Shifting the Discourse on Disability: Moving to an Inclusive, Intersectional Focus

Aurora H. Brinkman[1], **Gianna Rea-Sandin**[2], **Emily M. Lund**[3], **Olivia M. Fitzpatrick**[4], **Michaela S. Gusman**[5], **Cassandra L. Boness**[6], **Scholars for Elevating Equity and Diversity (SEED)**[7]

[1]Department of Psychology, Washington State University

[2]Department of Psychology, University of Minnesota

[3]Department of Educational Studies in Psychology, Research Methodology, and Counseling, University of Alabama

[4]Department of Psychology, Harvard University

[5]Department of Psychology, Arizona State University

[6]Center on Alcohol, Substance use, And Addictions, University of New Mexico

[7]Los Angeles, CA

Abstract

Individuals with disabilities comprise one of the largest marginalized groups in the United States and experience systemic barriers in healthcare. In Westernized communities, disability has historically been conceptualized via the medical model, which considers disability an individual-level deficit in need of correction. Although other models of disability (e.g., social model) have been developed to address the medical model's ableist shortcomings, these fail to consistently acknowledge intersectionality. Specifically, these models fail to consider that (a) a disabled individual may hold other marginalized or oppressed identities and (b) these intersecting oppressions may exacerbate health inequities. Intersectionality, which originates from Black feminist literature, describes the ways that systems of power and oppression (e.g., racism, sexism) interact to form an individual's unique experience. To date, the intersection of disability and other marginalized identities has been neglected in psychology and related fields, leaving little guidance for how scholars, clinicians, and other stakeholders can address disability via an intersectional lens. The current paper discusses how a *disability-affirmative, intersectional* approach can serve as a strategy for challenging and reforming oppressive systems across the field of psychology. We assert that, ultimately, this approach has the potential to optimize and expand access to equitable, inclusive mental health care, and we propose actionable steps psychologists can take in research, practice, training, and policy in pursuit of this aim.

Keywords

Intersectionality; disability; health equity; disability justice

Correspondence concerning this article should be addressed to Cassandra L. Boness, 2650 Yale Blvd SE, Albuquerque, NM, 87106. cboness@unm.edu.

Twenty-six percent of adults in the United States (U.S.) are diagnosed with at least one disability (Okoro et al., 2018), making people with disabilities one of the largest minoritized groups in the United States. Disability is a broad, heterogeneous term often used to describe mental and/or physical impairments that limit an individual in at least one part of daily living (e.g., developmental disabilities, sensory impairments, psychiatric conditions, traumatic brain injuries, chronic medical conditions; Americans with Disabilities Act [ADA], 1990). Disabilities can be "visible" (e.g., a physical disability requiring a supportive tool, such as a wheelchair or mobility cane) and/or "invisible" (e.g., a chronic illness, such as human immunodeficiency virus [HIV], or a learning disability, such as dyslexia; Wilbur et al., 2019). Historically, psychological disorders and mental illnesses, such as anxiety, schizophrenia, and personality disorders have been excluded from conversations about disability and ableism (Kattari et al., 2018; 2020). Disabilities can be a result of converging genetic and/or environmental factors (e.g., a mental illness to which an individual has a genetic predisposition developing due to a high level of stress; Esposito et al., 2018) and may occur at any point during the lifespan (Warner & Brown, 2011).

Historically, disability has been viewed as a deficit, and thus, people with disabilities have been subsequently marginalized[1] by society (Dirth & Adams, 2019). This view of disability as representing an inherent state of being "less than" has contributed to the stigma and discrimination that individuals with disabilities experience. This has been magnified during the COVID-19 pandemic. For example, disabled individuals were penalized by healthcare providers and policies prioritizing treatment and resources, such as medication and respirators, for "healthy, functioning" people (Lund et al., 2020).

Several frameworks and models have emerged over the last several decades to promote disability as an identity, rather than a deficit, as well as to establish a sense of belongingness and create a narrative independent of impairment (Murugami, 2009). Yet, many existing models and conceptualizations of disability fail to systematically incorporate other aspects of one's identity (e.g., race/ethnicity, sex) or consider environmental or systemic factors (e.g., accessibility of physical structures). Frameworks that more holistically regard individuals, such as intersectional frameworks, can be helpful for understanding and identifying methods to reduce health inequities (Harari & Lee, 2021). Although there have been calls to apply intersectionality in psychology (Buchanan & Wiklund, 2020; 2021), the intersection of disability with other marginalized identities has been largely ignored in this professional discourse.

The Present Paper

In the current paper, we first provide an overview of disability conceptualizations and models, noting where they fall short of considering the multiple identities disabled people may hold. Next, we provide an overview of intersectionality as a useful framework for improving the lives of disabled people. Finally, we apply this *disability-affirmative,*

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[1]No single word can capture all the nuanced experiences of unique individuals. For brevity, we will use iterations of the term "marginalization" to describe the harm perpetuated against disabled people on an individual, community, and structural level because of their disabilities.

intersectional approach to areas that are especially relevant to psychologists including research, practice, and training.

Disability-Related Language in the Current Paper

Ableism describes the marginalization of disabled people according to their disability status (Bogart & Dunn, 2019).[2] One reflection of ableism is the language used to describe disabled people (Andrews et al., 2019). The evolution of disability etymology influences how disability is conceptualized and how individuals interact with disability (Haegele & Hodge, 2016). Euphemisms, including "special needs" and "handicapped," that were originally designed to be de-stigmatizing, ironically have been found to promote ableist ideas and discourage positive disability identity development (Andrews et al., 2019). To move away from the use of dehumanizing language to describe disabled individuals, researchers and advocates proposed the use of person-first language, as it places the emphasis on the person before their disability (e.g., "person with a disability"; Wright, 1983). However, an increasing number of disabled individuals have adopted identity-first language (e.g., "disabled person") because it acknowledges the oppression that disabled individuals experience and frames disability as a cultural group (Dunn & Andrews, 2015).[3] Because disability is an individual and heterogenous identity, utilizing a flexible and inclusive approach to language and conceptualization aims to return power to a community that is presently, and has been historically, marginalized. To work towards dismantling ableist barriers and systems, we aim to empower people to determine their own identity through the integration of various approaches. Thus, in accordance with current preferences within the broader disability community (Andrews et al., 2019; Dunn & Andrews, 2015), we use both person-first and identity-first language to refer to disability throughout this paper. We encourage others to do the same unless a given individual or community within the broader disability community indicates a particular preference for either person- or identity-first language (Dunn & Andrews, 2015).

Conceptualizations and Models of Disability

In Westernized communities, disability has historically been conceptualized via the medical model, which considers disability to be an individual-level deficit in need of correction (Marks, 1996). Although the medical model offers key advantages (e.g., standardizing diagnoses for healthcare providers), it lacks consideration for how converging systemic and interpersonal factors (e.g., stigma, objectification by healthcare providers; Roscigno, 2013) adversely affect the health, quality of life, and ability to access key resources among disabled people (Clare, 2001; 2019). To address shortcomings of historical models of disability, alternate frameworks have been proposed by individuals within disability

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[2]Scholars and advocates have proposed a variety of definitions of ableism, including: "…a network of beliefs, processes and practices that produces a particular kind of self and body (the corporeal standard) that is projected as the perfect, species-typical and therefore essential and fully human. Disability then is cast as a diminished state of being human." (Cambell, 2001, p. 44); "…ideas, practices, institutions and social relations that presume ablebodiedness, and by so doing, construct persons with disabilities as marginalized… and largely invisible 'others'." (Chouinard, 1997, p. 380); "…stereotyping, prejudice, discrimination, and social oppression toward people with disabilities." (Bogart & Dunn, 2019); and "…a doctrine that falsely treats impairments as inherently and naturally horrible and blames the impairments themselves for the problems experienced by the people who have them" (Amundson & Taira 2005, p. 54).
[3]A clear example of this language utilization and advocacy is the Deaf community which regards "deafness" as a culture, identity, and source of pride rather than a medical condition (Boness, 2016; Mauldin & Fannon, 2020).

communities. Many of these models were largely reactive to perceived shortcomings of previous models and aimed to consider positive aspects of disability. For example, the social model asserts that disability is a result of barriers placed on an individual by society, as opposed to the biological determinism of the medical model (Shakespeare, 2013). Further, Britain and North America had different conceptualizations of the social model based on varying emphases on social class, income, and other factors. Although the intention of the social model was to emphasize the barriers imposed by society onto disabled people, this overlooked the significance of an individual's impairment and inaccurately portrayed disabled individuals as a homogeneous group (Shakespeare, 2013). As a result, the human rights model (e.g., recognition of all individuals' inherent right to dignity; Degener, 2017) was developed to address the limitations of the social model by acknowledging that all individuals are deserving of dignity and human rights, regardless of the ways in which they are perceived by society while also maintaining that the discrimination disabled individuals may experience is due to society rather than the person. Yet, the influences of the medical model are still pervasive today and its influence results in continued ableism and marginalization of disabled people. Table 1 offers a description of extant disability models and their potential advantages and disadvantages.

Even more modern disability models, which often explicitly aimed to move away from the medical model, are not without limitations. Most of these models fail to consider other identities a person may hold, particularly other marginalized identities, or within-group demographic heterogeneity, perpetuating a fragmented approach to conceptualizing disability (Lund et al., 2017). Relatedly, reliance on heuristics, such as disability models, often mischaracterizes diverse groups of people. Although new models have emerged, they have not been widely adopted at a societal level, likely due to factors such as managed care (i.e., healthcare delivery systems designed to reduce costs and improve care quality but limit healthcare choices for marginalized populations), difficulty enforcing the ADA and other disability rights legislation, and stigma (Cantor, 2008; Ditchman et al., 2013).

The Importance of Considering Other Identities Disabled People Hold

The failure of disability models to comprehensively consider other identities a person may hold is itself marginalizing because it overlooks the converging historical, societal, and personal factors that contribute to one's experiences in the world. For example, Latino and Black adults with intellectual and developmental disabilities have poorer health outcomes compared to White adults with intellectual and developmental disabilities and nondisabled Latino and Black adults (Magaña et al., 2016). Other work has suggested that disabled LGBTQIA+ youth report poorer overall health (Hall et al., 2020) and are at increased risk for suicidal ideation (Tejera et al., 2019) compared to heterosexual youth without disabilities. Further, students with disabilities who also live in poverty or other marginalized classes experience worse educational outcomes than their peers without disabilities and who live in higher income households from higher class families (Grant & Zwier, 2011). Ignoring the many facets that contribute to the experience of disability may further marginalize and exclude people along other axes (e.g., race, socioeconomic status, LGBTQIA+ status; Frederick & Shifrer, 2018). This exclusion can lead to the disproportionate representation of individuals being disregarded as "deviant" when,

instead, they are experiencing repercussions of an ableist system that perpetuates inequity. Thus, there is a dire need for a dynamic framework of disability that comprehensively acknowledges the diverse aspects of one's identity and the influence of various multi-level processes (e.g., individual, community, societal; see Figure 1) on one's life. Advancing disability-affirmative approaches within research, practice, and training in psychology can lead to more equitable mental health care access for disabled people.

Intersectionality and Disability

Intersectionality is a useful approach for integrating disability and other aspects of one's identity with contextual factors. Intersectionality originated within Black feminist literature (Combahee River Collective, 1995) to conceptualize how multiple systems of oppression (e.g., racism, sexism, classism) uniquely shape people's experiences based on one's identities (e.g., race, sex, or class) (Collins & Bilge, 2020; Crenshaw, 1989). Thus, an intersectional framework offers a solution to the failure of previous disability models to comprehensively consider other heterogeneous identities one holds, and has the added benefit of incorporating explicit consideration of the role of power and oppression.

There are several extant disability frameworks from fields such as Disability and Queer Studies that draw from intersectional perspectives. For example, Crip Theory argues that capitalist ideals rely on and maintain heteronormative able-bodiedness (McRuer, 2006). The Black feminist disability framework (Bailey, 2019) elicits historical and sociocultural perspectives that both explicitly and implicitly equate Blackness with disability, from ongoing eugenicist scientific agendas to medical apartheid designed to disable Black people (e.g., denial of care due to the racist belief that Black individuals have a higher pain threshold; Washington, 2006). Both frameworks critically consider the qualitative interactions of various identities and oppression of the wellbeing of disabled people. Within counseling psychology, the Hays' ADDRESSING model (Hays, 1996) considers multiple identity factors that may coexist within clients, including age, disability, religion, sexual orientation, national origin, and gender, as well as recognizes that individuals may concurrently experience both privileged and oppressed identities. Although this model considers a wide range of multiple identity factors an individual holds, it lacks an acknowledgment of the context in which a person functions.

Although intersectionality is not new, there have been renewed calls to expand its application within psychological research, clinical practice, and training systems (Buchanan & Wiklund, 2021; Fix et al., 2021; Valrie et al., 2020). However, to date, these efforts have largely ignored the intersection of disability with other marginalized identities—a pattern that is, unfortunately, consistent with historical neglect and epistemic exclusion of disability in psychology and related fields (Buchanan et al., 2021; Settles et al., 2020). Thus, we call for psychology to engage intersectional approaches to disability conceptualization across the areas of research, practice, training, and policy. In the sections that follow, we provide guidance on this approach.

Benefits of Adopting an Intersectional, Disability Affirmative Approach in Psychology

Although there are numerous benefits of adopting an intersectional, disability affirmative approach in psychology, we highlight three advantages in the following section. First, an intersectional model of disability captures the vast heterogeneity that exists among, between, and within disabled populations (Cieza et al., 2018; Oexle & Corrigan, 2018). This approach acknowledges that attempting to categorize people into discrete groups fails to recognize individuality and may perpetuate ableism and marginalization within psychology research, practice, and training (Cieza et al., 2018). Cole (2009) asserts that intersectionality-informed research should consider who is included within a social category. When applied to disability research, researchers could include individuals with various types of visible and invisible disabilities, as well as consider disabled individuals from varying socioeconomic backgrounds or geographic locations, for example. In doing so, using an intersectional, disability affirmative approach can highlight diversity within disability, dismantling stereotypes that exist about singular demographic categories (Buchanan & Wiklund, 2021).

Second, an intersectional approach to disability highlights concepts such as "double disadvantage" and "prominence." The double disadvantage theory describes "an accumulation of disadvantage" that occurs for marginalized individuals that are multiply-marginalized (Oexle & Corrigan, 2018). Prominence occurs when a person is stigmatized or oppressed based on an identity factor that is perceived as most salient within a given context. For example, a disabled, fat, Black woman may experience discrimination driven primarily by ableism when seeking sexual health care, because of the desexualization of disabled people, whereas she may experience discrimination driven primarily by racism when interacting with law enforcement, or by fatphobia when shopping for groceries (Mollow, 2017). Together, these concepts increase our understanding of the nuances of intersectionality and how an individual's multiple identity factors may be perceived and interacted with by others.

Third, an intersectional approach to disability acknowledges that power affects one's identities (Overstreet et al., 2020). The experience of disability does not exist in a vacuum, and forms of oppression, such as poverty, trauma, and police brutality, affect and interact with disability (Artiles, 2013; Artiles et al., 2010; Bogart & Dunn, 2019). For example, students of color are more likely to be incorrectly labeled as needing special education services, yet students of color who would benefit from additional educational services often attend under-resourced schools (Artiles et al., 2010) and may be more likely to be labeled with more highly stigmatized diagnoses than their White peers with similar symptoms and support needs (Atkins-Loria et al., 2015). This dual under-representation and over-representation of students of color in special education reveal complex interactions among individual, institutional, and systemic (e.g., fiscal and bureaucratic) factors (Skiba et al., 2008). Further, this educational performance gap (e.g., psychological assessment score differences, standardized testing results, classroom grades) between Black and White students is often falsely attributed to inherent cognitive differences when in reality, these

disparities result from middle- and upper-class White children having access to financial and tangible resources to perform better on assessments and in the classroom (Lund et al., 2014). Likewise, adults who are minoritized on the basis of their gender and sex are more likely to develop chronic health conditions as compared to their cisgender, heterosexual peers due to the social, financial, and medical discrimination associated with being LGBTQIA+ (Lund & Burgess, 2021). In these ways, the lived oppression of disabled people of color and disabled LGBTQIA+ individuals lies at the intersections of racism, ableism, classism, heterosexism, cissexism, and other oppressions and cannot be attributed to just one type of inequity but rather a complex intersectional system in which those with power often weld it in a way that both creates and magnifies dimensions of marginalization.

Indeed, systems of power and oppression are interdependent and strengthen one another, shaping society and maintaining inequity (Collins, 2019), yet psychology has failed to centrally incorporate intersectionality in research, clinical care, and training (Grzanka & Cole, 2021; Settles et al., 2020). Further, there has been limited focus on micro-level experiences and macro-level interactions between groups, in addition to interacting within-person identities and bidirectional interactions between individuals and their environments (Rice et al., 2019). Figure 1, adapted from Galán and colleagues (2022), depicts the various levels of a disabled person's social ecology, spanning from individual factors (e.g., SES, language, nationality) to sociohistorical events (e.g., eugenics, disability justice), that one might consider within an intersectional framework.

Applying a Disability-Affirmative, Intersectional Approach in Psychology

In the sections that follow, we highlight examples of how an intersectional, disability-affirmative approach can be implemented in research, practice, training, and policy with the ultimate goal of improving equity (e.g., in mental health care access and outcomes) for disabled people. Additionally, Supplement 1 offers a more detailed "starter kit" that helps readers identify methods for personal accountability and tools to begin implementing intersectionality in their professional practice and personal lives. It is important to note that the following examples are not exhaustive, as different individuals, groups, and communities likely have different preferences for how an intersectional approach can be implemented into their lives.

Research

A disability-affirmative, intersectional framework can be integrated at each stage of the research process, especially using community-driven research methods. These methods are intended to equitably and actively involve key stakeholders—such as people with lived experiences, advocates, and scholars—throughout the research process (Collins et al., 2018). Such prioritization of proactive collaboration among academic and non-academic stakeholders differs from widely used psychological research practices, which encourage scholars to speak for, rather than work with, disabled people (Forber-Pratt et al., 2019; Lund et al., 2021). The body of work on community-driven research methods is substantial (Collins et al., 2018) and goes beyond the scope of the current paper. With that in mind, we

aim to provide practical guidance for integrating these methods, as well as principles of a disability-affirmative, intersectional approach, throughout the research process.

Recruitment and Data Collection Processes—A researcher operating via a disability-affirmative, intersectional lens might consider the accessibility, appropriateness, and inclusivity of recruitment and data collection procedures. For example, prevailing methods of participant recruitment in treatment trials often do not involve direct contact with the target population (Liu et al., 2018). This method may not be effective for disabled people, given barriers to research participation that disproportionately affect this group, such as inaccessible research sites (e.g., designed to exclude people who rely on mobility aids) and materials (e.g., text-heavy documents that may disadvantage people with visual impairments; Banas et al., 2019), disability-related stigma, and warranted mistrust of academic institutions due to historical traumas (Banas et al., 2019). A disability-affirmative, intersectional approach will might explicitly consider these challenges and flexibly adapt their recruitment and data collection procedures, ideally alongside non-academic stakeholders, to be more inclusive of all people with disabilities. For example, researchers could include write-in options for demographic questions (e.g., disability status, ethnicity), inquire about micro- as well as macro-level processes (see Figure 1), ask disabled people about the appropriateness of included measures, provide appropriate payment (e.g., cash vs. check) that is accessible and adequately compensates participation, and use flexible scheduling procedures to accommodate a range of employment, transportation, and childcare needs (Collins et al., 2018).

Data Analysis—Researchers conducting data analyses within a disability-affirmative, intersectional framework may consider alternative approaches to widely used practices (e.g., Frequentist statistical method). For example, whereas intersectionality theory asserts that identities are flexible and heterogeneous, the Frequentist approach requires the categorization of identity factors as fixed, homogeneous, and orthogonal (Settles et al., 2020) and fails to explain why relationships across these factors may exist (e.g., underlying power structures; Mullings & Schulz, 2006). To address these limitations, experts have recommended using more flexible (e.g., Bayesian), qualitative, and person-centered approaches (e.g., cluster analysis, profile analysis; Else-Quest & Hyde, 2016). For example, one application of a data mining technique that tests all possible interactions among predictors and outcomes (Shaw et al., 2012), found that older, female, racially/ethnically minoritized people who worked for either a small or very large company were at the highest risk of experiencing disability-based workplace harassment. This study is an example of how scholars can incorporate principles of intersectionality within rigorous quantitative approaches. If such approaches are not feasible, Spivak (1996) suggests that authors, at a minimum, acknowledge in their interpretation that the Frequentist approach does not account for the changing nature of identities, relationalities, structures, or culture.

There is value in complementing rigorous quantitative tools with equally rigorous qualitative tools, with experts arguing that qualitative methods may be particularly well-positioned to promote intersectionality (Hunting, 2014). Indeed, employing qualitative methods allows researchers to better understand the nuances of an individual's experience (Denzin &

Lincoln, 1994). For example, qualitative research has shown that, as a function of disability status, disabled people report impeded access to sexual and reproductive health services (Burke et al., 2017) and poor-quality treatment for opioid-related problems (Ledingham et al., 2022). Efforts to leverage the strengths of both qualitative and quantitative methods, both separately and through mixed methodological approaches, can advance disability-affirmative intersectionality.

Scientific Interpretation and Dissemination Efforts—Researchers operating within a disability-affirmative, intersectional framework are able to acknowledge the possible influences of multi-level processes (e.g., individual, community, societal; see Figure 1) in their analysis of results, even if the study focuses on one level of analysis (Nelson & Lund, 2017). For example, although not every identity was considered, one South African study showed that racial identity–or more accurately, racism–was the strongest predictor of financial and educational outcomes in South Africa, intersecting with gender and disability to predict inequities (Moodley & Graham, 2015). More broadly, a disability-affirmative, intersectional researcher considers how ableism may impact how the results of research on people with disabilities are presented (e.g., ableist vs. person-centered language; Hyams et al., 2018) and take measurable steps toward improving the inclusivity of scientific writing (e.g., engaging with disability-related scholarly and advocacy work). In addition, researchers can consider disseminating findings through a variety of methods that will be more likely to reach diverse academic and non-academic audiences (e.g., podcasts, webinars, local community groups or churches), keeping in mind the importance of leveraging platforms that are accessible to a wide range of people (e.g., audio and visual options). Finally, consulting directly with members of an affected group can make dissemination efforts more acceptable, inclusive, and intersectional, as within-group and between-group variation in needs and preferences are likely.

Practice

Principles of a disability-affirmative, intersectional framework can also be integrated into clinical care. Below, we focus on three areas as a starting point and provide several examples of how to apply an intersectional approach to clinical work (Supplemental Material 2).

Care Delivery—Below are several examples of how mental health care can be delivered through a disability-affirmative, intersectional lens. First, it is critical that clinicians consider the ways that internalized ableism impacts care delivery on an individual and community level. Consistent with an intersectional approach, it is also key to think about how other "isms" such as racism or classism may interact with ableism. Alongside this, clinicians must be aware of discriminatory practices they may engage in including microaggressive actions (e.g., patting a person with a disability on the head) and comments (e.g., telling a disabled individual that they are "brave" simply for existing). Second, clinicians must take actionable steps toward addressing ableism in oneself and others (e.g., engaging with diverse educational content and adopting person-centered, rather than ableist, language; Hyams et al., 2018). Approaches for doing so may include prioritizing reflection, humility, and openness, rather than clinical or multicultural competence (see Galán et al., 2021). For example, experts have encouraged the dissemination of tools designed to

help clinicians understand the historical roots of health inequities, as well as engage in decolonization processes and activism on individual and institutional levels (Hall et al., 2020; Jones et al., 2019). There may also be value in leveraging competence-oriented tools to promote humility-oriented anti-ableism efforts, such as tools for adopting core competencies identified by the Alliance for Disability in Health Care Education (2019) to ensure quality care (e.g., communicating directly with the disabled individual rather than care providers, pursuing cultural and linguistic competency). Finally, a disability-affirmative, intersectional clinician may aim to adopt inclusive clinical care practices, such as the use of trans-theoretical principles of psychotherapy (Olkin, 2017), which are designed to position disability within the context of the client.

Assessment—A core component of psychological care is the assessment of a variety of symptoms, such as anxiety and depression (Flynn et al., 2017) and neuropsychological conditions (DiStefano et al., 2020). Widely used assessment practices in psychology were not designed with disabled people in mind, which is reflected in assessments rarely being developed or validated for disabled people (Lund et al., 2014). Further, lack of validated psychological measures may be magnified among disabled people who hold other marginalized identities. For example, the standardization of common intellectual assessments typically has not included diverse samples in terms of non-intellectual disabilities, race, nationality, gender, and other factors, often resulting in invalid or problematic results that may further marginalize disabled people (Lund, Miller, & Ganz, 2014; Shuttleworth-Edwards, 2019). Although community-based participatory researchers are increasingly working with disabled people to develop and adapt measures for clinical practice (Lund et al., 2021), under-representation of intersectional disabled voices in assessment research remains a significant barrier to access and inclusion. Disability-affirmative, intersectional clinicians and assessors should advocate for enhanced inclusivity within assessment procedures and seek to interpret assessment results considering the possible shortcomings (e.g., lack of appropriate norming) and influences of multi-level processes (e.g., neighborhood violence resulting in hypervigilance) (Figure 1).

Multidisciplinary Care—A disability-affirmative, intersectional clinician may openly collaborate with a variety of other providers and disciplines to provide comprehensive care for disabled clients (e.g., occupational therapists, biotechnology researchers, Tate & Pledger, 2003). Importantly, it is critical to expand the definition of "healthcare practitioner" beyond the medical model and consider the variety of practitioners with whom collaboration could occur to improve care, including those specializing in symptom management and overall functioning (e.g., occupational therapy, dietitian, case management). Likewise, it is also important to have providers who are informed about disability and intersectionality through a non-medical model lens so that the ableism embedded in much of traditional medical care and decision-making does not go unchallenged (Forber-Pratt et al., 2019; Lund et al., 2020; Nicolaidis, 2012). Having team members who are specifically trained in broader models of disability, such as rehabilitation psychologists, is critical, as is making a concentrated effort to recruit and retain more clinicians with disabilities (Lund, 2018, 2022), including multiply-marginalized disabled clinicians (Lund et al., 2022). By ensuring that broader perspectives of disability are included in conversations around care, there is

a greater likelihood that teams can provide truly culturally competent and effective care (Lund, 2018, 2022). Ultimately, multidisciplinary communication and collaboration among providers has the potential to integrate across levels of a disabled person's experience more wholly within clinical care (Daniel et al., 2018; Krahn et al., 2015).

Training

Next, we offer two examples of how principles of a disability-affirmative, intersectional framework can be integrated within psychology training.

Deconstructing Perpetuating Factors of Oppressive Systems—As described by Brown and colleagues (2022), despite the significant number of students with disabilities in clinical psychology (9–14% of recent internship applicants identified as having a disability; Lund, 2021) there is a lack of focus on disability-related issues in clinical psychology training. This becomes especially problematic when one considers that trainees with disabilities report high rates of disability-related barriers (e.g., inaccessible training environments; see Lund, Andrews, et al., 2014), experiences with disability bias in their clinical work (e.g., pressure to disclose disability to clients; Taube & Olkin, 2011), and lack of supervisor competence in working with trainees with disability (e.g., biased remarks and assumptions from supervisors; Andrews et al., 2013; Lund, Andrews, et al., 2014, 2016, 2021; Wilbur et al., 2019).

Training institutions should openly acknowledge their historical *and* ongoing role in perpetuating oppressive systems and dehumanizing practices against marginalized populations (APA Council of Representatives, 2021; Auguste et al., 2021). A disability-affirmative, intersectional training institution can empower trainees with tools for understanding and addressing individual, community, and structural ableism and other forms of oppression, with the ultimate goal of advancing justice and well-being for people with disabilities (Krahn et al., 2015). Moreover, training programs must more readily incorporate information oriented toward intersectional disability justice within education curricula, such as training on social determinants of health (Borowsky et al., 2021).

Increasing Representation of and Support for Disabled People in Psychology —The limited representation of disabled people in psychology substantially decreases the likelihood that disabled perspectives will be acknowledged within psychological science, clinical care, and training programs (Nishida, 2016), perpetuating ableism and other forms of oppression (e.g., centering people with privilege, and those without lived experiences, as experts; Lund et al., 2021). Instead, disability-affirmative, intersectional institutions should take proactive steps to recruit and retain people with disabilities at all levels. Critically, recruitment efforts must be matched with efforts to improve the experiences of these individuals within institutions that are inaccessible, discriminatory, and even dangerous for them (Brown & Ramlackhan, 2021; Lund, Wilbur, & Kuemmel, 2020; Wilbur et al., 2022). Students with disabilities may experience everything from microaggressions to denial of reasonable accommodations to outright exclusion and may often feel isolated and unwelcome in the field (Lund, Andrews, et al., 2016, 2021), leading to attrition (Callahan et al., 2018) and disenfranchisement (Lund, Andrews, et al., 2016).

As with other forms of ableism discussed above, ableism in education and training is often rooted in multiple dimensions of oppression and power. For example, the monetization of higher education has increased productivity demands (e.g., publication requirements), career standards, and promotion of perfectionism, resulting in an inaccessible environment that disproportionately excludes disabled academics (Lund et al., 2021) and particularly those at the intersection of other marginalized identities. For example, disabled women are expected to meet both patriarchally-defined standards of productivity *and* caregiving and disabled students from lower income backgrounds may not have the same access to resources to apply to numerous types and locations of graduate programs (Brown & Ramlackhan, 2021). A disability-affirmative, intersectional institution may make efforts to promote equity through universal design (e.g., ramps, light sensors) and the creation of accessible and barrier-free environments (Dolmage, 2017).

Institutions must also address intersecting forces of oppression that come into play in a classroom by enhancing accessibility for all students. For example, intersecting forces of neurodevelopmental, sensory, or communication disability, education disparities, and gender biases may impose barriers for students participating verbally in discussion-based classes. Faculty may consider allowing students to write their responses to class discussions to turn in after class (Dolmage, 2017). In addition, many institutions adapted to the COVID-19 pandemic by expanding options for education delivery (e.g., live-streaming, recording, live-captioning, and "hybrid" meetings), broadening accessibility at the intersections of disability and other marginalized identities (e.g., pre-recorded and camera-optional lectures may increase feasibility for low-income students and people with chronic pain to engage; Brown & Ramlackhan, 2021). Finally, disability-affirmative, intersectional institutions can work to improve healthcare coverage among trainees, as well as establish system-wide policies that ensure people with disabilities are better positioned to access necessary accommodations.

Public Policy

Finally, we delineate examples of public policy and advocacy considerations when utilizing a disability-affirmative, intersectional framework.

The Importance of Systems-Level Change—Policy is not neutral, as it affects the health, safety, and overall daily lives of the associated community, particularly marginalized individuals (Hankivsky & Cormier, 2011). To ensure equitable and inclusive policies, it is vital to understand overlapping identities and contextual factors to change oppressive systems and improve healthcare (Grant & Zwier, 2011). Incorporating people with lived experience into policy development helps to build local change and collective power through filling in knowledge gaps and aiding policymakers in generating better policies (Kayess et al., 2014), promoting better healthcare, personal, and justice outcomes for individuals and communities (Grant & Zwier, 2011).

Finally, considering the role of prevention in policy can have positive long-term impacts on health. Successful prevention efforts require the use of intersectionality in order to understand how identity and context can interact in order to influence health outcomes (Grzanka et al., 2020; Wong et al., 2017). For example, housing policies that delineate

timely and effective responses to mold can help reduce symptoms for individuals with breathing conditions.

Individual-Level Advocacy—Historically, psychologists have been taught to be "politically neutral and scientifically objective" (Nadal, 2017), yet psychologists play a vital and complicated role in society as their work affects the health and livelihood of countless individuals and communities. As such, psychologists must be aware and reflective upon how their beliefs and worldview affect their work with minoritized individuals and groups (Melton, 2018). Notably, a vast majority of psychology training programs lack specific training in public policy and advocacy which results in psychology trainees not receiving vital education and skills they need to work in numerous settings (Hill, 2013). A lack of this important education can result in psychologists making damaging statements or actions, which can be particularly harmful in situations in which psychologists hold expertise or power.

In order to be culturally humble, psychologists must be advocates and activists to improve health and understanding of diverse identities (Melton, 2018; Nadal, 2017). Specifically, psychologists can advocate for the clients and communities they work with and also utilize leadership and advocacy roles to promote change in policy, healthcare, education, and other important settings (see Nadal, 2017 for a further discussion).

Improving Accessibility and Affordability of Services—Reducing barriers to service access and utilization will aid in developing systems and policies that are based on inclusive and intersectional practices. For example, increasing service availability in rural areas and reducing out-of-pocket costs through improving insurance coverage can improve healthcare outcomes for individuals, regardless of geographical context (Strompolis et al., 2019). Generating policies utilizing collaborative teams of individuals with policy, human rights, and equality expertise also develops a comprehensive, well-fitting approach grounded in the needs of individual communities (Hankivsky & Jordan-Zachery, 2019; Strompolis et al., 2019). Further, maintaining flexible and dynamic re-evaluative practices ensures policies change with fluctuating communities and their needs (Hankivsky & Cormier, 2011). Recent policy changes, including the implementation of the 988 mental health crisis telephone line and the increased use of mental health first responders, provide timely examples of programs that will likely have a positive impact on individual and community health (Canady, 2021; Muhammad & Gray, 2021). Notably, it will be important to continue evaluating the structure and impact of these programs to ensure that they do not further harm marginalized individuals and communities and utilize a disability-affirmative, intersectional approach (Enos, 2022).

Increasing Retention and Recruitment of Intersectional-Minded and Culturally Humble Healthcare Providers—Finally, promoting policy that ensures the training of future mental health providers and highlights diverse identities, marginalized communties, and contextual factors empowers providers to challenge underlying discriminatory and oppressive systems (Smith et al., 2008). For example, training frameworks such as the science-practioner-advocate model promote traditional research and clinical practice training while adding vital elements of social justice education and development of advocacy

abilities (Mallinckrodt et al., 2014). Further building the field of psychology's understanding of how existing discriminatory systems negatively impact providers from marginalized identities as well as the individuals and communities they work with can aid in retention and recruitment efforts. This may include discussion of interconnected systems of oppression and social determinants of health as well as understanding how stereotypes of marginalized communities negatively impact their resource access, health, and well-being (Clare, 2019; Daniel et al., 2018). In addition, improving training and resource access for providers increases the presence and support of healthcare providers (see Training section; Brown et al., 2022; Guetta, 2020; Lund et al., 2021). These improvements may consist of informal mentoring, increasing graduate stipends to a livable wage, and clear policies for reporting discrimination and harassment (Jones et al., 2018; Rogers et al., 2013)

Conclusions

As both a theory and an approach, intersectionality highlights the importance of flexibility and reflection when considering how systems of power interact to form a person's experience. Intersectionality directly challenges the ideals of Western society, healthcare, and the field of psychology, which are based in White supremacist and colonialist mindsets. Yet, disabled people have been largely overlooked in professional discussions about intersectionality. A framework of disability that acknowledges these interacting forces and identities can begin the process of deconstructing oppressive systems and advancing health equity among disabled individuals, and especially those who also hold other marginalized identities.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

Acknowledgments

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Public significance statement:

This paper asserts that an intersectional approach to the conceptualization of disability should be implemented into research, practice, and training in psychology. In doing so, psychologists can improve access, representation, and experiences of disabled individuals, especially those with multiply-marginalized identities, with the ultimate goal of reducing health inequities and promoting well-being.
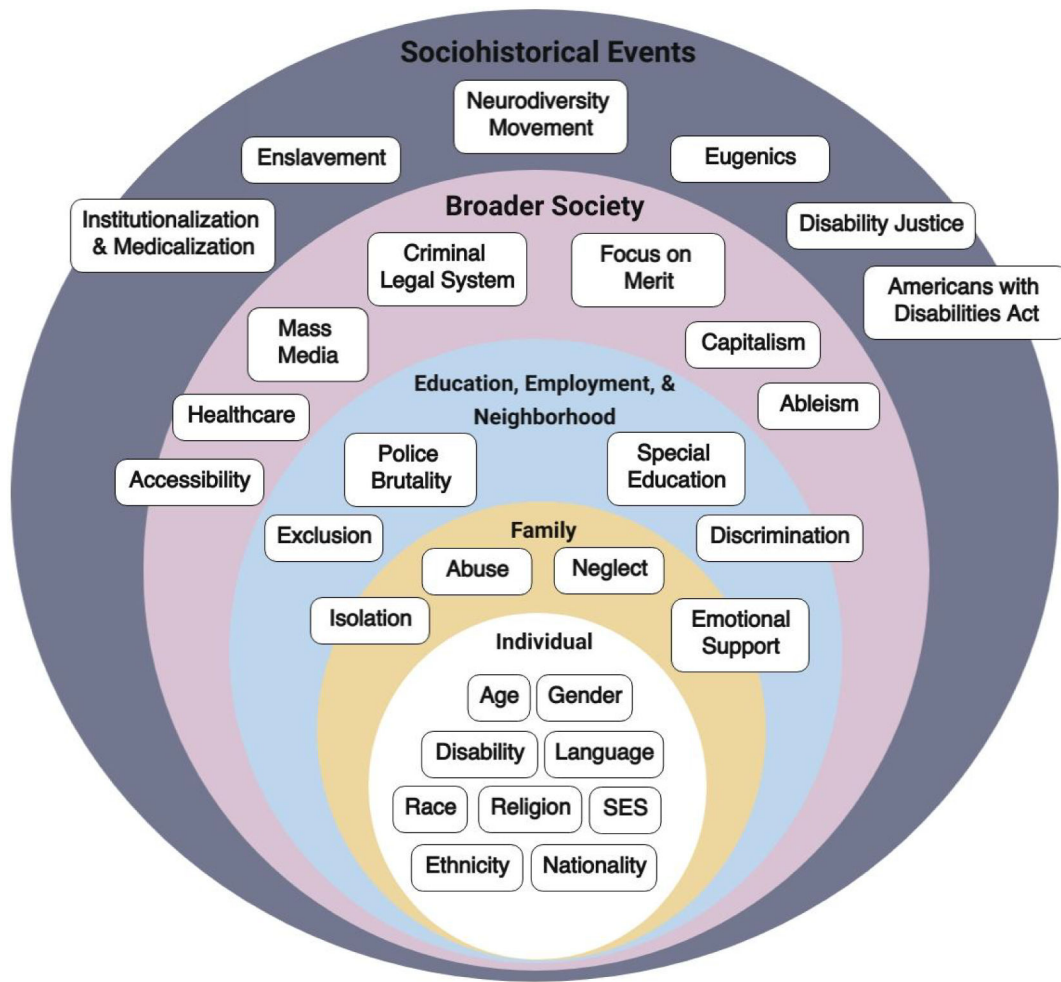
Figure 1.
The multiple levels of a disabled person's social ecology to consider in an intersectional framework. This figure is adapted from Galán, C. A., Auguste, E. E., Smith, N. A. and Meza, J. I. (2022). An intersectional-contextual approach to racial trauma exposure risk and coping among black youth. *Journal of Research on Adolescence, 32*(2), 583–595.

Table 1.

Shifting the Discourse on Disability: Moving to an Inclusive, Intersectional Focus

Model	Brief Description	Advantages	Disadvantages
Moral/ religious	Disability regarded as a punishment from a divine entity for a particular sin(s) that may have been committed by the person with disability or their parents/ancestors (Retief & Letsosa, 2018).	• First documented model of disability • Prompted efforts to understand disability • Encouraged further research on disability	• Resulted in social exclusion • Disability viewed as a curse and/or "challenge for special people" • Failure to experience healing from disability is viewed as the result of a lack of faith in God
Medical	Disability is conceptualized as an individual-level deficit in need of correction or fixing. Sometimes also referred to as the "personal tragedy" model (Clare, 2001, 2019; Dirth & Branscombe, 2018; Retief & Letsosa, 2018).	• Provides a common language and conceptualization for healthcare providers (e.g., insurance billing and reimbursement) • Addresses treatments that may prolong life or alleviate symptoms	• Promotes ableism (disability considered a deficit/weakness) • Fails to acknowledge other marginalized identities • Assigns power to medical professionals; positions disabled people in the passive "sick role" • Neglects extraindividual/sociopolitical factors • Detaches the disability condition from the person
Social	Disability is thought to be caused by the oppression of people in a society with disabling barriers. Frames disability as socially constructed (Dirth & Branscombe, 2018; Oliver, 2013; Shakespeare, 2006; Swain & French, 2000).	• Launched the disability movement • Has influenced civil rights legislation changes including reducing political, economic, and social barriers for disabled people (i.e., barriers to participation) throughout the world • Relatively straightforward in its tenets • Emphasizes disabled people as insiders and experts on disability experiences	• Narrow in its understanding of disability • Presents disabled people as a homogenous group equally impacted by society's barriers • Suggests people are solely disabled by society and not medically disabled by their bodies • Developed by White, heterosexual men with spinal injury or other physical disabilities, limiting generalizability • Does not address disability as a positive aspect of identity
Affirmative/ positive identity	Non-tragic view of disability and impairment that encompasses positive social identities rather than impairment or limitations. Views disability as socially constructed (Retief & Letsosa, 2018; Swain & French, 2000).	• Emphasis on disability as a beneficial, positive, and powerful attribute of a person • Abandons deficit or problem-based conceptualizations of disability • Explicitly incorporates affirmation • Promotes activism, pride, and empowerment • Emphasizes disability as a continuum	• "Forces" disabled individuals to identify with disabled people to the neglect of other groups • Fails to fully consider economic inequity • Fails to consider the challenges that many disabled individuals face (e.g., pain, comorbid health concerns) and that people may not always have a positive view of their disability
Human rights	Social justice framework for disability policy that emphasizes inherent human dignity plus civil, political, economic, social, and cultural	• Explicit acknowledgment of other identities • Comprehensively considers human rights	• Other identity factors are mentioned in the model but are not a central component

Model	Brief Description	Advantages	Disadvantages
	rights (Retief & Letsosa, 2018). Positions the 'problem' of disability outside the person and in society (Quinn & Degener, 2002).	• Offers concrete and actionable steps for improving the lives of disabled people • Defies the presumption that impairment may hinder human rights capacity (Degener, 2017)	• Fails to acknowledge the interaction between identity factors and multiply oppressed identities
Cultural	Focuses on a range of cultural factors in their relevance to disability and how different notions of disability operate in the context of a specific culture (Retief & Letsosa, 2018).	• Builds onto the social model by incorporating identity, culture, and worldviews (Devlieger, 2005) • Disability as a culture rather than deficit or difference	• Does not consider the interaction between identities and systems • May overemphasize disability as an identity group and lump all disabilities together