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Intersectional Stigma and the Acceptance Process of Women with Mental Illness

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Acceptance of mental illness is facilitated by the presence of various resources that are needed to deal with associated stigma, prejudice, and discrimination. However, women with mental illness experience added levels of stigma and intersectional oppression that affect the acceptance process, including higher rates of victimization, unemployment, poverty, homelessness, and clinical disparities. Practitioners and researchers can benefit from sensitivity to intersectional stigma, or overlapping, multiple levels of stigma and discrimination, faced by women with mental illness. Participant case narratives from a qualitative study will be presented in order to demonstrate the impact of intersectional stigma on the process of acceptance for women with mental illness.

KEYWORDS serious mental illness, women, mental health, intersectionality, acceptance

INTRODUCTION

Acceptance of mental illness is facilitated by the presence of various resources that are needed to deal with associated stigma, prejudice, and discrimination (Spaniol & Gagne, 1997). However, women with mental illness experience
added levels of stigma and intersectional oppression that affect the acceptance process, higher rates of victimization, unemployment, poverty, homelessness, and clinical disparities (Artacoz, Benach, Borrell, & Cortés, 2004; Jonikas, Laris, & Cook, 2003; Mowbray, Nicholson, & Bellamy, 2003). In addition, women with mental illness have historically encountered insensitivity and prejudice in the mental health field (Ussher, 2011). Further study is needed as to the intersectional stigma faced by women with mental illness—overlapping, multiple levels of stigma and discrimination (Logie, James, Tharao, & Loutfy, 2011).

In the present article, several case narratives will be presented from a qualitative study in order to examine the impact of intersectional stigma on the process of acceptance of mental illness for women. First, background literature will be presented on the intersectional stigma faced by women with mental illness. Next, qualitative method and data analysis will be discussed. Two case narratives from participants in the present study will be introduced to illustrate intersectional oppression experienced by women with mental illness. Implications for research and practice will be discussed.

Acceptance and Mental Illness

CONCEPT OF MENTAL ILLNESS

Use of the term “mental illness” evokes the medical model, potentially overlooking the sociocultural factors that contribute to mental health problems. In addition, activists and advocates have established the phrase “persons in recovery” as an alternative reference to mental illness in order to promote hope, meaning, and life satisfaction among this population. However, the term “mental illness” is commonly used in the literature to describe a specific level of severity of mental health problems. In this context, a “mental illness” connotes an Axis I diagnosis of a psychiatric disorder with significant impairment in at least two areas of functioning (social, vocational, academic, and activities of daily living) (National Institute of Mental Health [NIMH], 2008). While there are disadvantages to the use of the term “mental illness,” it is used in the present article for clarity of communication to refer to this specific group affected by severe mental health problems.

CONCEPT OF ACCEPTANCE

Leaders of the rehabilitation movement have identified acceptance of mental illness as central to the recovery process and one of its most challenging stages (Deegan, 1996; Ridgway, 2001; Spaniol & Gagne, 1997). A recent study found acceptance of mental illness to be a process of recognizing one’s mental illness and actively engaging in the management of related symptoms and experiences (Mizock, Russinova, & Millner, 2014). This study also found the acceptance process to be multidimensional, involving behavioral, emotional, cognitive, relational, and identity dimensions. Acceptance of mental illness
has been linked to a number of positive outcomes, including enhanced functioning, illness management, and quality of life (Cunningham, Wolbert, Graziano, & Slocum, 2005; Kravetz, Faust, & David, 2000). In addition, a number of barriers have been suggested to the acceptance process, with stigma being one of the most difficult barriers to overcome (Spaniol & Gagne, 1997).

STIGMA AND ACCEPTANCE

Stigma refers to negative attitudes, prejudice, and discrimination towards individuals with mental illness and other marginalized groups (Link & Phelan, 2001). Stigma interferes with recovery from mental illness by reducing one’s social status, social network, and self-esteem (Perlick et al., 2011). Stigma contributes to impairment in social and vocational functioning and has been found to prolong symptoms, increase hospitalizations, and delay treatment (Link & Phelan, 2001). Stigma is subdivided into two types, the external stigma of prejudice and discrimination by others, as well as internalized stigma, which is stigma directed at oneself (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001). Both men and women with mental illness face external and internalized stigma, which likely interferes with acceptance of mental illness.

Women with Mental Illness

GENDER-RELATED OPPRESSION

Barriers to acceptance of mental illness may be compounded for women with mental illness in contrast to their male counterparts. Women are overrepresented among people diagnosed with mental illness (Gove, 1980; Mowbray, Herman, & Hazel, 1992). Gender-related oppression is a central factor that is reasoned to impact the differences in rates, development, and recovery from mental illness among women (Gove, 1980). Women face disproportionate rates of violence, homelessness, and unemployment that contribute to elevated prevalence and further worsen mental health (Artacoz et al., 2004; Jonikas et al., 2003; Mowbray et al., 2003).

RISK FACTORS

In contrast to their male counterparts, women with mental illness experience elevated rates of victimization (Gove, 1980; Mowbray et al., 2003). It is estimated that as many as 51% to 97% of women with mental illness have a physical and sexual assault history (Goodman et al., 2001). Women in general are at increased risk of sexual abuse during childhood, which has been found to be associated with elevated rates of psychiatric symptoms in adulthood (Meyer, Muenzenmaier, Cancienne, & Struening, 1996). Women with mental illness also experience increased risks of sexual exploitation and prostitution (Padgett, Leibson Hawkins, Abrams, & Davis, 2006; Weinhardt, Carey, Carey, & Verdecias, 1998). Violence towards women with mental illness also
contributes to elevated psychiatric symptom severity among this group, as well as substance abuse and homelessness (Benbow, Forchuk, & Ray, 2011; Goodman, Rosenberg, Mueser, & Drake, 1997).

**CLINICAL DISPARITIES**

Women with mental illness also experience a number of clinical disparities. This population has historically encountered insensitivity and even prejudice from the mental health professionals they have sought for help (Ussher, 2011). Gender differences have emerged in diagnostic practices, with women often being judged by providers harshly when not conforming to gender stereotypes (Eriksen & Kress, 2008). Previous research has also found gender bias in clinicians to include pathologizing women’s emotional reactions with increased diagnoses of histrionic, borderline, or dependent personality disorders (Eriksen & Kress, 2008; Reich, Nduaguba, & Yates, 1988).

In addition, women with mental illness face unique considerations once in therapy (Mowbray, et al., 2003). Given the prevalence of mothers among women with mental illness, many women seek psychiatric treatment to get help with custody problems or other parenting stressors (Joseph, Joshi, Lewin, & Abrams, 1999). However, a parenting focus is usually lacking in psychiatric interventions (Joseph et al., 1999). While overt discrimination towards women with mental illness in clinical settings may be on the decline, subtle forms of stereotypes, biases, and various microaggressions may occur (Mowbray, 2003).

**Intersectional Stigma Among Women Mental Illness**

**INTERSECTIONALITY**

The added levels of oppression faced by women with mental illness demonstrate intersectional stigma encountered by this group. The theory of intersectionality refers to the multiple social, political, and cultural identities within an individual that lead to compounded experiences of oppression (Benbow et al., 2011; Crenshaw, 1993). This construct can be used to examine combined levels of privilege and oppression based on race, ethnicity, religion, age, class, gender, sexual orientation, and (dis)ability (Benbow et al., 2011). Different aspects of one’s identity may lead to privilege (i.e., unearned societal advantages) or oppression (Shields, 2008). For example, one may be disadvantaged in terms of racial identity in the broader society, but privileged with regard to socioeconomic status. Therefore, intersectional identities are contextual and not static (Collins, 2000; Shields, 2008).

**INTERSECTIONAL STIGMA**

There has been little research examining intersectionality in the lives of women with mental illness, and more research is needed in this area given
the compounded levels of discrimination and oppression experienced by this population (Benbow et al., 2011). Depending on one’s social identity, women with mental illness may experience intersecting oppression regarding stigma towards mental illness, sexism, racism, homelessness, and poverty (Benbow et al., 2011). As a result, the concept of intersectionality is valuable to the study of women with mental illness. A study by Logie and colleagues (2011) is among the few studies that have examined issues of intersectionality in the lives of women with mental illness. These authors coined the term intersectional stigma to describe overlapping marginalized identities among these women with regard to HIV-related stigma, mental illness stigma, sexism, racism, transphobia, and homophobia. Further research is needed to examine intersectional stigma in the lives of women with mental illness.

Narrative Research and Intersectionality

Qualitative case narrative research has been recommended for studying the complex construct of intersectionality (McCall, 2005; Shields, 2008). Qualitative case narratives have also been identified as useful in analyzing the multifaceted issues of intersectionality, multicultural identities, and mental illness stigma (Greene, 2010; Ridgway, 2001; Trahar, 2009). This research methodology entails attending to and constructing participant narratives based on research interviews, as well as identifying key themes from interview data (Adler, Kissel, & McAdams, 2006; Mishler, 1991). Case narrative research emphasizes meaning and content in the accounts of participants and is a valuable means of informing clinical practice (Edwards, Dattilio, & Bromley, 2004; Patsiopoulos & Buchanan, 2011).

Study Rationale

There is a gap in the literature on intersectionality among women with mental illness, particularly with respect to the process of acceptance. In addition, researchers have described the value of case narrative methodology for investigating issues of intersectionality among individuals with mental illness. Therefore, this study was conducted to examine intersectionality in the acceptance process for women with mental illness. Barriers and facilitators to acceptance of mental illness are presented in relation to intersectional stigma. Narrative methodology was utilized to analyze the interviews and develop case narratives based on this data to assist practitioners with extending these findings to the practice of psychotherapy.

Method

Participants

Participants were screened via telephone for meeting selection criteria. Participants were 18 years of age or older and had received mental health...
services for at least 5 years. Congruent with standard definitions of mental illness (NIMH, 2008), participants were screened for a primary diagnosis of Bipolar Disorder \( (n = 9) \), Major Depression \( (n = 9) \), or a Schizophrenia spectrum disorder (i.e., Schizophrenia or Schizoaffective Disorder; \( n = 12 \)) with significant impairment in at least two areas of functioning (social, vocational, academic, and activities of daily living). Number of years of mental health services received was selected as part of selection criteria to ensure participants had sufficient experience with mental illness.

The sample included 20 European American participants, 3 African American participants, 3 Asian participants, 2 biracial participants (1 Asian and African American participant; 1 African American and European American participant), 1 Latino participant, and 1 Native American participant. With regard to immigration, 3 identified as an immigrant to the United States, 3 as first generation, with 24 participants identifying as second generation or more. Four of the participants identified as lesbian, gay, or bisexual, and 26 identified as heterosexual. Ages of participants ranged from 19 to 72 years.

Procedure

Stratified sampling was used where participants were selected for the study based on the aforementioned selection criteria. Participants were recruited on an ongoing basis to fill approximately equal groups stratified by gender and diagnosis. Semi-structured qualitative interviews were conducted by the primary investigator (first author). In addition, a research team took part in data coding, analysis, and interpretation. The research team included 3 researchers that varied demographically by ethnicity, nationality, immigration experiences (Indian, Bulgarian, European American), as well as age (early 30s through mid 40s). Researchers included doctoral level investigators trained and experienced in qualitative data analysis and coding.

Institutional review board approval was received prior to conducting the study. Participants were then recruited from the targeted psychosocial rehabilitation center during a phone screening process that ensured participants met selection criteria. Participants were informed of the study’s focus on their experiences associated with mental illness and sense of self. The interviews ranged from 40 to 60 minutes in length and took place in a private research space within the psychosocial rehabilitation and education center from which participants were recruited. Each participant signed a consent form to participate and completed a brief demographics questionnaire. Participants were paid $25 for participation in the study. Audio recordings of the interviews were transcribed verbatim.

SEMI-STRUCTURED RESEARCH INTERVIEW

The research team developed a semi-structured interview guide to focus on several topics related to the acceptance process associated with mental
illness, including experiences with diagnoses, symptoms, mistreatment, sense of self, losses, coping, and resilience. Drafts of the semi-structured interview protocol questions were reviewed, revised, and modified by the research team in order to enhance the ability of the interview to gather narrative data related to the topics at hand. Per the iterative process of qualitative research, questions were added to the interview guide over the course of data collection to allow for further exploration of themes of interest (DiCicco-Bloom & Crabtree, 2006).

DATA ANALYSIS

Thematic analysis (Aronson, 1994) was used by the research team to analyze the 30 interviews. The research team read the interview transcripts and identified themes in the interviews by coding the transcripts in a line-by-line coding process. The research team convened intermittently throughout the reading of the 30 transcripts to compile a codebook of themes and representative quotes from transcripts related to these themes. Themes were extracted based on comparison of the coded transcripts of the research team members, followed by discussion to determine the codes applied to the transcripts. When investigators arrived at the same coding for themes individually, this enhanced confidence and confirmed accuracy of the resultant themes. In the case of inconsistency of coding, consensus was utilized to arrive at a final code. The theme selected from this codebook included data relating to intersectionality in the acceptance process of mental illness for female participants.

The interviews were further analyzed by the research team using narrative methodology (Mishler, 1991). This approach allowed for a selection of narratives of participant experiences regarding the process of acceptance of mental illness. Per the multiple case narrative approach, case narratives were selected by the research team to highlight themes pertaining to the impact of intersectional stigma on the process of acceptance of mental illness for women. The case narratives were selected based on consensus of the research team on several criteria: (1) the case would lend to rich analysis and understanding of the impact of the participant’s identities on the process of acceptance, and (2) the case would allow for the representation of a cross-section of participant narratives highlighting issues of intersectional stigma. The primary investigator (first author) wrote case narrative accounts based on the interviews, including content related to the identified focus of this research theme of intersectionality in the acceptance process.

The research team reviewed the interview transcripts to ensure consistency between the case narratives and the interview data. The narratives were organized as follows: (1) presentation of the participant’s demographic background and narrative of experiences with mental illness; (2) the participant’s definition of the acceptance process; and (3) the participant’s description of relevant barriers and facilitators to the acceptance process. Key quotes within
participant interviews were embedded into these case narratives, also based on consensus by the research team. Case narratives were developed from participant interviews to highlight intersectional stigma in the acceptance process for women with mental illness. In addition, case narratives were constructed to contextualize the intersectional stigma within the recovery stories of participants to help practitioners relate these findings to psychotherapy practice. In some cases, minor information was altered about the participants to further mask identity.

VALIDITY

Validity in the present study was maintained through a number of strategies. (1) Multiple coding of interview themes is a validity strategy that was used by the 3 researchers to enable the comparison and revision of themes to enhance validity of themes and the resulting case narratives (Barbour, 2001). (2) Cross-checking of the written case narratives and the interview transcripts was conducted by the research team to ensure consistency—a standard procedure in narrative methodology (Patsiopoulos & Buchanan, 2011; Polkinghorne, 2007). (3) Investigator triangulation was utilized through the use of 3 research team members to provide complementary perspectives on the development of the research case narratives (Guion, Diehl, & McDonald, 2011). (4) Memos of research team meetings were kept and redistributed to the research team over the course of the 4 months of data analysis to record themes, key quotes from the interviews, and interpretation of case narratives. Memo-keeping is a validity measure used to enhance reflexivity in qualitative data analysis (Corbin & Strauss, 2008). Finally, (5) Consensus among research team members was used in the selection of case narratives and when disagreement arose concerning coding. Consensus is a research strategy often used to reduce bias and enhance validity of case-based research (Edwards et al., 2004).

RESULTS

The following case narratives were selected to highlight issues of intersectionality and associated barriers and facilitators to the process of acceptance of mental illness among women. These case narratives include a presentation of the participant’s illness narrative, experiences with intersectional stigma, participant definitions of acceptance of mental illness, and related barriers and facilitators to this process.

Case Narrative 1

“Clara” is a biracial woman in her thirties of African American and South Asian heritage. Throughout her life, she has been diagnosed with a number of psychiatric and physical problems, such as Posttraumatic Stress Disorder,
severe Major Depression, Fibromyalgia, and Chronic Fatigue Syndrome. Her mother died when she was a child, and her father was unable to care for her because of his mental illness. Clara and her brothers went to live with other family where she was sexually abused by a family member. Her family members soon lost their housing and she became homeless. Clara began to engage in sex work to provide for herself and her siblings, as well as to support an opiate addiction that lasted throughout her teens. To add to these struggles, Clara reported a number of experiences of stigma and mistreatment by the providers she had sought for help, including racially derogative remarks and an incident of sexual assault by a former therapist. In middle-adulthood, Clara accessed a number of support networks that she found helpful in dealing with these injustices. She decided to use her mental health experiences to help others and became a peer specialist.

INTERSECTIONALITY

Clara discussed multiple experiences of oppression with regard to her racial, class, mental illness, and gender identities. Clara stated during the interview, “I feel more of an akin, and an identity as someone who’s poor, than I do as someone who’s mentally ill... Having to deal with not having money... felt a lot more pressing than my mental illness.” In Clara’s case, her intersectional experiences of oppression at times led one oppressed identity to take precedence over others, such as being poor. In addition, she spoke about multiple experiences of abuse as interfering with treatment. She stated, “when I was younger, I was sexually abused by one of my therapists when I was in juvenile for a weekend, because I got picked up for prostitution. And I was sexually abused by the first person I ever opened up to about what happened between me and my [family member]... I think it’s been why I have a really safe professional distance from my providers... it makes therapy something that I’ve been in and out of and in and out of, and in and out of since I was 12. It makes me not trust people and not want to stick around.” Clara’s abuse history reflects barriers to treatment for many women with mental illness given elevated risks of violence and mistreatment—contributing to intersectional oppression.

DEFINITION OF ACCEPTANCE

When asked about the meaning of acceptance, Clara responded, “It’s part of my identity... To me it means coming out and it means being able to advocate for others... I accept [my other psychiatric problems] as a part of my Fibro and my PTSD. I don’t think I look at my depression that much as a separate component. I mean, it just feels like it’s just one more thing that I have. So, I never had a big deal about it. I mean, accepting it was more like finding a reason for my pain, than trying to accept a label.” Clara defined acceptance of mental illness as a part of her identity. Her acceptance of mental illness
was made less difficult given her acceptance of other psychiatric and medical conditions. Moreover, developing a role as an advocate was also central to her acceptance process, highlighting multiple ways in which various aspects of her identity were central to her acceptance process.

**Barriers to Acceptance**

Clara was asked to comment on barriers she encountered to accepting her mental illness. Clara described these barriers to include lack of public acceptance, stating, “I just think that our society has a hard time dealing with depression as a real thing. As a disease and as—well, not a disease, but as something that’s more than just a part of someone’s personality.” Clara described another barrier to acceptance as access to mental health resources. She stated, “I mean, how helpful is it [to accept mental illness] to a person who has absolutely no money, who can’t go to a therapist?” These responses underscore the impact of socioeconomic status and mental illness stigma on acceptance of mental illness.

**Facilitators to Acceptance**

Clara was asked about what facilitated her process of acceptance of mental illness. She replied, “My depression advocacy group [for women of color]... Because, being a person of color, it’s not something that’s culturally talked about... Because so many...women in this culture end up taking care of everybody else other than themselves.” Clara’s response emphasized the importance of the support of others with shared experiences of intersectional oppression related to mental illness, race, gender, and class. In addition, she indicated that other medical disabilities enhanced her ability to accept her mental illness. She stated, “I kind of figure my depression is part of, I mean, it’s part of having Fibro and Chronic Fatigue, so it’s just one more...thing that you get when you get the whole like, range of crap which is CFS and Fibro.”

Clara’s narrative highlights how intersecting identities related to gender, race, ethnicity, socioeconomic status, and medical disability impact the process of acceptance of mental illness. As a woman with mental illness, Clara experienced increased risk of violence and mistreatment. However, awareness of these intersecting identities facilitated her acceptance of mental illness and allowed her to connect with women with shared experiences of intersectional oppression. Moreover, her class identity often took precedence over her mental illness identity, further influencing her sense of self and acceptance process surrounding mental illness.

Case Narrative 2

“Rita” is a White American woman of Jewish heritage. Rita was diagnosed with Asperger’s Syndrome¹, epilepsy, and learning disabilities in childhood. She
often wrote depressive notes to teachers during middle school and believed she had undiagnosed depression throughout childhood and adolescence. She received her first diagnosis of depression in college in a student health center and became interested in mental health services. After college, Rita began to work as a case manager in a group home for adults with development disorders. Her depression began to interfere with her ability to go to work everyday, and she decided to apply for welfare support. To cope with her struggles, Rita joined a depression support group for low-income women. She also became an advocate for people with autism and worked to change state policy.

INTERSECTIONALITY

Rita’s background highlights intersectionality in the number of experiences of oppression related to physical disability, mental illness, and gender identities. Rita described public stigma towards physical versus psychiatric disabilities. She stated, “As long as you’re obviously disabled, people are fine with you... But if you have anything invisible, and all of mine are invisible... Nobody wants to accommodate that... And then, the media constantly plays up that crazies are violent by definition... So you’ve got that sort of double whammy.” Rita emphasizes the impact of stigma associated with invisible disabilities like mental illness on her acceptance process. In addition, the term, “double whammy,” parallels the meaning of double stigma in her experience as a woman with mental illness and other disabilities.

DEFINITION OF ACCEPTANCE

When asked to define acceptance, Rita indicated, “Trying to work with it, figuring out how to realize when I’m beginning to slide when things aren’t going well and such, and figuring out what to do... I’m a big believer in radical acceptance... That you need to completely accept yourself for who you are, and that you need to accept others too, but before you can accept other people and not judge them you need to do the same thing for yourself.” This definition of acceptance revealed the identity development process of acceptance of mental illness.

BARRIERS TO ACCEPTANCE

When asked about barriers to acceptance, Rita described her age as being a barrier given that she was diagnosed during a time when little was known about depression and she did not receive treatment. She stated, “Well, because of my age, I think, I’ve probably been-- I mean, I think I was depressed as a child, but I think in the ’70s it wasn’t really a concept. I don’t think they thought children could be depressed really.” In addition, she cited
a barrier to acceptance as public dismissal of invisible identities like psychiatric disabilities and stereotypes of violence in the media surrounding mental illness. “As long as you’re obviously disabled, people are fine with you...because with that kind of attitude running around it can feel to you like it’s not real, as real as if you were in a wheelchair or as if you had crutches or whatever. It can run the risk for some people of feeling, ‘It’s just all in my head’ or dismissing it as something that you just need to fight or you just need to get over.” Moreover, Rita described public notions of coping with depression and disabilities as a barrier to acceptance. She stated, “Everyone says you have to fight depression and all of this,... And that that was the whole picture that everyone has of disabilities– the brave fight against your disability. The picture everyone has of the brave disabled person bravely fighting their disability and overcoming it, and that’s the wonderful, lovely picture.”

FACILITATORS TO ACCEPTANCE

When asked about facilitators to acceptance of mental illness, Rita replied, “Talking to other people about stuff. I went for like three years to a weekly low-income women’s group, and that was really good... I learned a lot about asking for help at this group.” Rita also described the impact of other psychiatric conditions on this process. She stated, “[Because of Asperger’s] I care less than a lot of people about what other people think... It’s helped me do what I want in life. I’ve always known a lot about who I am, and I’ve not been influenced that much—to some extent, but not that much—by other people.” She also described acceptance of mental illness as “Just one more disability on the long list, I guess. The laundry list is being added to, I suppose.”

Rita’s case demonstrates how acceptance of mental illness is impacted by intersectional identities. Like Clara, her previous acceptance process of her other disabilities such as epilepsy or Asperger’s Syndrome facilitated her acceptance of mental illness. Connecting with other low-income women with serious depression facilitated her process of acceptance. Moreover, stigma she faced as an American of her generation interfered with her acceptance of her mental illness. Although her Jewish background was not explored further during the course of the interview, it is possible that this religious and ethnic identity further contributed to her mental health experiences. In a related study, Jewish cultural values of academic achievement posed barriers to one participant’s acceptance of mental illness and associated academic impairment (Mizock & Russinova, 2013). In addition, Jews have a long history of marginalization, and higher rates of depression have been found among this group (McCullough & Larson, 1999). This case demonstrates that multiple, overlapping identities may lead to oppression and offer resources that impact the process of acceptance of mental illness. Similar to the first case, Rita’s advocacy work also became an important role and means to foster acceptance.
DISCUSSION

As evidenced by these case narratives, women with mental illness may face intersecting levels of oppression based on sexism and mental illness stigma. When these women face other levels of marginalization such as racism, disability, abuse, or poverty, these factors add further struggles and stress. These findings suggest that compounded levels of intersectional stigma may further interfere with the acceptance of mental illness. These results also underscore areas of resilience and strength among women with mental illness. Specifically, the findings indicate that women’s awareness of the impact of systemic discrimination, prejudice, and oppression surrounding intersectional identities can increase empowerment and acceptance of one’s mental illness. Results indicate that the advocate role is crucial to women’s acceptance of mental illness and helps to promote recovery among other women facing intersectional stigma.

These results highlighted and extended previous findings in the literature. For one, this study provided narrative evidence of intersectional stigma in the lives of women who encounter both sexism and mental illness stigma (Logie et al., 2011). These case narratives illustrated previous findings that women with mental illness may be at increased risk of poverty, sexual and physical violence, mistreatment in the mental health system, homelessness, and unemployment (Jonikas et al., 2003; Mowbray et al., 2003). In addition, a previous study found people with congenital psychiatric or physical disabilities had higher levels of acceptance than those with acquired disabilities (Li & Moore, 1998). The present study also confirmed that prior physical or psychiatric conditions facilitated the acceptance of later diagnoses of mental illness. The present study extended these findings to suggest that women with mental illness may be particularly aware of the impact of intersectional stigma on the acceptance process, and may benefit from identity-congruent supports and resources (i.e., support groups for women with mental illness).

Clinical Implications

These findings reflect the importance of some specific practices for therapists working with women with mental illness. First, therapists can ask clients about the impact of intersectional oppression, and support clients’ experiences with mental illness. It is important to learn of mistreatment in mental health services or otherwise that might add to intersectional stigma and affect the therapeutic alliance. Clinicians should investigate the client’s definition of acceptance of mental illness and identity-related barriers and facilitators in order to foster acceptance and empowerment. In addition, therapists can explore community resources and opportunities that might further facilitate the acceptance process and evaluate the effectiveness of these resources with the client. For example, practitioners can support women with mental
illness in accessing women’s support groups and becoming advocates to other women.

This research raises a number of clinical considerations for feminist therapists. For one, feminist therapists can be agents of social change in raising awareness of the impact of oppression on the lives of women with mental illness. Clinical training may be a valuable space to enhance awareness of intersectional stigma. In addition, feminist therapists may experience tension in assigning pathological diagnoses to women of mental illness due to diagnostic stigma and the history of labeling women as “mad.” Therapists can work with clients in a collaborative manner to find names for the problem in order to reduce power differentials in diagnosis. These findings also suggest the importance of referring female clients to academic or vocational counseling as well as women’s support groups. These resources may be effective in helping women with mental illness to increase self-esteem, academic and vocational motivation, as well as job networking opportunities (Jonikas et al., 2003).

Limitations and Future Research

A number of limitations in the present research can be addressed in future research. The present article focuses on intersectionality in the lives of women with mental illness, and future research may extend the study of intersectionality to the lives of men with mental illness as well. A small sample size and qualitative method was utilized in the present article to allow for in-depth exploration of the illness narratives of several women with mental illness. However, this sample and methodology pose limitations to generalizability. A larger, quantitative study would evaluate these findings with a broader sample. While research team members conducted cross-checking to ensure consistency of the case narratives and interview data, member-checking by research participants could further enhance validity in future studies. Follow-up interviews with participants may address limitations of the single semi-structured interview used in the present methodology. Interviews in the present study could have explored more deeply the topic of religion and ethnicity. Further study is needed as to the impact of religion and ethnicity on the acceptance process for people with mental illness. Lastly, additional study is needed to investigate strengths, resilience, and coping among women with mental illness.

Women with mental illness face intersectional stigma related to sexism and mental illness stigma. Due to intersectional stigma, women with mental illness may face increased risk of trauma, unemployment, poverty, and homelessness. Engaging in advocacy, women’s groups, and peer supports can help women with mental illness to gain awareness of the effects of intersectional stigma on their lives and promote acceptance of mental illness, recovery, and empowerment.
NOTE

1. Currently identified as mild autism spectrum disorder.

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