

## INTERSECTIONALITY AND MENTAL HEALTH: A CASE STUDY

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### ABSTRACT

The intersectionality framework holds promise as a means of conceptualizing the impact of diversity. Used exclusively by feminist researchers, we explore how it has ‘travelled’ to the mental health care field, where diversity is of growing importance. We critically review the first mental health (care) research informed by intersectionality and offer a series of critical reflections that focus on using intersectionality as a theoretical framework. To explore the added value of the intersectionality framework more thoroughly, we compare these with four studies on women and health that also include several social distinctions but are not informed by intersectionality. What stands out is the need to unpack ‘demographic factors’ and analyze power relations. Subsequently, we point to issues for future development, and especially the need for specific decision rules to deal with the current methodological plurality. Failure to address this latter point will likely undermine the transformative potential of intersectionality as a means for considering the *simultaneous* social differences and power hierarchies that shape individual lives, resulting in simplified disciplinary approaches to multiplicity.

**Keywords:**

*diversity, ethnicity, gender differences, intersectionality, mental health research, power.*

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Intersectionality, a concept that makes visible 'the multiple positionings that constitute everyday life and the power relations that are central to it' (Phoenix and Pattynama, 2006, 187), has been called the most important theoretical contribution to emerge from women's studies so far (McCall, 2005). First developed in the late 1980's, it has gradually been incorporated in feminist research projects in various fields, including gerontology (e.g., McMullin and Cairney, 2004) and public health (e.g., Schulz and Mullings, 2006). The chapters in Schulz and Mullings (2006) provide a glimpse of what an intersectional approach may mean for health care/prevention practices and specifically meeting the needs of diverse groups. On the one hand, intersectionality points toward new perspectives on the analysis and treatment of health problems for various social groups. On the other hand, it generates questions, such as how to use this rich theoretical concept in developing and carrying out research projects, bearing in mind the historical conditions that gave rise to the theory. More generally, there has been extensive critical discussion about putting intersectionality into practice in a variety of disciplines (e.g., McCall, 2005; Phoenix and Pattynama, 2006; Stewart and McDermott, 2004).

In this paper, we take the area of mental health research as a case study and critically assess how well intersectionality has "travelled" (Said, 1983, 2000), thereby advancing the understanding of what intersectionality may add to the consideration of social differences. To achieve our aim, we explore emerging understandings of intersectionality in mental health studies that have adopted an explicit intersectionality approach and reflect on the future of intersectionality as a framework for research.

The importance of such conceptual elaboration is evident for the field of health care research and policy in particular, because there continues to be a call for more research that incorporates social diversity concerns (e.g., Commission of the European Communities, 2007; Health Canada, 2000; World Health Organization Regional Office for Europe, 2005). The reasons are both moral and practical. As many governments and health sector management organisations acknowledge, clinical practice must be adequate for different populations, including, for example, seniors, women, Black and Latino/a, lesbians, people with disabilities and the economically disadvantaged. Specific concerns driving the diversity turn at the moment pertain to access, safety, and quality of health care services for everyone. The need for careful treatment of social differences has also been emphasized by the American Psychological Association in their *Resolution on Culture and Gender Awareness in International Psychology* (2004) and the recent *Guidelines for Psychological Practice with Girls and Women* (2007). With the growing emphasis on 'evidence-based' health practices, there is an increasing urgency for empirical research to underpin and legitimise the development of 'diverse' practices with scientifically produced knowledge.

The mental health context stands out for us, because there has been persistent emphasis on the importance of practitioner cultural competence and the need to be sensitive to the clients' cultural background and ethnic identities (e.g., Comas-Diaz and Greene 1994; Hays and Iwamasa, 2006; Hwang et al., 2008; Sue, S., 2006). Furthermore, we envision a synergy between psychology's concern with women's mental health and the interdisciplinary field of women's studies, with psychology contributing to the interdisciplinary dialogue on intersectionality through lessons learned from research and practice related to health psychology (Radtke and van Mens-Verhulst, 2007) and women's studies contributing to psychology through the theoretical and methodological debates related to intersectionality

(Stewart and Dottolo, 2006). Such cross-fertilization between a traditional academic discipline and women's studies remains exceptional (McCall, 2005).

Naming the differences is an important starting point for taking them seriously, but theorizing about their relationships and implications is also required. Linking together gender, race, sexuality and class is not innocent as Schueller (2005) has argued in her essay on the tradition of analogy in (white) feminist theory. Importantly, she places "white" in parentheses to emphasize that white feminists tend not to reflect on how race informs their perspectives. Perhaps because the nature of such differences and the means of incorporating them into research and practice are not straightforward, many researchers and practitioners focus on just one of the prominent social differences in western societies, usually gender, ethnicity, class, age, or sexuality diversity. Inside those specific fields, however, experts share remarkably similar concerns, mainly stemming from the tension between the nomothetic level of much research and the idiographic level of clients. These include: (1) inappropriately ascribing characteristics associated with a social group to individual group members, e.g., assuming that the depression of an elderly immigrant woman must be due to homesickness; (2) turning observed differences into new stereotypes, such as 'the depressive older lesbian'; (3) transforming descriptive categories into normative ones and pathologising those who depart from that norm - usually men, native speakers and healthy adults are depicted as the healthy standards with women, foreigners and the elderly seen as deficient and unhealthy or foolish; (4) blindness for within-group differences, resulting in a homogenized image of men and women clients, irrespective of their ethnicity, sexual preference, marital status, age, education and income; (5) overestimating differences and underestimating similarities between groups, such as between non-western and western women (although the health care system is mainly founded upon assumed universality of biological, psychological, and social processes that are related to health); and (6) essentialising differences by postulating a biological origin and claiming that they cannot be modified, e.g., presenting sex differences in depression as the inevitable consequence of a difference in hormone levels. Ignoring these concerns puts patients, women as well as men, at risk for (a) therapists to stereotype them and ignore their self-understandings, (b) being pathologized and trivialized because their complaints are incorrectly interpreted, and (c) having their treatment fail to take into account the limitations as well as opportunities associated with their social context.

Of note, the mental health care literature reflects very little direct engagement with the diversity debates to be found within the field of women's studies, especially in relation to intersectionality, a concept that has received considerable critical attention (e.g., Brah and Phoenix, 2004; Collins 1991, 1998; Crenshaw, 1989, 1991; Lorde, 1984; Phoenix, 1998; Phoenix and Pattynama, 2006; Smith, 1998; Stewart and McDermott, 2004; Williams, 1997; Yuval-Davis, 1997). Although researchers and practitioners within the mental health care field frequently recognize that more than separate social differences must be considered, they generally treat these social differences as independent variables. In contrast, intersectionality, which originated in Black Feminist Studies with the idea that Black women's lives cannot be adequately understood purely from a 'race' or a gender perspective, identifies these two types of social difference as intertwined and inseparable (Crenshaw, 1989, 1991). Our view is that intersectionality's generative potential is considerable, but the implications for research and practice are still being worked out. This would seem then to be the optimal moment to assess how intersectionality might best be utilized within the mental health context.

First, however, we situate intersectionality among other conceptualizations of diversity and provide an overview of intersectionality's practical relevance as advocated by some mental health care professionals.

## CONCEPTUALIZATING DIVERSITY

### *Diversity, social differences and multiple identities*

The most circumscribed view of diversity focuses on race and ethnicity, but there is a less narrow, though still limited view that also takes sex/gender into account. In its broadest sense, diversity has come to include many additional social differences such as sexuality, age, dis/ability, class, and, in some cases, philosophy of life (Nkomo and Cox, 1997). At an individual level, people's affiliations with specific social groups are tied to their sense of personal identity and social location (both who one is and who one is not). Subsequently, through processes such as internalization, identification, socialization and acculturation, social differences are thought to have widespread implications for a person's self-understanding, self-presentation and everyday life (Pheterson, 1986; Phoenix, 1998; Rummens, 2003).

Frequently, social differences are depicted as independent and additive with one single, dominant identity/social location, often, sex or nationality (Donaldson and Jedwab, 2003; Wilkinson, 2003). Not surprisingly, then, various models for multiple identities have gradually appeared. Rummens (2003), for example, described several additive models that fail to incorporate the relationships among the social identities. Generally within social psychology, however, 'social identity' is used as a unifying concept that refers to an individual's self-definition with respect to both unique characteristics as well as characteristics that are associated with group identifications, such as gender and race. Consequently, multiple identities simply become different aspects of a unified self. Nevertheless, some psychologists have recognized the need to develop means of conceptualizing persons who identify with more than one culture, but the various definitions of biculturalism ignore other identities such as social class (e.g., Hermans and Kempen 1998; LaFromboise, Coleman, and Gerton 1993; Nguyen and Benet-Martínez, 2007).

### *Intersectionality*

Although there are some variations in the conceptualization of intersectionality in particular disciplinary contexts (e.g., Browne and Misra, 2003), the essential idea underlying the concept is that social distinctions are related and *simultaneously* impact individual's lives. Formulated within a social constructionist framework, intersectionality emphasizes that when we make social distinctions, we construct differences and opt for indifference to similarities. Importantly, such social distinctions can be conceptualized in terms of a number of dimensions, including the cultural, psychological, and social. As such, it shifts attention to the individual's social positioning at the intersection of a complex set of social relations. Psychologically speaking, one's social positioning is tied to one's identity and sense of agency, but because social positioning shifts from one social context to another, so do identity and agency, making them fluid and ever-changing. Intersectionality refers to social groups, individual identities, *and* the connection between the two, but within this social constructionist framework the macro- and micro levels are not reducible to one other (Phoenix and Pattynama, 2006). By encompassing several social differences, an intersectionality framework draws

attention to the simultaneity of similarity and difference, i.e., an individual can be both similar (same age) and different (female rather than male) from others depending on the context of comparison. Moreover, when and where particular differences matter is subject to variations of time and place.

Reflecting its origins, the intersectionality framework incorporates a sensitivity to power hierarchies. This is in contrast with traditional mental health care research, where power relations typically appear only implicitly in concerns about the influence of poverty and violence on clients' health and response to treatment, equal access to health care, and the safety of treatments (e.g., the need for sex specific knowledge in order to prescribe correct medication). Intersectionality, however, refers to multiple oppressions that are simultaneous (i.e., gender and ethnicity and class, etc.), inseparable (e.g., the impact of ethnicity cannot be isolated from the impact of gender), and intertwined (e.g., ethnicity and gender are mutually significant in everyday life). Consequently, groups and communities do not occupy a subordinate position by virtue of some inherent property (e.g., their culture or religion), but rather acquire this position as the outcome of socio-historical and political processes. Moreover, they may be positioned in contradictory ways, being advantaged in some respects (perhaps by virtue of being middle class) and disadvantaged in others (perhaps by virtue of being Black). Consequently, the intersectionality framework is very suitable for highlighting the hybrid positions and identities associated with diversity.

Methodologically, intersectionality presents a problem of complexity and a need for interdisciplinary solutions. McCall (2005) argued that principally, this entails three main strategies/stances: anti-categorical, intracategorical and intercategorical. The first two entail a critical approach toward categories, and the latter takes up categories provisionally. The critical approach is rooted in long-standing feminist critiques of binaries, such as male/female, and essentialist thinking, both which perpetuate social inequalities. Here complexity is handled either by studying social locations at the intersection of a number of social differences or exploring the diversity within a particular social group. On the other hand, the intercategorical stance focuses attention on structural inequalities and power relations between social groups. However, the complexity implied by intersectionality is not adequately addressed by any of the individual methodologies adopted to date. Instead, she argues that we must cross disciplinary boundaries and adopt multiple methods, thereby generating many different, partial understandings of the significance of intersectionality.

In resisting a reductionist epistemology and at the same time including the individual and her identities, intersectionality potentially has much to offer to mental health care research and is particularly relevant to scholarship on health disparities that is critical of the biomedical paradigm's knowledge production and practices (Mann and Huffman, 2005; Schulz and Mullings, 2006).

### *Practical Relevance of Intersectionality*

Within the mental health literature, some attention has been paid to the practical worth of using intersectionality to conceptualize difference in a mental health context. Robinson (1993), an early advocate of intersectionality, argued that disadvantaged gender, race, class and cultural positions may provoke feelings of powerlessness and, by breaking the silence about the enormity of those intersections while also focussing on client strengths, counsellors might encourage their clients' empowerment. She argued further that this would enable them to accept their realities, reframe the situation, and resist the internalization of negative behaviours

and attitudes. More recently, Chantler (2005) suggested that incorporating intersectionality in person-centred therapy may address the structural dimensions of inequality in clients' experiences of racial and sexual abuse, harassment, and violence; and also their limited access to services due to lack of money, childcare, transportation, speed of response, preferred language or preferred sex or ethnicity of counsellor. In addition, Salazar and Abrams (2005) created a tool to conceptualize the client's self-perceptions in relation to a number of cultural groups as interwoven and at times inseparable by utilizing intersectionality to connect racial/cultural identity with marginalization within oppressive systems such as sexism, heterosexism, beauty-ism, and able-ism. Their stated aim is to support development towards 'increasing levels of awareness and empowerment' (p. 51). Such explorations reflect a burgeoning interest in finding new ways to incorporate social and political differences into the therapeutic context, articulating the power relations in client's lives and acknowledging clients' perspectives.

Burman (2004) has provided the most detailed example of an intersectionality-inspired mental health care analysis. She argues in favour of including multiple social differences to avoid the reproduction of existing power hierarchies by health care providers, administrators, and policy makers. For example, when culture is privileged over gender, problems like domestic violence and female circumcision (the two health issues she focused on) are defined as a private matter, i.e., as 'culturally specific' practices that are the concern of a particular cultural community and therefore are not matters to be addressed by the regular health care system. Also, discourses of ethnic specificity and specialisation may lead mental health care providers to simply assume that consulting room encounters will include cultural and language barriers. Such discourses contribute to 'race anxiety', whereby mental health care providers may not offer available mental health care expertise and treatments because they feel ill prepared and worry about being inappropriate and possibly accused of racism. Instead, clients may be referred to services available within their own cultural 'communities'. Poorer mental health care may be the result when there simply are no comparable services, and clients may avoid services within their cultural communities, especially smaller ones, because confidentiality is an issue, i.e., seeking those services may publicly expose the nature of the individual's health problem. Furthermore, mental health practitioners from within the cultural community may not question accepted cultural practices that have negative consequences for health. Finally, policies and laws, e.g., regarding immigration and residency status, may result in certain women being excluded from the health care system. In her view, an intersectionality framework that draws attention to similarities as well as differences can serve to disrupt the processes that obscure or exacerbate certain health-related problems, impede adequate care, and exclude some people from the mental health care system.

In conclusion, intersectionality has the potential to be a practical conceptual framework for mental health care providers. However, its feasibility remains in question due to the complexities associated with multiple, interdependent social differences. We now turn to the empirical research literature.

## **MENTAL HEALTH (CARE) RESEARCH INFORMED BY INTERSECTIONALITY**

We searched within SCOPUS and PSYCHINFO for mental health care research, published between 1995 and 2006, that was explicitly informed by intersectionality. Search

terms for the title and/or abstract were *intersection\* OR intertwine\**, *health and gender*. We excluded publications pertaining to health education and those in which ‘intersection’ did not refer to social diversity but, for example, to types of health care, disciplines, problems, and so on. This resulted in three hits: Burman and Chantler (2005); Rosenfield, Phillips and White (2006); and Whitney (2006). We also included a chapter (Caldwell, Guthrie, and Jackson) from the most recent book about intersectionality and health (Schulz and Mullings 2006). For these four studies, we reviewed: a) their definition of intersectionality, b) the aspects of mental health care they studied, c) their theoretical framework, d) the social distinctions used in their analyses, e) their research strategy, and f) their results/recommendations. This then enabled us to compare how intersectionality was incorporated in contrast with how it might have been utilized.

### *Burman and Chantler (2005)*

Burman and Chantler take for granted intersectionality’s meaning and offer no explicit definition, perhaps because Burman (2004, 2005) previously explored intersectionality as a theoretical contribution to psychological studies. They focus on the provision of mental health services to female survivors of domestic violence from ‘minoritized’ communities that are underrepresented among those utilizing the services. They tackle the question ‘Why don’t they leave?’ by comparing the survivors’ views with those of the service providers. Minoritisation is a central theoretical concept in their analysis: ‘to highlight that groups and communities do not occupy the position of minority by virtue of some inherent property (of their culture or religion, for example) but acquire that position as the outcome of a socio-historical process’ (p. 59). Commensurate with intersectionality, as a concept, minoritization is said ‘to encourage a reading that indicates areas of continuity as well as differences of position between women from different minoritized groups – so spanning the black/white divide that usually structures the discussion’ (p. 60, footnote 2).

For their action research project, they interviewed 23 survivors from five communities: African, African-Caribbean, South Asian, Jewish and Irish, as well as 29 service providers from three types of organizations: generic, specialised in domestic violence, and culturally specific. Interestingly, only the culturally specific domestic violence support services proved to be successful sites from which to recruit the type of respondents they sought. The interviews were semi-structured and oriented around five areas: experiences with identifying and using services; barriers to accessing services; meanings and perceptions of domestic violence; any associations of cultural specificities in relation to these issues; and service development needs in order to facilitate survivors’ transitions to independent living. In their analysis, they did not distinguish between Black and white women in advance. Furthermore, they explored contextual factors to avoid individualistic explanations and concentrated on the common barriers the women encountered, especially the barriers posed by immigration, poverty and employment status. By iterative readings of the interview transcripts, they identified convergent and divergent themes. In comparing the survivors’ and service providers’ responses, they concentrated on differences, thus revealing the failure of provider organisations to acknowledge the legal, material and practical barriers that survivors encounter. Furthermore, in comparing service providers, they noted that both generic service organizations and those specialized in domestic violence tended to refer the minoritized women to culturally specific organizations, thus locking them into their cultural context even if this may be detrimental. They argued that this cultural pathologisation obscures the responsibility of local governments

to care for all its citizens and effectively supports the violence. Their conclusions include legal and practical recommendations to improve the situation of minoritized women surviving domestic violence.

*Rosenfield, Phillips and White (2006)*

Here, intersection was depicted as the interaction among multiple statuses, and as part of 'a growing body of theory and research that attests to the importance of contextualising social statuses and identities' (p. 179). They were concerned with the internalization and externalization of problems, e.g., depression and anxiety (internalization) vs. delinquent and antisocial behaviors such as vandalism, theft, assault, and substance abuse (externalization). They utilized 'self-salience schema', i.e., beliefs and values about the importance of self versus the collective in social relations, as the central concept for explaining gender and race differences in mental health. Schemas that privilege the collective over the self facilitate internalizing problems at one extreme, and schemas privileging the self over others contribute to externalizing behavior at the other extreme. Ideally, they argue, 'a combination of high self-regard and high regard for others guards against both self-destructive tendencies and those destructive to others' (p. 165). Critically from within an intersectionality framework, they also argue that the development of self-salience schema depends on the combination of race and gender, because notions of femininity and masculinity vary with race. Individuals occupying different intersecting social locations of gender and race receive different messages about the relative importance of self versus others. Hence, as 'cognitive representations of the social hierarchies in which individuals are embedded' (p. 166), the schemas constitute 'a pathway through which social inequalities such as gender and race shape well-being' (p. 166) and affect mental health.

Their sample was obtained from the Rutgers Health and Human Development Project and representative (for the state of New Jersey) with respect to class (measured in terms of income and education) and religion. The Time 1 data had been collected between 1979 and 1981 from 1,227 and 106 self-described white and African American adolescents, respectively (ages 12, 15, and 18); Time 2 data were collected three years later. To assess socialization messages, they used items pertaining to self-worth, boundaries in relationships, and ranking or superiority to others from the Personal Attributes Questionnaire, a measure of masculinity and femininity. Respondents had been asked what adults expected from boys and girls in relation to each item. By conducting gender comparisons within race and race comparisons within gender, they demonstrated that socializing messages about self depend on the specific combination of gender and race as do the self-salience schema and the pattern of internalizing and externalizing problems.

To determine whether self-salience schema can explain the race and gender patterns in internalizing and externalizing problems, they used multivariate multiple regression. Consistent with their theoretical framework, self-salience schema assessed at both Time 1 and Time 2 accounted for a significant amount of variability in scores on the measures of internalizing and externalizing problems at Time 2, and the interactions of race and gender were no longer statistically significant. They argue that an individual characteristic, the self-concept, that is dependent on the social relations of gender and race, can account for mental health problems previously associated with race and gender. Moreover, because the socialization practices that shape one's self-concept are specific to the combination of gender and race, it is necessary to differentiate the content of interventions for the risk groups at both extremes of self-salience.



*Caldwell, Guthrie and Jackson (2006)*

Caldwell et al. argue that an intersectionality framework provides a more holistic lens to gain insights into health disparities and support social action. They investigated psychological well-being, defined primarily in terms of self-esteem and depressive symptoms. Doing so, they do not treat race, gender and class solely as demographic variables, but also as social identities. Racial identity development is their leading concept. They claim that racial socialization and experiences with institutional and interpersonal discrimination are the important practices in this developmental trajectory, with beliefs about the worth of one's own racial group as the outcome. Three attitudes are highlighted: private regard, public regard and racial centrality. Racial socialization is conceptualized in complex terms, highlighting differences related to involuntary and voluntary (migrated) minorities, gender, historical experiences, and social contexts: 'The traditions of oppression and racism persistently exert negative influences on the lives of many African Americans, resulting in more chronic economic disadvantages, less educational attainment, fewer career advancements, and poorer health outcomes than white Americans' (p. 166). On the other hand, they note that for Black Caribbean immigrants, social class matters more than race in their countries of origin, but the longer they remain in American society, the more discrimination based on colour affects them.

They used a weighted sample from the National Survey of American Life; African American adolescents were the involuntary minority (n= 810) and Caribbean Black adolescents were the voluntary minority (n= 360), with almost an equal number of females and males and varied family income. Adolescence was defined as age 13 to 17. Regression analyses, conducted separately for each race and gender combination, explored how the three racial identity attitudes and experiences with discrimination influenced self-esteem and depressive symptoms, while controlling for age and family income. The outcomes varied for the four race/gender groups, and they conclude that an intersectionality approach is essential for developing gender-responsive health interventions for black youth (especially for the boys).

*Whitney (2006)*

Even though 'intersections' is a term in her title, Whitney did not explicitly define intersectionality. Her study focussed on the social distinctions of sexual orientation and (dis)ability in women's lives in relation to mental health problems that are disabling and therefore complicate identity development, e.g., post-traumatic stress disorder, social anxiety and clinical depression. In exploring identity development, she drew on two interactional models that 'dynamically incorporate aspects of biology, cognition, and social and historical surroundings without using a fixed linear scale [and] ... posit identity as fluid and dynamic' (p. 41). Both models, Eliason's model of lesbian identity development and Gill's model of disabled identity development, explicitly refer to experiences, and awareness, of oppression and could be viewed as implicitly incorporating an intersectionality framework. Whitney's question was whether a single model can explain disability identity development and sexual orientation development, as well as the life experiences of queer women with disabilities.

She interviewed five self-identified queer women with disabilities, of whom four were Caucasian. Their ages ranged from 25 to 58 years. All lived in the Seattle area, and only one referred to her social class. The women were recruited from e-mail lists of groups providing disability advocacy, queer support or advocacy, social meetings for queer and deaf individuals, and word of mouth. Substantially more women responded to the study advertisements than

could be accommodated due to time limits. Those who participated received compensation. Whitney used a semi-structured interview format, beginning with separate questions about disability and sexual orientation and then asking 'How would you relate your sexual orientation and disability aspects of your identity?'. She analysed common themes across the five cases, but the primary analysis involved evaluating the women's accounts of their identity development in relation to the models of lesbian and disabled identity development. In doing so, she treated the development of an intersecting queer identity and disability identity as an empirical question. Apart from advancing theory, Whitney argues that her study's importance lies in making visible queer women with disabilities and uncovering the community's eagerness to share their experiences.

### COMPARATIVE ANALYSIS

As we have suggested in earlier sections of this paper, intersectionality offers a theory of social differences and an important emphasis on power relations. Consequently, it has implications for how one conducts research related to social diversity. Three questions guided our comparative analysis of how intersectionality was incorporated into the four target articles. Firstly, how do the researchers define and apply intersectionality as a theoretical framework, given the expectations raised in the scholarship on intersectionality? Secondly, how are power inequalities handled? Thirdly, what are the methodological characteristics of the studies?

#### *Defining and Applying Intersectionality*

Of the four articles reviewed, only Caldwell et al. incorporated an extended theoretical discussion of intersectionality. In the Rosenfield et al. article 'intersection' appeared on only four occasions and was treated as synonymous with 'statistical interaction'. Otherwise, the authors treated the meaning of intersectionality as self-evident, despite its use in the empirical literature being conceptually confusing. Burman and Chantler, for example, used intersectionality in two ways: (1) as intersecting types of difference and (2) to refer to other sorts of relationships, i.e., between practices and oppression (abstract, p. 59), assumptions (p. 66), tactics and agreements (p. 71), and policies and social differences (p. 72). Similarly, Whitney referred both to 'intersections of queer theory and disability studies' and 'intersections in these identities' (p. 50). The danger here is that intersectionality's transformative potential will be lost if attention is diverted from how individuals' social positions shape the meaning of their experiences.

All four studies limited their interest to a relatively small number of social distinctions (mainly two – gender and race, Whitney being the exception) with no explicit rationale for doing so. Although this may reflect the origins of intersectionality, recent scholarship has questioned this limitation (e.g., Knapp, 2005). Also, the practices for marking gender and ethnicity were limited and conventional, i.e., gender as men and women and ethnicity as 'culture' (but more specifically, geographical origin in Burman and Chantler and skin colour in Rosenfield et al.). Thus, the promise of intersectionality for moving away from simple categorical distinctions to incorporate multiple dimensions and complex intersections of varied power relations remains unfulfilled in these studies.

Nevertheless, all four studies make important theoretical contributions. Both Burman and Chantler and Rosenfield et al. introduce new concepts to develop a more comprehensive

understanding of mental health (care) problems. Burman and Chantler move away from an individualistic explanation of domestic violence survivors' behaviour by drawing on the concept *minoritization*. Rosenfield et al propose *self-salience schemas* as an alternative to a biological interpretation of internalizing and externalizing problems. Caldwell et al.'s and Whitney's theoretical contributions take a different form. They contextualize identity development as a process with historical and present difficulties (e.g., discrimination) and advantages (e.g., feelings of pride rooted in family and community socialization) that may be connected to race, queerness and disability. Thus, incorporating an intersectionality framework in these studies was generative in producing new ways of thinking about psychological concepts that may lead to more equitable and effective mental health care.

### *Sensitivity to Power Inequalities*

The four studies varied in the degree of attention paid to power relations. Burman and Chantler place minoritization in the centre of their analysis of a dominant narrative about women surviving domestic violence. As researchers, they opened up a space for survivors to speak about the barriers they face, thereby shifting analytic focus to the participants' concerns. In addition, they identify how cultural pathologisation takes place through service providers' referral patterns. Rosenfield et al.'s view of power and gender is broad (different types, positions and exchanges). They pinpoint the origins of power inequalities of race in economic differences and the historical conditions of slavery. Although they do not identify any achievable changes to the mental health care system, their analysis points to the advantages of the African American girls' self-reliance. Caldwell et al. implicitly point to power differences when they distinguish between involuntary and voluntary minorities. They use the terminology of 'oppression' and 'racism' in outlining African Americans' (the involuntary minority) historical experiences. Similarly, Whitney draws attention to a hitherto invisible group, the oppression associated with queerness and disabilities, and its influence on identity development.

All four studies advocate on behalf of gender- and ethnic-responsive interventions, but only Burman and Chantler and Whitney also propose improvements to the mental health care system and other services and institutions that contribute to the problems minorities face in accessing appropriate and effective services. Given the absence of similar proposals in the two other studies, we conclude that an intersectionality framework may stimulate more 'radical' solutions, but such radicalism is not inherent to the framework.

A power-related point that is missing from all four studies is the likelihood that a person is confronted with contradictory power relations. Using the geographic metaphor of intersectionality, an individual is located at any given moment at a particular point in the intersecting power relations that make up the specific social context. This precise point usually reflects both privilege and disadvantage, and the hybrid positions connected to it. For example, a highly educated, female survivor of domestic violence encounters both privilege and disadvantage. The assessment of her privileges and disadvantages shifts when we subsequently learn that she requires a wheelchair, has a well-paid job, is Black, but the wheelchair is only temporary. Importantly, then, we are dealing with a single individual situated in a single, complex location, whose personal strengths (or vulnerabilities), such as self-salience schemata, self-esteem and ability to cope with discrimination are connected to her shifting and multiple social positioning. When mental health researchers and practitioners treat specific social differences as independent variables that may interact, they overlook such complex and

contradictory power relations. Even if, in statistical terms, an advantage 'cancels out' a disadvantage, it is nevertheless important to understand how the positive and negative forces affect mental health. The four research examples discussed here are exploratory and ground-breaking in their use of intersectionality, and this more nuanced and complex level of discourse may be the next stage in advancing intersectionality as a workable framework. Still, their failure to enrich their analysis by considering privilege simultaneously with oppression means that they have not used intersectionality to greatest advantage.

### *Methodological Characteristics*

All four studies relied on respondents' self-identification regarding their membership in specific social groups. Clearly, this is consistent with an intersectionality framework, because it respects participants' self-constructions and avoids the 'oppression' of categorization.

The studies varied in adopting both qualitative (semi-structured interviews analysed by iterative reading) and quantitative (statistical analysis of survey data) approaches. Also, the two qualitative studies differed in their treatment of similarities and differences: Whitney focussed on similarities, whereas Burman and Chantler identified both convergent and divergent themes by challenging taken-for-granted assumptions about differences. In principle, such methodological diversity is consistent with the application of intersectionality in other fields, but still it remains controversial (McCall, 2005). What we found disappointing is the lack of justification for the methodological choices that were made.

In addition, we see some potential problems connected to the applied approaches, specifically, with the use of intersectionality in the Rosenfield et al. and Caldwell et al. studies. In order to compare race and gender groups using multivariate analyses, they needed large numbers of participants. Therefore, they used existing datasets and consequently had to be somewhat creative in deriving the variables for analysis given that the data were not tailored for their particular research questions. In our opinion, however, this solution contradicts the fluidity associated with intersectionality and its emphasis on differences being subject to variation in time and place. Indeed, they risked producing 'old' knowledge because adolescents' lives in 1980 likely differed from those in 2006 when the studies were published. Rosenfield et al. urge caution in applying their results due to possible racial or gender bias in the measures that were used at the time the data were collected, but more fundamentally, they risk producing an historical account instead of useful, current psychological knowledge.

A second potential problem pertains to the treatment of similarities and differences, because quantitative studies focus on statistically significant differences and patterns of co-variation and tend to ignore similarities. Nevertheless, both quantitative studies explored within group variation in their regression analyses. Rosenfield et al. first treated gender and race as independent determinants, and then checked for interaction effects of gender and race on the internalization and externalization of problems (p. 175). Finally, consistent with the assumption that gender and race are socially constructed, they tested whether self-salience could explain the gender and race differences in internalizing and externalizing problems. Thus, there is a tension between conventional statistical analysis and the type of analysis called for within an intersectionality framework, in the sense that the social differences should also be treated as dependent variables. Caldwell et al. used categorical variables to compose gender/race subsamples on which they applied regression analyses with 'racial identity attitudes' and 'experiences with discrimination' as independent variables while controlling for age and family income, i.e., two other social difference variables. Removing variability due to

age and income in this case is as problematic as ignoring the variability within gender and race groups as happens in much quantitative research not informed by intersectionality. Thus, for the time being, how to appropriately acknowledge both similarities and differences in analysis and interpretation remains a challenge for intersectionality-informed quantitative research. Consistent with McMullin and Cairney's (2004) well-rationalized study, we argue that researchers must explicitly account for their decisions (a) to identify some social differences as more important than others; (b) to consider social differences only as independent variables; (c) to explore some within-group differences and ignore others; and (d) to use particular statistical tests to explore these relationships.

### *Comparison with more Traditional Studies*

To better grasp what intersectionality studies contribute compared to more traditional studies that include comparisons of social differences but are not informed by intersectionality, we searched within the abstracts of *Women and Health* as this journal focusses on gender and has a tradition of being sensitive to issues of power. For the period 2004 to 2006, we selected abstracts mentioning some combination of the differences *ethnicity, culture, age, class, and sexuality*. From the resulting list of 25 articles, we first selected those concerned with mental health problems, and second, those mentioning the largest number of social differences (i.e., three or four): McLaren (2006); Outram, Mishra and Schofield (2004); Song, Sands and Wong (2004). To cover class as well as ethnicity/race, we added Boury, Larkin and Krummel (2004).

Notably, these articles lack explicit recognition of the complexity of social differences. For example, in examining mental health services utilization among low-income, white and African-American women during the perinatal period, Song et al. (2004) used data integrated from three administrative datasets. Ethnicity (their term) was treated as an independent variable, coded "1" if African American and "0" if white, and remained unpacked just like the sociodemographic factors, age, education, marital status, and number of children. The analyses consisted of chi-square, t-tests and hierarchical logistic regression (for predicting the probability of mental health services use) in which ethnicity was added as second step. Interestingly, they acknowledged the limitations of their analysis at the end of the article and noted that qualitative research could better identify how ethnicity and other factors affect mental health service utilization.

Similarly, Outram and colleagues (2004) aimed to examine associations between poor mental health and sociodemographic, psychosocial and health related variables in midlife Australian women. They used the dataset from the Australian Longitudinal Study on Women's Health. From a gender perspective, the quality of these data is refreshing and impressive in its sensitivity to the variation in women's lives, including employment status, main occupation, country of birth, and marital status. Nevertheless, they missed the opportunity to examine the intersection of age, ethnicity, and social class. Even 'midlife', with its multiple dimensions, oppressions, and contradictions, did not receive much elaboration. On the other hand, in their conclusions they attended to the broader context of women's lives and suggested that policies are needed to facilitate women's re-entry into the workforce after childbearing or child-rearing.

McLaren's (2006) research examined whether sense of belonging in the community and sexual orientation were associated with dysphoria among women. Drawing on the notions of internalized and externalized homophobia together with sense of belonging, she pointed to the relevance of socio-cultural context and power when studying mental health care issues. Her quantitative analyses are very sophisticated; she tested for additive, moderator and mediator

effects of sense of belonging. Nevertheless, from an intersectionality perspective, the analysis was incomplete because class and race variation within the heterosexual and lesbian groups was omitted, and no historical information was given.

Boury et al. (2004) studied depressive symptoms within a community sample of women who were post-partum and participating in a course aimed at weight management. Their hypotheses focussed on the relationships among income, depressive symptoms, body weight and physical activity levels. They treated age, ethnicity, education, and employment as demographic variables and reported descriptive statistics in their article. Confirming one of their hypotheses, the sample was characterized by relatively high rates of depressive symptoms. These symptoms were related to perceived stress and social support but not to body weight and physical activity levels. In discussing their results, they could only point to the range of possible stressors and areas of insufficient support that coincide with low income. An intersectionality perspective, however, could have led them to consider the importance of unpacking this social category and considering the power relations involved. In addition, they probably would not have mentioned a possible connection between ethnicity and weight concern when studying a sample that was 91% Caucasian.

In general, then, we find a common pattern among these four studies. All four focus on gender combined with one other social difference: namely income, age or sexual orientation. By choosing just one social location (e.g., low-income or midlife), however, they homogenize their samples and create subgroup profiles. This simplifies the range of social locations contained in the analysis, and although subgroup profiles may serve a useful purpose in preventive mental health care by identifying people at risk, the potential negative consequences of stereotyping in the absence of any serious consideration of the sociocultural context offer a reason to use such profiles with caution and to adopt an intersectionality perspective. Additional social variation was incorporated in regression analyses where the other social differences were included as independent variables. By combining multiple social differences in this way, however, the variability accounted for by the relationships among those differences is actually removed from the analysis. We conclude that these four studies stand apart from the four intersectionality studies primarily in their lack of interest in the sociocultural context of mental health (care) and their treatment of diversity as simple demographic categorizations.

## ISSUES FOR FUTURE DEVELOPMENT

In our view, the remaining challenge is adapting intersectionality's holistic lens and the complexity it entails beyond the gender and race concerns of its origins. A handful of others with a similar interest in intersectionality have already offered some suggestions. Both Carter, Sellers, and Squires (2002) and Stewart and McDermott (2004) highlight the importance of: (1) sufficiently large, heterogeneous samples that allow for an analysis of at least gender, race, and social class; (2) measures of social class that make explicit the power relations and living conditions that remain invisible with traditional demographic measures of class; (3) multidimensional comparisons instead of the common pairwise comparisons; and (4) acquiring the resources needed for the qualitative investigations that allow for the social/power relations associated with social differences to be explicated. Furthermore, they advocate basing decisions regarding the relevance of particular types of social difference on logical and empirical considerations such as the research project's goals (i.e., description vs. explanation),

the practical aim of the researcher/clinician (i.e., support for policy vs. diagnosis or treatment/intervention), the type of practice and client (i.e., physical, mental, or public health), constraints of the proposed statistical analyses, consultation with experts, or preliminary tests of statistical relevance if the data are quantitative. We would add that these decisions should be made explicit at each stage of the research process, bringing a reflexive orientation to the intersectionality framework.

Kohn and Hudson (2002) argue further that it is important to study variations in ethnic and gender identity. Simply categorizing individuals as female or male and ethnicity A or B does not adequately reflect the variability in their adoption of values, beliefs, attitudes and actions associated with ethnicity and gender. This has particular importance for mental health care providers, who may make incorrect assumptions about their clients based on apparent social category membership, and given the emphasis on empirically-supported treatment this is also a concern for researchers. In this critique, they highlight the social/power relations associated with ethnicity and gender as well as their multidimensionality. Their methodological recommendations include the adoption of ethnographic methods, investigating within-group variability in order to develop within-group profiles, and giving primacy to interaction effects. These recommendations are clearly consistent with the concerns we expressed about the way social differences are translated into variables, particularly in the traditional studies.

Finally, McCall (2005) warns that methods such as personal narratives and single-group analyses may easily lead researchers away from a multidimensional view to the articulation of a single dimension of each social difference. Regarding this point, we would add that in general there is a need to integrate available knowledge on social differences to inform research and practical mental health care decisions. For example, ethnicity can be unpacked not only as 'culture', geographical origin or color of skin (Rosenfield et al., 2006), but also as reasons for migration, nationality, religion, and sense of belonging or adherence to cultural practices (Phinney, 1996). Similarly, gender can be unpacked not only in terms of the assumed biological differences underlying the traditional gender dichotomy (as men and women) or cultural differences (masculinity and femininity), but also socially and psychologically: as gender stereotypes, gender roles, and rate of gender socialization. This would address the homogenization associated with treating social differences as categorical variables. Thus, simply adding more categorical variables is not the solution; instead, having a broad conceptual, interdisciplinary understanding of the meanings of social distinctions in the context of everyday life provides researchers and practitioners alike with a foundation from which to ask questions about mental health. Acker's (2006) recent conceptualization of intersectionality in terms of inequality regimes might be adaptable for the mental health (care) field.

Clearly, the time for descriptive studies that document differences between categories of social difference and leave the explanation for such differences to future research is past. To move to the explanatory level of research, a variety of methodological approaches will be required. For the moment, mental health (care) researchers seem mainly to utilize familiar methods. This however runs the risk of ignoring the phenomenological complexity implied in intersectionality (McCall, 2005). 'Methodological plurality' (Stewart and McDermott, 2004) may be advised, but the on-going challenge will be to develop decision rules for such pluralism. Certainly, one criterion for selecting appropriate methodology must be its capacity to treat race, gender, and other relevant social distinctions as interdependent in their potential relationships with mental health (care). Mental health (care) researchers who have used

intersectionality as a framework are only beginning to work out its implications for research methodology. What is needed now is research that uses intersectionality to inform *all* facets of the research process, from the research questions to the research design, analysis and interpretation. Methodological plurality in the absence of adequate attention to what the intersectionality perspective means will only lead to more studies falling back on familiar methods and modes of doing research and failure to capitalize on the promise of intersectionality.

## CONCLUSIONS

We began our study of intersectionality in the mental health (care) field with considerable optimism, having found the feminist scholarship promising. The paucity of empirical research adopting an intersectionality framework in mental health (care) research seemed to us an advantage in offering a space for critical reflection – to identify problems and offer solutions when they can have the most effect in shaping the direction of research, i.e., before orthodoxies develop. Simultaneously, we wondered about the scarcity of research formulated within an intersectionality perspective, even among feminist researchers. However, after our explorations, we wonder – in terms of the metaphor of ‘travelling theory’ whether the borders are closed except for those willing to pursue extraordinary measures and perhaps risk their position within the academy and their likelihood of obtaining research funding. Still, we now understand that the conceptual richness and complexity of intersectionality as a theoretical position must still be translated into convenient procedures for research and practice, and certainly in order to appeal to the mainstream in the mental health (care) field. Intersectionality has the potential to transform the field from an emphasis on a discourse of disease toward a framework that incorporates the socio-political context of gendered lives. This possibility may prove too radical however and encounter significant resistance from those with other epistemological and ontological commitments. Hence, we are somewhat sceptical about the likelihood that intersectionality will become the standard approach to diversity. Nevertheless, as we have demonstrated in our evaluation of existing research developed within an intersectionality framework, there are definite advantages to this approach, in particular its transformative potential.

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