Intersectionality and how it can inform See Me's approach

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Contents

Statement on language

See Me recognises that terminology and labels used to refer to groups marginalised by society is ethically and politically complex, can be harmful and is subject to debate and update. Throughout this report we have mirrored the terminology used within the literature we have reviewed. Wherever possible, we have also tried to use the terminology partners themselves have used to refer to the communities they are led by and work with. We are committed to continually engaging with this critical debate to understand and mitigate harm.

Glossary

Intersectionality originates in Black feminism and critical race studies. It is a lens through which researchers seek to understand the complex nature of identity, health, social relationships, and power that plays out within human interaction and experiences (Crenshaw 1989).

Intersectional approaches to understanding and designing interventions, which take account of every form of discrimination (e.g., racism, homophobia, mentalism) individuals and groups face, are therefore recommended to improve health outcomes (Turan et al., 2019).

Intersectional stigma describes how social identities and structural inequities shape and influence each other (Sievwright et al., 2022). This means we cannot understand any one stigma (more often discussed in terms of prejudice when related to other protected characteristics) in isolation from another, which might simultaneously be at play, compounding negative experiences, e.g. of services as well as health outcomes.

A full glossary of terminology is available on the See Me website.

Executive Summary

This rapid review conducted by the Mental Health Foundation for See Me explores the concept of intersectionality and how it relates to mental health stigma and discrimination.

Intersectionality examines how multiple social identities and systemic power structures intersect to influence experiences, particularly in mental health and stigma. This approach highlights the compounded disadvantages faced by marginalized groups and the importance of addressing these layered inequities to improve mental health outcomes and reduce stigma in Scotland.

Key Points

- **Intersectionality origins:** Coined by Kimberlé Crenshaw in 1989, intersectionality focuses on how overlapping social identities, especially those of marginalized groups, create unique experiences of discrimination and structural inequality. It emphasizes addressing the needs of the most disadvantaged to benefit all.
- **Defining intersectionality:** Key elements include simultaneous membership in multiple social categories, the interaction of these categories within power systems, and resulting structural inequalities. It is distinct from but related to equity, equality, and diversity concepts.
- **Scottish Government alignment:** The Scottish Government recognizes intersectionality as addressing structural inequality beyond diversity and emphasizes the importance of understanding power relations rather than simply counting inequalities. This aligns with See Me's goals to tackle mental health stigma inclusively.
- **Mental health context:** Mental health outcomes and stigma are shaped by intersecting identities and social determinants such as poverty, ethnicity, and sexuality. Marginalized groups often face compounded stigma and structural barriers affecting their mental health.
- **Intersectional stigma:** This concept describes the convergence of multiple stigmatized identities and their synergistic effects on health and wellbeing. Stigma operates at micro (individual), meso (community), and macro (structural) levels, requiring nuanced understanding for effective intervention.
- **Intervention principles:** Effective intersectional interventions are person-centered, target societal inequities, address multiple forms of dominance, and engage communities with lived experience. They avoid one-size-fits-all models and emphasize power dynamics at various levels.

- **Project planning recommendations:** Successful initiatives involve flexible approaches responding to participants' complex needs, culturally appropriate language, community engagement, and consideration of practical barriers like transport and childcare.
- **Evaluation frameworks:** Hankivsky's intersectionality-based policy analysis framework guides the design and evaluation of interventions by focusing on intersecting social categories, power structures, reflexivity, and social justice outcomes.
- **Challenges and gaps:** There is limited data on mental health stigma intersecting with multiple identities in Scotland, and few interventions have been explicitly designed or evaluated through an intersectional lens. More research and practice integration are needed.

Introduction

This review aims to understand intersectionality and why it should be considered when working to tackle mental health stigma and discrimination in Scotland. It is estimated that around one in four people are affected by mental health problems in Scotland in any one year (Scottish Health Survey 2021). Mental health issues often co-exist with physical health conditions and in Scotland poor mental health is directly linked to poverty and social exclusion (Public Health Scotland 2018). Further, it has been evidenced that some population groups in Scotland are at increased risk of poor mental health including people living in poverty, people from the LGBTI community, minority ethnic communities and carers (Public Health Scotland 2018). This evidence demonstrates that mental health problems are not equally distributed across the Scottish population, and that intersecting factors including social disadvantage, poverty, unemployment childhood adversity and long-term health conditions often result in poorer mental health outcomes (Public Health Scotland 2021). There is also a gradient of mental health stigma in Scotland, with those who experience severe and enduring mental health illness facing more stigma than those who experience other conditions such as depression and anxiety (Scottish Mental Illness Stigma Study 2022).

We know that that mental health stigma is multi layered, and experienced in different ways by people with different mental health conditions and varied protected characteristics. It is therefore important that an intersectional approach considers the different levels and types of stigma experienced by individuals, and encompasses the complexity of dual and multiple stigma that exists and the practical steps that can be taken to address this, to reduce mental health stigma and discrimination in Scotland.

If we wish to change outcomes for the most disadvantaged in Scotland then having a grounding in intersectionality will aid this. This review has been designed as a source of evidence to support See Me to explore how it might embed an intersectional approach in its work going forward. We first look at what intersectionality is – its roots, how scholars have defined it and how it has been approached by the Scottish Government. We then seek to understand intersectionality in relation to mental health and mental health stigma. Finally, we provide practical information about existing interventions designed to tackle mental health stigma through an intersectional lens, with key intervention requirements as outlined by those working in this field.

Methods

In June 2023, several searches of grey and academic literature were conducted using Google, Google Scholar and the NHS Knowledge Network. Combinations of the following key words were used:

- Mental health/ Mental*
- Intersectional*
- Intervention*
- Stigma

Titles or headers were screened and if they appeared relevant, abstracts (academic articles) or the web page (grey literature) were read. Relevant articles and reports were downloaded in full, and read by a member of the research team. The research team extracted key pieces of information from each document into a shared file, which sorted the data by research question. This was used to form the basis of the review.

What is intersectionality?

Beginnings in feminism and critical race studies

Intersectionality is a term that was coined by Kimberlé Crenshaw in her 1989 essay 'Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics' (Crenshaw 1989 In the essay she outlines the need for an analysis that takes into account every form of discrimination that a person or group may face in order to understand how they are disadvantaged in society. Her work focuses specifically on Black women, arguing that they are 'multiply-burdened' compared to Black men (in cases of racism) and white women (in cases of sexism) (Crenshaw 1989, p.140). She examines the power structures that are at play and how they create structural inequality. Crenshaw closes her essay by saying that 'if their [those wishing to eliminate racism and sexism] efforts instead began with addressing the needs and problems of those who are most disadvantaged and with restructuring and remaking the world where necessary, then others who are singularly disadvantaged would also benefit' (Crenshaw, 1989 p.167). This highlights that an intersectional approach is necessary if we want to improve the lives of all people who are disadvantaged in our society.

Since then, the theory has been used by a number of scholars in the fields of both critical race theory and feminism. The theory has shaped how those working in these fields conduct research. McCall (2005) explains that feminist social scientists often use the focus group method in order to understand any new or invisible groups that may otherwise be missed. Often qualitative approaches are used, as quantitative approaches can miss crucial nuances which is often where the intersection lies.

However, some academics working in the field of health studies have suggested that a mixed methods approach could allow for a more dynamic study into intersectionality (Jackson, Mohr and Kindahl 2022).

How do we define intersectionality?

In more recent times, the term *intersectionality* has entered the mainstream, and is now commonly used across a variety of different fields including business, policy and international development. While many see this mainstreaming as a positive move, other argue that this means the term has become diluted. Bauer et al (2021) argue that it is possible that intersectionality can lose its 'complexity and focus on social power dynamics and structural inequality' as it is adopted by other disciplines outside of the United States (p.3).

Collins argues that between scholars and practitioners, it is very hard to define what intersectionality is as it appears that different disciplines and practices use and define it in their own way. She finds that 'scholars and practitioners think they know intersectionality when they see it. More importantly, they conceptualise intersectionality in dramatically different ways when they use it' (Collins, 2015 p.3). The use of intersectionality in spaces that are far removed from its initial roots can be seen as superficial as they define it in ways that may suit their agenda whilst not fully understanding the full power structures at play. This is expressed by Cho et al. (2013, p.789) who argue that these spaces are 'constituted by power relations that are far from transparent'. Perhaps this is part of the reason why the power dynamic element of intersectionality – which is vital – has become lost over time.

If we were to define intersectionality, then there are three key issues that the Scottish Government argue need to be included:

- A recognition that people are shaped by simultaneous membership of multiple interconnected social categories.
- The interaction between multiple social categories occurs within a context of connected systems and structures of power (e.g. laws, policies, governments). A recognition of inequality of power is key to intersectionality.
- Structural inequalities, reflected as relative disadvantage and privilege, are the outcome of interconnected social categories, power relations and contexts. (Scottish Government, 2021 p.3)

The systemic power structures and relations that we operate in are important here. Aguayo-Romero (2021) reiterates this:

> *'The distinction that intersectionality focuses on intersecting systems of privilege and oppression rather than on intersecting social identities is key; everyone has intersecting social identities, but not everyone belongs to historically marginalized groups or experiences intersecting systemic oppression' (Aguayo-Romero 2021, p.101).*

While every identity can intersect with another, not every identity faces the same levels of discrimination. Therefore, at every point in an intersectional approach we must continue to remember the power structures at play.

What is *not* intersectionality?

With its rise in popularity, the usage of the term intersectionality has begun to appear in less academic settings such as institutions and organisations. However, this has led to it frequently being conflated with equity, equality and diversity. It can be said that this shows a superficial understanding of intersectionality and those using the term rarely seek to address the systemic issues relating to it (Kelly et al, 2022). In doing so, they are incorrectly using the term which can lead to misleading information being produced. Using key terms relating to improved outcomes for those who are more disadvantaged in society is critical in order to make improvements in their lives. Kelly et al (2022) outline the differences between these phrases:

Key term	Definition
Intersectionality	• Intersectionality typically includes an explicit commitment to social justice—that is, an aim to redistribute wealth, opportunities, and privileges at a societal level. • Suggests that privilege and oppression shift based on context, and thus one may be privileged in one context but disadvantaged in another. • Requires researchers to be reflexive of their own social locations and state a theoretical orientation. • Teams "using" intersectionality in their research must also "do" intersectionality through [different] practices
Health Equity	• Health equity is a societal goal of global and public health research and practice, seeking to eliminate unjust health disparities at the population level that are shaped by the social determinants of health. • The World Health Organization (WHO) describes: "Health equity is achieved when everyone can attain their full potential for health and well-being".
Equity, diversity and inclusion	• Policy-focused initiative aimed at addressing the ongoing exclusion of under-represented groups in employment, education, and other institutional contexts. • Equity refers to achieving fair outcomes, recognizing diversity, and addressing inequality through intervention • Diversity refers to the welcoming and embracing of difference, in relation to social demographics as well as a diversity of perspectives and ideas • Inclusion is fostering an environment and culture that is welcoming and supports diverse individuals and/or groups of people, and may also require concrete changes
Equality	• Equality refers to treating all people the same (e.g., offering the same opportunities)

Table 1: Kelly et al (2022) Intersectionality, health equity, and EDI: What's the difference for health researchers? p.2-4

All of these terms are useful tools to draw from, but they all bring different things to the table and therefore must be used correctly.

Being aware of our own privileges

It is crucial that when carrying out any work with an intersectional approach, we are aware of and address our own privileges. For example, this review has been researched and written by white women who are professional researchers. This means that we come to the work with particular privileges - in fact we come to it as women with arguably the most power. These privileges shape how we understand power and how it is operating, how we understand a system to work and details that we may miss if we have not experienced them ourselves. Having an understanding of the power dynamics within an area of work and how they might impact a piece of work in its entirety at every stage is crucial if we are to take a truly intersectional approach.

How does the Scottish Government approach intersectionality?

The Scottish Government published a report in 2022 entitled 'Using intersectionality to understand structural inequality in Scotland: Evidence synthesis' (Scottish Government, 2022). The report outlines what intersectionality is, how it has been incorporated into the work of the Scottish Government and how an intersectional approach can be used in research. In the report they highlight that 'intersectionality is not a synonym for diversity' and outline that when speaking about people who face multiple forms of inequality then we should refer to them as those from 'intersectionally marginalised communities' (Scottish Government, 2022 p.13). The Scottish Government also reiterates what scholars such as Cho et al (2013) have said about how power shapes inequality and not identity. Another issue that they press is that 'intersectionality is not about adding up different kinds of inequality' but instead about how these inequalities interact (Scottish Government, 2022 p.13).

How does this align with the work of See Me?

Having a shared understanding of intersectionality will support an approach that ensures that See Me is consistently tackling stigma and discrimination for every person in Scotland. There is no stigma free society if it is only being tackled for and by people who are more advantaged in society. However, it has been demonstrated that reaching people who experience more disadvantages in Scotland can be challenging, which was an issue that arose during the Scottish Mental Illness Stigma Study (SMISS). The study was aimed at any adult in Scotland aged 18 and over with a mental illness, however analysis later showed that it was not reaching three groups including men, people aged over 65 and people from minority ethnic backgrounds. From this we can infer that the likelihood is that a man, aged over 65 and from a minority ethnic background was least likely to participate in the study. In order to address this in future studies, an intersectional approach to research, research recruitment and communications could be useful. The power structures in place in our society may make it more difficult for people to feel that they can interact with See Me and partners and so a greater understanding of these power structures may also lead to improved data with which to inform anti-stigma work.

Understanding intersectional approaches and mental health

With a greater understanding of what intersectionality is and why it is important, it is crucial that we have a well-developed intersectional approach and that can be applied to the field of mental health. Although some of the data that has been surfaced in this review relates to intersectionality and mental health, where necessary findings have been included that are related to wider public health.

Public health and intersectionality

Intersectionality in public health is an area that has been adopted in more recent times and has given way for a move from an individual understanding of inequality and how it impacts public health outcomes to one that considers structural power dynamics and how they intersect (Alvidrez et al, 2021).

Fagrell-Trygg et al (2019) found that in public health 'simultaneously experienced disadvantages tend to produce more than additive disadvantage' thus meaning that taking an intersectional approach in public health is vital if we wish to improve outcomes for every person in the population (Fagrell-Trygg, 2019 p.1). It can be hypothesised from this that the more disadvantages that someone faces in society, then the more they may be at risk of experiencing poorer public health outcomes.

The use of an intersectional approach to public health helps policymakers, researchers and those working in communities to develop interventions that are able to 'tackle the complexity of health inequalities' (Huang et al, 2020). In order to take an intersectional approach to public health, Bauer et al (2021) report that those working in this space must have a good understanding of the three core principles: multiple intersecting identities, historically oppressed and marginalised populations, and the social-structural context of health. These three principles allow for those working in public health to develop a map of how different disadvantages intersect within different areas of public health. These multiple intersecting disadvantages can include a wide variety such as gender, race, sexuality, socio-economic status and refugee status. Where people sit in relation to these can impact how they approach public health and more critically, how public health approaches them. Some of these identities are historically oppressed and marginalised, and therefore the power systems in place are not set up in their favour. Health is one system in which this is true. Those working in public health would benefit from having a good grasp on these principles to ensure that every person is able to access health in a system that has historically not been structured around them.

Mental health and intersectionality

We know that mental health does not exist separately from people's individual characteristics, it is shaped in unique ways by their multiple identities and impacted by life experiences in each of these domains (Alegría et al. 2018). Alegría et al. write

that people from minoritised ethnic groups are more likely to experience social stressors and disadvantages compared to people from majority ethnic groups. Similarly, people with mental health issues and/or physical disabilities are at increased risk of experiencing stigma and discrimination because of their mental or physical health conditions (Mental Health Foundation 2021).

Considering the experiences of people with protected characteristics – such as inequality, poverty, stigma, and discrimination – is crucial for obtaining a more accurate picture of how people's lived experience impacts their mental health (WHO 2022). People's unique characteristics are not the cause of poor mental health. Rather, it is how identity markers are perceived by others and (un)accommodated for by systems that result in power imbalances that lead to people and communities becoming marginalised. This othering of people and groups because of their differences is a cause of mental health issues (The Mind Clan 2020).

Fagrell-Trygg et al (2019) found that research into intersectionality and mental health is still quite limited. They find that the different intersections that may be relevant will change depending on context. They question which intersections matter and what should be considered when researching mental health and intersectionality in Europe. They argue that the race and ethnicity measures in the United States are sometimes controversial and therefore of 'limited value for policy and practice in Europe' (Fagrell-Trygg 2019, p.9). So the key intersections that should be considered in European based studies are sexual orientation, socioeconomic position and religion. However, while this is a useful insight into which intersections could be considered in different geographic locations, we would argue that in the context of the third sector in Scotland this may not always be valid. While academic research may rely on larger sample sizes, work within communities does not. Therefore, to better understand how to make a positive difference to anyone living in Scotland who is negatively impacted by mental health stigma and discrimination, every disadvantage they might face should be considered.

In adopting an intersectional approach to mental health and therefore gaining a more in-depth view of people's disadvantages and privileges, it is possible to identify where the risk factors and protective mechanisms lie for different groups within our society and what power systems are in place that exacerbate poor mental health (Torres et al 2018). Gaining greater insight into these power systems will allow practitioners to develop solutions and interventions that lead to greater mental health outcomes for every person within our society. Chovaz (2013) argues that mental healthcare providers must have a critical understanding of the effects of different intersections that exist so that they can develop systems that work for every person who seeks them out. The aim of an intersectional approach to mental health should be to gain the knowledge needed to address how mental health, mental health services and outcomes are experienced by different groups – particularly those who face multiple disadvantages – and to develop a plan to achieve systemic change that will lead to better mental health outcomes for every person in our society.

Understanding the link between intersectionality and mental health stigma and discrimination

As a programme that primarily works to tackle mental health stigma and discrimination, it is important that See Me can learn from previous studies about mental health stigma and discrimination and intersectionality. However, this is an area that can be lacking in available data. There are a number of reasons for this including: a lack of consensus on how best to define and analyse intersectional stigma (Turan et al 2019) and difficulty in measuring lived experience of intersecting stigmas (Hall et al 2023). In Scotland, it has been highlighted that data that can be used to measure these different intersectional stigmas is not collected at government level, making it difficult for researchers and organisations alike (Engender, 2022). The Scottish Mental Illness Stigma Study recommended that more partnership working with stakeholders in other sectors could lead to improved intersectional mental health stigma and discrimination measures. Therefore, when necessary, we have reviewed studies into other types of stigma and intersectionality that are underpinned by similar principles.

What is intersectional stigma?

There are a number of studies that outline what they understand to be intersectional stigma. Turan et al. (2019) found that intersectional stigma is a concept that has emerged to characterize the convergence of multiple stigmatised identities within a person or group, and to address their joint effects on health and wellbeing. While Abubakari et al. (2021) builds on this with their understanding that it 'denotes the synergistic effect produced by systems of oppression at the intersection of these stigmatised identities, behaviours and/or conditions on well-being and health' (Abubakari et al. 2021 p.1)

An example of intersectional stigma in action is in Rice et al's (2018) study into HIV and intersectional stigma, where they conclude that a 'lack of social and economic power among women may limit their ability to negotiate power in sexual relationships, access preventive healthcare, and use protective resources around HIV prevention; increasing vulnerability to HIV infection' (Rice et al. 2018, p.4). This highlights how these stigmas compounded and resulted in a negative impact on the health of the women researched in the study.

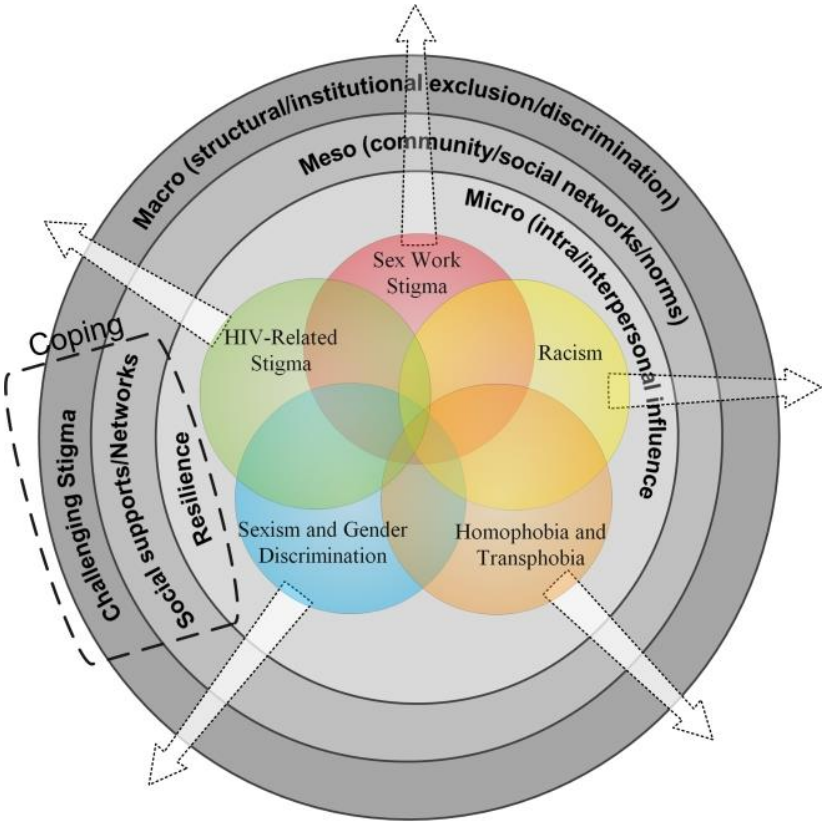

Figure 1: Levels of intersectionality, Logie et al (2011) p.3

Logie et al (2011) expand our understanding of intersectional stigma when they explain in their research into stigma and HIV that stigma is not only intersectional but that it has different levels of intersectionality that must be understood. There are: 'micro (e.g., individual attitudes and beliefs), meso (e.g., community and social norms/networks), and macro (e.g., structural factors including organizational and political power; laws and policies; health and social service systems)' (Logie et al. 2011 p.8). Logie and colleagues' visualisation of this (Figure 1) helps us to think about how stigmas can intersect, and the layers of stigma that these exist within. This form of mapping has inspired others working in the field of HIV stigma such as Rai et al (2020) who highlight that in order to have interventions that work to tackle intersectional stigma, we need to have a good grasp of each of the levels of stigma that the group being studied are experiencing.

How do we address intersectional stigma?

Addressing intersectional stigma can only be done once we understand the different stigmas and how they intersect with each other. We also must have a clear idea of what lies in the macro, meso and micro levels for the group(s) we are working with. Once a clear picture has been formed, we then need to ask what needs to be done in order to reduce the stigma experienced. Reducing stigma through interventions is discussed in the next section of this review, however from a theoretical perspective it is also crucial that we think about the importance of power dynamics in

intersectionality. According to Sievwright et al (2022) 'systems of power perpetuate intersectional stigma', therefore as part of an intersectional approach to mental health stigma, the systems in place need to be addressed (Sievwright et al. 2022 p.357). These systems of power change for every type of disadvantage and stigma. They also argue that 'recognising the contexts that drive and mutually shape these stigmas' is vital when we wish to reduce stigma (Sievwright et al. 2022 p. 357).

Intersectional mental health stigma

We know from previous work that those who experience poor mental health and who come from a background that may disadvantage them in any way will have a very different experience from someone who is part of groups that are more advantaged in society (such as those who are white, middle class, heterosexual etc.). In a previous evidence review on women and girls, we highlighted that women from different minority ethnic backgrounds experienced mental health stigma differently as they were faced with different forms of mental health stigma from different people (family, friends, community members, colleagues etc.). What was not addressed was that some of these women may also face intersectional stigma – such as socio-economic status and sexual orientation – but there was no data available in Scotland on this that could be included. However, from the information in the evidence review we can infer that they experienced stigma due to their mental health, their gender, their ethnic backgrounds and their socio-economic backgrounds. When each of these stigmas intersect with one another they compound to create a layered experience that is beholden to a number of different power systems. This could then mean that in order to address mental health stigma for these women, an understanding of every power system and how they operate together would be beneficial.

From the literature, it is clear that there is still much academic work to be undertaken to further explore what intersectional mental health stigma looks like and what we can learn from it beyond a 'doing research' perspective. While some studies have explored these intersections, they appear not to have discussed how this approach can be applied to a delivery setting. These studies have raised some areas and intersections within mental health stigma however with a number of studies in the United States focusing on Latinx communities and mental health with intersections including sexuality, gender and age (Lopez et al 2018; Torres et al 2018; Schmitz et al 2019); studies looking into how cancer survivors experience mental health with a focus on race and gender (Boehmer et al 2021); young women in the judicial system and how they experience mental health with a look at intersections that include race, socio-economic background and adverse childhood experiences (Kelly et al 2016) and in the United States there have been studies that have looked at Black women and mental health examining different intersections including socio-economic background and education (Banks and Kohn-Woods 2002; Seng et al 2012). Studies from the UK have also analysed mental health intersections including those faced by the Chinese population (Tang and Pilgrim 2017) and men and mental health including intersections such as religion and sexuality (Smyth et al 2022).

Interventions addressing intersectionality

Intersectionality has become a more widely understood and applied theory within recent years and is beginning to influence policy and practice across Scotland and internationally (Tinner et al, 2023). Whilst some are now applying intersectionality theory to intervention evaluation, few have yet risen to the challenge of using intersectionality frameworks to design and deliver interventions (Rojas-Garcia et al, 2022). Where intersectionality is applied in practice, it is not reportedly done so in a consistent way; Christoffersen (2021) identifies five different definitions of intersectionality that are used in policy and practice in the UK, of which the majority do not fully address the core principles of this approach.

How can intersectionality inform which projects and work to prioritize?

Intersectionality Principles

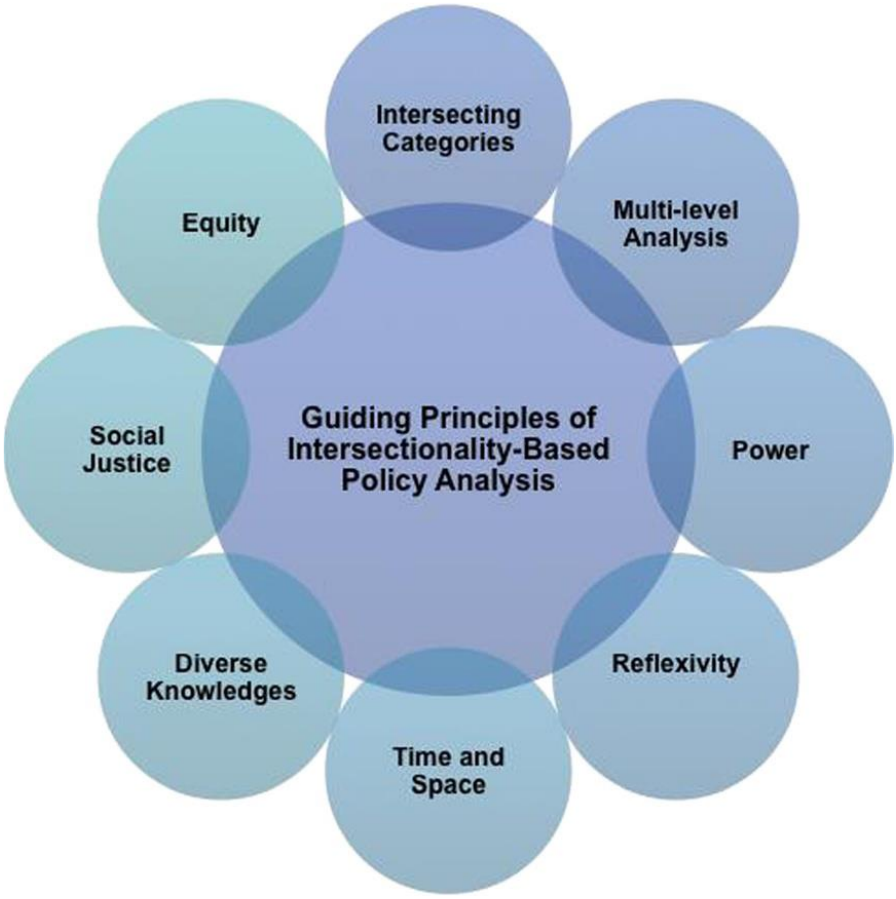

Figure 2: Guiding principles of Intersectionality-Based Policy Analysis (Hankivsky, 2014)

Research into the experiences of mental health stigma among racialised men in Toronto found that “mental health stigma cannot be understood in isolation of other social and structural barriers” (Morrow et al, 2020, p. 1304). Intersectionality is therefore an important framework for identifying and designing mental health stigma interventions. Several key principles underpinning intersectionality can be identified from the literature. Weber proposes that an intersectional intervention should seek

to: “(1) eliminate societal inequities; (2) uncover multiple forms of dominance; (3) attend to fluidity and contextual specificities of power hierarchies; and (4) address power and oppression at both micro and macro levels.” (Weber, 2006 as described in Huang et al, 2020 p221). Core principles identified by Tinner and colleagues (2023) include: “(1) an explicit focus on structural factors or social determinants of health; (2) consideration of discrimination, particularly across more than one axis of inequality; and (3) a focus on an equitable power dynamic with communities and users of services.”

Targeted approach

Huang et al (2020, p221) propose that embedding intersectionality theory in practice requires an end to ‘one-size-fits-all’ interventions suggesting a person-centred approach might be more appropriate. Christoffersen (2021) however advises that intersectionality does not equate to an individualised approach. Instead, intersectionality’s emphasis on interwoven societal identities highlights the importance of positioning a person-centred approach within a wider societal lens to take a targeted, but not individualistic, approach.

Oexle & Corrigan (2018) argee, arguing that applying intersectionality theory to mental illness stigma necessitates the use of targeted interventions and that contact-based interventions are therefore better than universal educational campaigns at addressing intersectionality. They state that universal strategies and assumptions of homogeneity in anti-stigma campaigns can “strengthen ‘existing disparities’ by using messaging such as ‘just like everyone else’” (Oexle & Corrigan, 2018 p588). Oexle & Corrigan (2018) further write that contact-based interventions can lead to improvements in attitude and behaviour if the contact is: ‘targeted, local, credible, and continuous and targets specific behavioral changes’, and credible lived experience facilitators match the targeted community group (Oexle & Corrigan, 2018, p588). Research by Morrow et al (2020) supports this. They found that older Asian-Canadian men’s attitudes towards mental health stigma improved following exposure to younger Asian-Canadian men with lived experience. The authors argue that mental health anti-stigma campaigns should address issues of intersectionality by explicitly addressing issues such as racism, economic inequality, ageism etc.

Challenging Western Medical Norms

Several authors point out the apparent conflict between a Western, medical approach to conceptualising mental illness, and intersectional theory. For example Samra and Hankivsky argue that “challenging medical cultural norms and the system inequities they produce and reproduce starts with rejecting the idea that one system of inequality is more important than any other. Different inequities are intertwined and experienced simultaneously” (Samra & Hankivsky, 2021, p. 858.) Fung and colleagues go further, highlighting the potential harm that taking a biomedical view of mental health can cause “interventions that solely emphasize Western biomedical concepts of health and illness may further marginalize and re-stigmatize participants through socioculturally exclusive concepts, techniques, or approaches” (Fung et al,

2020, p. 656). There are however a few good examples of how those working within clinical healthcare settings are working to integrate these two apparently conflicting approaches. For example, Stevens and colleagues describe a detailed intersectional approach to perinatal clinical care in the USA. In a pre-post designed intervention study, they reported high treatment engagement and effectiveness (improvement in symptoms of perinatal depression/ anxiety). Results were similar for participants from different racial backgrounds, despite commonly reported favourable outcomes for white women.

An intervention promotes intersectionality when it:
• Takes a person-centred/ flexible, targeted approach
• Seeks to eliminate societal inequities
• Seeks to uncover multiple forms of dominance
• Seeks to attend to fluidity and contextual specificities of power hierarchies
• Seeks to address power and oppression at both micro and macro levels
• Involves close collaboration with people with lived experience, including during the design and development of the intervention, and during identification of outcomes to evaluate
• Addresses and reports on intersectionality of participants (not treating them as a homogenous group)
• Provides a (safe) critical space for participants to highlight other types of disadvantage in their lives
• Flexibly addresses a range of issues, based on the unique intersectional experiences of participants
• Promotes peer support/advocacy
• Uses an intersectional analytic framework
• Takes “a sensitive, coordinated, and effective system of care to address the constellation of issues” (Powell et al, 2016, p. 182) participants face
• (Anti-stigma interventions) contact-based interventions that offer contact which is “targeted, local, credible, and continuous and target specific behavioral changes”
• Is trauma-informed (trauma as a key driver of oppression)

Figure 3: Attributes of intersectional interventions identified in the literature

Intersectionality and project planning

The literature included in this review makes a series of recommendations for planning and delivering effective intersectional mental health interventions, as described below.

Lived experience engagement

Huang et al. (2020) reviewed interventions to evaluate the extent to which they took an intersectional approach. Common to all ‘high intersectionality’ interventions was good engagement with people with lived experience (Huang et al, 2020 p. 222). Huang and colleagues argued that privileging the voices and perspectives of people or communities with lived experience – through co-production and/or community based participatory research – helps address inherent power imbalances. Christoffersen (2021) argues that intersectionality interventions must consider who is represented by the intervention (and whether/how to represent others) and focus on “coalition and solidarity building” (Christoffersen, 2021, p. 8).

Peer support can be an important mechanism through which to address intersectionality, as demonstrated by the 40 & Forward intervention (Reisner et al., 2011) reviewed by Huang and colleagues, who summarised that this peer support intervention was "designed to address their unique need for social support and to compensate for their experiences of social isolation, depression, and anxiety caused by the intersection of internalized ageism and sexual minority stress" (Huang et al., 2020 p. 224).

Responding flexibly to complex needs

The development and implementation of an intervention needs to be guided by a good understanding of the intersectionality and challenges faced by the people it is aimed at (Huang et al., 2020). This should be reflected in the format of the intervention, for example whether it is group-based or individual (Lloyd et al., 2021), online, in-person or hybrid. Intersectional interventions also need to be flexible in nature, able to change direction or go beyond the original objectives in order to respond to the challenges and experiences of participants. This was demonstrated by the Helping to Overcome Problems Effectively (HOPE) intervention (Hergenrather et al., 2013) which went beyond the original aims of the project (to mitigate unemployment among African gay men living with HIV) to respond to an 'array of challenges confronting this community, including mental health and stigma and discrimination-related challenges' (Huang et al., 2020, p. 224).

Group interventions

Tinner and colleagues (2023) point out that for some, group interventions designed around key intersectional characteristics of participants may help people feel like their experiences are 'normal' and valid, and can help people understand their distress through their identity. Group facilitators who share key intersectional characteristics can enhance a feeling of safety. For other people however, being assigned to a group based on any characteristics can feel uncomfortable - like they are being treated differently because of an aspect of their identity, or are being 'shoehorned in' to a group that doesn't feel like a good fit.

Language

Multilingual communications and culturally appropriate terminology are crucial for engagement, to "attune with participants' cultural values" (Baker et al., 2015 p. 394). Those designing interventions should seek to understand how members of the community that the intervention is aimed at speak about the topic (i.e. mental health and mental health stigma and discrimination), so that everyone has a shared understanding. Where no appropriate terminology exists, this should be co-constructed/agreed upon. For example, the name of one online intervention programme was modified from 'Sadness' to 'Brighten Your Mood Program' to avoid the negative connotations related to depression in Chinese culture (Choi et al. 2012)."

Semlyen and Rohleder reviewed a series of papers on intersectionality and mental health in LGBTQ+ communities and identified a key theme relating to the labelling

and categorisation of mental health conditions. They found that papers highlighted issues of power and dominance resulting from the use of labels - including mental illness diagnoses. They note that diagnostic labelling and the medicalisation of experience more broadly doesn't "meaningfully capture the experiences of distress linked to oppression and discrimination." (Semlyen & Rohleder, 2022, p. 1107)

Further recommendations for project planning

Baker and colleagues (Baker et al., 2015) reviewed literature pertaining to best practice examples of engaging with culturally and linguistically diverse (CALD) communities in Australia to reduce the impact of depression and anxiety. Their findings were structured around six key themes, and highlighted several important recommendations:

- Community based resources can be helpful, but are often found by chance – intervention planning should carefully consider how to target their intended population.
- Timing of initiatives is important. Planners need to ensure that religious and cultural holidays and other key events are taken into consideration. Consideration of timing can also extend to the working, family and other commitments that community members are likely to hold.
- Face to face interventions need to be held in venues that are culturally acceptable, accessible and comfortable (e.g. buildings with religious, cultural or historical connotations need to be carefully considered).
- Build rapport with community groups and organisations. Groups can help with recruitment and advise on topics such as dates to avoid, possible venues etc.
- Provide a welcoming environment which encourages interaction: use traditional greetings where appropriate.
- Culturally appropriate refreshments should be provided.
- Establish confidentiality and ground rules/ expectations.
- Seek to understand cultural practices, needs and beliefs (e.g. prayers, alternative medicine).
- Seek to understand cultural values e.g. central role of family – adapting CBT to focus on the personal dimensions of a relationship, and then to focus on family-based activities (Gonzales-Prendes et al, 2011).
- Consider gender preferences.
- Central role of trust:
    - Western medicine widely mistrusted: consider non-medicalised language, use a more holistic approach.
    - Explore beliefs relating to mental health/illness.
- Collectivist cultures: invite or find ways to include natural supports, but important to check with each individual.

- Creative and artistic methods can be a helpful way of communicating and targeting stigma for example in young people. Fotonovellas have been used successfully with some Hispanic communities (Unger et al, 2013).
- Technology including internet-based and phone-based interventions, can be a helpful tool when seeking to enhance intersectional engagement. Websites can offer a tailored experience for different audiences, whilst phone interventions can be more private, accessible, flexible, confidential and anonymous. (Baker et al., 2015)
- Barriers to participation include:
    - Transport – can your participants drive? Will they feel safe/comfortable travelling by themselves? E.g. provide transport facilitators of same cultural background.
    - Childcare.

Intersectionality and community engagement strategies

Community groups can be a key resource for understanding the experiences, cultural norms, language and values of the community or population targeted by the intervention (Baker et al., 2015). Community groups can also help with participant recruitment – either directly by appealing to their members and wider community, or by helping inform a culturally sensitive recruitment strategy (e.g. Kiropolous et al., 2011). Finally, community groups be engaged as partners in the coproduction of interventions. For example, the HOPE programme worked with African/American gay men living with HIV to develop the intervention and design a study to evaluate it (Hergenrather et al., 2013).

Intersectionality and project evaluation

Hankivsky's intersectionality framework (Hankivsky, 2012, Hankivsky et al., 2014) is widely used to inform the design and evaluation of interventions (see Figure 1 and text box 1). Although created for developing and evaluating public policies, the guiding principles and overarching questions posed by the framework are easily translated to the development and implementation of mental health stigma and discrimination interventions. For example, Ghasemi and colleagues (2021) conducted a scoping review of health interventions applying intersectionality theory. The authors used a checklist for intersectionality against which they assessed the interventions, based on the guiding principles in Hankivsky's framework. A copy of the checklist can be found in Appendix A.

Data analysis methodology in many evaluations does not consider intersectionality. Several reviews have now been conducted, exploring the best approaches to intersectional data analysis (e.g. Turan et al., 2019; Bauer et al., 2021).

Hankivsky (2014) Intersectionality Questions:

- What knowledge, values, and experiences do you bring to this area [of policy analysis]?
- What is the [policy] 'problem' under consideration?
- How have representations of the 'problem' come about?
- How are groups differentially affected by this representation of the 'problem'?
- What are the current policy responses to the 'problem'?
- What inequities actually exist in relation to the 'problem'?
- Where and how can interventions be made to improve the problem?
- What are feasible short, medium and long-term solutions?
- How will proposed policy responses reduce inequities?
- How will implementation and uptake be assured?
- How will you know if inequities have been reduced?
- How has the process of engaging in an intersectionality-based [policy] analysis transformed:
    - Your thinking about relations and structures of power and inequity
    - The ways in which you and others engage in the work of [policy] development, implementation and evaluation
    - Broader conceptualisations, relations and effects of power asymmetry in the everyday world

Figure 4: Descriptive and transformative overarching questions of Hankivsky's Intersectionality-based poilicy analysis framework (Hankivsky et al., 2014, p. 4

How can intersectionality help identify problems?

Taking an intersectional approach requires critical and ongoing appraisal of how interventions address the complicated multi-stranded discrimination and disadvantage experienced by people participating in them. Interventions perceived to be highly intersectional commonly offer participants a safe, critical space in which they can talk about their experiences of discrimination and disadvantage, without this being limited by the original objectives of the intervention (Huang et al.). Importantly, these experiences should then be responded to within the intervention.

Concluding remarks

This rapid review seeks to understand concept of intersectionality and its relevance to mental health stigma and discrimination in Scotland. It explores the origins, definitions, and applications of intersectionality, particularly in relation to mental health, and provides guidance on how intersectionality can inform effective interventions and policy analysis to reduce stigma and improve mental health outcomes

Intersectionality, coined by Kimberlé Crenshaw in 1989, examines how overlapping social identities, especially those of marginalized groups, create unique experiences of discrimination and structural inequality. It is crucial to differentiate intersectionality from related concepts such as equity, equality, and diversity. The key factor in intersectionality is the way that it seeks to address how different disadvantages interact with each other and how that can lead to an increased disadvantage. It is important to consider the power systems that come with each of these intersections. It is also key to remember that intersectionality is about disadvantage as opposed to identity.

Mental health outcomes and stigma are deeply influenced by intersecting identities and social determinants such as poverty, ethnicity, and sexuality. Marginalized groups often face compounded stigma and structural barriers that adversely affect their mental health. Using an intersectional approach when working in the mental health space provides a clearer understanding of how different people experience mental health and how this may make their overall mental health outcomes different too.

There is limited data on mental health stigma intersecting with multiple identities in Scotland, and few interventions have been explicitly designed or evaluated through an intersectional lens. Despite limited data and few explicitly intersectional interventions in mental health stigma, valuable lessons can be drawn from broader literature, which highlights the importance of targeted, flexible, and community-engaged approaches to reduce stigma and promote mental health equity in Scotland.

Few mental health interventions have yet been designed or evaluated from an intersectional perspective. Where practitioners and researchers have described taking an intersectional approach, reviews suggest that the focus remains on intersectional dimensions other than mental health-related stigma and discrimination, and how these interact with mental health. Lessons can still be learned from the broader literature regarding how to deliver and evaluate an intersectional intervention, as described above. Key learnings specifically linked to mental health stigma stem from the work of Oexle and Corrigan (2018), who recommend taking a targeted rather than universal approach to anti-stigma mental health campaigns.

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Appendix

Checklist for application of Intersectionality in health interventions and programs, from Ghasemi et al., 2021 (p. 4-5)

	Intersectionality Principles	Items	Yes	No	Unclear
Problem identification	Intersecting Categories	1- Has the combination of different social factors, such as age, gender, race/ethnicity, class, migration, been addressed in identifying the causes of the problem? And is not focused solely on a single variable, apart from others?			
		2- Have target groups been selected based on considering to differences, variations and similarities between relevant groups? As well, based on that, have target groups been identified as the most vulnerable group?			
		3- In identification of the most vulnerable groups, have the differences and similarities of the subgroups in terms of social factors, been considered?			
	Multilevel Analysis	4- Have the various factors at the individual, interpersonal, organizational, and governance levels been addressed in the process of problem identification?			
		5- Have the intersections of social factors across micro, meso and macro level been considered? For example, among immigrants as a marginalized group, how the interactions at the individual level (age, gender, race, class,...) link to social institutions and broader structures and processes of power such as migration policies?			
	Power	6- Have the most advantaged and the least advantaged groups been identified within representation of problem?			
		7- Have stakeholders such as affected populations been participated in problem identification?			
		8- Have the structures of power such as policies and laws been addressed to be responsible to the framing the health problem?			
	Reflexivity	9- Do the planning committee/research team look critically at their values, experiences, beliefs and assumptions, about the health problem?			

	Time & Space	10- Has the process of problem framing over time (historically) or across different places (geographically) and changes of privileges and disadvantages, including intersecting identities and the processes that determine their value over time and place, been considered?			
	Diverse Knowledge	11- Has the perspective of people who are typically marginalized been used in the process of problem identification?			
		12- Has the knowledge generated from several recourses including qualitative or quantitative research; empirical or interpretive data; and Indigenous knowledge?			
	Social Justice & Equity	13- Do current interventions/programs focus on health promotion of vulnerable groups?			
		14- Are existent interventions/programs being considered in terms of being successful in reducing inequality or, conversely, creating inequality? (For example, are there supportive policies or empowerment programs for vulnerable groups?)			
Design & Implementation	Intersecting Categories	15- Has the intervention/program been selected based on identifying problem using intersectional perspective?			
		16- Is the target group representative of the experiences of diverse groups of people for whom the issue under study is relevant?			
	Multilevel Analysis	17- Have the researchers/health planners considered the transformation across multiple levels (individual and interpersonal, family, Neighborhood, city)?			
	Power	18- Have various stakeholders, in particular affected population, been engaged in health program design and implementation?			
		19- Has the intervention/program been framed within the current cultural, political, economic, societal context? And has it reflected the needs of affected populations?			
		20- Does the intervention/program focus on vulnerable groups?			
		21- Does the intervention/program lead to a change of power relations? (For example, the participation of target groups in decision making and/or policy making)			
		22- Is it clear who are responsible to ensure the implementation of the intervention/ program? In other words, are there mechanisms for accountability (organizational commitment, etc.)?			

		23- Can the intervention/program find a practical position in line with government policy priorities such as budget allocations, ministerial priorities, etc.)?			
	Reflexivity	24- Do the researchers/health planners have reflexive practice? In other word, Do they have critical thinking about their values, experiences, beliefs, assumptions, and current actions and decisions>			
Evaluation	Time & Space	25- Is the intervention/program flexible in terms of time and place conditions?			
	Diverse Knowledge	26- Have the target group's knowledge been used in process of health program design and implementation?			
		27- Has the intervention/program been selected based on diverse evidence (academic sources, gray literature, policy reports,…)?			
	Social Justice & Equity	28- Has intervention/program been designed and implemented to reduce inequalities?			
		29- Is there assurance that the intervention/program does not lead to produce further inequities for some populations?			
	Intersecting Categories	30- Have intersectional factors been measured in the evaluation process?			
	Multilevel Analysis	31- Have the effects of the intervention/program at individual and interpersonal levels, family, neighborhood, and city, been evaluated?			
	Power	32- Have affected groups been engaged in the evaluation process?			
		33- Has the intervention/program enhanced the inclusiveness?			
	Reflexivity	34- Do the researchers/planners have reflexivity about the values, experiences, beliefs, assumptions, and current actions and decisions related to measuring the effectiveness?			
	Diverse Knowledge	35- Has stakeholder perspectives, in particular target groups, about whether the intervention or program has been effective or not, been considered?			
		36- Has the intervention/program been evaluated based on diverse evidence (academic sources, gray literature, policy reports,…)?			
	Social Justice & Equity	37- Is the measure of success in intervention/program determined on the basis of reducing inequalities?			
		38- Has intervention/program led to a reduction in inequality?			

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