



# Professional Leadership, Racial Microaggressions, and Career Adaptability Of Minoritized Clinicians in the United States

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## Abstract

The impact of racial microaggressions on career adaptability and professional leadership engagement of racial/ethnic minoritized counsellors in the United States was examined. The sample included 489 counsellors and counsellors in training. Structural equation modeling pathways indicated a positive pathway from racial microaggressions to both career adaptability and professional leadership development, and a negative pathway from career adaptability to leadership engagement. Additionally, a thematic analysis of written responses from participants who shared why they did not participate in professional organization leadership positions revealed four themes including limited time, opportunity or awareness, newness to the profession, and lack of desire or interest. Study limitations and implications for counsellors, counselor education programs, and counselling/mental health professional organizations are discussed.

**Keywords** Career construction theory · Career adaptability · Racial microaggressions · Career development · Leadership

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## Professional Leadership, Racial Microaggressions, and Career Adaptability of Minoritized Clinicians in the United States

Career construction theory (CCT) references the importance of adaptively managing career opportunities (Savickas, 2013). Career adaptability, a key CCT construct, explains that higher levels of adaptation are expected among those who are willing (adaptive) and able (adaptability) to perform behaviors consistently in various career situations (Savickas & Porfeli, 2012). Adaptation occurs when individuals can make positive changes in career-related situations and adaptability refers to the psychological resources one must use to respond to tasks, transitions, and traumas in their career-related roles (Savickas, 2013). Career adaptability influences career and job satisfaction (Han & Rojewski, 2015), career engagement (Nilforooshan & Salimi, 2016), career success (Zacher, 2014), and overall well-being (Maggiori et al., 2017). In addition, career adaptability is developed through interactions between one's inner world view and external environment (Yang et al., 2019). To increase one's career adaptability, an individual needs to gain external career-related experiences that positively shape their inner thoughts and beliefs about their strengths (Savickas & Porfeli, 2012).

### Career Adaptability in Diverse Populations

Highlighting the role of both one's inner world view and external environment, Zhang et al., (2021) found that in a sample of 1,163 Chinese technical students, participants' career-related parental support (external environment) and increased vocational identity (inner world view) strengthened their career adaptability. Further, Datu and Buencosejo (2021) noted that in a sample of Filipino high school students, participation and involvement in extracurricular activities was a strong predictor of career adaptability. Career adaptability was examined in diverse populations. However, no studies to date discuss the relationship between racial microaggressions and career adaptability for counsellors and clinicians of color.

### Racial Microaggressions and Career Development

Sue et al., (2007) described microaggressions as “commonplace daily verbal, behavioral, and environmental indignities” (p. 273) that communicate harmful and negative racial slights. Racial microaggressions have a psychological impact on marginalized individuals and groups (Sue et al., 2007). A person of color's (POC) repeated exposure to racial microaggressions can have damaging impacts on their psychological health and career development (Bonifacio et al., 2018; Sue, Copodilupo, et al., 2007).

Although Bonifacio et al.'s (2018) study did not focus specifically on clinicians, they sought to understand the impact of racial microaggressions on the career development of 202 Latina college and graduate students. Bonifacio and colleagues (2018) found that Latina students with more experiences with racial microaggress-

sions reported lower career decision-making self-efficacy and negative outcome expectations.

Hernández et al., (2010) investigated how mental health professionals cope with racial microaggressions by interviewing 24 racially diverse professionals. Participants relied on the support of colleagues, collective organizing, and mentorship to manage the microaggressions. Branco & Bayne (2020) interviewed eight racial and ethnic minoritized counsellors about how racial microaggressions impacted the counselling relationship. The counsellors explained that they had to buffer the effects of racial microaggressions by bracing themselves for the negative reactions that could influence the counselling relationship. In addition, the counsellors shared that their responses to racial microaggressions included: (a) seeking or not seeking consultation; (b) giving the client the benefit of the doubt; and (c) minimizing stereotype threat to make the client more comfortable or decrease the likelihood of stereotypes. Haskins et al., (2013) interviewed eight Black counselling master's students regarding their experiences as Black students at a predominantly White institution (PWI). The counselling master's students discussed negative racial experiences such as social isolation, tokenism, lack of inclusion, and lack of support. The master's students discussed that support from faculty was both proactive and reactive when negative racial experiences occurred. However, proactive support came mainly from faculty of color.

Likewise, Constantine & Sue (2007) examined the racial microaggressions experienced by Black doctoral supervisees with White supervisors in counselling and counselling psychology programs. Constantine & Sue (2007) suggested that supervisees' career development and self-efficacy may have been negatively impacted by their experiences with White supervisors (a) invalidating their racial-cultural issues, (b) making stereotypic statements about Black clients and supervisees, and (c) offering culturally biased feedback. Additionally, Sue and Constantine (2007) found that Black clinicians' experiences with racial microaggressions negatively impacted their career development. However, few studies have quantitatively examined the relationships between racial microaggressions and career development constructs such as career adaptability in racially minoritized counsellors.

Previous studies (a) do not explore the career adaptability of clinicians of color and (b) primarily focus on predicting career adaptability. In doing so, previous studies have overlooked the contextual factors that influence career adaptability. We focus on racial microaggressions as a contextual factor that influences career adaptability. Similarly to Nilforooshan and Salimi's (2016) research on career adaptability and career engagement, we explore the impact of career adaptability on engagement. Specifically, we examine leadership engagement in professional counselling or mental health organizations.

## Racial Microaggressions and Leadership

Racial microaggressions influence leadership experiences of POC. Leadership, multiculturalism, and advocacy are critically important to the success of the counselling profession (Meany-Walen et al., 2013). Recently, there has been more movement

towards social justice leadership within the counselling and mental health professions (Peters et al., 2020) discussed that social justice leadership is intentional and leadership should not be predominantly held by those with privileged identities. Thus, there is a need for increased diversity within counselling and mental health leadership. For example, 19 of the first 20 American Counseling Association's (ACA) presidents were White males (Meyers, 2017). Further, the recent president of ACA is only the eighth Black president of ACA (ACA, 2021).

According to the ACA strategic plan and core values, everyone is welcome and the organization goes above and beyond to ensure that there is diversity at the leadership table (ACA, 2021b). There has been increased diversity in professional counselling and mental health leadership (Meyers, 2017). Even still, there is also a need to (a) improve the leadership experiences of racial and ethnic minoritized clinicians and (b) address the racial microaggressions experienced by racial and ethnic minoritized clinicians in leadership positions (Chin et al., 2020; Wines, 2013). For instance, when examining the leadership experiences of Black school counsellors, Wines (2013) highlighted that Black school counsellors often experience microaggressions and systemic resistance from colleagues. Chin et al., (2020) interviewed three directors of color at college counselling centers. The directors discussed the challenges they faced with having to meet unattainable expectations while also combating racial microaggressions and negative stereotypes from their peers. Unfortunately, experiences with racial microaggressions are commonplace among counsellors and clinicians of color in leadership positions (Chin et al., 2020; Wines, 2013).

Thus, the purpose of this study was to utilize career construction theory to examine the relationships between racial microaggressions, career adaptability, and leadership engagement. We also aimed to explore the reasons minoritized counsellors and clinicians choose not to leadership. Our quantitative hypotheses were threefold. We hypothesized that (1) racial microaggressions will have a negative pathway to career adaptability, (2) racial microaggressions will have a negative pathway to leadership engagement, and (3) career adaptability will have a positive pathway to leadership engagement.

## Method

### Participants

Participants were  $N=489$  racial/ethnic minoritized counsellors and clinicians in the United States of America (US). To be eligible to participate in the study, volunteers needed to self-identify as racial/ethnic minoritized counsellors; school, clinical, or counselling psychologists; clinical social workers; art therapists; or graduate students in these professions. Most participants identified as Black (68%). Some participants identified as Asian/Pacific Islander (5%), Native American (3%), Multiracial/Biracial (8%), White (2%), Middle Eastern/North African (5%), and a few participants identified that their race was not an option provided on the survey (1%). Additionally, 15% of participants indicated that they were of Hispanic/Latinx descent. Note that percentages are greater than 100% due to participants' ability to identify in more

than one racial/ethnic category (e.g., White and Hispanic/Latinx descent). Most participants identified as cisgender females (79%). However, the sample also included cisgender males (8%) and a small percentage of gender non-conforming or nonbinary counsellors and clinicians (1%). Some participants indicated that their gender was not listed on the survey (3%), and some participants did not disclose their gender (10%). The average age of participants was 35.40 years old ( $SD=8.15$ ).

Most participants graduated from a CACREP (Council for Accreditation of Counseling and Related Educational Programs) accredited program (62%) and indicated that they were independently licensed (51%). In addition, most counsellors and clinicians in the sample were practicing for 1–6 years (68%) while 32% indicated that they had been practicing for 7 or more years. Most participants were master's level counsellors or clinicians (81%). Participants were able to select multiple specialty areas and work settings. At the time of the study, approximately 27% of participants indicated they worked at a private practice. Participants also indicated that they worked at a community agency (19%), k-12 school (19%), hospital (6%), college/university (9%), government agency (5%), recovery center (5%), intensive outpatient center (4%), in-home setting (1%), workforce development/career counselling center (1%), and/or residential facility (1%) at the time of the study. About 4% of participants indicated that they worked in a different setting than the options provided. Regarding clinical specialty areas, most participants indicated that they had a clinical mental health counselling specialty (36%). Participants also had specialties in clinical social work (16%), school counselling (14%), marriage and family counselling (6%), career counselling (2%), college counselling (2%), rehabilitation counselling (3%), clinical psychology (6%), counselling psychology (6%), school psychology (1%), counselor education (5%), and/or art therapy (1%). Approximately 2% of participants indicated that they had a specialty other than the areas provided on the survey.

Most participants were actively involved in counselling or mental health organizations (57%), and 23% indicated that they served in professional leadership positions at the time of the study. Regarding racial microaggressions, 45% of participants indicated that they experienced racial microaggressions while in counselling or mental health leadership positions, 65% indicated that they experienced racial microaggressions in their current counselling or mental health job position, and 89% indicated that they experienced racial microaggressions at any point during their counselling or mental health career.

## Measures

### Demographics Questionnaire and Leadership Engagement Survey

Demographic data were gathered including: race, gender, education, ethnicity, counselling specialty, counselling work setting, and whether the participant graduated from a CACREP-accredited program. In addition, participants were asked to rate their professional leadership and participation in mental health and counselling organizations. Four items related to leadership engagement and commitment were used in the analysis to develop a latent professional leadership engagement variable. There

is previous research support for using four-item surveys. A four-item questionnaire can decrease participant burden and increase the future use of the items (Simons et al., 2011). For example, widely used measures like the Perceived Stress Scale (PSS) have a four-item alternative (i.e., PSS-4; Cohen et al., 1983).

In the present study, a four-item survey was developed by Cabell and Kozachuk as part of the demographic questionnaire. Participants were asked to rate their level of commitment to leadership positions in counselling or mental health professional organizations from “1-not committed at all” to “5- extremely committed.” Participants were also asked to rate their leadership engagement in counselling or mental health professional organizations from “1- not engaged at all” to “5- extremely engaged.” Participants rated their level of involvement in counselling or mental health professional organizations and their commitment to counselling and mental health advocacy from “1- not involved at all” to “5- extremely involved” and “1- not committed at all” to “5- extremely committed,” respectively. The Cronbach’s coefficient’s alpha for the four professional leadership items in this sample was 0.71.

**Racial Microaggressions Scale (RMAS; Torres-Harding et al., 2012).** The RMAS is a 32-item Likert-type scale that measures how often an individual has experienced various microaggressions from “1-never” to “6- almost all the time.” The RMAS consists of six subscales: invisibility, criminality, low achieving/undesirable, sexualization, foreigner/not belonging, and environmental invalidations. Example items include, “other people assume that I am successful because of affirmative action not because I earned my accomplishments,” “I am ignored in school or work environments because of my race,” and “I notice that there are few role models in my racial background in my chosen career.” The internal consistency of the RMAS ranges from 0.81 to 0.89 for the subscales and the RMAS shows convergent validity with the Schedule of Racial Events (SRE) scale (Landrine & Klonoff, 1996; Torres-Harding et al., 2012). The Cronbach’s coefficient’s alpha for the RMAS in this sample was 0.93.

**Career Adapt-Abilities Scale (CAAS; Savickas & Porfeli 2012).** The CAAS is a 24-item Likert-type scale that measures how strongly individuals have developed in four aspects of career adaptability: concern, curiosity, control, and confidence. Participants rate how strongly they have developed various strengths like “becoming curious about new opportunities,” “planning how to achieve my goals,” and “looking for opportunities to grow as a person” from “1-not strong” to “5-strongest.” The CAAS has shown evidence of concurrent validity with self-esteem (Rossier et al., 2012; Savickas & Porfeli, 2012) previously found a Cronbach’s coefficient’s alpha of 0.92. The Cronbach’s coefficient’s alpha for the CAAS in this sample was 0.91.

## Procedure

First, institutional review board (IRB) approval was obtained for the study. Participants were invited to participate in the study through email and social media recruitment. Flyers with the study’s details were posted to social media sites such as LinkedIn, Facebook, and Twitter. Online flyers were specifically posted in social media groups that included counsellors and clinicians of color (e.g., Clinicians of Color in Private Practice Facebook Group, Professional School Counselors of Color

Facebook Group). In addition, recruitment emails were sent on professional counselling listservs including, Counselor Education and Supervision Network Listserv (CESNET) and the American School Counseling Association SCENE. Participants were able to click on a Qualtrics link to the study. Since recruitment took place online, the survey response rate cannot be calculated. However, 72% of participants completed the survey in its entirety. The survey took approximately 20 min to complete. Participants could stop the survey at any time. After completing the survey, participants were taken to a separate link where they could enter their email address to receive a \$50 electronic Amazon gift card. Participant email addresses were assigned a number. Then, an online random number generator allowed the researchers to randomly select five participants to receive the gift cards. Funding for the electronic Amazon gift cards was provided by the North Central Association of Counselor Education and Supervision (NCACES).

## Data Analysis

Stata Version 16 was used to conduct the data analysis (StataCorp, 2019). First, an *a priori* power analysis was conducted. Kline (2016) suggested that 20 observations per each parameter indicates a sufficient sample size for structural equation models (SEM). This study included seven parameters which resulted in needing 140 participants for adequate power. Further, MacCallum et al., (1996) developed power analysis estimates based on the null root mean square error of approximation (RMSEA) and the alternative RMSEA. Gnambs (2013) developed an online estimator based on the MacCallum et al.'s (1996) power analysis estimates (<https://timo.gnambs.at/research/power-for-sem>). To estimate the recommended sample size for sufficient power, we created an estimate based on eight degrees of freedom; a null RMSEA hypothesis of 0.05; an alternative RMSEA hypothesis of 0.10; a 0.05 significance level; and a 0.80 desired power. The power analysis revealed a sample of 375 was sufficient. Thus, based on Kline's (2016) recommendation and MacCallum et al.'s (1996) power analysis estimates, there is evidence to suggest that our model with 489 participants was sufficiently powered.

Next, data were analyzed for patterns of missingness. The dataset included approximately 20–30% of intermittent missing data. To ensure that there were no significant patterns in the missing data, a series of logistic regressions was used to predict missingness in the four leadership items based on demographic variables. None of the demographic data were statistically significant predictors of missingness. In addition, Little's test was performed to determine if the leadership items data were missing completely at random (MCAR; Little, 1998). The result was not significant ( $p = .70$ ), indicating data were MCAR. Therefore, full information maximum likelihood (FIML) was used to impute missing cases. Descriptive statistics including: mean, standard deviations, and bivariate correlations, were calculated for the study's variables (i.e., CAAS, RMAS, and the four leadership items). Next, a series of univariate analyses were performed. ANOVAS, t-tests, and linear regressions were used to determine if there were significant relationships between demographic variables, CAAS, RMAS, and the four leadership items. Any significant predictors of the study's variables would be added to the model so long as they did not decrease model

fitness and hinder the power of the model. Significant differences were not found between the demographic variables (e.g., age, race, gender, education, whether the participant graduated from a CACREP-accredited program, counselling specialty, or work setting) and the study's variables.

To account for any non-normality in the assumptions, a SEM was then built using robust standard estimates for one latent dependent variable and two observed independent variables. The latent professional leadership engagement variable was developed using four leadership items collected from the demographic data. The two observed variables were the RMAS and CAAS instruments. Pathways from (1) racial microaggressions to career adaptability, (2) career adaptability to professional leadership engagement, and (3) racial microaggressions to professional leadership engagement were estimated. Then, fit statistics were calculated. Modifications to the model were examined by correlating error terms of the four leadership items. These modifications did not significantly improve the model fit and the final model is presented below.

To add context to the professional leadership engagement variable, a thematic analysis was conducted using the qualitative answer to one of the demographic questions. Participants were able to write a short statement about why they were not in leadership for professional counselling or mental health organizations. Participants' responses to this question were analyzed using the thematic analysis approach developed by Braun & Clarke (2006). The six steps to thematic analysis include: familiarization; coding; generating themes; reviewing themes; defining and naming themes; and writing up. First, Cabell reviewed the 117 statements made in response to the item. Then, the statements were coded to highlight salient themes in the responses. Following, four themes emerged and were named: limited time, lack of opportunity or awareness, new to the profession, and lack of desire or interest. The research team then defined the themes and picked excerpts that most accurately portrayed the sentiments of the participants.

**Table 1** Bivariate Correlations of the Study's Variables

Measure	<i>M</i>	<i>SD</i>	1	2	3	4	5	6
1. RMAS	59.19	39.12	--					
2. CAAS	38.19	25.57	0.81***	--				
3. Leadership Engagement	3.82	1.05	0.07	-0.49***	--			
4. Leadership Commitment	4.01	1.01	0.30*	-0.44**	0.55***	--		
5. Engagement Mental Health Organizations	2.73	1.07	0.06	0.01	0.35*	0.18	--	
6. Commitment Mental Health Advocacy	4.26	0.85	-0.003	-0.17*	0.35*	0.51***	0.24***	--

Note: RMAS=Racial Microaggressions Scale, CAAS=Career Adapt-Abilities Scale, \* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .001$



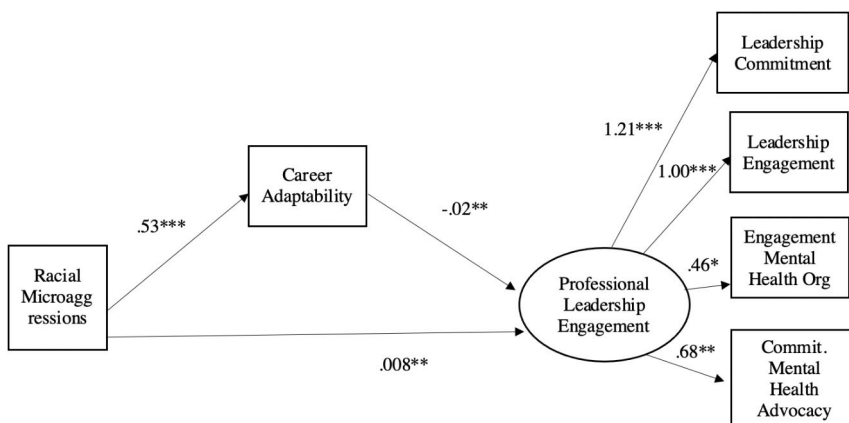
## Results

### Preliminary analysis

The descriptive statistics including bivariate correlations for the study's variables are presented in Table 1. The CAAS was positively correlated with RMAS; the leadership engagement and leadership commitment items were negatively correlated with CAAS; the leadership commitment item was positively correlated with RMAS; the engagement in mental health organizations and leadership commitment items were positively correlated with the leadership engagement item; the commitment to mental health advocacy item was negatively correlated with CAAS; and the commitment to mental health advocacy item was positively correlated with the engagement in mental health organizations and leadership commitment items.

### Primary analysis

The results of the SEM model are shown in Fig. 1. All four items that were used to develop the latent variable for professional leadership engagement were statistically significant and positive indicators ( $p < .001$ ) for the leadership engagement, leadership commitment, and commitment to mental health advocacy items; and ( $p < .05$ ) for the engagement in counselling and mental health professional organizations item. Kline (2016) recommends reporting four fit statistics. The model was an acceptable fit for the data,  $\chi^2(8)=20.78$ ,  $p < .01$ , RMSEA=0.06 (90% CI [0.03, 0.09]), CFI=0.98, and TLI=0.96. In addition, the model had a large effect size,  $R^2 = 0.69$  which indicates that approximately 69% of the changes in the professional leadership engagement



**Fig. 1** Structural Equation Model of Racial Microaggressions, Career Adaptability, and Professional Leadership Engagement. Note: Racial Microaggressions=Racial Microaggressions Scale, Career Adaptability=Career Adapt-Abilities Scale, \*  $p < .05$ , \*\*  $p < .01$ , \*\*\*  $p < .001$

latent variable were explained by changes in the racial microaggressions and career adaptability observed variables.

### Secondary thematic analysis

Participants who indicated that they did not participate in professional counselling or mental health organization leadership positions received a prompt to share why they did not participate. Thematic analysis of the 117 participant written responses revealed four themes: limited time (50% of responses), lack of opportunity or awareness (9% of responses), new to the profession (32% of responses), and lack of desire or interest (9% of responses).

Many participants indicated that time was a constraint to their participation in leadership positions. Participants cited the challenges with balancing their other roles, such as one participant who wrote that they do not participate in leadership because of “time constraints with work-life balance.” Another participant stated that they are “balancing a lot in [their] schedule.” Additionally, participants found it difficult to find time to fully commit to the leadership role, as highlighted by the participant quotes: “lack of time to commit,” “not enough time right now,” and “I don’t have the time.”

Unfortunately, some participants cited a lack of opportunity or awareness of leadership options in mental health organizations. One participant shared that they had “never been asked” to participate in a leadership position. Another shared that they “have not had the opportunity.” A participant also shared that they are “not sure how to go about getting a position.”

The third theme highlighted how new professionals and graduate students may struggle to engage in professional organizations. One participant noted, “I don’t feel I have the time and am very new to the profession.” Several participants discussed being new to the profession in terms of licensure. For example, a participant noted that they are “not fully licensed yet.” While licensure is usually not a requirement to hold a leadership position, it shows that those who are working on their license might find it challenging to partake in leadership roles while balancing obtaining hours and studying for license exams. Similarly, another participant wrote “I am a graduate student” as their response for not participating.

Finally, participants also indicated a lack of desire or interest in participating in leadership positions in professional organizations. For example, one participant shared that they “choose not to be,” while another stated “not interested” in professional leadership.

### Discussion

This study adds a nuanced quantitative lens to the impact of racial microaggressions on counsellors and clinicians of color career development and professional leadership engagement. Additionally, this study adds to the literature reasons minoritized clinicians and counsellors choose not to engage in leadership.

Previous research addressed the negative impacts of racial microaggressions on clinicians of color leadership experiences and experiences in their profession (Branco & Bayne, 2020; Chin et al., 2020; Haskins et al., 2013; Wines, 2013). However, few studies quantitatively explored the effects of racial microaggressions on minoritized counsellors and clinicians. Additionally, no studies to date examined career development factors such as career adaptability. While we hypothesized that there would be both positive and negative pathways between the study's variables of career adaptability, racial microaggressions, and professional leadership engagement, the directional pathways in our results were not what we hypothesized. Racial microaggressions had a positive pathway to career adaptability, career adaptability had a negative pathway to professional leadership engagement, and racial microaggressions had a positive pathway to professional leadership engagement.

Being on the receiving end of racial microaggressions is stressful (Sue 2007), burdensome, and may require counsellors and clinicians of color to develop coping resources to adapt and respond to leadership tasks and challenges, resulting in higher levels of career adaptability. Despite the development of coping resources after being exposed to racial microaggressions, their bandwidth to engage in professional leadership experiences may be limited, resulting in a negative pathway from career adaptability to professional leadership engagement. Savickas & Porfeli (2012) explained that higher levels of career adaptability are achieved when individuals are *willing* and *able* to perform behaviors consistently in changing environments. However, the negative pathway from career adaptability to professional leadership engagement might indicate that some clinicians and counsellors of color are willing to engage in professional leadership but are not able to fully engage due to their career adaptability resources being expended in response to racial microaggressions experienced at work, in life, or even in leadership positions.

On the other hand, some clinicians and counsellors of color might use their experiences with racial microaggressions as a reason to be engaged in professional leadership to make changes in the field, explaining the positive pathway from racial microaggression to professional leadership engagement. Clinicians often come into the mental health field after experiencing their own adverse traumas and stressors in life (Bell & Robinson, 2013). This may be a similar phenomenon for clinicians of color regarding leadership engagement wherein clinicians of color become more engaged in professional leadership after experiencing their own racialized stress in the form of racial microaggressions.

Branco & Bayne (2020) discussed that counsellors who experience racial microaggressions may seek consultation. Although counsellors and clinicians may experience racial microaggressions, some might have access to proactive mentorship opportunities (Haskins et al., 2013) that help them cope and increase their desire to be involved in professional leadership. Receiving mentorship and consultation after experiencing racial microaggressions might explain the positive relationship between racial microaggressions and leadership engagement. Counsellors and clinicians of color who receive support in the form of mentorship may be able process the racial microaggressions they experience and still engage in leadership.

However, racial microaggressions are slights and injustices (Sue, 2007). So, even though experiencing racial microaggressions might drive a counsellor or clinician

of color to be engaged in professional leadership to improve their profession or they may receive supportive mentorship, there are healthier motivators for being engaged in professional leadership. For instance, professional organizations can demonstrate to racially minoritized counsellors and clinicians that they are needed by sharing opportunities for engagement based on their talents and abilities.

Our thematic analysis resulted in four themes that explained why minoritized clinicians are not engaged in leadership. When given the opportunity to explain why they were not involved in professional leadership, participants mainly identified that their lack of involvement was due to a lack of opportunity or awareness of leadership opportunities in mental health organizations, a lack of time, lack of desire or interest, or because they were new in their profession. These four areas are opportunities for counselling and mental health organizations to intervene and better reach counsellors and clinicians of color regarding leadership. In addition, the responses indicated that counsellors and clinicians of color (a) need more mentorship opportunities that discuss the benefits of getting involved in professional leadership, (b) need to receive information about leadership opportunities, and (c) need professional leadership opportunities to be manageable given their other professional and personal commitments.

## Implications

There are several implications for this study encompassing training and supervision practices, counselling/mental health organizations, and clinicians of color. Most of the participants in the study were master's level clinicians. While CACREP explains that counselor education and supervision doctoral programs must equip students with the skills needed to assume leadership positions in the profession (CACREP, 2021), counsellors-in-training might also benefit from learning about the importance of becoming engaged in counselling leadership. Having more master's level counsellors and clinicians of color equipped with leadership skills and awareness of leadership opportunities could help to diversify leadership at all levels of the profession and help in the advancement towards social justice leadership (Peters et al., 2020).

In addition, counselling and clinical training programs might consider (a) openly discussing racial microaggressions and their occurrence in the mental health field and (b) providing students of color with genuine and proactive support rather than reactive support when negative racial experiences happen. Being proactive about educating students on racial microaggressions and providing supportive supervision and mentorship before they enter the field can help in the development of their career adaptability.

## Counselling and Mental Health Organizations

In addition, counselling and mental health organizations can work to better support and increase the representation of counsellors and clinicians of color in leadership. Participants noted that they were not engaged in leadership because they were new to

the profession. New professionals and graduate students of color would benefit from transparency regarding leadership opportunities and processes.

Also, for new professionals and graduate students the requirements to be involved in leadership should include low-stakes options. For instance, having to go through an interview process in combination with receiving multiple letters of recommendation could be daunting to a new professional in the field. Ensuring that the eligibility requirements for leadership positions are equitable and inclusive of incoming and new professionals can help organizations gain more diverse candidates.

Participants also noted that they were not engaged in leadership because they have limited time to commit to professional leadership. Houle et al., (2005) noted that when volunteering, people prefer that tasks are clearly outlined and prefer to engage in tasks that align with their personality and goals. Similarly, Henderson et al., (2021) explained that individuals assess the burdens and benefits of giving their time to volunteer activities. To improve transparency, counselling organizations can (a) preemptively discuss time commitments and (b) ensure that there are no arbitrary hurdles to getting involved in leadership. For instance, organizations can add estimates of how much time committee members or leaders spend in their role to leadership opportunity announcements. To increase representation and have prospective leaders of color learn from current leaders of color, organizations can offer panel discussions wherein interested clinicians can ask current leaders of color about their experiences with the organization and in their role.

Participants also discussed having a lack of awareness of opportunities and being disinterested in professional leadership. Organizations can extend personal invitations to counsellors and clinicians who show strong leadership qualities or interest in leadership. Instead of relying solely on applicants to apply to positions, calling counsellors and clinicians into leadership positions can develop a sense of belonging in the organization. Intentional recruitment can help increase the engagement of minoritized counsellors and clinicians in professional leadership. Recruitment can include connecting with counsellors and clinicians on LinkedIn and other social media sites to message them about leadership opportunities. In addition, having intentional and proactive discussions about racial microaggressions with counsellors who hold privileged racial identities can help ensure that minoritized counsellors have the support they need when in leadership positions and help improve the interpersonal dynamics of the organization. Similarly, providing counsellors and clinicians in leadership positions with opportunities to foster their strengths can help to increase their career adaptability and the likelihood of further engaging in leadership roles.

## Counsellors and clinicians

Developing career adaptability can help in combating the negative effects of racial microaggressions. Counsellors and clinicians may benefit from pursuing work and leadership opportunities that help to build their career adaptability. For example, some of the strengths that are developed when career adaptability is high include looking for opportunities to grow as a person, planning to achieve goals, and learning new skills (Savickas & Porfeli, 2012). Rather than engaging in leadership in response

to experiencing racial microaggressions, counsellors and clinicians can choose leadership opportunities that align with their goals, help them grow personally or professionally, and/or help them to learn new skills that serve their long-term career goals.

## Limitations and Future Research

Though this study adds to the literature on racial microaggressions, there are still several limitations. First, the study is correlational in design; therefore, causal inferences cannot be made. Also, the study was over-represented by counsellors and clinicians who identified as Black counsellors. Though there were no significant differences based on race or specialty area, this may be due to a lack of diversity in these aspects of the sample. Future studies can further look at the leadership engagement of specific groups (e.g., Latinx psychologists or Native American social workers) to develop more effective interventions. Also, although the RMAS has shown evidence of strong psychometric properties, it needs to be validated in more populations, including counsellors and clinicians of color. Future studies can conduct confirmatory factor analysis of this scale with minoritized counsellors and clinicians. Similarly, the four items that were used to develop the professional leadership engagement latent variable need to be validated in future research.

In addition, more contextual information is needed regarding racial microaggressions and their influence on counsellors and clinicians of color. Future studies can utilize mixed-method approaches to understand the impact of racial microaggressions on career development and desire to be engaged in the profession by exploring: (a) the settings where racial microaggressions occur for minoritized counsellors and clinicians (e.g., leadership positions at the national level, leadership positions at work),( b) who the aggressor is (clients, peers in the profession, supervisors), and (c) what counsellors and clinicians do when they experience racial microaggressions. Further, the qualitative data used for the thematic analysis was from typed statements to one question on the survey. Future studies can do more in-depth qualitative studies on the barriers for minoritized clinicians to engage in professional leadership. Lastly, data were collected during the coronavirus (COVID-19) pandemic which may have impacted participants' responses and the generalizability of the findings. Thus, future studies should examine the study's constructs outside the context of a pandemic.

## Conclusions

In sum, this study quantitatively explored the impact of racial microaggressions on racially marginalized clinicians and qualitatively examined the reason why racially marginalized clinicians choose not to engaged in leadership. With the increased demand for counsellors and clinicians of color to engage in professional leadership, it is critical that counselling and mental health organizations understand the impact of racial microaggressions and career adaptability. Counseling and mental health organizations have a unique opportunity to support counsellors and clinicians of color who have experienced racial microaggressions and foster their career adaptability.

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## Declarations

**Conflict of interest** The authors declare they have no financial interests.

**Ethics approval** Approval was obtained from the ethics committee of DePaul University. The procedures used in this study adhere to the tenets of the Declaration of Helsinki.

**Consent to participate** Informed consent was obtained from all individual participants included in the study.

**Consent to publish** The authors affirm that human research participants provided informed consent for publication.

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