study involves completion of several online surveys, including:

a. The Adverse Childhood Experiences (ACEs; Karatekin & Hill, 2018): measures number of stressful and adverse experiences as a child
b. Adverse Adult Experiences (AAE; modified version of survey by Karatekin & Hill, 2018): measures number of stressful and adverse experiences as an adult
c. Everyday Discrimination Scale (Williams et al., 1997): measures experiences with multiple types of discrimination and what the participant perceives the reason for the discrimination to be
d. Experiences in Supervision Scale (ESS; Gunn & Pistole, 2012): Measures a supervisee’s experiences in relationship with their clinical supervisor
e. Measure of Attachment Qualities (Carver, 1997): measures participant’s general relationship style, beliefs, and behaviors
f. The Supervisory Working Alliance Inventory-Trainee (SWAI–T; Efstation et al., 1990): measures how effectively the supervisee and supervisor work together towards a common goal
g. The Supervisee Needs Index (SNI; Muse-Burke & Tyson): measures how effectively the supervisor meets the supervisee’s needs in clinical supervision
h. The Supervisory Satisfaction Questionnaire (SSQ); Ladany et al., 1996): measures supervisee’s overall satisfaction with the supervision process and relationship
i. Demographics including information on the participant (e.g., age, race/ethnicity, gender, training level, years of counseling experience, expected grade in training course with supervisor) and the participant’s graduate program (e.g., clinical focus)

The first 200 participants will also receive this survey in addition to the previous surveys:

a. Trauma-Informed Practice Scales (Goodman et al., 2016): measures multiple trauma informed principles (including transparency, trust, collaboration) in clinical supervision

All surveys are for research-only purposes and are not part of routine care activities. Participation is expected to last between 25-35 minutes. Participants may decline to answer any survey question or discontinue participation without penalty. Following completion of the surveys, participants may opt to enter their email address in a drawing for a $30 dollar amazon gift card. Email addresses will be collected and saved using a Google form separate from the Qualtrics survey data to minimize risk of loss of anonymity. If participants choose to opt into the gift card drawing, they will click on a link redirecting them to the Google form where they may enter their email to join the drawing. A total of 40 gift cards will be randomly distributed among participants opting into the drawing.

VII. Potential Risks
Identifying information will not be collected from participants; thus, participation will be anonymous.

There is the potential for psychological risk involved in participation in this study. During the study, participants may recall emotional, traumatizing, or otherwise distressing experiences. Participants will be told in recruitment materials that the study involves survey questions about trauma history and current mental health functioning. Participants will have the freedom to discontinue the survey at any time without penalty. Participants also have the freedom to refuse to respond to any of the survey questions. During participation the following hotline numbers will be visible on each survey page in the event participants feel distressed: National Sexual Assault Hotline 1-800-656-4673; National Suicide Prevention Lifeline 1-800-273-8255; National Domestic Violence Hotline 800-799-7233). These hotline resources will also be provided at the end of the study. Unanticipated problems that are serious adverse events will be reported to the IRB within 5 days of the investigator becoming aware of the event.

VIII. Anticipated Benefits

Participants may choose to enter a drawing for one of 40 $30 Amazon gift cards (details in section IX). The data will contribute to the larger body of knowledge about supervision practices in counselor education programs.

IX. Compensation

Following completion of the surveys, participants may opt to enter their email address in a drawing for a $30 dollar Amazon gift card. The chances of winning the gift card are estimated to be about 5% depending on the final number of participants. Email addresses will be collected and saved using a Google form separate from the Qualtrics survey data to minimize risk of loss of anonymity. If participants choose to opt into the gift card drawing, they will click on a link redirecting them to the Google form where they may enter their email to join the drawing. A total of 40 gift cards will be randomly distributed among participants opting into the drawing. The chances of winning the gift card are estimated to be about 5% depending on the final number of participants. The PI will obtain prior approval from Campus Accounting as required by the university Gift Card Policy.

At each 100 participant interval, 5 participants entered into the drawing will be randomly selected to receive compensation. In other words, after 100 participants complete the study, 5 participants from those opting in to receive compensation from the larger group of 100 will be randomly selected to receive a gift card. This process will continue until 800 participants complete the study and 40 gift cards are distributed. This way participants opting into the drawing will not have to wait to receive compensation until all data is collected.

X. Data Safety Monitoring Plan
Participation in this study will be anonymous. If participants opt into the gift card drawing after completion of the surveys, their email addresses will be stored separately from their study data and kept on a password protected computer accessible only by the principal investigator. Survey data (anonymous) will also be stored on a password protected computer accessible only by the principal investigator. No further data monitoring plan is necessary for this study.

XI. Multiple Sites

NA

XII. References


Invitation to Participate

Investigating Variables Related to Counseling Supervision

Study Introduction

You are invited to participate in a research study conducted by Nikki Hurless under the supervision of Dr. Susan Kashubeck-West at the University of Missouri St. Louis.

This study is investigating factors that may affect clinical supervision. You must be an adult over the age of 18 and currently in a counseling training program (masters or doctoral level) and currently receiving individual (one on one) clinical supervision. If you consent to participate in the study, you will be shown a series of online surveys asking about your personal history of traumatic experience, perceptions of your supervisor and your supervision relationship, and your views on relationships overall.

Approximately 800 participants may be involved in this research nationwide.

Participation is voluntary and will take approximately 25-35 minutes.

During the study, you may recall emotional, traumatizing, or otherwise distressing experiences. During participation the following hotline numbers will be visible on each survey page in the event you feel distressed:

National Sexual Assault Hotline: 1-800-656-4673

National Suicide Prevention Lifeline: 1-800-273-8255
National Domestic Violence Hotline: 800-799-7233

These hotline resources will also be provided at the end of the study. If you decide you would like to exit the study, you may do so at any time. You will not be penalized in any way for choosing not to complete the study.

If you wish, at the end of the study you may enter into a drawing to win one of 40 $30 Amazon gift cards. If you enter the drawing, your email address will be stored separately from your survey answers.

This study is completely anonymous. Your name, email address, and other personally identifying information will not be collected as part of the study. While there are some risks of data breaches when sending information over the Internet that are beyond the control of the researchers, we will take care to keep your information safe. Your anonymous responses will be stored in password-protected, encrypted files on password-protected computers. Only the researchers (principal investigator and her research team) will have access to the responses collected in this study.

If you have any questions or concerns regarding this study, or if any problems arise, you may contact the Investigator (Nikki Hurless, 410-910-4174) or the Faculty Advisor (Dr. Susan Kashubeck-West, SusanKW@umsl.edu). You may also ask questions or state concerns regarding your rights as a research participant to the Office of Research, at 314-516-5897.

By moving forward with this study, you are consenting to participate.

I agree to participate in this study: Yes ____ No _____

*Please print or save a copy of this form for your records.*
Appendix B: Adverse Childhood Experiences Scale

For each item please answer YES or NO. Prior to your 18th birthday:

1. Did you get scared or feel really bad because grown-ups who took care of you (for example, parents, adult relatives, other adults who lived with you) called you names, said mean things to you, or said they didn't want you?

2. Did you often feel that no one in your family loved you or thought you were important or special? Or did you feel that your family members didn’t look out for each other, feel close to each other, or support each other?

3. Not including spanking on your bottom, did grown-ups who took care of you (for example, parents, adult relatives, other adults who lived with you) ever hit, beat, kick, or physically hurt you in any way?

4. Did any grown-up in your life (whether you knew him/her or not) touch your private parts when they shouldn’t have or make you touch their private parts? Or did a grown-up force you to have sex, that is sexual intercourse of any kind?

5. When someone is neglected, it means that the grown-ups in their life didn’t take care of them the way they should. They might not get them enough food, take them to the doctor when they are sick, or make sure they have a safe place to stay. Were you neglected?

6. Was a member of your household diagnosed with depression, bipolar disorder, anxiety, or other psychiatric disorder? Or did a household member attempt suicide?

7. Was there a time that a member of your household drank or used drugs so often that it caused problems?

8. Was there a time when a grown-up member of your household (for example, a parent, step-parent, an adult relative, your parent’s boyfriend or girlfriend) was arguing with, yelling at, and angry at another grown-up family member a lot of the time?

9. Did you SEE a grown-up in your household get pushed, slapped, hit, punched, beat up, or hurt with or threatened with a weapon by another grown-up in the house?

10. Did you SEE a grown-up member of your household hit, beat, kick or physically hurt your brothers or sisters, not including a spanking on the bottom?

11. Did a parent, or someone who was like a parent to you (for example, a step-parent, guardian, close adult relative), have to go to prison?

12. Did a parent, or someone who was like a parent to you, die for reasons other than being murdered?

13. Were your parents separated or divorced?

14. Did a parent, or someone who was like a parent to you, have to leave the country to fight in a war and was gone for several months or longer?

15. Were you sent away or taken away from a parent or your family for any reason (not including voluntary separations, such as going to summer camp)?

16. Sometimes people are attacked with sticks, rocks, guns, knives, or other things that would hurt. Did other kids, your siblings, or a girlfriend or boyfriend hit or
attack you on purpose WITH an object or weapon? Somewhere like: at school, at a store, in a car, on the street, or anywhere else?
17. Did other kids, your siblings, or a girlfriend or boyfriend threaten to physically hurt you when you thought they might really do it?
18. Did you get scared or feel really bad because other kids, your siblings, your girlfriend or boyfriend were calling you names, saying mean things to you, or saying they didn’t want you around?
19. Did other kids, your siblings, a boyfriend, or a girlfriend force you to do sexual things?
20. Were you hit or attacked because of your skin color, religion, or where your family comes from? Because of a physical problem you have? Or because someone said you were gay?
21. Excluding instances where you were hit or attacked because of your skin color, religion, physical disability, sexual orientation, or where your family comes from, did you FEEL discriminated against because of these characteristics?
22. Did you SEE anyone in real life get attacked on purpose WITH a stick, rock, gun, knife, or other thing that would hurt? Somewhere like: at school, at a store, in a car, on the street, or anywhere else outside of home?
23. Did anyone steal something from your house that belongs to your family or someone you lived with? Things like a TV, stereo, car, or anything else?
24. Was anyone close to you (for example, a family member, a friend, or neighbor) murdered?
25. Did you see someone murdered in real life (not on TV, video games, or in the movies)?
26. Were you in any place in real life where you could see or hear people being shot, bombs going off, or street riots?
27. Were you in the middle of a war where you could hear real fighting with guns or bombs?
28. Did anyone steal something from you and never give it back? Things like a backpack, money, watch, clothing, bike, stereo, or anything else?
29. Did anyone use force to take something away from you that you were carrying or wearing?
30. Did anyone break or ruin any of your things on purpose?
31. Was there a period of time when you had no really good friends and there was no one else you felt close to?

Scoring: sum all items (no = 0, yes = 1) for a total score
Appendix C: Adverse Adult Experiences Scale

For each item please answer YES or NO. *After* your 18th birthday:

1. Did a member of your household (for example, a parent, step-parent, an adult relative, a sibling, or your significant other) call you names, said mean things to you, or said they didn’t want/love you?
2. Did you often feel that no one in your family loved you or thought you were important or special? Or did you feel that your family members didn’t look out for each other, feel close to each other, or support each other?
3. Did anyone in your household or close to you ever hit, beat, kick, or physically hurt you in any way?
4. Did anyone in your life (whether you knew him/her or not) touch your genitals when they shouldn’t have or make you touch their genitals? Or did anyone force you to have sex, that is sexual intercourse of any kind?
5. Was a member of your household diagnosed with depression, bipolar disorder, anxiety, or other psychiatric disorder? Or did a household member attempt suicide?
6. Was there a time that a member of your household drank or used drugs so often that it caused problems?
7. Was there a time when a member of your household (for example, a parent, step-parent, an adult relative, a sibling, or your significant other) was arguing with, yelling at, and angry at another grown-up family member a lot of the time?
8. Did you SEE a member of your household get pushed, slapped, hit, punched, beat up, or hurt with or threatened with a weapon by someone else in the house?
9. Did you SEE a member of your household hit, beat, kick or physically hurt someone else?
10. Did a parent, or someone who was like a parent to you (for example, a step-parent, guardian, close adult relative), go to prison?
11. Did a parent, or someone who was like a parent to you, die for reasons other than being murdered?
12. Were your parents separated or divorced?
13. Did a parent, or someone who was like a parent to you, have to leave the country to fight in a war and was gone for several months or longer?
14. Did anyone close to you hit or attack you on purpose with an object or weapon?
15. Did your peers, friends, siblings, or significant others threaten to physically hurt you and you thought they might really do it?
16. Were you hit or attacked because of your skin color, religion, nationality, disability, gender, or sexual orientation?
17. Excluding instances where you were hit or attacked because of your skin color, religion, physical disability, sexual orientation, or where your family comes from, did you FEEL discriminated against because of these characteristics?
18. Did you SEE anyone get attacked on purpose with a weapon?
19. Did anyone steal something from your house that belongs to you or someone you lived with?
20. Was anyone close to you (for example, a family member, a friend, or neighbor) murdered?
21. Did you see someone murdered in real life (not on TV, video games, or in the movies)?
22. Were you in any place where you could see or hear people being shot, bombs going off, or street riots?
23. Were you in the middle of a war where you could hear real fighting with guns or bombs?
24. Did anyone use force to take something away from you that you were carrying or wearing?
25. Did anyone break or ruin any of your things on purpose?
26. Was there a period of time when you had no really good friends and there was no one else you felt close to?

Scoring: sum all items (no = 0, yes = 1) for a total score
Appendix D: Everyday Discrimination Scale (EDS)

Respond to the following questions using this rating scale:

1: Never
2: Less than once a year
3: A few times a year
4: A few times a month
5: At least once a week
6: Almost everyday

In your day-to-day life, how often do any of the following things happen to you?
1. You are treated with less courtesy than other people are.
2. You are treated with less respect than other people are.
3. You receive poorer service than other people at restaurants or stores.
4. People act as if they think you are not smart.
5. People act as if they are afraid of you.
6. People act as if they think you are dishonest.
7. People act as if they’re better than you are.
8. You are called names or insulted.
9. You are threatened or harassed.

Follow-up Question (Asked only of those answering “A few times a year” or more frequently to at least one question.):

What do you think is the main reason for these experiences? (CHECK MORE THAN ONE IF VOLUNTEERED)
1. Your Ancestry or National Origins
2. Your Gender or Gender Identity
3. Your Race or skin color
4. Your Age
5. Your Religion
6. Your Height
7. Your Weight
8. Some other Aspect of Your Physical Appearance
9. Your Sexual Orientation
10. Your Education or Income Level
11. A physical disability
12. Your Native or Indigenous tribe
13. Another option not listed
Appendix E: Experiences in Supervision Scale

The statements below concern how you feel in supervision with your current individual (one on one) supervisor. Respond to each statement by circling a number to indicate how much you agree or disagree with the statement.

1 = Strongly Disagree………7 = Strongly Agree

1. I worry a lot about my relationships with my supervisor
2. I am very comfortable being close to my supervisor
3. I worry that supervisor won’t care about me as much as I care about them
4. I prefer not to show my supervisor how I feel deep down
5. If I can’t get my supervisor to show interest in me, I get upset or angry
6. I want to get close to my supervisor, but I keep pulling back
7. I find that my supervisor doesn’t want to get as close as I would like
8. I get uncomfortable when my supervisor wants to be very close
9. I get frustrated when my supervisor is not around as much as I would like
10. When my supervisor gets close to me I find myself pulling away
11. I get frustrated if my supervisor is not available when I need them
12. I turn to my supervisor for many things, including comfort and reassurance
13. When supervisor disapproves of me, I feel really bad about myself
14. I don’t mind asking my supervisor for comfort, advice, or help
15. I worry a fair amount about my supervisor not being available when needed
16. I don’t feel comfortable opening up to my supervisor
17. I worry about being abandoned by my supervisor
18. I feel comfortable sharing my private thoughts and feeling with my supervisor
19. I worry about being alone, without as much supervision as I want
20. I try to avoid getting too close to my supervisor
21. I do not often worry about being abandoned by my supervisor
22. I find it relatively easy to get close to my supervisor
23. I often wish that my supervisor’s feelings for me were as strong as my feelings for him/her
24. I find it difficult to allow myself to depend on my supervisor
25. My desire to be very close sometimes scares my supervisor away
26. I usually discuss my problems and concerns with my supervisor
27. I resent it when my supervisor doesn’t have as much time as I’d like
28. I feel comfortable depending on my supervisor
29. I need a lot of reassurance that I am liked by my supervisor
30. It helps to turn to my supervisor in times of need
31. Sometimes I feel that I pressure my supervisor to show more commitment to our relationship
32. I am nervous when supervisor gets too close to me
33. I often want to be very connected with supervisors, and this sometimes scares them away
34. I prefer not to be too close to supervisors
35. When my supervisor is unavailable, I feel somewhat anxious and insecure
36. I could tell my supervisor anything and s/he would not reject me

Scoring:

Items 20, 22, 26, 27, 28, 29, 30, 31, 33, 34, 35, and 36 will need to be reverse keyed before you compute the average score.

The first 18 items above comprise the attachment-related anxiety scale. Items 19 – 36 comprise the attachment-related avoidance scale.
Appendix F: Measure of Attachment Qualities (MAQ)

Respond to each of the following statements by expressing how much you agree with it (if you do generally agree) or how much you disagree with it (if you generally disagree). Make all your responses on the answer sheet only. Do not leave any items blank. Please be as accurate as you can be throughout and try especially hard not to let your answer to any one item influence your answer to any other item. Treat each one as though it is completely unrelated to the others. There are no right or wrong answers, you are simply to express your own personal feelings and opinions. Choose from these response options:

1 = I DISagree with the statement a lot
2 = I DISagree with the statement a little
3 = I agree with the statement a little
4 = I agree with the statement a lot

1. I have trouble getting others to be as close as I want them to be.
2. I find it easy to be close to others.
3. Others want me to be more intimate than I feel comfortable being.
4. I am very comfortable being close to others.
5. My desire to merge sometimes scares people away.
6. I prefer not to be too close to others.
7. I find others are reluctant to get as close as I would like.
8. I get uncomfortable when someone wants to be very close.

Scoring:
Items 2 and 4 are reverse coded.

Avoidance = sum items 2, 3, 4, 6, and 8.
Ambivalence-merger = sum items 1, 5, and 7.
Appendix G: Supervisory Working Alliance Inventory-Trainee (SWAI–T), Rapport Subscale

Please indicate the frequency with which the behavior described in each of the following items seems characteristic of you and your work with your current individual (one on one) supervisor. Click the appropriate box next to each item to indicate your response (1-7), where 1 = “Almost Never” and 7 = “Almost Always.”

1. I feel comfortable working with my supervisor.
2. My supervisor welcomes my explanations about the client's behavior.
3. My supervisor makes the effort to understand me.
4. My supervisor encourages me to talk about my work with clients in ways that are comfortable for me.
5. My supervisor is tactful when commenting about my performance.
6. My supervisor encourages me to formulate my own interventions with the client.
7. My supervisor helps me talk freely in our sessions.
8. My supervisor stays in tune with me during supervision.
9. I understand client behavior and treatment technique similar to the way my supervisor does.
10. I feel free to mention to my supervisor any troublesome feelings I might have about him/her.
11. My supervisor treats me like a colleague in our supervisory sessions.
12. In supervision, I am more curious than anxious when discussing my difficulties with clients.

Scoring:

Rapport subscale: Sum items then divide by 12
Appendix H: Supervisee Needs Index (SNI)

Please rate your current, individual supervisor. Using the following scale as a guide, select a number to deviate how much you agree with each statement.

1 -------------- 2 -------------- 3 -------------- 4 -------------- 5 -------------- 6 -------------- 7

Strongly Disagree Strongly Agree

1. My supervisor does not encourage me to grow personally.
2. Supervision regularly includes opportunities to review recordings of my clinical work.
3. When faces with a client issues that is new to me, supervisor provides little guidance.
4. I am content with the emphasis placed on learning therapy techniques in supervision.
5. When ethical issues arise, my supervisor provides meaningful assistance.
6. Countertransference issues are not discussed as much as I would prefer in supervision.
7. There are sufficient opportunities to receive formal evaluation of my therapy work during supervision.
8. I feel my supervisor has ample focus on my client’s needs.
9. I leave supervision feeling that my pressing issues were not addressed.
10. We have a regular scheduled time for supervision that my supervisor honors.
11. My supervisor helps me to feel self-assured in my clinical work.
12. My supervisor is clearly motivated to help me in my supervision.
13. There are many times when my supervisor does not seem to be listening to me.
14. I do not receive the mentoring I want in supervision.
15. My supervisor has helped improve my ability to understand my clients.
16. My supervisor spends time explaining his or her expectations of me.
17. My supervisor rarely makes time for me when I need it.
18. I feel safe in supervision.
19. I frequently leave supervision feeling I did not learn enough about therapy.
20. My role as a supervisee is not clear.
21. I wish my supervisor would suggest literature related to my clinical work when I request it.
22. My most significant concerns are afforested in supervision.
23. I feel my supervisor only wants me to utilize her or his theoretical orientation.
24. My clinical knowledge has expanded through supervision.
25. I am concerned about my client’s wellbeing is overlooked in supervision.
26. My supervisor appropriately challenges me to think for myself.
27. The emphasis in supervision on my personal growth meets my needs.
28. At times, my supervisor’s behavior feels invalidating.
29. I am dissatisfied with the supervisor relationship.
30. It would be helpful for my supervisor to give me greater autonomy in clinical decision making.
31. I wish my supervisor would directly observe my therapy sessions more often.
32. I am not able to be myself in supervision.
33. When I ask for readings on a particular issue, my supervisor provides recommendations.
34. I would prefer more emphasis to be placed on issues of diversity in supervision.
35. My supervisor encourages me to work from the theoretical approach that works fits for me.
36. Multicultural issues are sufficiently discussed in supervision.
37. My supervisor’s feedback about my therapy skill is insufficient.
38. I feel the supervisory relationship is supportive.
39. In supervision, we appropriately discuss my personal issues as they relate to my clinical work.
40. Conceptualization of my clients during supervision has little impact on my clinical work.
41. I wish my supervisor would willingly discuss my ethical concerns.
42. It seems that my supervisor does not give much consideration to my needs.
43. My supervisor is not trustworthy.
44. My supervisor serves as a guide in my professional development.
45. My supervisor makes our relationship a priority.
46. My supervisor is hopeful when I am unfamiliar with a participant clinical issue.
47. I feel able to disclose my honest reactions to my supervision.
48. My supervisor does not focus enough on utilizing different therapy interventions.

Scoring:

To find a total score for the SNI, reverse score the items listed below. Then, add each Likert-scale score to achieve a total score (range = 28 – 336).

Reverse scored: 1, 3, 6, 9, 13, 14, 17, 19, 20, 21, 23, 35, 28, 29, 30, 31, 32, 34, 37, 40, 41, 42, 43, 48
Appendix I: The Supervisory Satisfaction Questionnaire (SSQ)

Please answer the following questions about your relationship with your current individual supervisor.

1. How would you rate the quality of the supervision you have received?

2. Did you get the kind of supervision you wanted?
   1. No, definitely not  2. No, not really  3. Yes, generally  4. Yes, definitely

3. To what extent has this supervision fit your needs?
   1. None of my needs have been met  2. Only a few of my needs have been met  3. Most of my needs have been met  4. Almost all of my needs have been met

4. If a friend were in need of supervision, would you recommend this supervisor to them?
   1. No, definitely not  2. No, not really  3. Yes, generally  4. Yes, definitely

5. How satisfied are you with the amount of supervision you have received?

6. Has the supervision you receive helped you feel more effectively in your role as a counselor or therapist?
   1. No, definitely not  2. No, not really  3. Yes, generally  4. Yes, definitely

7. In an overall, general sense, how satisfied are you with the supervision you have received?

8. If you were to see supervision again, would you come back to this supervisor?
   1. No, definitely not  2. No, not really  3. Yes, generally  4. Yes, definitely

Scoring: sum all items for a total score between 1 - 32
Appendix J: Trauma-Informed Practice Scales

How do you feel about your current individual clinical supervisor? Please indicate how true the following statement are as you think about your interactions with you supervisor.

1. My supervisor respects my privacy.
   0 (not at all true), 1 (a little true), 2 (somewhat true), 3 (very true)

2. My supervisor is supportive when I’m feeling stressed out or overwhelmed.
   0 (not at all true), 1 (a little true), 2 (somewhat true), 3 (very true)

3. I decide what I want to work on in supervision.
   0 (not at all true), 1 (a little true), 2 (somewhat true), 3 (very true)

4. I have the opportunity to learn how trauma and other difficulties affect responses in the body.
   0 (not at all true), 1 (a little true), 2 (somewhat true), 3 (very true)

5. I have the opportunity to learn how trauma and other difficulties affect my client’s mental health.
   0 (not at all true), 1 (a little true), 2 (somewhat true), 3 (very true)

6. My supervisor treats me with dignity.
   0 (not at all true), 1 (a little true), 2 (somewhat true), 3 (very true)

7. My supervisor respects the strengths I have gained through my life experiences.
   0 (not at all true), 1 (a little true), 2 (somewhat true), 3 (very true)

8. My supervisor respects the strengths I get from my culture or family ties.
   0 (not at all true), 1 (a little true), 2 (somewhat true), 3 (very true)

9. My supervisor understands that I know what’s best for me.
   0 (not at all true), 1 (a little true), 2 (somewhat true), 3 (very true)

10. Supervision creates opportunities for me to learn how abuse and other hardships affect peoples’ relationships.

11. The strengths I bring to my relationships with my children, my family, or others are recognized in supervision.
   0 (not at all true), 1 (a little true), 2 (somewhat true), 3 (very true)

12. My supervisor respects the choices that I make.
   0 (not at all true), 1 (a little true), 2 (somewhat true), 3 (very true)

13. In supervision, I can share things about my life on my own terms and at my own pace.
   0 (not at all true), 1 (a little true), 2 (somewhat true), 3 (very true)

14. Supervision gives me opportunities to learn how trauma, and other difficulties affect peoples’ ability to think clearly and remember things.
0 (not at all true), 1 (a little true), 2 (somewhat true), 3 (very true)

15. My supervisor can handle difficult situations.
   0 (not at all true), 1 (a little true), 2 (somewhat true), 3 (very true)

16. I am learning more about how to handle unexpected reminders of potential trauma and other difficulties people endure.
   0 (not at all true), 1 (a little true), 2 (somewhat true), 3 (very true)

17. I can trust my supervisor.
   0 (not at all true), 1 (a little true), 2 (somewhat true), 3 (very true)

For the rest of the questions, please indicate how true the following statements are on a scale of 0 to 3. Note that as you think about these statements you have the option to circle “I don’t know.”

18. My supervisor respects peoples’ cultural backgrounds.
   0 (not at all true), 1 (a little true), 2 (somewhat true), 3 (very true), I don’t know

19. My supervisor respects peoples’ religious or spiritual beliefs.
   0 (not at all true), 1 (a little true), 2 (somewhat true), 3 (very true), I don’t know

20. My supervisor respects peoples’ sexual orientations and gender expressions.
   0 (not at all true), 1 (a little true), 2 (somewhat true), 3 (very true), I don’t know

21. My supervisor understands what it means to be in my financial situation.
   0 (not at all true), 1 (a little true), 2 (somewhat true), 3 (very true), I don’t know

22. My supervisor understands the challenges faced by people who are immigrants.
   0 (not at all true), 1 (a little true), 2 (somewhat true), 3 (very true), I don’t know

23. My supervisor understands how discrimination impacts peoples’ everyday experience.
   0 (not at all true), 1 (a little true), 2 (somewhat true), 3 (very true), I don’t know

24. My supervisor recognizes that some people or cultures have endured generations of violence, abuse, and other hardships.
   0 (not at all true), 1 (a little true), 2 (somewhat true), 3 (very true), I don’t know

25. My supervisor treats people who face physical or mental health challenges with compassion.
   0 (not at all true), 1 (a little true), 2 (somewhat true), 3 (very true), I don’t know

Scoring:
Agency: sum items 1, 2, 3, 6, 9, 12, 13, 15, 17
Information: sum items 4, 5, 10, 14, 16
Strengths: sum items 7, 8, 11
Inclusivity: sum items 18-25
Appendix K: Demographic Items

What type of program are you currently studying in?
Clinical Mental Health Counseling
School Counseling
Dual Degree, please specify which degrees ______________
Rehabilitation Counseling
Marriage and Family Therapy
Counselor Education and Supervision

Select your training level:
Master’s practicum   Master’s internship   Doctoral Practicum   Doctoral Internship

Do you anticipate you will receive a passing grade in your practicum or internship course?
Yes   No   Unsure

Please estimate the number of supervision sessions you have completed with your current supervisor: ____________

As far as you are aware, has your supervisor received formal supervision training?
Yes   No   Not sure

Please enter your age_____

Gender (check all that apply):
Man   Woman   Nonbinary   Transgender   Prefer not to answer

Race/Ethnicity:
Black or African American
Asian American (including Southeast Asian and Indian American)
Hispanic or Latino/a/x
Native American
White or European American
Biracial/Multiracial
Not listed

Do you have any experience as a counselor prior to your current program? Yes  No
If yes, how much? In months or years ____________
Appendix L: Figures and Tables: Manuscript 1

**Figure 1.** Hypothesized Mediation Model.

![Diagram of a mediation model](image1.png)

**Figure 2.** Hypothesized model with standardized path coefficients.

*p < .05, ** p < .001

![Diagram with standardized coefficients](image2.png)
### Table 1. Means, standard deviations, and zero-order correlations for main study variables

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Note: ACES = Adverse childhood experiences. AAES = Adverse adult experiences; EDS = Everyday Discrimination scale; MAQ Avo = Measure of Attachment Qualities, Avoidance subscale; MAQ Amb = Measure of Attachment Qualities, Ambivalence-Merger subscale; ESS Avo = Experiences in Supervision, Avoidance subscale; ESS Anx = Experiences in Supervision, Anxiety subscale; SWAI-T-R = Supervisory Working Alliance Inventory-Trainee version, Rapport subscale; SSQ = Supervisory Satisfaction Questionnaire. Pass/Fail scores 1 = pass, 0 = fail. * $p < .05$, ** $p < .001$. 
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Note: ACES = Adverse childhood experiences. AAES = Adverse adult experiences; EDS = Everyday Discrimination scale; MAQ = Measure of Attachment Qualities; ESS = Experiences in Supervision; SWAI-T-R = Supervisory Working Alliance Inventory- Trainee version, Rapport subscale; SSQ = Supervisory Satisfaction Questionnaire. * p < .05, ** p < .01.
Appendix M: Figures and Tables: Manuscript 2

Table 2. Hierarchical Regression Analysis Summary of Predictors of SWAI-T-Rapport

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<td>-</td>
<td>-</td>
<td>1.51</td>
<td>.07</td>
<td>.81**</td>
<td></td>
</tr>
<tr>
<td>R²</td>
<td>-</td>
<td>.14</td>
<td>-</td>
<td>-</td>
<td>.57</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>F for change in R²</td>
<td>-</td>
<td>9.60**</td>
<td>-</td>
<td>-</td>
<td>438.61**</td>
<td>-</td>
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</tr>
</tbody>
</table>

Table 3. Hierarchical Regression Analysis Summary of Predictors of SSQ

<table>
<thead>
<tr>
<th>Variable</th>
<th>Step 1 (control variables)</th>
<th>Step 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>SE B</td>
</tr>
<tr>
<td>1. Age</td>
<td>.19</td>
<td>.06</td>
</tr>
<tr>
<td>2. Supervision Sessions</td>
<td>.07</td>
<td>.02</td>
</tr>
<tr>
<td>3. Gender (woman)</td>
<td>2.68</td>
<td>.70</td>
</tr>
<tr>
<td>4. Passing grade</td>
<td>2.66</td>
<td>1.05</td>
</tr>
<tr>
<td>5. TIP full scale</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>R²</td>
<td>-</td>
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</tr>
<tr>
<td>F for change in R²</td>
<td>-</td>
<td>14.85**</td>
</tr>
</tbody>
</table>

Note. SSQ = Supervisory Satisfaction Scale; TIP = Trauma-informed practice. *p < .05. **p < .01.

Table 4. Hierarchical Regression Analysis Summary of Predictors of SNI

<table>
<thead>
<tr>
<th>Variable</th>
<th>Step 1 (control variables)</th>
<th>Step 2</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>SE B</td>
</tr>
<tr>
<td>1. Age</td>
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<td>.001</td>
</tr>
<tr>
<td>2. Supervision Sessions</td>
<td>.001</td>
<td>.00</td>
</tr>
<tr>
<td>3. Gender (woman)</td>
<td>.04</td>
<td>.01</td>
</tr>
<tr>
<td>4. Passing grade</td>
<td>.02</td>
<td>.02</td>
</tr>
<tr>
<td>5. TIP full scale</td>
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<td>-</td>
</tr>
<tr>
<td>R²</td>
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</tr>
<tr>
<td>F for change in R²</td>
<td>-</td>
<td>12.81**</td>
</tr>
</tbody>
</table>

Note. SNI = Supervisee Needs Index; TIP = Trauma-informed practice. *p < .05. **p < .01.