Intersectionality (or, the Whole Is Greater Than the Sum of Its Parts): Informing Sociocultural Formulation and Improving Mental Health Inequities

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I will not have my life narrowed down. I will not bow down to somebody else's whim or to someone else's ignorance.

~ bell hooks

A tense climate of race relations, conflict over sociocultural identity, and the ongoing problem of discrimination have been highlighted in recent events across the nation. Children and families fall across a broad spectrum of cultures, ethnic backgrounds, races, genders, and sexual orientations. The conceptualization of these varied identities deepens our understanding of families and their access or barriers to care. As child and adolescent psychiatrists providing care for diverse families, we must consider whether the connection between a given provider and family is culturally appropriate. Is the provider's conceptualization of the family formed from a full picture, complete with an understanding of their culture, or are key parts excluded through the omission of the unfamiliar? For example, within the social sciences, the concept of *intersectionality* has been presented as a means of formulating, among other things, relevant aspects of oppression and privilege, given that people's social standings often expose them to privilege, marginalization, or a combination of the two. Incorporating intersectionality can thus enrich a biopsychosocial formulation of sociocultural identity.[1]

More broadly, intersectionality refers to the confluence of gender, sexuality, race, class, and other facets of social identity that contribute to an individual's experience across multiple contexts. Intersectionality seeks to improve our understanding of marginalized social identities by proposing that features of an individual's identity in isolation are an oversimplification that ignores a rich and complex interplay between social facets.[1] In other words, the theory postulates that social identities impart privilege, disadvantage, or a combination of the two depending on circumstances. This concept of the "interconnected nature of inequalities" underlying the complexity of discrimination was first described in the early 1980s by bell hooks and Gloria Hull. Noticing that the movements for race and gender equality largely relied on the perspectives of black men and white women, hooks, Hull, and their colleagues arrived at this theory, which would later be termed "intersectionality" by Kimberlé Crenshaw.[2]

Kimberlé Crenshaw, a feminist and currently a professor of law at UCLA, first used the term "intersectionality" in her 1989 paper "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Anti-racist Politics."[1,3] In her paper, Crenshaw examined attitudes toward discrimination as they related to black women across disparate contexts: the legal system, within the black community, and in the feminist literature. Crenshaw highlighted the "single-issue framework for discrimination" as a device to marginalize multiply disadvantaged people, for example black women who are subject to "double discrimination" based on their race and sex, and who lacked a voice in the race and sex equality movements. Her paper presented a history of the black woman's experience being viewed as either female or black, as opposed to the more complex concept of a combination of the two identities, which yields outcomes that differ from other women and black men. She cited court opinions that failed to recognize

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black women as a protected minority group because of the view that sex discrimination and race discrimination are separate processes that cannot co-occur.

Intersectionality is especially relevant to families living in underserved areas that commonly encounter discrimination attributable to multiple factors. Conventional practice examines the impact of these aspects of identity one facet at a time, for instance evaluating only the effect of poverty on a family, which leads to facile understandings, such as "the family does not come to treatment because they are poor." The family that struggles with poverty at the same time might be black, a minority in their regional community, and have a single parent as the family leader, which could result in a different conceptualization: "the family does not come to treatment because of the stigma within their cultural community, discriminatory processes that lower the family's confidence in the healthcare system, and a single parent having to choose between the visit and work obligations." In reality, these social components of identity converge and simultaneously shape an individual's experience and have the potential to act as barriers to healthcare. The concept of intersectionality offers a deepening understanding of the complexity of social identity by considering the interaction of multiple social facets, as opposed to a succession of disjointed sociocultural features.

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Sociologists and medical professionals have increased the understanding of healthcare inequity by applying the theory of intersectionality to their investigations of mental health outcomes. Gerry Veenstra[4] examined the impact of interactions between an individual's race, class, sexual orientation, and gender on self-report measures of health outcomes, including mental well-being. The study analyzed Canadian Community Health Survey (CCHS) data and found that bisexual, lower social class, aboriginal and Asian respondents reported poor health outcomes, and that homosexual individuals with low income and South Asian women were more likely to report fair-to-poor health outcomes. However, low-income women and low-income Asian Canadians reported lower rates of fair-to-poor health. These sample results suggest that an individual's demographics will interact in ways that both ameliorate and exacerbate health status factors. High levels of discrimination have been associated with a lower sense of wellbeing and high levels of anxiety.[2] Seng et al.[5] examined the quantifiable impact of intersectionality on health outcomes by retrospectively analyzing data from measures of post-traumatic stress disorder (PTSD), discrimination, and the number of marginalized social identities in a population of pregnant women in Ann Arbor and Detroit, MI. The authors used data collected during a prospective, cross-sectional study of the impact of PTSD on birth outcomes. Participants from the maternity clinic in Ann Arbor were privately insured, and the women served by the Detroit clinics were largely publicly insured. In the retrospective analysis, 619 women were included; 55.3% were white and 33.9% were black. The study classified participants by race/ethnicity, income, whether their residence was in a high crime area, education level, whether they were classed as a minority in their city, episodes of trauma, number of PTSD symptoms, quality of life, frequency of discrimination, and the social identity to which the discrimination was attributed. PTSD symptoms were measured using the National Women's Study PTSD Module; the Quality of Life Inventory was used to quantify life satisfaction, and the Everyday Discrimination Scale indicated the frequency of discrimination experiences and assessed for attributions for discrimination (number of marginalized identities). There was a significant and negative correlation between high frequency of discrimination and quality of life. The frequency of discrimination scores were significantly and positively correlated with the degree of PTSD symptomatology. The sum of attributions for discrimination on the Everyday Discrimination Scale was significantly associated with PTSD symptomatology, and this

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finding suggests that the number of marginalized identities has an impact on mental health outcomes. Interpersonal-level intersectionality, or, in other words, the frequency of discrimination and the sum of marginalized identities, explained more of the data variance on measures of PTSD and quality of life than the participants' income and education level. The researchers demonstrate the relationship between intersectionality and health outcomes. However, they also present the challenges related to quantifying intersectionality, such as whether intersectionality is best characterized by an additive, multiplicative, or interactional approach. Additionally, the authors acknowledge that their study failed to measure the identities that represent privileged status and these protective identities' relationship to health outcomes. These studies linked mental health outcomes to the intersection of race, gender, sexuality, income, education, and social context.

Intersectionality as it relates to mental health outcomes and access helps clinicians to more accurately appraise the social experiences of their patients. Population health research points toward intersectionality's potential to enhance the accuracy with which health inequities are identified, guide the development of interventions, and increase the utility of targeted efforts in particular groups.[1]

An individual is a mosaic of disparate social identities that coalesce to form the image of the self that interacts with society. This is the image around which society builds its expectations, privileges, and discriminatory processes. Bauer likened the theory of intersectionality to the biopsychosocial model in respect to the shared acknowledgement of and emphasis on the complicated interaction of multiple factors that when considered in isolation produces an incomplete picture. Intersectionality guides the formulation of the child's sociocultural identity, which can enrich the provider's understanding of the family and their societal experience.

Take Home Summary

- Intersectionality refers to the intersection of gender, sexuality, race, class, and other facets of social identity that together interact in a complex (and not simply additive) fashion to influence an individual's experience across social contexts.
- Intersectionality can provide an individual with privileged status, disadvantage, or a combination of the two, depending on the circumstances.
- Intersectionality provides a framework for conceptualizing the sociocultural identities of children and families and recognizes the complexity of an individual's interaction with his/her environment.

Resources

- The Intergroup Resources website provides online educational materials related to intersectionality and social justice. **http://www.intergroupresources.com/intersectionality**.
- Douglas Ray's Exploring Identity and Intersectionality in Poetry – Lesson Plan published on the PBS News Hour Extra website uses self-monitoring prompts and poetry to guide the audience through an explanation of intersectionality theory. The target age is grades 10 to 12 and could be helpful to engage with patients in this age group around the concept of intersectionality. **http://www.pbs.org/newshour/extra/lessons_plans/exploring-identity-and-intersectionality-in-poetry-lesson-plan**.

John F. McDermott, Jr., MD (1929-2015)

In early December, we learned that Dr. John F. McDermott, Editor Emeritus of the *Journal*, had passed away peacefully in his sleep. Jack was a leader in our field and a great mentor and friend. His incredible work for the Academy and his commitment to teaching are only a small part of his legacy. Later this year, we will remember and honor Jack in the pages of both the *Journal* and *Connect*. Until then, our thoughts and sympathies are with his family and the many friends whose lives he touched.

About the Author

Patrice Janell Holmes, MD, earned a Bachelor of Science degree in Psychology and was inducted into Phi Beta Kappa at the University of Oklahoma in 2006. In 2010 she earned her MD from the University of Oklahoma. After medical school she completed a preliminary year in general surgery at the Greenville Hospital System, an affiliate of the University of South Carolina School of Medicine. Dr. Holmes began her life-long learning in psychiatry at Georgetown University Hospital in 2011 and completed her adult requirements in 2014, before training at the Yale Child Study Center. Currently a second-year child and adolescent psychiatry fellow at the Yale Child Study Center, Dr. Holmes will complete her chief residency year in June 2016. Since joining the Yale Child Study Center, Dr. Holmes has travelled to Brazil for an international experience in child psychiatry, organized and presented lectures on child and adolescent psychiatry to the Yale School of Medicine students, and served as a member of the Medical Student Education Committee.

Disclosure: Dr. Holmes would like to acknowledge the trainees and faculty of the Yale Child Study Center for their support. Dr. Holmes reports no biomedical financial interests or potential conflicts of interest.

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