

Black Eyes Matter: Nuances of Intersectionality and their Impact on Inclusion and Support

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Abstract

This article explores the author's experience with navigating invisible intersectionality factors, erroneous judgments by others and discovering her own resilience in the process. The author considers the binary of activism and respectful distance as responses to social problems, offering connection as a strategy to enhance human rights within the Black community. Personal and professional strategies are provided to promote recovery and healing; utilizing an autoethnography qualitative research method.

Intersectionality refers to the diversity traits that make each of us unique and the corresponding power and privilege (or lack thereof) associated with the combination of factors. Managing the impact of circumstantial, life changing elements like grief, illness, disability or trauma is challenging, as they are often invisible and unacknowledged, frequently absent at birth, and represent a shift from previous intersectionality identification. When people are experiencing a juncture of stress or crisis and facing identity change, they are increasingly vulnerable, making the role of those providing personal or professional support more significant. Despite connection to certain communities, the ability to access one's strengths and resilience is influenced by how one experiences these largely invisible elements. As a result, intersectionality is not static, providing opportunities to be defined and redefined throughout the life cycle depending on how one negotiates these experiences.

Keywords: Intersectionality; Disability; Autoethnography; Black community; Human rights; Religion

Introduction

Intersectionality refers to the intricate amalgamation of diversity factors each individual identifies with, and the corresponding power and privilege (or the lack thereof) associated with those factors. While this seems straightforward, the possible combinations and identity manifestations are both complex and infinite. There are innumerable factors with which to identify, and each person's combination of power, privilege, history and experiences associated with each identity factor as well as the intersection of all of the factors on the person as a whole are individually unique.

While it is up to each individual to define their own intersectionality, relational communication involves utilizing perception and visual cues to ascribe others to social identity categories. Many diversity factors correlated with privilege (such as sex, race, and socioeconomic status) are based on visible traits or observable characteristics. However, numerous identity factors, including gender identity, religion, sexual orientation and education are often indecipherable, ambiguous or invisible. As a result, various identity factors may be ignored or excluded in how we interpret and judge others' intersectionality. Research supports the notion that lack of acknowledgement of intersectionality minimizes or invalidates people's experiences and existence. Crenshaw [1] asserted that for marginalized groups, identity based politics are a source of strength, development and community. Thus, the politics of identity are powerful frameworks in which to understand and support interpersonal interactions.

This article is about my experience as a Licensed Clinical Social Worker, Clinical Psychologist, and Assistant Professor at a university. I am also a marginalized African American woman who maintained a four month black eye as a consequence of intensive brain. During my recovery process, I watched people look at my face, settle on my black eye and look at my husband. Then they would look at me, faces scowling, confused, pensive or concerned; their responses were saturated with

emotional reactivity and judgment. Because I had this black eye for four months following my surgery, I had an opportunity to observe and analyze the exchanges that occurred between strangers, friends, colleagues and myself. What I wondered through and following this process was: "Does my black eye matter? Or is it simply a confirmation of who others think I am based on my more distinguishable identity factors?"

The core of this self-reflective narrative is my subjective experience, which is reflective of the larger social, cultural and political world around me. Ellis [2] describes autoethnography as "a form of ethnography" that includes portions of the autobiographical self and elements of the larger culture, with a result greater than the individual parts. Marechal [3] defines autoethnography as "a method of research that involves self-observation and reflexive investigation in the context of ethnographic field work and writing." This account analyzes reflexivity as it relates to intersectionality, stereotypes and interpersonal interaction within the Black community. It is my objective to confront and explore the binary oppositions between the content contained within my story and additional disparities between researcher and researched, process and product, personal and political and objectivity and subjectivity with a larger goal of enhancing emerging theoretical discourse [4].

My Story

Intersectionality is a core component of my research, practice and

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Received October 20, 2016; Accepted June 29, 2017; Published July 05, 2017

Citation: Ashley W (2017) Black Eyes Matter: Nuances of Intersectionality and their Impact on Inclusion and Support. Social Criminol 5: 165. doi: [10.4172/2375-4435.1000165](https://doi.org/10.4172/2375-4435.1000165)

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teaching. As a Black, bi-racial female, tattoo wearing, youthful looking person, I have spent the majority of my life struggling to learn how to personally and professionally navigate the world. As the child of an interracial marriage, I am very familiar with judgmental looks. Growing up, I would see people look at me, then at my White mother and back at me. The looks would consistently have a quality of judgment, and were sometimes followed by questions like “Is she adopted?” or “Who’s her mother?” My mother, enjoying a different level of privilege than myself, never experienced these looks or questions as invasive or judgmental. However, I recall them very clearly and compared them with the looks people gave when I was with my Black father, which required no correlated questions about my identity and carried minimal judgment.

Despite my current professional dossier including published articles, conference presentations, courses taught and speaking engagements in which I explore contemporary, relevant clinical issues utilizing an intersectionality lens, I am assiduously working to assure my students, colleagues, and the university that I am competent as an academic and educator. The demographics and culture of academia is distinctly white, heterosexual and middle to upper middle class; those differing from that norm often find themselves “presumed incompetent” by students, peers and supervisors [5]. No one directly approaches me and asks if I am capable or proficient, but microaggressions and microinvalidations abound. Harris and Gonzalez describe these experiences as belittling, at times openly racist, and questioning of qualifications, activities and research [5]. African American women scholars experience a double bind through the combination of being a woman and a woman of color [6] and double marginalization through the lived experiences of academic culture [5]. However, since I was a Black, female, tattoo wearing, youthful looking human being prior to working in academia, I have learned to balance oppression in both my personal and professional lives with some degree of grace and skill.

This year, my life turned upside down and as a result, all my methods of managing stress were challenged. After some vision limitations and a relatively poor optometry appointment over the summer, I was sent to a neural ophthalmologist and later to obtain an MRI. Almost as fast as lightning it was discovered that I had a tennis ball sized, skull based brain tumor. The recommendation was immediate surgery and subsequent radiation to treat the tumor. Because time was limited, everything moved rapidly. I informed my boss and my colleagues and cancelled virtually everything in my life. I was pleasantly surprised and humbled to see so many family, students, friends and colleagues stepping forward to be supportive. They formed a healing community around me and my journey.

Waking up following brain surgery, I had no idea how I looked. I anticipated that I may be a bit of a fright, so prior to the surgery, I asked my husband to take photos of me every day so that I would later have a visual external memory to match my internal experience. I didn’t look in a mirror until a few days later, while in the hospital. The two things that stood out to me were the HUGE scar running from my scalp in the middle of my forehead to my left sideburn -with gigantic metal staples throughout and the big, black shiner encompassing my left eye. Frankly, it was both shocking and terrifying. I looked like me, but me after a major brawl...which I suppose is an accurate depiction. At the time, I was thrilled to remember my own identity and recognize my loved ones visiting me in the hospital; I was less concerned with how I looked to the rest of the world.

After being released from the hospital, I stayed home, relatively bedridden for a few weeks. When I was able to leave the house, my husband took me to Target, a daily outing that would be the highlight

of many days. I was out and about, feeling “normal,” despite being exhausted for the remainder of the day afterward. Because my scar was so tender and I was cautious about protecting the staples, I wore a hat whenever I left the house to abate questions and allow myself some anonymity. Despite these efforts, I was keenly aware of ‘the look,’ which took a few consistent forms. With strangers, the look was one in which people would take in my black eye, scan me from head to toe, look at my husband and end with what appeared to be an involuntary look of disgust or discomfort. There seemed to be a consistent pattern; the initiator scanned me from head to toe, looked at me and focused on my eye, looked away, looked again, looked away and looked again.

In trying to make sense of these exchanges, I have come to the conclusion that several factors transpired in a perfect storm to construct the dynamics that provoked what I perceived to be judgment, emotional reactivity and discomfort. Inaccurate assumptions of domestic violence, a culture of disconnection and a binary of “appropriate reactions” to social problems appear to be contributing influences. Deficits in intersectionality research regarding the impact of invisible developmental identity factors and the mental health community’s risk assessment methods add complexity to the discourse. As further discussed herein, connection is a viable strategy to address these challenges, promoting intrapsychic healing, positive professional and personal interactions and a collective sense of community.

Faulty Domestic Violence Assumptions

I believe the people around me who were unfamiliar with my medical journey incorrectly perceived my black eye as a consequence of domestic violence. With good reason, domestic violence is a pervasive problem, impacting one in four wives and three to four million American women annually [7]. Black women in particular experience alarming rates of violence, with one quarter of Black women reporting physical violence [8]. Further, homicide by intimate partner violence is the leading cause of death for African American women between ages 15 and 24 [8]. Despite distinct evidence of domestic violence as a social problem, intimate partner violence carries its own set of inherent interpersonal judgments. Some common beliefs include the notion that women’s behavior contributes to their experience of violence, some women want to be abused, and women can easily leave abusive relationships [9,10] Crenshaw [1] defined intersectionality as a useful framework with which to mediate the tensions between assertions of multiple identities and the ongoing necessity of group politics. Critical to intersectionality discourse is both consideration of stereotypes regarding women who experience domestic violence as well as stereotypes specific to Black women and domestic violence. Stereotypic images of Black women as matriarchs, hostile, or seductive influence how information is encoded and interpreted regarding these women, subsequently impacting power dynamics [11], perceptions, and interpersonal interactions with them [7]. Thus, the perception of domestic abuse has the potential to contain gender and race specific nuances, adding complexity to how survivors are viewed by others and the type of resources and support they receive.

My identification as both Black and female aligns me with multiple marginalized groups associated with increased domestic violence risk factors, making the inaccurate assumptions understandable. However, comprehending the intense negative reactions from others is perplexing. It was both difficult and painful to see others look away from my injury and my supportive spouse with what appeared to be disgust. The gender and culture based stereotypes associated with domestic violence place Black women in positions of responsibility or power regarding how they contribute to, experience or maintain

abusive relationships. I began to wonder what stereotypical images others were seeing superimposed over my black eye: An angry woman who solicited violence due to her hostile behavior, a seductive temptress who liked or enjoyed violent interactions, a stoic matriarch preferring to stay with an abusive partner or a host of other possible configurations. The only way to clarify their position would have been through contact, which did not occur. As an unfortunate result, I was left observing the exchanges and managing my own narrative regarding their origin. For Black women, differentiating between stereotypes and lived individual experiences requires a nuanced intersectionality lens and human connection to facilitate inclusive interpersonal interactions.

Developmental Intersectionality

Many of the theories that define intersectionality describe identity factors, power and privilege as elements that are connected to unearned, unchosen parts of the self. With universally destabilizing experiences like grief, trauma, disability and illness, our sense of who we are and our corresponding power and privilege is altered. Despite connection to certain communities based on assertion or observable characteristics, the ability to access one's strengths and resilience is influenced by how one experiences these largely invisible elements. Life experiences provide ongoing opportunities to clarify perspective and determine how to integrate life altering bouts with grief, trauma, disability or illness into the sense of self. Thus, intersectionality is defined and redefined throughout the life cycle, fundamentally influenced by how these experiences are navigated. While most of us are conceptually aware that we have the capacity to choose or change many parts of our identity, there is an absence of literature describing intersectionality as an ongoing, developmental process. Assumptions, lack of validation and judgment can have a substantial impact on this journey. When people are experiencing a juncture of stress or crisis and facing potential identity reform, they are increasingly vulnerable, making the role or positionality of those providing support more significant.

Positionality is critical to intersectionality theory and praxis. Black women in academia are frequently involved in interpersonal exchanges with those who maintain significantly more privilege, placing them in a subordinate position and increasing their awareness of indicators of difference. When there is an inherent privilege and power differential, the message is that different is both inferior and unsuitable, reinforcing the original power and privilege dynamics. While often unintentional, the most painful microaggressions occur between those with power and those who are disempowered [12]. But what is the psychological impact of these exchanges, especially when the recipient is in a vulnerable state? When you add a life altering personal experience such as grief, trauma, illness or disability, the person attempting to respond to the judgment may be unprepared to manage external opinions with their internal experience and may struggle significantly. This is essential during times when change, recovery, obtaining support and connection are vital to healing.

Positionality is significant to my personal experience. Because I am someone with a history of multiple marginalized identities, I am familiar with being subordinated, scrutinized and discredited. Preparation, planning and personal branding have been solid tools to developing an image of competence. However, after my surgery (a combined source of illness, trauma, disability and grief), I was unprepared to manage the reactions of others while simultaneously navigating my own journey and confronting who I was to become afterward. An example of my struggle with microaggressions while vulnerable occurred when I returned to work following my recovery. I informed my supervisor

and colleagues of the potential short term repercussions of my surgery, which included slower responses and cognitive confusion. I also informed them of the permanent repercussions, including visual impairments and decreased stress tolerance. Because I was going up for tenure a few months after I returned to work, I was conscious of the political bargaining that occurs during the tenure process, often placing me in an agreeable but silent position with authority figures. Thus, when my chair asked me to teach a class offered in the fall, I knew the appropriate answer was "of course." Except I couldn't teach the class, as it was offered in the evening and driving in the evening is extremely challenging for me. When I reminded my supervisor that I couldn't take a class in the evening because of my visual impairments, she said "Shouldn't you be fine by the fall?" Saying no and acknowledging an invisible impairment as a Black Assistant Professor to my White chair (and full Professor) in the context of going up for tenure was a significant source of discomfort and shame for me. Having to remind someone with infinitely more power and privilege that yes, I was even more impaired than I look was painful, especially as I was still in the midst of healing.

A Culture of Disconnection

It is frightening that we live in a culture in which photos or videos are created in a nanosecond to be documented on social media, while people physically and interpersonally remain unable to offer interpersonal support, comfort or warmth. Whether one is a friend, a colleague or a stranger in a store, we frequently notice other people's struggles but our willingness to intervene varies. There are many theories about why we often fail to connect with others who appear in distress, appearing indifferent or apathetic. People of color, in particular, fall victim to the phenomenon of "staying out of other people's business." Crenshaw [1] noted that there is a more generalized community ethic against public intervention, describing it as a product of desire to create a safe haven free from the indignities of a racist society and "the diverse assaults on the public lives of racially subordinated people." This dynamic, denoted as conventional wisdom or common knowledge maintains minimal representation in research.

For many people of color, the positions for response to political and social concerns are often polarized. The continuum consists of activism, often associated with service, revolution, and violence [13], or respectful distance, often regarded as silence, apathy or indifference. Research indicates that the emotional response initiated by the person or situation in need largely impacts the response of the other person. Empathy and personal distress are emotional responses that have been found to foster or inhibit helping behaviors [14]. Empathy, defined as a feeling of sympathetic concern, is associated with low levels of physiological arousal, resulting in a positive emotional response to the perception of others in need [14]. Conversely, personal distress is experienced as a feeling of internal anguish and associated with high levels of arousal, resulting in a negative emotional response to others with concern regarding the cost to self [14]. Thus, how we internally experience the circumstances or presentations of others has a significant impact on our willingness for – or disinterest in connection. Over-identifying with someone's experience can produce high levels of internal anguish and are potentially as much as a barrier to connection as not identifying at all [15].

It is impossible to ascertain how my black eye impacted the strangers, friends and others I interacted with during my recovery from surgery. It is possible that congruent with Paciello et al. [14] research, people reacted to my black eye with personal distress rather than empathy. The incorrect interpretation of my eye as a symptom

of domestic violence may have contributed to others' anguish, high arousal and negative response pattern; however, this indicates a need for additional domestic violence research to address lowered empathy as a barrier to service delivery and effective intervention. As a consumer in this experience, the lack of empathy (whether real or a product of my own experience) was palpable. What I needed and did not receive in response to "the look" was the experience of being heard, validated and understood.

Discussion and Recommendations

Connection as a resolution strategy

Additional possibilities for interaction or intervention with those we perceive as struggling must be identified; we cannot remain attached to the polarized options of revolution and apathy. However, managing intersectional experiences with individuals within marginalized populations does not mean attempts to organize as communities of color are futile or unnecessary. Rather, reconceptualizing intersectional identities and politics may promote the need to develop additional strategies for transformational activism that include connection. Connection is a viable option to solicit and support the stories and experiences of those who are subordinated, unempowered and voiceless. Brene Brown [15] describes the critical nature of vulnerability and connection, noting "We are physically, emotionally, socially, spiritually hard-wired for connection. And in the absence of connection, there is always suffering." Connection is also vital to empowerment in that it allows people to be seen and heard. Shame is often a corollary of oppression, marginalization and microaggressions. Because shame is isolating, judgmental and painful, experiencing shame often throws people into crisis mode, bypassing advanced, rational thinking and processing [15]. Brown [15] describes empathy as the strongest antidote for shame, and defines it as the ability to be genuinely present and engaged with someone as they tell their story. When responders are able to manage their own internal experience and feel empathy, they are able to validate the experiences of the other, promoting resilience, strength and empowerment. As a result, connection can be comforting, nurturing and healing.

Additional research needs

While the literature contains a plethora of information regarding the differences between and impact of visible and invisible identity factors, there is a dearth of research regarding the impact of circumstantial, life changing elements like grief, illness, disability or trauma that directly influence intersectionality. These are universal, human experiences that occur throughout the life cycle and frequently represent a shift from previous intersectionality identification. Despite their invisibility, their existence may be critical in terms of self-identification and identity, impacting how intrapsychic and interpersonal exchanges are navigated. Grief, trauma, illness and disability often damage areas of strength, impacting resilience in those who previously managed marginalization successfully. For many weakened by these experiences, they are increasingly vulnerable to healing or damaging interpersonal exchanges. While these experiences offer an opportunity for positive connection, damaging exchanges may be experienced as oppressive or subordinating. Experiences that maintain polarized positions of privilege or subordination have the potential to isolate or activate emotional responses that further polarize supportive, well intentioned folk, rather than increase mutual understanding [16]. Therefore, the end result of subordination is often isolation, the opposite of what family, friends and mental health professionals are attempting to nurture with those who are vulnerable.

Practitioner education and training

I am both a social work educator and a practitioner. The implications of my experience in the field are noteworthy. Professionally, the role of critical thinking in a context of clinical awareness cannot be underrated. Clinicians implement critical thinking in relation to risk in both assessment and practice [9], which is typically research or evidence informed. However, Taleff [17] noted that practitioners frequently assess clients with limited information and fill in gaps with their own ideas, emotions and assumptions. Social workers, therapists and clinicians can easily access empirical research data to support erroneous theories or hypothesis regarding marginalized groups. Because women of color occupy positions of both physical and cultural marginalization within the dominant society, efforts to intervene with them must be targeted directly to their needs [1]. In effective practice, utilizing an intersectionality informed lens is essential in extricating personal biases, managing judgment and clarifying questions to avoid faulty assumptions. Assumptions regarding risk factors, sexual identity, cultural background or other diversity factors are often justified by research steeped in white privilege, patriarchal standards or heteronormative expectations. Similarly, microaggressions, microinvalidations or microassaults perpetuated by the "helpful" practitioner are critical errors that must be anticipated and addressed. Without thoughtful assessment or clarification, assumptions regarding intersectionality translate into judgment, putting those with marginalized, subordinate identities in a position to be labeled, further subordinating them. Practitioners and educators must emphasize how critical the fundamental clinical skills of engagement, assessment, clarification, validation and authentic interpersonal interaction are in mental health, treatment and recovery.

Conclusion

Black eyes do matter, and not only within the limits of domestic violence discourse and praxis. In our human efforts to understand one another, we categorize based on observable characteristics and visible identity factors. Sadly, these socially constructed identity factors may be heavily influenced by stereotypes, microaggressions, and erroneous assumptions, provoking unhelpful responses. Thus, utilizing an intersectionality lens to inform our engagement is crucial to interpersonal efficacy. This is particularly critical when many relevant factors are invisible or may develop through the life cycle. As a culture, we continue to develop effective strategies to address discrepancies in managing our responses to social problems and interpersonal distress. The status quo of revolutionary activism vs. respectful silence is polarized options limiting individual and community healing. Connection is a healing strategy to support transformational activism, promoting individual and collective empowerment by providing a platform for individuals to reveal and resolve the complexities of invisible identity factors that are critical to how persons view themselves and are seen by others.

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Citation: Ashley W (2017) Black Eyes Matter: Nuances of Intersectionality and their Impact on Inclusion and Support. *Social Crimonol* 5: 165. doi: [10.4172/2375-4435.1000165](https://doi.org/10.4172/2375-4435.1000165)

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