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Integrating Intersectional Identity into Clinical Supervision

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Abstract

Differentiated from general social work supervision, clinical supervision is a core means by which post-graduate clinical social workers develop and refine their professional skills and ethical practice, and secure terminal licensure. The integration of the supervisee's composite intersecting aspects of identity, which is conceptualized here as their intersectional identity, is a critical component of clinical supervision given the ethical demands of the profession, the nature of growth and regrowth that occurs in any educational process, and the impact each clinical social worker's self has on their own clinical practice (Association of Social Work Boards, 2013; Bubar, Cespedes, & Bundy-Fazioli, 2016; Kolb, 1984). The structure and relationship of clinical supervision has a significant role in supporting supervisees as they begin to incorporate aspects of their intersectional identities with their clinical social work practice. This dissertation offers recommendations from the existing body of literature and the results of an exploratory qualitative study on how themes and concepts from intersectionality and intersectional identity might be integrated into clinical supervision.

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Integrating Intersectional Identity into Clinical Supervision

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Dedication

I dedicate this to Steph, who has always been my greatest source of support and motivation. I simply could not have done this without you.

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Introduction

Contemporary applications of intersectionality recognize it as a theoretical framework, a critique, an analytical tool, and a call to action which emphasize the relationality of an individual's unique identities with the larger (and largely invisible) social contexts of inequality, as well as the complexity of how daily interactions reflect power relationships (Cole, 2009; Cole, 2015; Collins & Bilge, 2016; Bowleg, 2008; Davis, 2008; Goff & Kahn, 2013; Grzanka, Santos, & Moradi, 2017; Moradi & Grzanka, 2017; McCall, 2005; Mehrotra, 2010). The integration of composite intersecting aspects of identity, conceptualized here as intersectional identity, is a critical component of clinical social work supervision given the ethical demands of the profession, the nature of growth and regrowth that occurs in any educational process, and the impact each clinical social worker's self has on their own clinical practice (Association of Social Work Boards, 2013; Bubar, Cespedes, & Bundy-Fazioli, 2016; Kolb, 1984). While there is available research examining these concepts in social work field education and also research examining one or two aspects of an individual's identity as they relate to supervision (see Mor Barack et al., 2009; Hair & O'Donoghue, 2009; Lee & Kealy, 2018), there is limited research examining intersectionality and intersectional identity within post-graduate clinical social work supervision.

The following dissertation includes two conceptually linked, article-length papers that explore how themes and concepts from intersectionality and intersectional identity might be thoughtfully integrated into clinical supervision as a means of enhancing social work's commitment to working towards anti-oppressive practices and social justice within larger systems of oppression and marginalization that are reflected in therapeutic relationships. The first paper offers an examination of the theoretical and conceptual foundations for an

intersectional identity-integrative approach to clinical supervision. This approach is theoretically grounded in adult attachment theory, intersubjectivity, Kolb's Model of Experiential Learning, Kadushin and Harkness's (2014) functions of clinical supervision, and intersectional theory, and informed by the research on clinical supervision from social work and related disciplines. A case-study is presented as a means of illustrating how these theories in combination might support the integration of intersectional identity into clinical supervision. Building on the theory and research presented in paper one, the second paper details insights for an intersectional identity-integrative approach to clinical supervision informed by an exploratory qualitative study that utilized individual interviews to explore the specific ways clinical social work supervisors and supervisees support and integrate intersectional identity into clinical supervision and by association, into clinical practice itself.

Paper One: Making it Visible: A Theoretical Exploration of How Intersectionality and Intersectional Identity Enhance Clinical Supervision

Introduction

Clinical supervision is the principle means by which post-graduate social workers are prepared to become independent practitioners, and is defined as a collaborative process by which supervisees learn and refine their ability to apply "social work theory, standardized knowledge, skills, competency, and applicable ethical content within the practice setting" (National Association of Social Workers and Association of Social Work Boards, 2013, pg.6). Differentiated from general supervision, clinical supervision is a core means by which post-graduate clinical social workers develop and refine their professional skills and ethical practice, and secure terminal licensure (2013). In order for a supervisee to grow personally and professionally through this educational process, there needs to be a contextually-specific attachment to their clinical supervisor (Kadushin & Harkness, 2014; Kolb, 1984; Main, Kaplan, & Cassidy, 1985; Pistole & Watkins, 1995; Watkins & Riggs, 2012). The nature of the structure and relationship of clinical supervision can therefore serve as the external support for supervisees as they begin to incorporate the intersecting aspects of their personal identities (which can also be referred to as social locations) including race, ethnicity, age, sexual orientation, ability, gender identity, marital status, status of parentage, veteran's status, professional identity, and immigration status with their clinical social work practice.

The integration of the supervisee's composite intersecting aspects of identity, which is conceptualized here as their intersectional identity, is a critical component of clinical supervision given the ethical demands of the profession, the nature of growth and regrowth that occurs in any educational process, and the impact each clinical social worker's self has on their own clinical

practice (Association of Social Work Boards, 2013; Bubar, Cespedes, & Bundy-Fazioli, 2016; Kolb, 1984). At the individual level, intersectionality can be understood as "an analytic tool that gives people better access to the complexity of the world and of themselves" (Collins & Bilge, 2016, p. 193). Although the current body of research recommends an increased focus on a social worker's intersectional identity as it impacts the various aspects of social work practice, the available literature is focused on specific aspects of a social work student's intersectional identity within the context of field placements and focuses on the implications of race *or* gender versus race *and* gender (Mor Barack et al., 2009; Hair & O'Donoghue, 2009; Lee & Kealy, 2018). Further, there is limited research offering clinical supervisors the practical tools that they could utilize in incorporating intersectional identity into their existing clinical supervision content areas. This paper will therefore examine the structure and significance of clinical supervision for the emerging clinical social worker, focusing specifically on work with identified client populations, and identify how the framework of intersectionality can enhance this work, specifically regarding the integration of identities.

Clinical Supervision

In this dissertation, clinical supervision is broadly defined as the process by which clinical social workers receive feedback, guidance, support, instruction, and administrative assistance from a qualified social work clinical supervisor. Sometimes this supervision is required for an emerging clinical social worker due to licensure regulations or agency policy, while at other times it is sought by a social worker who wishes to continue to receive this type of support to enhance their clinical practice skills. Additionally, clinical supervision utilizes theoretical frameworks and employs clinical knowledge based on the areas of emphasis for each member of the dyad and based on their clinical scope of practice (differing treatment modalities

or populations). In short, clinical supervision is as varied and multifaceted as the field of social work and its practitioners. Research has also found that clinical supervision is helpful in related disciplines such as psychology and nursing and Milne et al. recommend it be studied from an interdisciplinary perspective (as cited in Sewell, 2018). Clearly, clinical supervision is regarded as a necessary component of a mental health practitioner's professional development and is regarded as vital to the delivery of quality therapeutic care (Borders et al., 2014).

There are, however, some differences in the principle goals of supervision based on the discipline. In the field of social work, for example, supervision has three functions originally developed by Alfred Kadushin; supervisors are called to provide administrative monitoring and regulatory authority (Kadushin & Harkness, 2014), educational skill development, and emotional support to their supervisees (Bogo & Sewell, 2018). This administrative monitoring has significance in instances of agency-based supervision. Later research has expanded the scope of these three functions to emphasize the role of the clinical supervisor as a role model to their supervisees (Bogo & McKnight, 2006), the use of clinical supervision as a mechanism to transfer practice wisdom between supervisor and supervisee (Kadushin & Harkness, 2014), the use of adult attachment theory to theoretically orient the mechanism by which supervisee growth and development occurs (Watkins & Riggs, 2012), and an increased focus on multicultural factors within the supervisor/supervisee dyad (Hair & O'Donoghue, 2009; Lee & Kealy, 2018). This focus on multicultural factors is particularly salient to social work, given the foundational tenets of the profession to combat oppression and social injustice as evidenced within all interventions (Hair & O'Donoghue, 2009; McDowell, & Hernández, 2010).

The process by which practice knowledge passes from supervisor to supervisee is theoretically supported by Kolb's Experiential Learning Theory, which posits that skills and

knowledge are learned through a process of conceptualization, planning, hands-on application, and reflection (Kolb, 1984). This theory centralizes the learning potential of lived experience coupled with reflection, which aligns with the functions of clinical supervision and the layers of clinical supervision that emphasize education and mastery of knowledge (Prouty, 2014). In this theory, Kolb argues that adults learn through a circular four-stage process which is guided by the teacher or supervisor. The domains of active experimentation, concrete experiencing, reflective observation, and abstract conceptualization build from one another and help supervisees retain and move towards mastery in their respective fields. Depending on the learning style or situational needs of the supervisee, any one of these domains can be highlighted to promote learning throughout the length of clinical supervision (2014). This ability to tailor supervision to meet the needs of the situation and supervisee are critical, as several studies in child welfare and gerontology have found that a supervisee experiencing beneficial outcomes from clinical supervision will be better equipped emotionally and educationally to support positive client outcomes (Acker, 2004; Landsman, 2001; Poulin & Walter, 1992). These findings additionally suggest that when done well, clinical supervision develops supervisees' proficiency in their professional skills, so the supervisees can then help their identified client populations benefit from interventions and achieve a satisfactory completion of goals (Mor Barack et al., 2009).

Parallel Process in Clinical Supervision

Rather than conceptualizing the supervisory relationship as exclusively between a supervisor and supervisee, there is evidence to suggest that the parallel process, initially introduced in psychodynamic literature as an unconscious pattern in supervision of the therapeutic relationship, impacts not only the supervisory dyad but also has an effect on the relationship that the supervisee in turn has with their clients (Searles, 1955; Tracey, Bludworth,

& Glidden-Tracey, 2011). Importantly, Doehrman (1976) suggested that parallel process can be

bi-directional, meaning the supervisee as well as the supervisor may be responsible for initiating

the process. The parallel process contextualizes supervision as a triadic process between a client,

the therapist they work with, and the clinical supervisor who helps explore and can influence the

client/therapist interaction (Tracey, Bludworth, & Glidden-Tracey, 2011). If patterns of

interaction are unconsciously enacted by the supervisee/supervisor in a way that mirrors the

interaction between client and therapist, and again in the reverse, then it is necessary that all

three members of the supervisory relationship be considered by researchers seeking to enhance

clinical supervision.

Attachment in Clinical Supervision

Attachment theory has evolved since its origination from John Bowlby's seminal writings

about an attachment behavioral system designed from early in human evolution to protect infant

safety that continues to be foundational in many systems of human growth and development

throughout the lifespan (Bowlby, 1969; Main, Kaplan, & Cassidy, 1985). Specifically, Bowlby's

theoretical concept of the internal working model argues that the imagined relationship with

caretakers formed by infants and children inform these relationships and even change the infant's

attachment pattern to a caregiver (Bowlby, 1969; Main, 2000; Sroufe et al., 2015; Marmarosh et

al., 2013). These internal working models that infants and children develop continue through

adulthood and "move to the level of representation" that can impact individuals' romantic

partnerships and relationships with their own children, as well as professional relationships

(Main, Kaplan, & Cassidy, 1985, p.66; Shilkret & Shilkret, 2016). These conclusions were based

on Bowlby's observations then supported by Main's analysis of James and Joyce Robertson's

Young Children in Brief Separation films (Robertson, 1967 - 1973) and data from the Adult

Attachment Interview, the companion interview for parents of children participating in the Strange Situation procedure to measure their level of childhood attachment, which found that adults with historically secure attachments "tended to be coherent, clear, and collaborative during discussions of their own life histories" (Main, 2000, p.1060).

As clinical supervision is one of the foundational learning tools of social work, it serves as a space for supervisees to explore, grow, receive emotional support, and test the strategies and interpersonal skills they in turn bring into their own client interactions (Marmarosh et al., 2013). Adult attachment theory can be applied to describe the bond between supervisor and supervisee, the mechanism for how clinical supervision can positively impact the growth of the supervisee, and the way supervisees can use the relative longevity of the supervisory relationship as a secure base to guide then test their therapeutic interventions (Ainsworth, 1989; Bennett, 2008; Bennett et al., 2008).

While traditional attachment styles are characteristic of other forms of adult attachment beyond supervisory relationships, Watkins and Riggs (2012) recommend supervisors exercise caution in how closely they adhere to traditional attachment and bonding patterns during clinical supervision work, reiterating that one of the primary functions of supervision is to support the education of a supervisee rather than provide treatment. They theorize that clinical supervision invokes *attachment dynamics*, defined as *context-specific* comfort and secure-base support during interactions in the supervision dyad (Pistole & Watkins, 1995; Watkins & Riggs, 2012). The *context-specific* attachment style, therefore, is one layer through which the supervisor/supervisee relationship functions to instill support and growth for the supervisee.

The available research which has examined the potential relationship between supervisee professional development and the supervisee attachment style, evidences conflict, which

suggests that more work needs to be done at the intersection of identity and supervisor/supervisee attachment (Foster, Lichtenberg, & Peyton, 2007; Marmarosh et al., 2013; Pistole & Watkins, 1995; Renfro-Michel & Sheperis, 2009, Watkins & Riggs, 2012). However, the supervisory relationship within the supervisor/supervisee dyad has been found to positively impact a supervisees' interventions with their clients as there has been found to be a positive relationship between the supervisory alliance (the strength of the bond between supervisor and supervisee) and the supervisees' confidence in their own skills and ability to perform various clinical skills appropriately (Marmarosh et al., 2013). Conversely, if the relationship is compromised and the supervisee does not trust their supervisor, then subsequently they are less likely to develop their skills and experience less confidence in their abilities over time (Marmarosh et al., 2013).

Intersectionality

The history and soul of intersectionality emerged from the writings of black feminists in the 1960s and is rooted in advocacy, social justice, and the recognition that the complexity of the world and of individuals cannot be trimmed, simply because it is messy. As a concept, intersectionality can be understood as the way in which categories of difference (not limited to race, class, or gender) interact with "individual lives, social practices, institutional arrangements, and cultural ideologies and the outcomes of these interactions in terms of power" (Davis, 2008, p. 68). As such, forms of oppression interrelate, creating a system of oppression in which structures resist change. Specifically, the foundational understanding of intersectionality can be found in the writing of black feminists during the women's liberation movements of the 1960s through the 1970s as a means of describing and acknowledging the differences in experiences with oppression between the experiences of women of color compared to their white

counterparts. In other words, the experiences of sexism in combination with racism were a more appropriate lens from which to describe the nature of the oppression Black women were fighting against (Mehrotra, 2010). More simply, Vivian May (2015) describes this type of thinking as using a *both/and* perspective. An early example can be found in a 1977 mission statement from the Combahee River Collective, a Black US feminist lesbian group, who were "actively committed to struggling against racial, sexual, heterosexual, and class oppression, and see as our particular task the development of integrated analysis and practice based upon the fact that the major systems of oppression are interlocking" (Combahee River Collective, 1986). The term intersectionality itself was coined by Kimberlé Crenshaw in a *Stanford Law Review* article to describe the diversity and multiple experiences of women of color related to their social locations, identities, and the multiple ways in which they experienced oppression (Crenshaw, 1994; Mehrotra, 2010). While this concept was used to describe the unique impact that the combination of sexism and racism has on Black women, specifically on Black women's experiences with employment, it did not provide a precise definition or set of standards for its implementation (Crenshaw, 1988; Crenshaw, 1994; Else-Quest, Hyde, & Shibley, 2016).

This singular word has since been used to represent much larger concepts, and can be helpful to scholars as a mechanism for making visible the individual and systematic power struggles that often go unseen in daily life, as well as the impact of positioning, or the examination of a specific vantage point, can lead to complex and deeply varying experiences within that struggle (Davis, 2008). As a concept, intersectionality has expanded to include many tenants since its original application, and can now be found in varying ways in a variety of interdisciplinary contexts; it is regarded throughout the literature as both a study and a critique of how multiple social systems intersect with one another to create complicated inequality (Cole,

2009; Bowleg, 2008; Davis, 2008; Goff & Kahn, 2013; Grzanka, Santos, & Moradi, 2017;

Moradi & Grzanka, 2017; McCall, 2005; Mehrotra, 2010). In 2016, for example, Collins & Bilge

defined intersectionality as "a way of understanding and analyzing the complexity of the world:

in people, and in human experiences. The events and conditions of social and political life and

the self can seldom be understood as shaped by one factor. They are generally shaped by many

factors in diverse and mutually influencing ways" (p.193). More broadly, intersectionality is a

framework for understanding social events and experiences which are typically shaped by

multiple diverse factors (Collins & Bilge, 2016).

    As an analytical tool, Collins & Bilge (2016) regard intersectionality as encompassing

four key themes: relationality, social context, power relations and social justice, and complexity.

Relationality in this context emphasizes the various combinations of systems that an individual's

self-identifiers may fall into, as well as how those systems may interact, systems including but

not limited to age, biological sex, citizenship status, ethnicity, gender identity, immigration

status, marital status, professional identity, race, sexual orientation, status of parentage, and

veteran's status. Social context as a theme emphasizes that the relationality of an individual's

internal systems also impact and are impacted by their environment, families, political systems,

and other macro systems. These systems, by informing and impacting one another, naturally

reflect power relationships, and from its inception the framework of intersectionality has been as

much a call to action for social justice as a theoretically guiding framework. No discussion of

these systems and the results of their interactions could be understood from simply a two-point

dialectic; conversations about intersectionality as a theoretical framework must acknowledge the

complexity of its real-world application and practice of its tenets (2016). Indeed, the omission of

intersectional identity in conversations of power and privilege can be viewed as an expression of

power just as oppression in one context can be a privilege in another (Bubar, Cespedes, & Bundy-Fazioli, 2016; Samuels & Ross-Sheriff, 2008).

Another key tenant of intersectionality is that individual identities are multiple, multifaceted, and mutually constitutive (Bowleg, 2013; Collins, 1991; Crenshaw, 1988). In contrast, single-axis constructs like gender or race cannot be fully understood unless they are explored in conjunction with their interlocking social locations (Samuels & Ross-Sheriff, 2008). Further, a multifaceted and mutually constitutive perspective challenges researchers to monitor how context will shift meaning given the interconnectedness between privilege and oppression in the matrix of identity (2008). As individuals are simultaneously situated within their particular combination of identities, the interplay of these identities with the external systems of power and status give meaning to each individual category (age, race, gender, and sexuality among others) (Collins, 2016; Crenshaw, 1994; Curtin, Stewart & Cole, 2015; Else-Quest, Hyde, & Shibley, 2016). Without taking the whole of intersectional identities into consideration, a single axis point like "woman" for example, would have little meaning according to intersectional theory (Spelman, 1988). Rather than using this single-axis focus, May (2015) emphasizes understanding intersectional identity from a matrix-focused perspective, which can be applied not only to rationality, social context, power relations and social justice, and complexity but also "across (and within) categories of experience and personhood (including race, gender, sexuality, disability, social class, and citizenship" (p.23). As a way to provide a visual representation for this structure, the way a prism retracts light can be used as a metaphor for how various aspects of this matrix will intensify various components (like race or gender, power or oppression), while still honoring and encompassing all the facets of the whole (Crenshaw, 1994; May, 2015). Using a different metaphor which highlights the mutually constitutive nature of intersectional identity,

a participant in a study of intersectionality among Black gay and bisexual men referred to his experience as "once you've blended the cake, you can't take the parts back to the main ingredients" (Bowleg, 2013, p.758).

Application of Intersectionality to Clinical Supervision

As a theoretical framework, intersectionality provides a basis for understanding human life and behaviors that are rooted in the experiences of disenfranchised populations, and acts as a means of linking theory to practice towards individual and community empowerment (Collins & Bilge, 2016). Given intersectionality's assertion that the social identities of an individual cannot be teased apart from one another nor from the larger processes that maintain systems of inequality, it can serve as a moderating framework that can connect feminist theory, multicultural perspectives, and traditional counseling approaches; separate approaches which have historically been focused on the intrapsychic at the expense of how the environment impacts an individual and their mental wellbeing (Enns, 2004; Warner & Shields, 2013). This is critical to clinical social work practice, supervision, and social work's emphasis on the person in environment, and brings into sharp focus the fact that feminist and multicultural theories independently have "failed to consider the influence of possessing multiple stigmatized identities in individuals' lives" (DeBlaere, Watson, & Langrehr, 2017, p.576).

As it is applied to clinical social work practice research, intersectionality is an emerging area; what research exists is limited in its adherence to the key tenants of intersectionality, perhaps attributable to the complexity and ambiguity of the concept (Shin et al., 2017). Although the body of research is emerging, intersectionality can serve as an organizing concept for clinical social workers to explore themes of social justice, privilege, oppression, marginalization, and strengths when working with individuals and systems, as well as within the context of clinical

social work, and clinical supervision. As an understanding of a social worker's identities is necessary in order to fully know their strengths, limitations, values, beliefs, and biases and how they impact clinical work and a supervisory relationship, expanding the application of intersectionality within clinical supervision is critical (Lee & Ali, 2018).

Recognizing that supervisees may have difficulties initially articulating experiences and encounters using the frame of intersectionality, clinical supervisors should acknowledge their own intersectional identities, including areas of power and privilege, increase reflexive thinking for themselves and supervisees pertaining to critical thinking related to multicultural complexity, and explore the supervisee's social locations within supervision (Peters, 2017; Phillips, Parent, Dozier, & Jackson, 2017). This recommendation aligns with an overall recommendation that clinical supervisors foster a sense of safety, where both the clinical supervisor and supervisee both feel they will be heard as they grapple with the complex and often deeply personal aspects of identity (Bloom, 2007).

There must be a recognition, however, that creating safety may not be attainable for every supervisory dyad given the levels of interpersonal fear that can be evoked during discussions of identities within supervision, as well as the profoundly personal experiences supervisees and supervisors alike may bring into supervision related to oppression, marginalization, power, and privilege. Brave space, in contrast, encourages each participant to be as brave as they can within the supervisory relationship, and to support one another's risk taking within clinical and supervisory spaces as they pertain to topics of social justice, including intersectionality (Arao & Clemens, 2013; Blasini-Mendez, 2019). Bravery within the supervisory relationship as it pertains to initiating conversations about their own identities and experiences with power and oppression

can be a powerful tool the supervisor shares, not only as a modeling experience but as a

reduction in the inherent power the supervisor holds within the supervisory dyad.

The utility of having open discussions between supervisor and supervisee regarding

race/ethnicity, gender, and sexual orientation during clinical supervision was found to be

positively correlated with the quality of these working relationships, interventions used with

clients, and sense of self efficacy with trainees and intern helping professionals (Phillips, Parent,

Dozier, & Jackson, 2017). Although not explicitly examining intersectional identity, a qualitative

study examining the impact of racial identity (i.e., the psychological experiences of race) in

clinical supervision for supervisees and supervisors of color found that supervisees had negative

supervision experiences when racial issues were not explored by their supervisor; it also found

that supervisees experienced affective reactions of anger, frustration, confusion, or discomfort

when conversations related to race were brought up by supervisees and were met by perceived

unsupportive responses from their supervisors (Jernigan et al., 2010). While this study was

focused on a single-axis perspective like race, these findings highlight how important the

visibility of social locations can be on the supervisory relationship.

Similarly, a qualitative study conducted by Davis & Gentlewarrior (2015) explored the

impact of white privilege, a significant component of racial inequality, within clinical social

work practice; they found that intersectionality has been used among white clinical social

workers to enhance their self-awareness, the complexity of their clinical interactions, and

formulate strategies for mitigating the impact their white privilege had on their work. This same

study additionally found that these clinical social workers found supervisory relationships, both

available from peer and supervisor/supervisee clinical supervision, were the most useful as they

refined these particular skills. The participants found these relationships helpful as they allowed

for in-depth explorations that could be both personal and honest, as well as gave them opportunities to grow (2015).

To help foster an understanding of the key tenants of intersectionality, the use of creative activities in supervisory relationships may help emerging social workers grasp the complexity and ambiguity of intersectionality as a theoretical construct but also to explore their own identities; beyond this, creative activities can foster multiple ways of learning, practicing, and reflecting for the supervisee (Kolb, 1984; Ali & Lee, 2019). Ali and Lee (2019), for example, identify several activities that can be conducted individually or build off one another including the *flower of life*. Here, participants are encouraged to write each of their self-identified or prompted social locations on paper petals, which can then be analyzed and reorganized as part of a larger conversation to illustrate the matrix-perspective of power, privilege, oppression, and marginalization with these social locations.

Just as ignoring the connection between privilege and oppression with intersecting identities negates the power of intersectionality as a guiding framework, using a single-axis perspective makes invisible the potential range and complexity of a client and supervisee's experience (Shin et al., 2017). A 2017 content analysis of the Journal of Counseling Psychology and The Counseling Psychologist argues that much of the available research related to clinical supervision and intersectionality is applying the framework of intersectionality in a weakened state, pointing out that, "intersectionality should not be used simply as a synonym for multiple identities or intersecting identities" (Shin et al., 2017, p. 459). For intersectionality to effectively be applied to identity, the ways in which structural inequalities impact both privileged and marginalized social locations must also be taken into consideration (2017). In this content analysis, Shin et al. found that the majority of articles (79%) recently published in the

aforementioned journals were "weak" in their adherence to intersectionality, meaning that they incorporated multi-axis social identities without theoretical rationale or as a means of diversifying their sample or results; the current published articles did not include, theoretically or in their results, a focus related to social inequality or the interplay of privilege and oppression on multiple social identities (2017). Instead, these articles largely incorporated marginalized groups within larger groups (homosexual people of color, rather than simply people of color) to explore themes that could not be explored by using a single-axis identity framework (2017).

Disciplined Self-Disclosure

Given the value discussions of supervisor and supervisee intersectional identity can have on supervisee growth and client outcomes, the context-specific attachment-style bond that can be formed during clinical supervision, and the parallels in which theoretical and ethical considerations for self-disclosure are applied to therapist/client relationships as well as supervisor/supervisee relationships, self-disclosure is an area of particular emphasis in this discussion of how supervisee's grow as a result of clinical supervision (Goldstein, 1997; Knox et al., 2008; Reamer, 2013; Siebold, 2011). One theoretical framework that can be applied to the concept of self-disclosure is intersubjectivity, where "both therapist and patient shape all aspects of the therapeutic situation since both participants exist in an intersubjective field in which they mutually and reciprocally influence one another" (Goldstein, 1997, p.48). Although originally applied to therapeutic relationships, the application of intersubjectivity within clinical supervision recognizes that the frequency and content of supervisor self-disclosure is critical, as the unconscious and conscious aspects of the supervisor are engaged with subjective components of the supervisee's educational process (Goldstein, 1997; Siebold, 2011).

Since the person of the supervisor impacts the educational process of their supervisee, ethical considerations are also a significant factor in explorations of when and how to employ self-disclosure and what content to include especially from the real and perceived position of power within clinical and supervisory relationships. By applying Reamer's discussion on therapist self-disclosure to the supervisor self-disclosure in clinical supervision, one recognizes that inappropriately utilized self-disclosure can blur boundaries, impact the trust the supervisee has for the supervisor, and shift the focus of the relationship (Reamer, 2013). Reamer gives recommendations for how and when to employ ethically appropriate self-disclosure which calls for the supervisor to examine the content, intimacy, duration, and frequency of self-disclosures; if any of these domains are too great in intensity and frequency for the nature of the relationship then they are more likely to risk ethical violations and may ultimately harm the supervisee (2013). In order to determine if a self-disclosure would be ethically appropriate to the supervisory relationship, supervisors should examine not only the content of the disclosure and whose needs would be met by sharing the disclosure, but also what the possible risks and benefits would be for the supervisee. In determining the amount of personal information that could appropriately be shared in the disclosure, supervisors might consider how a panel of social work peers would react to this self-disclosure (Reamer, 2013). Supervisors should further determine if sharing the process of deliberation regarding the self-disclosure with the supervisee would be appropriate to the relationship, thus allowing for boundaries and the relationship to be protected as much as possible (2013).

Although Reamer's ethical arguments emphasize the impact of poorly made supervisor self-disclosures, the effects of role modeling, normalizing, and processing self-disclosure decision-making have also been found to be powerful tools within social work field education

and post-graduate supervisory relationship when done properly (Knox et al., 2008, Knox et al., 2011). When the self-disclosure fits within the confines of the therapeutic relationship, or are what Reamer refers to as judicious self-disclosure, there is an increased sense of reciprocity within the relationship, and a stronger therapeutic alliance as the therapist can normalize, serve as a role model, and "demonstrate the universality of human frailty" (Reamer, 2013, p.128). Certainly, Reamer's reference to judicious self-disclosure within the context of a therapeutic relationship can be well applied to the supervisory relationships. Goldstein further supports judicious self-disclosure using anecdotal evidence of a peer supervisory group supporting a therapist's navigation of self-disclosure during an illness. Here the therapist's peers were helpful as the therapist navigated how and when to share personal information, thus allowing the client's needs to be met as the therapist did not cross a line into seeking comfort from the client (1997). This type of decision-making process supports the use of supervision as a means of building a sensitivity and nuanced understanding of how and when to employ self-disclosure. These findings are additionally supported by a 2008 qualitative study of supervisor perspectives on supervisor self-disclosure in a clinical supervisory relationship, which found that supervisors believed self-disclosures had positive effects on their supervisees and their ability to conduct their own therapeutic interventions (Knox et al., 2011). A later qualitative study of supervisee responses found that well-timed supervisor self-disclosures helped normalize supervisee experiences, not only helping them feel understood, but also helping them gain insight into complex clinical situations . Poorly timed or inappropriate disclosures, on the other hand, were found to be unhelpful and uncomfortable to supervisees. This research goes on to recommend that supervisors should be very clear about the intention and function of any self-disclosure in helping define the relationship and reinforce its boundaries (Knox, 2011).

While these findings help inform the use and function of supervisory self-disclosure, the authors recognize that the findings have been limited by the relative hegemony of participants' racial and gender identities, most being white and female (Knox et al., 2008; Knox et al., 2011). The nature and value of self-disclosure can take a different shape and relevance when related to exploration of identity within the therapeutic and/or supervisory relationship (Siebold, 2011). A recent autoethnographic study by King and Jones (2019) found that the supervisor held the greater power within cross-cultural supervisory or counseling relationships to set expectations for discussions related to multicultural topics, including issues of intersectionality and visible difference. They go on to suggest that when a supervisee is more confident in discussions of multicultural topics during cross-cultural counseling supervision, they may have an increased comfort in engaging in these discussions within their clinical relationships (King & Jones, 2019).

Recommendations for Current Intersectionality Research

The research pertaining to intersectionality and clinical supervision further offers criticisms for how these two bodies of research connect as well as areas for future scholarship. In a context analysis of articles within counseling psychology that pertained to intersectionality, Shin et al. (2017) point to a trend in the current research to be overly focused on the negative outcomes of marginalized social identities and groups, as opposed to resilience and strengths that are also a part of the narrative of these populations and identities. They suggest that the current published research is "weak" on intersectionality due to authors receiving feedback from editors encouraging them to "tone down" criticisms of oppressive systems, but also point to an ongoing marginalization of nontraditional forms of knowledge procurement within psychology and the related disciples in favor of quantitative methodologies (Grzanka, 2016; Shin et al.,2017). Additionally, researchers who incorporate intersectionality into qualitative or quantitative

research are encouraged to emphasize commonalities of intersectional identities with privilege and power, rather than focus solely on the disadvantage and oppression of marginalized groups as a means of broadening the use of intersectionality beyond a theory that overemphasizes difference (Else-Quest, Hyde, & Shibley, 2016). Similarly, May recognizes intersectionality as a concept that should maintain a flexible and nonessentialist definition, highlighting the complexity of its matrix-focused approach and how it may be applied differently given the emphasis of research and future scholarship (2015).

Given the significant amount of flexibility that intersectionality as a concept offers, there can be ambiguity for current researchers who seek to explore and apply it. Davis (2008) suggests that this ambiguity is precisely what has made the concept of intersectionality so effective; intersectionality can grow and give space for future scholars to examine the social justice issues of their time. Despite this flexibility, current intersectionality scholars maintain an emphasis on striking a balance between the historical foundations of intersectionality within Black feminism, the call for radical social change, and current academic needs (Moradi & Grzanka, 2017; Shin et al., 2017). Elizabeth Cole, for example, calls for *responsible stewardship* among current researchers exploring and applying intersectionality as a way to emphasize the responsibility current scholarship has for upholding the values of intersectionality, noting that they are something precious we have been given by earlier generations (2015). Building off Cole's argument, Moradi and Grzanka (2017) suggest that a stance of responsible stewardship needs to be held by a large audience of researchers, rather than solely clinical psychologists or feminist theorists, in order for a wider set of voices to impact how we understand how intersecting systems and structures may be applied to people and identities.

Case Illustration

The following case illustration demonstrates concepts surrounding intersectional identities and themes of power, privilege, marginalization and empowerment as they pertain to clinical social work supervision. Although it is acknowledged that clinical supervision can serve many functions for a supervisee, including administrative and/or task management functions, this discussion will focus on the clinical aspects of clinical supervision.

Using the example of Audre Lorde in *Sister Outsider* (1984), I would like to first identify some of my own intersectional identities: I am a clinical social worker and supervisor, lesbian, cis-gender woman, wife, mother, white, able-bodied, and monolingual native English speaker in my mid-thirties. I work with "Andrea", who is an MSW-level clinical social worker who receives clinical supervision from me towards terminal licensure. She identifies as a cis-gender female, heterosexual, Hispanic, recently married, and mother to a young son; she is in her mid-twenties and is a bilingual English and Spanish speaker. Prior to completing her MSW, she had worked in the private sector; receiving her MSW signified a significant career change for her. The following case illustration demonstrates how Andrea and I integrated the concepts of intersectional identities and themes of power, privilege, marginalization and empowerment as they pertain to clinical social work supervision.

As part of our rapport building process I provided Andrea with an understanding of intersectional identity as a concept and tool for our toolboxes, using myself as an example and disclosing some of my key identifies that I felt comfortable sharing. As discussed in a previous section, exploring intersectional identities (how they converge, how they inform clinical decisions, and how they shape our context) early and often within clinical supervision can have a profound positive impact on the bond between supervisor and supervisee (Lee & Ali, 2018;

Phillips, Parent, Dozier, & Jackson, 2017) and ultimately between supervisees and their clients. In this way, the identities, contexts, and experiences of one member can engage with those of the other to form a larger matrix of knowledge and understanding, making visible larger swaths of the systems that impact our clinical practice. Integrating an intersectional approach at the beginning of our supervisory relationship meant that I must first orient Andrea to the concepts of intersectionality and intersectional identity, brave space (see Arao & Clemens, 2013), acknowledgement of my own intersectional identity including areas of power and privilege, and encourage Andrea towards reflexive thinking (i.e. to examine the bias and values brought by the social worker) related to her own clinical practice (Else-Quest, Hyde, & Shibley, 2016; Peters, 2017; Phillips, Parent, Dozier, & Jackson, 2017). To accomplish this, I introduced the key concepts of intersectional identity as part of my larger clinical orientation throughout the initial stage of our working relationship. Here is an example of what that orientation looked like:

> Heather: "Another perspective that I rely heavily upon is intersectionality: have you heard about it before?"
>
> Andrea: "I think so? I'm not completely sure what it entails though."
>
> H: "Intersectionality is a theoretical perspective that explores the various ways key identifiers like race, gender expression, sexual orientation, and social class intersect within a person and are impacted by the larger and largely invisible systems of oppression and marginalization. For me, it serves as a way to bring an emphasis on these systems of social justice and the larger systems of oppression into the room, and in my mind serves as a way to connect theoretical knowledge from feminism and cultural competence in a way that feels more useful with supervisees and clients, as well as explore uncomfortable discussions that are likely to occur. So, as an example, I have a

tremendous amount of privilege as a result of the color of my skin, as well as my

education and employment. At the same time, I've had some experiences as a lesbian

which have been particularly profound in my life. What is important from an

intersectional perspective is that these identities are not separate from one another: I

experience homophobia which has also been impacted by my places of privilege, and

vice versa. I'm wondering how you are understanding and experiencing this discussion?"

A: "For me, it makes perfect sense. I have had a lot of privilege economically before I

changed careers and finished my MSW, but people didn't see that necessarily when they

looked at me at the time."

Providing concepts of intersectionality in the form of a theoretical perspective, just like I would

explain trauma-informed perspectives or cognitive behavioral perspectives, was important at this

stage in our relationship, as it allowed the relationship to be focused on skill development and

give Andrea the opportunity to engage with the material at her own comfort level. Additionally,

sharing this information for Andrea is this manner drew a parallel to how I might explain these

concepts in a clinical setting; by engaging Andrea in a way that I might a client, I am giving her

skills that she then might transfer to working with her own clients.

Incorporating intersectionality into these early conversations with Andrea allowed me to

further normalize the exploration of the biases that stem from our social locations. As Rosenthal

notes, "a benefit to intersectionality is that because social justice and equity goals are at its core,

its potential bias is stated explicitly and therefore can be directly explored in relation to other

forms of bias that may go unquestioned without an intersectional perspective" (2016, p. 476).

The purpose of disclosing my intersectional identities to Andrea, therefore, was not to connect

with her on a personal level, give her clarity into my own life's experiences with privilege and

oppression, or seek to gain an understanding of Andrea's identities as a means of diagnosing or treating her. Rather, the purpose of these initial discussions was to begin to build Andrea's awareness of the external systems, many of which serve as systems of oppression, that shape how we engage with our clients in every interaction (Lee & Ali, 2018).

This emphasis on clinical relationships served to integrate concepts of intersectionality into the theoretical frameworks and intervention strategies Andrea has already learned from her MSW program, but also offered validation and normalization for the mistakes and discomfort that can often accompany discussions of privilege, oppression, and marginalization. I also wanted to ensure that Andrea knew that feedback and reflection would be encouraged in our supervision together, not only as a mechanism to help her growth through the process of clinical supervision but again to serve as a way she might parallel these discussions with her clients.

H: "So the same unique combinations of privilege and marginalization that happen for us also occur for our clients: these interlocking perspectives shape how we see and are seen by the world. I also use intersectionality to remind me that what I see is likely the result of these intersecting identities, and my privilege will sometimes create blind spots with supervisees and clients. So, as we start talking about your clients, we will be talking about three unique systems of intersectional identities: the clients, yours, and my own. I hope over the course of our time together to use this to help us become more aware of our blind spots, but also to help our client's begin to see some of the power structures that are usually invisible to us, but nonetheless impacting their lives and coping. I really appreciated what you shared just now about some of your own experience: we may find it helpful over our time together to explore some of these themes as they are impacted by your work or as we see patterns develop. I do want to reiterate that while we may get to

know aspects of one another through this process, my goal is that we will do so as they are related to clinical issues. Does this align with some of your expectations for supervision? What else can I do to support you in this work?"

A: "I think that's good for now; I'm just glad we will be able to incorporate this into our time together. Where I worked before, it was very difficult to be honest about these things even though everyone could see how the bilingual Hispanic employees would get extra work because we could speak Spanish. Not only were we not compensated for this additional work, but we were frequently pulled from our own responsibilities which made it harder to meet productivity deadlines. It will just be refreshing to see how these things are also potentially impacting my clients."

What was critical was that this introduction also incorporate a modeling of my own disciplined self-disclosure, without the expectation that Andrea share information about her own intersectional identities reciprocally. These disclosures were brief and integrated into the why and how of the clinical orientations I employ in my work; to discuss the personal struggles I have had with various systems of oppression at this stage of our relationship would have been inappropriate and not-relevant to the context, therefore violating Reamer's recommendations on ethical supervisor self-disclosure (2013). As our context-specific bond grew over time, Andrea in turn began to self-disclose her intersectional identities in a way which initially modeled mine, but soon were incorporated into her own communication style.

Integrating an intersectional lens also helped Andrea, for example, more fulsomely conceptualize the impact of societal-level isolation, gender, race, ethnicity, and socioeconomic factors when working with Bianca, a Caucasian transgender female client who was referred to counseling services following an arrest for stealing beauty products, in addition to experiencing

profound symptoms of depression and suicidal ideation. Bianca had been working with Andrea

for six months at a community mental health agency, initially seeking services as part of a

deferred judgment in lieu of probation for the shoplifting charges. Early into their relationship,

however, it became apparent that Bianca had been experiencing symptoms of severe depression

including suicidal ideation since becoming estranged from her family six years prior. This

estrangement coincided with her initial transition to living full-time as a woman. Bianca worked

part-time at a national grocery chain and had challenges finding secure full-time employment

since she began her transition. She was single and had additionally, since her transition,

experienced challenges finding meaningful romantic relationships as well as friendships, which

she and Andrea later attributed to living in a rural town with limited access to participate in the

LGBTQ+ communities of a larger urban area.

During clinical supervision, Andrea's initial assessment and conceptualizations of Bianca

were full of questions and ambivalence related to her ability to effectively help Bianca given the

acuity of her symptoms and her fear of Bianca's suicidal ideations. As Andrea was a newer

clinical social worker, her fear of Bianca's suicidality and her chronic depression were aligned

with this ambivalence. I had a sense that Andrea was experiencing an emotional response to

working with Bianca, which may have at least in part been related to Bianca's identities. Since

that feeling might have been drawn from my own lens of perspective, I did not want to make this

assumption explicitly, but began to normalize the presence of inequity, bias, and oppression

brought from the outside into the therapy room, in this case, the therapy room occupied by

Andrea and Bianca. This was critical, as a primary assumption of clinical social worker practice

oriented in intersectionality is that effective clinical treatment needs to focus on the identities of

a person as well as the greater societal structures impacting those identities, as they cannot be separated from one another and maintain their context (Enns, 2004; Warner & Shields, 2013).

My role as an intersectionality-oriented clinical supervisor, therefore, was to encourage Andrea to examine and engage the complexity of her interactions with Bianca while making identities and oppressive systems visible, as well as allow Andrea to guide where we went from there. As intersectionality encourages us to pose many more questions than we have answers for, I had to be willingly to take a stance of discomfort and reduced authority. I also had to be honest and self-reflexive about my own bias and privilege, including the fact that I was a senior clinician with a significant amount of authority over Andrea. As a result, I chose to maintain a non-directive, curious stance in the process of this exploration. From this stance I encouraged, but did not require, Andrea to explore the environmental factors that might be impacting Bianca's suicidality and depression, as well as how she and Bianca may have experienced each other in their initial encounter. In this way, we were able to highlight the power and privilege of a therapist over a client as well as examine any external systems of race, age, or gender that may also be impacting Andrea and Bianca, just as I had initially done for Andrea in our relationship. Making visible what can be hidden in this way helped begin the process of moving towards equity, social justice, and strengthening the bond between Bianca and Andrea (Shin et al., 2017).

Integrating intersectionality into clinical supervision should generate a significant number of open-ended questions. For example, in this case, what are some of Andrea's historical experiences with gender-identity and gender expression? How does her identification as a cis-gender woman impact her confidence in working with Bianca? How does her religious identity shape this perspective? How does Bianca experience her diagnoses, among them Gender Identity Disorder? How does Bianca experience counseling services, as she has been referred from the

criminal justice system? How does the power differential in the therapist/client dyad impact these factors? In short, how are the larger (and largely invisible) systems of gender, criminal justice, mental health insurance and diagnosis, race, religion, age, and families of origin (among others) impact how Andrea is experiencing Bianca, and vice versa? As supervision is a triad between Bianca, Andrea, and myself (Tracey, Bludworth, & Glidden-Tracey, 2011), is Andrea afraid I will judge her if she is unsure or unwilling to work with Bianca given her identities, including the labels imposed by the mental health and criminal justice systems? How do my reactions and perspectives indirectly impact Bianca for all these same reasons? What questions have I overlooked given the narrow matrix of my own identities regarding these larger systems? As the clinical supervisor, I am not solely responsible for answering these questions, but I may be the one to encourage their generation.

This non-directive, curious stance serves two functions: in one way, I am acknowledging and honoring the reality that Andrea and I are different social workers and therefore I am giving her the space she needs to grow her therapeutic toolbox and confidence as a clinical social worker. Yet in another way, I am also encouraging her through modeling and parallel process (Tracey, Bludworth, & Glidden-Tracey, 2011) to take a non-directive, curious stance with Bianca (and her other clients) with the same goals of building self-efficacy and an internal locus of control, as well as honoring the fact we walk through the world in a variety of ways.

For Bianca, using intersectional identity was a critical component of her work with Andrea. Bianca has gone through the world rejected, judged, and misunderstood not only by the people she loved, but also by larger systems of society; it is clear from this perspective how the multiple areas of marginalization have negatively impacted her earning potential, her intimate relationships, and ultimately her mental health and legal standing. As the expert on her own life,

Andrea did not hinder Bianca in identifying her own oppression, which was more focused on her lack of immediate social and economic opportunity then, for example, national gender politics. Intersectionality, therefore, allows the client to determine what constitutes power, privilege, and disadvantage within their own experience. The context of owning and applying those concepts to the client does not lie with the therapist from this perspective, but rather reduces the impact of a therapist's biases and inherent authority imbalance to be less impactful (Witkin, 2017). This process can be mirrored within the clinical supervisory relationship, with a similar impact.

Just as asking questions was an important component of intersectionality-oriented work for this triad, so too was listening for the subtle presence of oppressive systems. This was critical for Andrea, as Bianca would not explicitly talk about the marginalization in her sessions with Andrea, but rather it was through the language of her depression that you can also hear the burden of the oppressive systems impacting her life; words like trapped and burdened, which from one lens evidenced her depression and suicidal ideations, but also could be seen as how she felt at work and with her family. Being deadnamed and misgendered by her mother, feeling like the only transgendered person at work and in her community, and being seen not quite as a woman (or a man since transitioning) by society at large also invoked similar words to describe her experience.

Incorporating intersectionality into her work with Bianca, however, meant that Andrea not only must explore these areas of marginalization with Bianca, but also examine the places of power and privilege from which to foster a basic belief that Bianca can heal (Shin et al., 2017). Bianca, over time, began to accurately connect her internal struggles and identities with the external constructs of our larger society, which served as a powerful place from which she began to explore and process the choices she has made in coping with the internalized burdens she has

carried from her world. This is not simply justification for prior choices, importantly, but a scaffolding on which she and Andrea were able to stand and see the extent of the damage she had internalized then perpetuated on herself.

Here, Andrea's mastery of these concepts and the creativity she brings as a counselor became critical, as every therapeutic dyad is unique and individualized in its use of an intersectional lens. As part of their early work, Andrea oriented Bianca to the key concepts of intersectional identity and began to explore with Bianca the possible connections between identity and the larger oppressive systems played into her feelings and experiences. Further, as the relationship between Andrea and Bianca evolved, so did the matrix of their awareness regarding these larger systems. For example, when Andrea became pregnant with her second child, the dyad was able to explore Bianca's feelings about womanhood, parenting, and her own relationship with her mother in a way that had not been explicitly available to them previously.

In clinical supervision too, following the process of experiential learning as explored by Kolb (1984), Andrea and I frequently revisited intersectionality and intersectional identities in the context of her clinical work in order to give her the space to conceptualize, plan, apply in her clinical encounters, and reflect again in supervision. At the end of every supervision session, I would ask Andrea how she had experienced me that session. Did she get what she had expected to get from this session? How had she experienced our time together? These are not explicitly intersectional identity questions, but their repetition and place of prominence in our work reinforced the understanding that we are multi-axial, as well as the expectation that we will shift in our identities over time and context (May, 2015). Since I am also a willing learner in this process, I too benefit from our conceptualizations and reflections both as a supervisor and in my work with clients.

Working with Andrea, despite our distinct intersectional identities, from this space was easier once we found a language and an awareness of a shared common desire to commit to incorporating intersectionality into our supervision; an experience shared by Duch (2017) when she offered that, "differences were seen as fruitful based on a foundation of shared concerns" (p. 487). Earlier in my career I worked with another clinical supervisee, Erin, where this foundation was not established. Erin, like me, identified as a cis-gender woman, Caucasian lesbian. Although Erin and I shared these similarities, there were key differences related to the social locations of age and socioeconomic status, which in combination with sexual orientation created vastly different spheres of experience. The age and economic disparity, in this instance, meant that Erin had gone to a progressive private high school and had witnessed the rapid societal and political changes around LGBTQ+ rights and same sex marriage of the 2000s at an earlier developmental stage than I had. In contrast, I had grown up in a conservative, less socioeconomically advantaged community and had experienced a more conservative political environment during the coming out process.

Although some brief conversations related to sexual orientation were a component of the supervisory relationship between Erin and me, these other key components of our identities were not explored for their impact on client treatment. Further, a failure to discuss these key similarities and differences made the supervisory bond difficult to form, perhaps because there was an expectation that there should be more similarities between us then there really were. Since the bond was less connected, the content and discourse of the supervision was shallower. While I can only speak from my perspective, I suspect that Erin did not feel wholly understood or supported in this relationship, and as a result may have had many clinical questions and concerns that went unexplored.

Discussion

As this case study of Andrea illustrates, integrating intersectionality into clinical supervision asks the supervisory dyad to conceive identities as mutually constitutive as well as seek to hold power as relational, emphasizing that there is "permeability of the binary between oppressed and oppressor" (Hancock, 2016, p.110). Further, intersectionality anticipates discovery and growth, simply by virtue of being open and reflexive (Hancock, 2016). As it specifically relates to clinical supervision, this bravery and reflexivity perhaps need to be generated from the supervisor at the onset of the relationship for many supervisees, given their power relative to the supervisor to practice these skills independently in their clinical work.

Starting this integration, however, may initially be difficult for many supervisors given the relatively limited experience many supervisors have in formal cultural competence training (Hird et al., 2001). Additionally, since power is relational and non-binary according to intersectionality (Hancock, 2016, Collins & Bilge, 2016), supervisor bravery within clinical supervision may include a willingness to share power more fulsomely with their supervisees. For many supervisors, sharing this relative power with their supervisees may be a new experience and can invoke concerns related to the professional boundaries and ethical standards of the social work profession as well as supervisor comfort with certain topics: *how do I handle microaggressions from a supervisee related to my places of oppression while also sharing authority? How much is too much to share with a supervisee? What if I know I have work to do surrounding an oppressed identity, and I do not want to sound like I am uninformed or perpetuating that oppression?* Essentially, the question becomes: what if a supervisor makes a mistake in such a critical, important aspect of their work within clinical supervision?

What may begin to ameliorate these considerations can be found in the nature and structure of intersectionality itself. By virtue of engaging in reflexive thinking surrounding their own interlocking identities, as well as having a willingness to admit and relate when they are experiencing bias due to their identities, supervisors are accepting and encouraging the relationality, social context, complexity, and mutually constitutive nature of intersectional identity (Collins & Bilge, 2016; Hancock, 2016). This is a powerful acknowledgment that the supervisor is capable of, and will likely, make judgment calls or conceptualizations based on their biased position; this acknowledgment makes visible their positions of power and bias and communicates a willingness to engage with the supervisee (and their clients) on possible alternative ways of experiencing the situation at hand.

Intersectionality further does not place demands on how it is expressed in each supervisory relationship: given the complexity of power and oppression in society at large that is brought into clinical supervisory relationships, the boundaries of each member of the triad and how they relate to one another will dictate the frequency and intensity of the integration of intersectionality concepts. Under circumstances where the *context-specific* attachment between the supervisor and supervisee may not be fully developed, or in cases where a member of the dyad has a particular identity or social location that would cause them harm to discuss, forcing self-disclosures would be ethical violations and harmful to the supervisory relationship (Bubar, Cespedes, & Bundy-Fazioli, 2016; Reamer, 2013; Mor Barack et al., 2009). Again, the both/and perspective of intersectionality informs how the supervisory dyad may proceed: the pair can work towards making visible oppressive or marginalizing systems that impact themselves and their clients and simultaneously respecting one another's professional or personal boundaries.

Under these circumstances, the relative longevity of the supervisory relationship allows for an ongoing exploration to naturally unfold over time.

Conclusion

This paper sought to explore potential ways in which themes from intersectional identity, including the relationality, social context, power relations and social justice, and complexity of largely invisible systems of power and oppression exist and impact social work clinical supervision (Collins & Bilge, 2016). As noted, the incorporation of these tenants into clinical supervisory relationships might be used as a transtheoretical organizing concept to promote self-reflexivity, awareness of bias, and both/and perspectives (May, 2015) towards social justice; ultimately in service of the clients served. Intersectionality's flexibility allows for contemporary supervisors and supervisees to apply its tenants in *responsible stewardship* (Cole, 2015), allowing for each dyad (supervisee/client and supervisor/supervisee) to uniquely inform its expression by the intersectional identities of involved supervisors, supervisees, and clients served.

Foucault reminds us that, "power is tolerable only on condition that it mask a substantial part of itself. Its success is proportional to its ability to hide its own mechanisms" (1976, p.86). As intersectionality-oriented clinical supervision dyads engage in the ongoing multidirectional process of reflexivity and collaboration, as well as practice responsible stewardship of intersectionality, they can begin to reduce the power of oppressive systems. In this way, social workers are better able to contextualize both shared and unique identities, as well as understand these phenomena from a global systematic perspective which provide clarity to the intrapsychic struggles that many clients like Bianca experience. While she continues to struggle to live her

authentic life and keep her depression in remission, Bianca is now better equipped to put into context her places of power, as well as her places of marginalization and oppression.

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Paper Two: All the Parts of Who We Are: Integrating Intersectional Identities into Clinical Supervision

Introduction

As an emerging body of knowledge within the context of clinical supervision, intersectionality can offer clinical social workers an organizing framework from which to explore themes of social justice, privilege, oppression, marginalization, and empowerment when engaged with individuals' client systems. As it was introduced by Kimberlé Crenshaw in a 1989 Stanford Law Review article, the concept of intersectionality was originally applied as a means of articulating the diverse experiences women of color had related to their social locations, identities, and unique experiences of oppression (Crenshaw, 1994; Mehrotra, 2010). This original conception of intersectionality has expanded over time to serve as a theoretical framework, a critique, an analytical tool, and a call to action which emphasize the relationality of an individual's unique identities with the larger (and largely invisible) social contexts of inequality, as well as the complexity of how daily interactions reflect power relationships (Cole, 2009; Cole, 2015; Collins & Bilge, 2016; Bowleg, 2008; Davis, 2008; Goff & Kahn, 2013; Grzanka, Santos, & Moradi, 2017; Moradi & Grzanka, 2017; McCall, 2005; Mehrotra, 2010).

According to intersectionality, individuals are comprised of many aspects of identity which are multifaceted and mutually constitutive (Bowleg, 2013; Collins, 1991; Crenshaw, 1989). These aspects of individual identity are then contextualized by the larger and largely invisible complex societal systems of power and oppression (May, 2015; Collins & Bilge, 2016; Crenshaw, 1994; Curtin, Stewart & Cole, 2015; Else-Quest, Hyde, & Shibley, 2016). Here, intersectional identity is conceptualized as the key aspects of a person's identity (which are sometimes referred to as social locations) which include but are not limited to an individual's

ability, age, biological sex, citizenship status, ethnicity, gender identity, immigration status, marital status, professional identity, race, sexual orientation, status of parentage, and veteran's status; how these components intersect and interact with one another is unique to each person in forming a cohesive yet evolving whole. It can be helpful to regard these social locations and the larger societal factors from a matrix perspective, in which each facet of the whole can be highlighted under different circumstances while still existing in relation to one another (May, 2015; Crenshaw, 1994).

The critical lens of intersectionality can be used to examine significant aspects of clinical supervision within the context of the relationship between the supervisor, supervisee, and, by extension, the client. Differentiated by Bogo and McKnight from general social work supervision to centralize a focus on clinical interactions between a supervisee and clients, the process of clinical supervision supports growth as a clinical social work supervisee experiences their work through a cyclical process of conceptualization, planning, hands-on application, and reflection under the direction of an experienced clinical social work supervisor (Bogo & McKnight, 2005; Kolb, 1984; Prouty, 2014). While research is available which examines how considerations of culture and identity impact social work students during field education (see Hair 2015; Lee & Kealy, 2018), there is limited research examining the same considerations during postgraduate clinical supervision. This represents a significant missed opportunity, as the process of clinical supervision for post-graduate Master of Social Work[1] (MSW) social workers is not only required for those seeking terminal clinical licensure, but can also be a source of support, education, and feedback for emerging practitioners (Bogo & McKnight 2005; Kadushin & Harkness, 2014). Further, there is a similarly limited amount of research available which specifically examines the

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[1] Master of Social Work is used here to refer to any Masters Level Social Work degree from a CSWE-accredited institution.

implications of intersectional identity within clinical supervisory relationships; the available research instead has examined how singular identities (ex: sexual identity *or* race, versus sexual identity *and* race) impact social work students during field placement (Mor Barack et al., 2009; Hair & O'Donoghue, 2009; Lee & Kealy, 2018). Given the significance of a social worker's intersectional identities to the development of their strengths, limitations, values, beliefs, biases, and use of self in their clinical work, expanding the application of intersectionality within clinical supervision is critical (Lee & Ali, 2018).

There continues to be a gap in the literature which offers practical guidance on how to integrate tenants of intersectionality into clinical supervision, despite the benefits it may offer given its foundational focus on social change and its ability to engage multifaceted aspects of social work and clinical practice simultaneously. The aim of this exploratory study, therefore, is to address this gap within the literature and answer the following questions: How does the process of clinical supervision impact the recognition and understanding of the intersectional identity of post-graduate Master of Social Work (MSW) supervisees? What features of clinical supervision enhance the recognition and support of intersectional identity for post-graduate MSW supervisees? In what ways does the recognition and understanding of intersectional identity by supervisees translate into their work with clients? Responses to these questions by clinical supervisors and supervisees will contribute to the development of strategies by which key perspectives from intersectionality and intersectional identity might be integrated into clinical supervisory relationships with post-graduate MSW supervisees, as well as serve as a basis for future research.

Methods

Participants

The expansiveness and complexity of intersectionality challenges researchers to resist

oversimplifying social locations (ex: woman as an umbrella term invoking a homogeneity of

experience) (Samuels & Ross-Sheriff, 2008). In responding to this challenge, a maximum

variation sample strategy was used to seek participants who have various combinations of

intersectional identity. Using a maximum variation sample strategy, clinical supervisors and

supervisees who were willing to share their experiences pertaining to intersectional identity

within the context of clinical supervision were targeted through a distribution of digital flyers to

online professional platforms and list serves that were focused on eastern United States social

workers, and to community mental health agencies and private practices in the same catchment

area. Snowball sampling was then used as additional participants were needed to achieve a

targeted number of clinical supervisors and clinical supervisees (Padgett, 2017; Krueger &

Casey, 2000).

Once a participant expressed an interest in participating in the study, they answered

several pre-interview questions to determine eligibility, as well as identifying a pseudonym that

was used to de-identify recordings and transcriptions; all but one interested participant was

determined eligible based on this pre-interview questionnaire. In order to be eligible, supervisees

had to be a graduate from a CSWE accredited MSW program, had to have participated in at

least fifteen months of dyadic clinical supervision towards their terminal licensure with an

agency-based or private clinical social work supervisor, and be willing to discuss their own

intersectionality as it pertains to clinical supervision and/or client interventions. Supervisor

eligibility required that they have completed an MSW degree from a CSWE accredited program,

have provided clinical supervision from an agency-based or private clinical setting for at least

five years, have provided dyadic clinical supervision to at least five social workers towards terminal clinical social work licensure, and were willing to discuss intersectionality identity as it pertains to clinical supervision. In total 20 clinical social workers, including eight social workers receiving clinical supervision and 12 providing clinical supervision, were interviewed; none of the participants reported any preexisting clinical supervisory relationship with one another. After eligibility was determined and the consent form was signed, participants engaged in a semi-structured interview, with interviews ranging in length from 27 to 58 minutes for both supervisees and supervisors. The open-ended structure of these interviews was particularly helpful in developing a broad understanding of what aspects of clinical supervision are important to intersectional identity integration (Padgett, 2017).

The eight social work clinical supervisees who participated in this study were explicitly asked where and how they came to participate in clinical supervision. Three of these supervisees received only agency-based supervision, three received private supervision, and two received a combination of agency and private supervision during their training. Five reported being assigned to supervisors while the remaining three selected their own supervisors; seven of the eight reported changing supervisors over the course of their supervision due to the cost of supervision or due to supervisee and/or supervisor transitions in employment.

There were thirteen clinical social work supervisors who met eligibility requirements for this study; however, one was removed from the study due to a lack of clinical supervision experience. Three of the twelve supervisors provided strictly agency-based supervision, while one provided strictly private supervision; the remaining eight provided both agency-based and private practice supervision. Similarly, three were assigned supervisees, three had a combination

of assigned and selected supervisees, and the remaining half selected which supervisees they supervised.

The supervisee participants were asked to identify their intersectional identities with an open-ended question and provided myriad responses including some cases which did not include identifiers; for example, along racial/ethnic identifiers, one supervisee identified as African American and five identified as white or Caucasian while three did not include race as an identifier but presented as Caucasian. Three participants identified as Jewish, two identifying as Jewism their Judaism in ethnic and religious terms and one as an ethnicity only. One participant identified as a Christian, while another identified as a *recovering Catholic*. Six participants identified either as female or a woman, with one further identifying as cis gender, one identified as male, and one identified as non-binary; two identified as heterosexual/straight, one identified as a lesbian, and one identified as queer. Six identified their age in their description of themselves, with the ages ranging from 23 to 53. All eight identified their professions using language like *professional*, *therapist*, or *social worker*; similarly, three identified as middle-class. Two identified as able-bodied, while six used language to identify themselves in relationship to their others like *mother, parent, dad, blended family, grandmother, husband, wife,* or *divorced*. All the participants included identifiers that were unique to themselves compared to other supervisee participants, including mental health diagnoses, veteran's status, being a sexual assault survivor, or descriptions of their families of origin.

Additionally, there were twelve supervisors who participated in this study who used similar verbiage for their intersecting identifiers, some of which overlapped and offered context to other social locations. All twelve identified their race as either exclusively *white* or using descriptors like *considered white* or *W.A.S.P.Y*. Four participants identified as Jewish, three

referring to their Judaism from an ethnic and/or religious perspective and one solely as an ethnicity. Two identified other ethnicities including *Italian American* and *middle American Angelo*. One participant identified as a Christian, one as a Catholic, and one as a *terrible Catholic*. Two identified as spiritual but not religious, believing in a *combination of Buddhism and Paganism*, and two reported they were not religious at all. Nine participants identified either as female or a woman, with five further identifying as cis-gender, and three identified as male; five identified as heterosexual/straight, one identified as gay, and two identified as queer. Eight identified their age in their description of themselves including words like *middle aged*, *baby boomer, generation x-er,* or *older, but new to the field*. Nine identified their professions using language like *professional*, *supervisor*, *helping professional,* or *social worker*; similarly, three identified as middle-class. Two identified as able-bodied, while six used language to identify themselves in relationship to their others like *married, daddy, mother, single, friend, recently separated, wife,* and *husband.* Like the supervisees, many used descriptors that were specific to themselves; words like *evolving, solidly blue, child of immigrants,* and *daughter of a veteran.*

Method of Analysis

Participant responses were analyzed using a narrative analysis, which has been found to be particularly effective in the analysis of integrating the person with culture and change (Daiute & Lightfoot, 2004; Padgett, 2017). Differentiated from other qualitative methods of analysis, narrative analysis strategies embrace diversity and variation within participant responses and "may employ literary tools like metaphors, linguistic devices like pronouns, or cultural conventions like time or insight about diversity within and across participants in their research, and thus create ways to explain phenomena without reducing them" (Daiute & Lightfoot, 2004, p.viii). Given the diversity of holistic human experience, a qualitative method of analysis that

values this complexity likewise can take a wide variety of forms. Across all narrative analysis, however, there remain several organizing principles. Delineated by Daiute & Lightfoot (2004), a narrative analysis will centralize the narrative, or story, to develop emerging themes along culturally organized genres of knowing. As narrative analysis is structured on the belief that our mental lives are understood through the symbols we employ to make meaning, the narrative further serves as metaphor when people engage in storytelling (2004). Lastly, and perhaps most critically for this research project, is the understanding that narrative processes have an ability to explore how human processes like identity or knowledge develop over time (Daiute & Lightfoot, 2004; Bamberg, 2004). As growth such as the type that occurs during clinical supervision for the clinical supervisee can be contradictory and complex in culturally specific ways, the utilization of a qualitative method of analysis that can investigate these processes will align with this study's research questions.

The Listening Guide

An analysis of individual participant responses requires an analysis strategy that is designed to explore individual voices. *The Listening Guide*, a narrative analysis strategy, listens for the contrapuntal voices of each participant and "is best used when one's question requires listening to particular aspects of a person's expression of her or his own complex and multilayered individual experiences and the relational and cultural contexts within which they occur" (Gilligan et al., 2006, p.267). *The Listening Guide* was used for this analysis because of the similarity of perspective that it shares with clinical supervision: both centralize human development's link to the relationships and the cultural considerations that shape it (Spencer, 2000 as cited by Gilligan et al., 2003, pg. 254; Kadushin & Harkness, 2014; Marmarosh et al., 2013). Further, the emphasis on cultural and interpersonal factors within *the Listening Guide*

analysis mirror the goals of this project to explore how a supervisor and supervisee's intersectionality, or a person's voice as a chord comprised of many social locations, shape and impact the clinical supervision process (Gilligan et al., 2003; McDowell, & Hernández, 2010). Intersectionality within an individual recognizes how various social locations can blend and sometimes contradict within one person in a situation (Collins & Bilge, 2016). Using an analysis protocol that listens for those contrapuntal voices within an individual was significantly helpful in examining identity within the multiple interplays of intersectionality in clinical supervision and during clinical interventions (Gilligan et al., 2006). Each of the participants came to this research with layers within themselves related to not only their social locations, which in themselves include aspects that are privileged and aspects that are marginalized or oppressed. Further, they came with their experiences as clinicians (in the case of supervisees) or as supervisee/clinicians (in the case of supervisors; using *the Listening Guide* offered a way to hone in and analyze these complex voices, each which carry varying amounts of power and oppression, within each individual participant (2003).

An analysis using *the Listening Guide* is comprised of four steps, which are referred to as listenings, that guide a researcher towards emerging themes based on participant responses (Gilligan et al., 2003). These layers must be completed in order, as in combination they "leave a trail of evidence for the listener's interpretation, and thus leaves room for other interpretations by other listeners consistent with the epistemological stance that there is multiple meanings in such stories" (Tolman, 1994, p.327). This layering component of the Listening Guide not only honors and aligns with the values and demands of intersectionality as a framework, but it also supports the study's efforts to honor and centralize the voices of the participants (Collins & Bilge, 2016; Samuels & Ross-Sheriff, 2008). Each of the four listenings was demarcated on the transcriptions

using a separate colored pencil: *Listening 1* was in purple, *Listening 2* was in blue, *Listening 3* was in green, and *Listening 4* was in orange, creating a visual representation of the contrapuntal voices and themes that emerged from each participant (Doucet, 2019).

Listening 1: Listening for the Plot. The first step, listening for the plot, is comprised of two parts: listening for the plot and the listener's response to the interview (Gilligan et al., 2003). This first step directs the researcher to read the text with an emphasis on attention to what the plot of the responses is, the stories that are being told, and the presence of any repeated or contradictory images, metaphors, and dominant themes (Gilligan et al., 2003). To conduct Listening 1, I started by conducting a close reading of each participant's transcription with the appropriate colored pencil, marking narratives and words that indicated a central plot, subplot, key characters, themes, recurring words, contradictions, omissions, and events within the transcription (Brown & Gilligan, 1982; Mauthner & Doucet, 2003).

Listening 1 directs the researcher to focus on the personal experiences of the narrative, with our own subjectivities placed at the forefront of the analysis through the explicit feelings and thoughts about the responses (Gilligan et al., 2003). To achieve this, the researcher/listener documents from their context how they experience the story, both intellectually and emotionally; this information was written to the side of the first reading and indicated with the purple colored pencil. As narrative analysis and *the Listening Guide* each recognize the researcher as part of the analysis, this process was critical to examine how the listener's "assumptions and views might affect her [researcher] interpretation of the respondent's words, or how she later writes about the person" (Mauthner & Doucet, 2003, 419). It is important to acknowledge in this second part of Listening 1 my own intersectional identity as a doctoral student and novice researcher, as well as a clinical social worker and supervisor, lesbian, cis-gender woman, wife, mother, white, able-

bodied, and monolingual native English speaker in my mid-thirties. My experiences and clinical perspectives have also compelled me towards research focused on addressing social justice and anti-oppressive social work practices. This positioning impacted determinations on what the research goals were, how the interview guides were developed, and how participant responses were engaged, reflecting *the Listening Guide's* relational approach to analysis (Brown & Gilligan, 1992; Johnstone, 2016).

Listening 2: I Poems. This second listening calls for the researcher to isolate components of the participant responses that focus on the first-person pronoun and arranging them in order to develop an *I poem* (Gilligan et al., 2003). As discussed by Gilligan et al., oftentimes the statements fall into natural stanzas with meanings and voice changes that serve to clarify, enrich, or contradict emerging themes (2003). *I poems* became an excellent way to honor and bring to the foreground a participant's perspective, which is critical in any examination of the voices of minority populations (women, sexual minorities, immigrant populations, etc.), who are socialized to dial down their needs or feelings in social situations (Gilligan et al., 2003). Here, Woodcock's (2016) example of how to develop *I Poems* may be applied: first, every first-person "I" within an excerpt was isolated with any verbs that accompanied it. Then, these were arranged in their exact sequence in a separate document in order to maintain the original intent of the participant. In some instances where the participant was indicating relational content, the first person was accompanied by the second person "you" or "they." This except, for example, is an *I Poem* in which a supervisor is discussing how she engages supervisees in the work of intersectionality and intersectional identity within clinical supervision:

I noticed I have to slow everyone down
*They come in like, 'I just want to push through this' [*client conceptualization*]*
I'm like, 'so can you tell me a little more about them?'
that's our job as supervisors to like, slow this.

we slow it all down, we gather the information, right?
I will specifically say like, 'Okay, what race are they? What class are they, what religion?'
the family culture is really important
as well as the individual identities within the family; 'how is it all interacting?'
I'll just straight up ask about it
I also asked them how they talk about identity with the people that they work with
I do have like, just bring it out into the open right then and there in that first initial meeting

This *I Poem* allows for the first person to be isolated from the larger narrative and allows the researcher to accurately identify, in this case, how the supervisor is experiencing this conversation with her supervisee. Significant to this *I Poem* is the supervisor's and/or supervisee's use of first person as well as the language that she uses with supervisees and demonstrates how a supervisor might integrate concepts from intersectionality into the case conceptualization of a client.

   Listening #3: Listening for Contrapuntal Voices refocuses the analysis on the research questions by reading through each interview repeatedly, each time tuning into a different aspect of the story, voice, or expression of the participant responses (Gilligan et al., 2003). It is recommended that the voices of silence and of knowing are included in these different reviews. This process continues until no further unique voices can be identified from the transcript (Gilligan et al., 2003). Informed by the first and second listenings, the purpose of Listening #3 is to identify voices related to intersectional identity within clinical supervision and subsequent interactions with client populations; here three distinct voices were isolated for analysis which were prompted from the interview questions. The first was called *expressions of intersectional identity within clinical supervision* and was defined as the ways in which the supervisee's or supervisor's intersectional identity is being expressed or explored within the supervisory relationship. The second was called *expressions of the relationship between the supervisee and supervisor* and was defined as the relational elements that may describe feedback, emotion,

takeaways, lessons, and criticisms of the supervisee or supervisor. The third was called *voices of the work*, and was defined as narratives, feelings or relational comments that reflect the advocacy, clinical work, intersectional identity or other details of interactions with clients. As with Listening 1, each voice was separately listened for and demarcated using different colored pencils for each separate participant.

   Listening 4: Composing an Analysis. Lastly, this reading reiterates that a qualitative analysis be focused on the research questions, maintain fidelity to participant responses, and work to acknowledge researcher bias through all stages. In this final step, the researcher pulls what has been learned from the participant responses back to the research question and synthesizes the entirety of the process into a cohesive analysis (Gilligan et al., 2003). This step asks the researcher to answer the following questions in addition to any that have presented during the process of analysis: "What have you learned about this question through this process and how have you come to know this? What is the evidence on which you are basing your interpretations?" (Gilligan et al., 2003, p.266). Once potential patterns of themes were identified and compiled using the listenings of individual participant narratives from each of these above voices, I then went through each participant's story a final time to identify themes using a common language. This final listening created a final set of emerged themes that offer insights for how intersectional identity might be integrated more fulsomely into clinical supervision as well as tied into the existing research.

   As is the case with other qualitative methodologies, *The Listening Guide* acknowledges the voice of the researcher in the analysis of the findings, honoring the way in which the dynamics between the researcher and participants can offer a richer exploration of the participant responses (Gilligan et al., 2003; Woodcock, 2016). This commitment to a relational, voice-

centered approach can be further applied to the way in which the findings of a single study

engage with the larger body of research on clinical supervision and intersectionality. The

discourse between the larger body of research and a single study's findings allows for a more

holistic and comprehensive presentation of this study's findings as the voices of each narrative

engage with one another simultaneously. The following section, therefore, offers insights from

the participant responses as to how the tenants of intersectionality and intersectional identity

might be integrated into various stages of the supervisory process. Where the discourse between

the two appeared salient, relevant research from the larger body of knowledge has been

incorporated into this study's findings section.

Integrating Intersectional Identity into Clinical Supervision

As with other theoretical perspectives or therapeutic strategies explored within clinical

supervision, supervisees may develop an understanding of the concepts related to

intersectionality if they are considered through a process of conceptualization, planning, and

hands-on application, followed by reflection in supervision (Kolb, 1984). Expanding on this

supervisor/supervisee process, responses to this exploratory study suggest that concepts of

intersectionality and intersectional identity can be explored using the triadic nature of clinical

supervision as suggested by Tracey, Bludworth, & Glidden-Tracey (2011). This means that the

context and concepts of intersectionality and intersectional identity may be introduced within the

supervisor/supervisee relationship and specifically related to each person's unique

intersubjective identities, which are then incorporated into clinical sessions by the supervisee and

client. Feedback and reflections of these sessions may then be reexamined by the

supervisor/supervisee dyad, enhancing each member's awareness of how intersectional identities

and the larger systems of inequality are impacting and are impacted by the therapeutic/supervisory process.

The Supervisee/Supervisor Relationship

At the start of clinical supervision, the supervisee and supervisor relationship initially benefits from a period of rapport building and the development of mutual trust as described in Shulman's preliminary and beginning stages, which emphasize the ways in which the supervisee/supervisor will work together in the service of clients, as well as identify the specific goals supervisees have for supervision (2010). These initial stages also emphasize the development of the supervisory alliance or bond; the strength of which is associated with supervisee skill confidence in clinical encounters, and therefore a critical component of the supervisee's learning and clinical growth (Marmarosh, 2013; Shulman, 2010). During this initial phase of rapport and supervisory alliance building, intersectionality and intersectional identity might be introduced by the supervisor as a clinically supportive theoretical framework, enhanced by supervisor boundaried self-disclosures, then revisited through explorations of supervisee clinical encounters which are brought to supervision.

Early Supervisor-led Introduction. Clinical supervisor participants expressed a preference to introduce the tenants of intersectionality and intersectional identity as part of the early rapport-building phase of the supervisory relationship, and specifically during an orientation of key theoretical or therapeutic techniques they utilize frequently during supervision. As a means of normalizing and grounding this discussion in early rapport-building discussions, one supervisor incorporated the use of supplemental templates to engage the supervisee with the concepts of intersectionality:

I have a little document called like the supervisee bill of rights. And it's from some supervision textbook that I picked up along my journey. And it's a really cool tool that, goes through, like,

'Who are you? And like, what's important to you?'...And they get to choose which ones they want to discuss... I asked them, 'Who are you? Like, what are your identities?' ...I'll ask students, what's your intersectionality? And sometimes they'll be, I don't know, what is that? And I'm like, okay, we gotta go back. We need the operational definition of that. So, I wound up asking the question a little bit more broadly, in that sense of like, 'Who are you, what identities do you embody?' But that's something that we're very upfront about in the very first meeting.

The same supervisor went on to share:

I share mine [intersectionality] *as well... the reason for that is, sort of just in the way that I just said it is, too, because part of like my first my first session spiel is like, I come I enter the space with an anti-oppressive lens, and trauma-informed blah blah blah, and a way for us to start that conversation is it starts with us. So, then we open that up that way.*

In this illustration, when a supervisor sets the initial expectation that concepts from intersectionality and intersectional identity will be incorporated into the supervision, they may also choose to disclose their own social locations as a means of contextualizing their own experiences in clinical work for a supervisee; these initial disclosures, however, were largely superficial regarding the supervisor's own intersectional identity, and were used as a means of illustrating and modeling how intersectionality might be defined, or as a means of reinforcing the definition for the supervisee. As will be explored more fully below, these disclosures were *boundaried* and *intentional,* as they did not include information that were deemed too personal or sensitive to be shared by the supervisor.

As a means of offering justification for the expectation that intersectionality and intersectional identity would be integrated into the clinical supervision, another supervisor described the ways in which intersectional identities impact conceptualizations and clinical decisions, establishing an understanding that these factors too would impact and be impacted by the supervisory relationship:

Because in supervision, you're sometimes giving directives... you're doing a lot more self-disclosure even by discussing how you work with clients in a supervisory relationship. So, I think it's that much more important for them to know how I'm socially located, and then it's important

*for me to know how they're socially located based on who they're working with [*client social locations, environmental, and therapeutic setting considerations*].*

Again, the discussions at this stage are introductory and reflective of the burgeoning relationship between the supervisee and supervisor, rather than the more detailed explorations potentially associated with an established supervisory relationship. Although introductory, they represent a critical awareness of several key concepts from intersectionality, specifically the understanding the social context, power dynamics, and the mutually constitutive and therefore complex nature of intersectional identities which are ever present, even within supervisory and therapeutic spaces (Bowleg, 2013; Collins, 1991; Crenshaw, 1988; Collins & Bilge, 2016). In addition to offering intersectionality as a means of working towards social justice, having these discussions at the onset of the supervisory relationship will further a means of contextualizing some of the missteps, decisions, or moments of disagreement that inevitably occur within clinical supervision due to bias, power differentials, and/or experiences of oppression or privilege unique to that relationship.

Foster Brave Space. Simply introducing the theoretical concepts of intersectionality and intersectional identity during the initial phase of a supervisory relationship may be insufficient for many supervisees to feel safe enough or brave enough to overcome their own places of bias, marginalization, or oppression in order to continue these conversations in a meaningful way (Arao & Clemens, 2013; Blasini-Mendez, 2019). As a means of anticipating and normalizing this, introductory conversations between the supervisor and the supervisee additionally benefit from the acknowledgement that topics associated with intersectionality may be uncomfortable, and that a sense of bravery within the relationship may be an area of focus for the dyad. Again, supervisor-led initial conversations at this stage in the relationship are critical, given the nature of the power imbalance between the supervisee and the supervisor. As one supervisor explained,

developing bravery related to conversations of intersectional identity were critical as the work of

supervision focused on the supervisee's clinical encounters, asserting that the ability to explore

imperfect interactions with clients within the supervisory dyad also requires bravery:

And they're [supervisees] *definitely not going to bring up experiences of culture independently in which they think they didn't handle it right. I don't think they will. I mean, I can create as safe a room as humanly possible. And I just don't think social workers do that. Well, and definitely not early in their career. We want to like make everybody think we're doing this just like, oh, culturally humble, and they're not gonna bring that up.*

If the work of social justice with clients also requires bravery and an acknowledgement that

things might not go perfectly at every therapeutic encounter, then normalizing and anticipating

that reality within clinical supervision may help reduce the intensity of the missteps with clients,

as well as foster a sense of support within supervision.

As a means of fostering a sense of support for these conversations within the supervisory

dyad, most supervisor participants followed the lead of their supervisees to determine the pace

and intensity of explorations of intersectionality and intersectional identity once the key concepts

were understood. This was especially true directly following the introductory discussions of

intersectionality, when the dyad was still in a period of developing their alliance and rapport.

This required the supervisors to listen for, normalize, validate, and/or highlight themes from

intersectionality and intersectional identity as they were introduced by the supervisee during case

conceptualizations, client assessment, or other clinically focused discussions. Although the

development of rapport and the extent to which bravery is fostered will be different for each

supervisory dyad, supervisees may experience a sense of comfort and a motivation to push their

development related to intersectionality and intersectional identity as a result.

Conversations related to marginalization and privilege require substantial bravery within

the supervisory dyad because of how these systems operate as part of everyday life, including

clinical social work and supervision. Importantly, the supervisee participant who identified as a

person of color described the challenges of engaging supervision with bravery due to the

systematic oppression and marginalization of African Americans, social workers, as well as the

clients they serve:

I think is hard for African American supervisors and supervisees. I think it's harder for us because we come to the job, we come to the door with some thoughts that we may be judged, simply, you know, presumed to be a certain kind of way. And you know, especially a lot of the agencies that we work in and most of our clients that we serve are African America and you know, marginalized oppressed populations, and we just, I think there's a fear sometimes and a lot of supervisors in the same suit. And then? I know, I was I was worried about, you know, the fact that, you know, power and privilege, you know, this person may have, and they might not want the power and they don't want the privilege over me, but they have it is just embedded into our society - is it embedded in this institution? Is it an embedded in this agency? Will it affect my supervision? Will they judge me? Will they right here? - you know that type of assumed fear of power and privilege. That's my biggest thing.

Unless a supervisor demonstrates bravery, sensitivity, and a willingness to bring visibility to

systematic oppression, their supervisees may never feel comfortable enough to bring up these

themes and challenges in supervision. As this supervisee suggests, a fear of judgment may be a

default perception for supervisees with marginalized social locations that the supervisor, as the

member of the relationship with greater authority, needs to overcome as a prerequisite for their

work moving forward. As will be more substantively addressed below, the ability to explore and

advocate against the damaging impact of systematic oppression and marginalization within

supervision may offer an example that a supervisee may later implement in their clinical work.

Weave Intersectional Identity Throughout. Even as supervisor participants did not force the

conversations of intersectionality, many did revisit the concepts of intersectionality and

intersectional identity often and chose to *weave it throughout the experience* of supervision.

Specifically, this might be done through case conceptualizations offered by the supervisor during

supervisee case presentations. One supervisor, for example, used a presentation of a client case

to reiterate the intersectional concept of relationality with her supervisee. The supervisee self-identified as a Christian but has a historically Jewish-presenting last name and had become upset and confused when a client's parent was making veiled anti-Semitic remarks during an encounter. The supervisor shared,

… the supervisee…comes in and she's like, 'She [the client's mother] *said this thing that's like, it's just so weird.' And I was like, you're the Jew in the room…Do you recognize, you've not disclosed to her what your religion is because your last name is just describes the whole thing.' Um, so, that's how* [I]*, bring it into the room sometimes to* [say]*, 'Hey, remember this* [interaction feels off] *because you know that* [aspect of your identity]*about you? …. They don't know that they know that about you.'*

Here, the assumptions made regarding last names and the negative stereotypes associated with Judaism had a negative impact on the relationship between the supervisee and the client's mother. If this had gone unexplored within the supervisory dyad, this might have had a greater impact on the client's overall treatment or the family's adherence to treatment attendance or recommendations over time.

Utilize Boundaried Disclosures. In order to incorporate supervisor and/or supervisee disclosure into discussions of intersectional identities, narratives emerged from participants related to the nature of self-disclosure. Disclosures should be related to intersectional identities that were either relevant to a clinical issue or within a reasonable level of discomfort for the dyadic relationship and the context of the supervision (i.e., agency or private supervision, individual or group). Boundaried disclosures, both on the part of the supervisee and the supervisor, were found to be useful within the supervisory relationship, particularly as supervisees were grappling with how their identities and those of their clients were related to the work. The supervisees expressed this desire to be understood with statements like, *I feel like supervision is a place where the more your supervisor sees and understands the more… the more there is, the more you stand to benefit.* These disclosures, however, were associated with non-apparent aspects of the

supervisee's intersectional identity such as their sexual orientation, relationship status, mental health diagnosis, or *anything super, super personal*; further, they were presented as related to a clinical issue that was being discussed in supervision. In this way, the goals of the supervisor relationship remained intact; rather than sharing to connect as friends might, most supervisee self-disclosures were relevant to their clinical work.

While disclosures were boundaried, the majority of both supervisee and supervisor participants used adjectives or language to otherwise identify their social locations with greater specificity, using phrases like, *strong female*, *single mom,* or *recovering Catholic* which were consistent throughout their narratives but were particularly evident when they were describing their own intersectional identity. These identity qualifiers may demonstrate an application of mutually constitutive thinking, as a single identifying word in many instances was insufficient to accurately convey the context for an aspect of their self (Bowleg, 2013; Collins, 1991; Crenshaw, 1988).

Importantly, however, supervisees felt they were unable to share aspects of their intersectional identities within supervision. Supervisees further explored the impact of these silenced intersectional identities, which were described as aspects of the supervisee's intersectional identity that were not discussed during supervision due to concerns of stigma, safety considerations, or a fear that such discussions might restrict future opportunities. One participant noted,

so sometimes it's like, for me, it's challenging to disclose things about myself because I have this underlying fear that it will cause me not to be hired or cause me a problem in the future with like, professional work.

As this supervisee participant suggests, a stigmatized intersectional identity like a mental health diagnosis or a substance abuse recovery status may not be so openly shared in supervision, particularly when it is agency based and/or the supervision is related to employment. In these

circumstances, it may again be the responsibility of the supervisor to find ways to bridge their authority and model boundaried ways to engage in these conversations with supervisees which demonstrate a space for these considerations to be explored.

Supervisor participants similarly felt a reluctance to share specific social locations and/or detailed information about identities with supervisees, especially when the identity was non-apparent. This was the most evident when disclosures were related to the supervisor's own marginalized and/or oppressed intersectional identities in the face of a supervisee's privileged or less-marginalized intersectional identity. Under these circumstances a supervisor may choose to foster an authentic relationship with their supervisees before discreet disclosures occur. In one example, a supervisor who identified as a member of a religious minority group was working with a supervisee who disclosed early in their supervisory relationship as a Christian. During a session, the supervisee experienced a client attempt to manipulate her by invoking core tenants of Christianity, which was later processed in supervision; *what was that like for take that…for her to weaponize your religion against you?* At the time of this conversation, the supervisor had not yet disclosed her own religious beliefs, noting:

I wanted her to know who I was. Experienced [sic] me as a person before like checking the box [aspects of her intersectional identity] *with her. … it was hard for me to disclose who I was knowing that I could be reduced to just a checkbox and whatever media attention has been brought to those check boxes, those identity markers…*

When the disclosure of the supervisor's religious beliefs was made later, the disclosure felt more natural and comfortable for the supervisor, since this new information was informed and supported by the previously established supervisor/supervisee alliance.

Other supervisors found it helpful to describe self-disclosures in terms of *professional* versus *personal,* with *professional* disclosures used to help supervisees differentiate between the two and illustrate intersectional identity. While discussing her desire to demonstrate professional

vulnerability for her supervisees, one supervisor noted that she was motivated by a desire for her supervisees to implement a similar stance in their clinical encounters regarding noticing and exploring intersectional identity within their work:

I don't want to be personally vulnerable with them [supervisees]. *I don't particularly want them to be personally vulnerable with me. But I do want them to be professionally vulnerable and like willing to notice those things. So I think when you role model that, and be and you know, I'll say, 'Well, let me tell you a way I really screwed some things up', then I think that creates an environment where people feel like it's okay to say that* [explore intersecting identity] *and, you know, I'm not dumb. I'm not gonna judge you.*

This distinction may inform a contradiction identified in the narratives of both supervisee and supervisor participants: the participants overall felt intersectional identity should be disclosed by the supervisor and supervisee early in the supervisory relationship, while simultaneously verbalized a preference of supervisors and supervisees to introduce certain aspects of their identities later in the relationship, particularly when those social locations that were associated with real societal oppressions and stigmas. This theme aligns with findings of researchers examining adult attachment within clinical supervision, who describe a *context-specific* bond which forms between a supervisee and supervisor rather than the more classic attachment bonds found in other adult attachment relationships (Ainsworth, 1989; Bennett, 2008; Marmarosh et al., 2013; Pistole & Watkins, 1995; Watkins & Riggs, 2012). Ultimately, a balance unique to the supervisory relationship and relying on the dyad's alliance, the bravery, and the relative longevity of that relationship must be primary considerations regarding how often and how intensely self-disclosures are offered.

The Supervisee/Client Relationship

Once established, the concepts of intersectionality and intersectional identity integrated into clinical supervision through the bond, bravery, and boundaried self-disclosures of the supervisory dyad then have the potential to be offered by the supervisee to their clients as part of

their clinical work. Specifically, this may be done using supervisor role-modeling and parallel

process. As one supervisee participant noted, emphasizing this work is critical in clinical

encounters since:

...the point of the work is that we're trying to take apart these systems and we're trying to work against them. And we can do that on an individual level with our clients by acknowledging oppression and helping clients heal from oppression and creating their own new ways of living in new possibilities of liberation.

Utilize the Parallel Process. Providing education on and utilizing the experience of parallel

process within clinical supervision is a powerful mechanism by which the integration of

intersectionality identity may be transmitted from the supervisor/supervisee to the

supervisee/client dyad. Originally conceptualized in psychodynamic literature as an unconscious

pattern of interaction, parallel process creates mirroring patterns of interaction between the

supervisor/supervisee that can be seen replicated in other relationships, most significantly in the

supervisee/client relationship (Searles, 1955; Tracey, Bludworth, & Glidden-Tracey, 2011;

Doehrman, 1976). To illustrate this point, one supervisor participant shared an example of a time

in which parallel process was used to explore and work through an assumption she made with a

supervisee:

I had a supervisee at one point in time. We were talking and I said, you know, how do you identify as an African American female working in an environment that works predominantly with people who are white? She said, well, number one, I don't consider myself an African American. I'm from Jamaica, you can just say, I'm black or Jamaican. I was like, 'Oh, okay'. It kind of took me off guard because I was just, I wanted to be politically correct. It was really important that she said that...I said, 'thank you so much for clarifying that with me'. Now... I kind of start out saying like, how do you identify, you know, like, let's talk about this. So I don't make that mistake again.

What was significant about this uncomfortable conversation was that the member with the

greater relational authority (the supervisor in this situation) made an assumption from her

perspective and the larger social pressure she felt to be politically correct. As the dyad was

ultimately able to work through that assumption, the supervisee was later able to replicate this

experience in her clinical encounter, where she was the member with greater perceived authority. The same supervisor then shared how later the same supervisee experienced a similar error when she did not take the lead of a client, who identified as Latinx, non-binary, and a native Spanish speaker, to select their own pronouns and language for their experience when the two were conversing in Spanish:

She [the supervisee] *was really struggling with some of the language…It wasn't that she's like personally struggling, it was just like such a traditional old language and it's, it's masculine and feminine... There's this, this whole hierarchy of it, so we, I do my best to help her. Ultimately, she had to let the client take the lead and continue to address it…each session.*

The supervisee and supervisor had not explored this particular scenario during supervision prior to the start of the supervisee's work with this client, and yet she was able to tap into a previous way of relating to another (in this case the supervisor) to initially help her through the clinical encounter.

Role Modeling. The theme of role modeling additionally emerged as a significant theme in this study as one aspect of the supervisory relationship that supervisors and supervisees alike found extremely helpful in this integration. Both supervisors and supervisees discussed how specific behaviors were role-modeled within the supervisory relationship which could then be implemented in clinical encounters by the supervisee related to themes and concepts from intersectionality and intersectional identity. One circumstance in which role-modeling was most frequently utilized as related to intersectional identity was when the supervisor made an error from bias as the result of a privileged social location(s). When a supervisor makes an error from bias or privilege, which can inevitably occur given length of a supervisory relationship, the supervisor may model how to appropriately acknowledge and handle that error within the dyad without causing irrevocable damage to the alliance. Towards this end, the supervisor may offer an acknowledgement of the error and engage in a dialogue with the supervisee as to how to

repair the error and/or prevent its occurrence from happening in the future. Importantly, the supervisor must communicate that they recognize what error has taken place and display a willingness to explore strategies of repair collaboratively.

Another role-modeled behavior helpful to integrating intersectional identity into clinical work was the implementation of collaboration and asking for help. The practice of supervision, both as it is explored in this study and also as components of ongoing clinical practice among peers, represents a significant resource for both emerging and more seasoned clinical social workers. When a clinical supervisor finds themselves unable to offer adequate support to a supervisee due to their own places of privilege and/or bias, or through a lack of knowledge, it may be appropriate to role-model collaboration for their clinical supervisee. As described by one self-identified white male supervisor, reaching out and seeking collaboration with colleagues was an effective way of exploring how the matrix of intersectional identity might factor into different clinical conceptualizations or therapeutic interventions;

If I'm working with a woman, or if I'm working with someone who is… African American, I'll talk about me being a white male and her being an African American woman. And just having a different experience because of that and having to hear from them what their experiences are is important. And then I'll encourage them, like when we're talking about different working with different patients. I'll encourage them to get other perspectives about how to handle different things from people who are similar to them with as far as intersectionality, just because I can't understand their experience because I have all this privilege.

Importantly, this represents a willingness from the perspective of the supervisor to engage in a shared authority with the supervisee, itself a form of professional vulnerability and bravery as discussed above. This more balanced authority perspective is well-aligned with intersectionality's mandate to bring more visibility to previously invisible systems which may be preventing success for a particular client or client system, as well as further serve to explore both supervisor and/or supervisee bias, limitations, or values that might be impeding the supervisee's clinical interventions (Collins & Bilge, 2016; Lee & Ali, 2018; May, 2015).

Supervisor/Supervisee Feedback and Reflections

As supervision continues, supervisees continue to meet with their supervisors regularly

(typically once a week) to review clinical encounters, reflect on those experiences, and develop

strategies on how supervisees might approach their upcoming clinical encounters (Kadushin &

Harkness, 2014; Shulman, 2010). As the foundational understanding of intersectionality and

intersectional identity were introduced at the beginning of this process, their concepts and

impacts on the clinical work should also be explored more deeply and thoughtfully, reflective of

the enhanced bond between the supervisor/supervisee and the growth of the supervisee's

reflexivity and technical skills.

Encourage Reflexivity. Supervisors and supervisees alike described the use of supervision as a

space for reflexivity, (i.e. the ability to examine personal bias and values brought by the social

worker) to be cultivated for the supervisee; this development can be a significant means by

which intersectional identity can be integrated into clinical supervision. Specifically, the

supervisor may ask open-ended *curious* questions intended to encourage the supervisee to think

about how their own intersectional identities might be impacting aspects of the clinical

encounters. Supervisor participants often engaged supervisees using these open-ended *curious*

questions as a means of enhancing a supervisee's intersectional reflexivity; this was found

particularly helpful given the desire of the supervisor's themselves as a means of mitigating their

own bias and places of privilege or marginalization.

Similarly, many of the participant supervisees offered strategies which were implemented

during clinical supervision which they found helpful in the development of their reflexivity:

some supervisory dyads continued the use of process recordings, while others experienced their

supervisors intentionally slowing down the implementation of interventions, diagnosis, or

formalizing case conceptualizations as a means of encouraging the supervisee's reflexivity. This

self-examination, in order to integrate intersectional identity, should include ways in which the

identities of the supervisees are interacting with and impacting their relationships with clients. As

one supervisee described, her status as a white woman and social worker was impacted by the

larger criminal justice and child protection systems, both of which had a profound impact on the

clients she engaged:

...they [the clients] *have* [an intellectual] *disability but, they also are black and, I don't think that the criminal justice system like treats people fairly based on race. And so, I've processed fears around having to report things. And talking about, also how that affects my relationships with families who previously they didn't have a social worker in this role. So worrying that I didn't want to be perceived as just someone that was trying to get a window into their* [lives] *and find reasons to report things I wanted to build rapport and have now I'm, I love my families. I love the kids, but feeling a lot of worrying about, how blackness and disability will create hurdles for them when they're not with us.*

It is important to note that this reflexivity expands the scope of the work for the supervisee,

which in turn has an impact on her work with clients. The supervisee participant goes on to

explore how bringing that understanding of how systems of oppression and marginalization work

from her clinical supervision into her clinical sessions had an equally helpful effect for her client

in bridging their sense of isolation:

Also because a lot of times like I would have female clients who were like, not where we weren't the same race, they're women of color... and thinking about like how some of our experiences overlapped and some didn't and like how to have conversations [in supervision] *about racial difference, or gender difference that was really important to me and something that I learned to do and that supervision because a lot of my clients felt really isolated. And therapy was a really important relationship to them. And I felt like we had to talk about our identity is to have like a really authentic connection, but talking about* [it in] *supervision to figure out how to start those conversations...*

For this supervisee, the connections made it possible not only to effectively offer clinical

interventions that were addressing the whole of the client's experience outside of the counseling

office, but also to find ways to acknowledge differences as well as similarities inside the

counseling office. Importantly, this emphasis on the development of supervisee reflexivity found

in this study aligns with the findings of Davis & Gentlewarrior's findings that peer and/or

clinical supervision might be used as a place to engage in in-depth and open conversations to

mitigate the effects of white privilege on white social worker's clinical work (2015).

Examine Alternative Perspectives. It may be an indicator that intersectional identity is

effectively being integrated into clinical supervision when the supervisee begins to explore its

tenants without prompting from the supervisor, as well as when the supervisee demonstrates

more flexibility in their ability to see different tenants of intersectionality at play and respond to

those tenants in the supervision and/or during clinical interventions. The use of a matrix-focused

perspective can contextualize the perspectives and experiences of each member of the triad as

well as take into consideration the relationality, social context, power relations and social justice,

and complexity that comprise the triad's overall intersectional identity (Crenshaw, 1994; May,

2015). Once a sense of this vast matrix is understood, the various clinical presentations and client

experiences can then be examined and reexamined as the triad move through various points

within this matrix. For example, one supervisee participant explored how this matrix-perspective

was used to generate alternative perspectives when the supervisee was unsure how to proceed

with a clinical issue:

*Okay, this person is facing, like, depression and she's not like, for example, she's like having a
hard time caring for her kids or something. We would kind of frame that in the ideas of like, how
does that relate to her identity and like, how does it relate to her place in the world and what the
traumas that she's experienced through different oppressions, so like how those things influence
the person and also how they're individual and then all the other like, typical social worker stuff,
like okay, what medications are they on? Like, where? How did they grow up? Did they have like
a supportive parent did they have not supportive caregivers? What's their relationship to the
social worker right now? Like, are the person guarded with me? Is the person open with me?
How is that person with me? You know, what kinds of things we'll be exploring right now? What
are their motivations? are they connected to community and community support?*

As this supervisee shared, clinical supervision that integrates intersectional identity examines

factors beyond biopsychosocial assessment or theoretical-factor specific, and, in addition,

reflects the impact of systems of oppression and privilege and the ways in which the clinical triad operate within those systems. For these nuanced examinations to be effective, however, they must also be associated with ways in which the supervisee/client can offer support to the client: where can empowerment be promoted? How is the client/system/organization relating to the supervisee? What shifting can the supervisee take within their clinical orientations, pattern of relating, or how they contextualize the therapeutic relationship for the client in a way that might be more effective?

Summary Discussion

In summary, several critical themes emerged from this study related to how concepts from intersectionality and intersectional identity might be integrated into clinical supervision. The first theme identified by the participants was that concepts and themes from intersectionality and intersectional identity be introduced at the beginning of a supervisory relationship, with the responsibility for this introduction belonging to the clinical supervisor as the member of the supervisory dyad with the greater perceived authority. Specifically, supervisor participants found it easier to normalize and secure supervisee buy-in when intersectionality and intersectional identity concepts and themes were introduced during initial supervisory discussions and in conjunction with other foundational theoretical frameworks to be explored during clinical supervision.

Similarly, an early effort to recognize and foster bravery within the supervisory relationship was found to support the integration intersectionality and intersectional identity concepts, as bravery was understood to be necessary for a deepening expression and exploration of intersectionality during the supervisor relationship. Fostering bravery within supervision was found to be particularly helpful as the work of bringing visibility to systematic oppression

requires that supervisees not only examine how intersectionality impacts clinical interventions, but also how they themselves impact and are impacted by systems of privilege and marginalization.

It was further found that supervisors could reinforce the tenants of intersectionality and intersectional identity by encouraging supervisees to develop self-reflexivity and the ability to examine alternative perspectives. Supervisor's might demonstrate an open and curious approach to the supervisory relationship itself, as well how they engage the supervisee's clinical work. This interpersonal stance was further encouraged in the supervisees by the supervisors, particularly as it was related to supervisee's own biases, privileges, and marginalized social locations.

During the initial stage of the supervisory alliance, supervisors and supervisees additionally found it beneficial to offer self-disclosures related to visible or non-marginalized social locations as a means of illustrating concepts and themes from intersectionality and intersectional identity. Less visible and/or more marginalized social locations were more likely to be explored once there was a stronger alliance within the supervisory relationship, although many highly marginalized social locations (ex: substance abuse or the mental health diagnosis) might never be disclosed. The supervisor and supervisee participants alike chose to introduce and explore self-disclosures when they were *boundaried* and *professional*, here understood as disclosures related to the larger context and focus of the supervisee's clinical work.

Another theme which emerged from this study was that once they were introduced, themes and concepts from intersectionality and intersectional identity could be weaved into the existing content of clinical supervision; different from the initial conversations, here the supervisor and supervisee sharing the responsibility for these explorations. Supervisors and

supervisees alike might reintroduce and/or explore themes and concepts from intersectionality during assessment, case conceptualization, and during examinations of clients/supervisee interactions, particularly as impacted by societal systems of oppression and marginalization. This shared responsibility allowed for fluid, nuanced discussions to take place and grow as the supervisee's clinical work required it, and as the supervisory alliance evolved over time. This ongoing integration further allowed for the complexity of tenants from intersectionality to be more fulsomely integrated into supervision; as the individual members of the dyad evolve both as individuals, as clinical social workers, and within the supervisory dyad, so might different perspectives and components from intersectionality and intersectional identity become more visible.

Finally, the supervisor's ability to role-model the above-named themes as they relate to tenants of intersectionality and intersectional identity was a critical theme which emerged from the findings of this study. Specifically, supervisors chose to role-model a desire to work towards self-reflexivity, to work against their own biases and privileges, to maintain a curious and open stance by seeking alternative perspectives, and/or to seek collaboration and support from others as a means of expanding their understanding within the matrix of intersectionality. These types of professional vulnerabilities were viewed as powerful examples for supervisee participants, which in turn could be applied by the supervisees in their own clinical work.

Considerations for Integration of Intersectional Identity Related to Supervision Setting

The location of supervision and the structures related to the supervisee's work with clients were identified as significant themes as to how intersectional identity was integrated into the work among supervisors and supervisees alike. The structures of the organizations and the relationships the supervisees and/or supervisors had with the supervisees place of employment

were central considerations for the participants, particularly in how they formed their supervisory

alliance, how brave they could be in their explorations, and to what extent they disclosed

challenges they were having within the supervisory dyad. In agency-based supervision, for

example, the administrative realities of task supervision being combined with clinical

supervision and the connection between evaluation with promotion and/or economic opportunity

can have a negative impact how integrated intersectional identity can be:

...they [supervisees] *really want to impress, and that can be a barrier to supervision in in general, just like being worried about what the implications are going to be and if they disappoint me...So I think that might prevent people from talking about different things.*

Additionally, the demands of administrative tasks and/or organizational structures can deter

larger conversations:

I mean, there's the whole agency at play and not sharing religious or political opinions... I mean, even as people do that collegially I don't tend to I just stay away just because, um, you know, it's a very divisive anyway, usually those topics, so if they don't need to be brought up, then I don't... my focus is usually just on the work ...usually that hour is pretty full up. And then of course, that like I said, I do it in kind of an agency structure. So, we do talk about things such as a level of service and how we're doing in that in that aspect of how many folks are seeing a week.

      As a means of responding to these perceived inevitabilities impacting agency-based

supervision, supervisors may choose to slow down conversations of intersectional identity in

order to enhance the bravery, safety, and support within the supervisory relationship where the

supervisee themselves might introduce their own intersectional identity as it relates to their

clinical work or their supervision:

So within that context, I think they [supervisees] *tend to feel comfortable bringing that up, because I've showed them that I'll listen to them and even if I don't connect or have the same experiences, I'll support them and help them think it through and brainstorm together... I just wait for it to come up naturally and it does. It'll come up naturally. I just don't push for it.*

It is critical to note that slowed down does not mean unacknowledged, as the omission of these important discussions may indicate to a supervisee a lack of awareness for personal privilege on the part of the supervisor and become an expression of the supervisor's own power (Bubar, Cespedes, & Bundy-Fazioli, 2016; Samuels & Ross-Sheriff, 2008). Therefore, once the tenants of intersectional identity are explored, then the intensity and frequency of their reinforcement may be focused on the issues and challenges raised by the supervisee/client relationship, rather than initially focused on the supervisor and supervisee's roles within the matrix of impacting systems. This may be of critical importance in agencies where the clinical supervisor has additional administrative supervisory duties. This may also be helpful in agency-based supervisory relationships when the supervisor appears to have privileged social locations, which may further restrict the possibility of shared authority within the clinical supervisory relationship.

Comparatively, private supervision offered challenges in a supervisor's ability to assess where and how a supervisee was experiencing blind spots or biases within their clinical encounters, which may be critical for integrating intersectional identity into the work. For example, one supervisor detailed the concerns he has about not being able to conduct his own assessment of a client and instead had to rely on the developing assessment skills of his supervisees:

Unfortunately, I am left with their blind spot in my blind [spot]*...I'll never be able to, to walk into a house and be like you never thought to bring this up. So, I tried to ask as many questions that...I can think of. But is it? Yeah, if it's in their blind spot, really in their blind spot, I may not even know to ask them if they if it's in their blind spot. It's...one of the downsides of being off site.*

As discussed above, collaboration with the supervisee's agency or a more detailed exploration during the assessment and case conceptualizations may offer greater insight into the supervisees biases in their clinical work.

Limitations & Areas for Future Exploration

As with all research, there were limitations to this study. This study was an exploratory qualitative study with a relatively small sample size; future studies may benefit from samples that are more diverse across all social locations with an emphasis on racial/ethnic and/or citizenship status identifiers. Specifically, this study would have benefitted from an increased representation of racial and ethnic minority social workers; this may be reflective of the ongoing underrepresentation of racial and/or ethnic minority clinical social workers within the field and in professional associations (National Association of Social Workers, 2011), which were used as a primary recruitment method for this study. Further, participants in this study may have had either very positive or very negative experiences with supervision and/or intersectionality in their work: this may have impacted their responses, thus impacting the recommendations of how intersectional identity may be integrated into clinical supervision.

Similarly, there are limitations to all analysis strategies which includes *the Listening Guide*. A narrative analysis using *the Listening Guide* does not allow for results to be generalized or transferred to other populations or study findings (Drisko, 1997; Gilligan et al., 2003; Werner-Lin, 2008). Further, triangulation, a common method of ensuring rigor within qualitative research, was not possible using a narrative analysis given the limitations of time in this exploratory study as triangulation frequently calls for additional observers, sources of data, or alternative methodologies (Padgett, 2017).

Finally, the impacts of intersectional identities as it relates to specific treatment populations, like substance abuse, eating disorders, schools, and or hospital based social work were not explicitly taken into consideration as part of this study and would benefit from a more detailed exploration on how intersectional identity might be integrated explicitly into those

settings. Additionally, future research examining the integration of intersectional identity into peer and/or group-based clinical supervision may be prudent given the frequency through which they are used in social work.

Conclusion and Recommendations

In conclusion, there are several recommendations for clinical social workers interested in integrating concepts from intersectionality and intersectional identity into their existing clinical supervision practice. First, it is recommended that supervisors and supervisees explore concepts and themes from intersectionality in their own non-supervisory clinical work as a means of developing a keener awareness of how their own biases and perspectives impact and are impacted by systematic oppression and marginalization; this individual work can then be brought into the clinical relationship in the service of the dyad. For example, an unanticipated result of this study was that several of this study's participant supervisors verbalized an increased comfort in discussing their intersectional identities and biases simply through the process of exploring their work with this researcher, and commented that this would be more frequently integrated into their work moving forward. This pattern demonstrates that it may be beneficial for colleagues, under non-supervisory circumstances and in a non-judgmental, supportive manner to explore and collaborate with one another as to how themes from intersectionality and intersectional identity might be integrated into their clinical work.

As the member of the supervisory dyad with the greater authority, it is also recommended that supervisors imbed intersectionality into supervision from the onset of every new supervisory relationship, and then make it a regular component of the work each week. This is not to say that intersectionality, intersectional identity, and supervisor/supervisee self-disclosures should become boxes to check each week; integrating concepts from intersectionality requires

commitment, creativity (see Ali & Lee, 2019), a *context-specific bond* (see Ainsworth, 1989;

Bennett, 2008; Marmarosh et al., 2013; Pistole & Watkins, 1995; Watkins & Riggs, 2012),

personal reflexivity, flexibility, and bravery (see Arao & Clemens, 2013; Blasini-Mendez, 2019)

from both the supervisor and supervisee on an ongoing basis. As one supervisor described,

concepts from intersectionality and intersectional identity can be understood and engaged

differently over time:

I'm just figuring out how to use that [intersectionality] *within my own supervision,* [as well as]
*how to how to identify myself... it definitely has a lot of room for growth within our field because
it has a lot of really great aspects of it and, and more so just like becoming more familiar with
using it over and over again. So, adding that term* [and it's concepts] *to our clinical toolbox, I
think is something that's going to be beneficial in the long run.*

Finally, supervisors can help supervisees develop an ability to examine clients and

clinical encounters through the lens of intersectionality and intersectional identity. Just as

supervisees strengthen their diagnostic and conceptualization skills through the support of

clinical supervision, they can also strengthen their ability to recognize and translate into clinical

terms how the matrix of intersectional identity, emphasizing the interplay between personal

identities with the societal dynamics of marginalization and inequality, impact every clinical

encounter. While explorations of clinical encounters are an important way to strengthen this

understanding, the supervisor's use of relevant, boundaried self-disclosures regarding their own

intersectional identities can help bring the matrix of intersectionality more wholly into the

supervisory dyad, as well as serve as a model for supervisees in their own clinical encounters.

In summation, the recommendations which emerged from this study represent initial,

exploratory strategies by which clinical supervisees and supervisors may begin to organize their

existing clinical supervision practices in a way that is more integrative of the tenants of

intersectionality and intersectional identity. The aim of these recommendations, therefore, are to

encourage future research with larger and more diverse participant samples to expand and

enhance the body of knowledge surrounding intersectionality, intersectional identity, and clinical

supervision. This is critical at this point in clinical social work given the diversity of challenges

and social locations that the upcoming generation of clinical social workers and clients embody,

as well as the discipline's reemphasis on centralizing social justice in clinical social work.

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