LGBT Health
Volume 7, Number 5, 2020

DOI: 10.1089/lgbt.2019.0328

REVIEW

How Intersectional Are Mental Health Interventions for Sexual Minority People? A Systematic Review

Yu-Te Huang, PhD,[1] Yuk Tung Ma, MA,[1] Shelley L. Craig, PhD,[2]
Daniel Fu Keung Wong, PhD,[1] and Marty W. Forth, MSW[1]

Abstract

Purpose: Complex and widespread stigma exposes sexual minority people to disproportionate risks for adverse mental health. Intersectionality theory calls for consideration of the unique experiences of living with multiple forms of inequality. Yet, concerns remain regarding the extent to which intersectionality theory has been integrated into mental health interventions for sexual minority populations. This systematic review aims to assess the degree to which available mental health interventions account for intersecting forms of marginalization and to identify methods that facilitate the application of intersectionality.
Methods: A search for peer-reviewed English language journal articles was conducted using PsycINFO and PubMed to locate reports of mental health interventions for sexual minority groups. A coding framework was designed to evaluate how interventions incorporated intersectionality theory.
Results: Of 1877 potentially eligible articles, forty-three were included in the analysis. They were each classified as low, medium, or high with regard to intersectionality. Thirteen (30.2%) were rated as low on intersectionality for only recruiting a homogeneous group of participants in the interventions; 23 (53.4%) were classified as medium for including additional identities in recruitment without responding to possible intersectional disadvantages; 7 (16.3%) were rated as high with adequate consideration of the complex effects of intersecting positions. In addition, the review identified community-based participatory research as a common and instrumental method to ensure intersectionality.
Conclusions: This review highlights the limitations of interventions for sexual minority people in addressing intersectionality. Guidelines are needed for clinical practice and evaluation to adequately incorporate intersectionality theory.

Keywords: intersectionality, mental health interventions, sexual minority people, systematic review

Introduction

Worldwide, sexual minority people (i.e., people who identify as lesbian, gay, bisexual [LGB], asexual, pansexual, queer, or engage in sexual activities with same-sex others) report disproportionately higher rates of mental health risks compared to their heterosexual counterparts, due to pervasive and multilevel stigma directed at them because of their sexuality.[1,2] Other than identifying factors responsible for the mental health disparities, a growing body of research, as well as theoretical frameworks, have contributed to the development of clinical therapies and social services to effectively address sexual minority people's exposure to psychological risks. In a systematic review that aimed to scope distinct approaches of mental health interventions for sexual minority people, Chaudoir et al.[3] identified an array of programs, which differed in their goals, structures, and contexts, yet, proved to be efficacious in either reducing stress or enhancing coping resources among sexual minority individuals.

Despite the emerging and promising evidence for the efficacy of existing interventions, these reviewers called for a departure from the current focus on sexuality-based stigma alone as a root cause of psychological distress endured by sexual minority groups, to develop interventions that consider the ''intersecting effects'' (p. 609) of multiple and systematic disadvantages.[3] The American Psychological Association's

[1]Department of Social Work and Social Administration, The University of Hong Kong, Hong Kong, Hong Kong.
[2]Factor-Inwentash Faculty of Social Work, University of Toronto, Toronto, Canada.

guidelines for working with sexual minority people urge mental health professionals to ''understand the different ways in which multiple minority statuses may complicate and exacerbate the difficulties their clients experience.''[4] (p. 20) In view of the complex consequences of intersecting discrimination and the ascending quest for intersectionality-informed practices, exploring whether existing mental health interventions for sexual minority people respond to their multifaceted needs and experience of intersecting disadvantages is therefore critical. This systematic review addresses this question by examining current interventions through an intersectional lens and seeks to identify the intervention components that have the potential to take account of intersectionality.

Intersectionality

Intersectionality theory is primarily concerned with ''the interaction between gender, race, and other categories of difference in individual lives, social practices, institutional arrangements, and cultural ideologies and the outcomes of these interactions in terms of power.''[5] (p. 68) At the center of intersectionality theory lies a critique of the long-held focus on a single social position[6] and responses to intersectional inequalities. On an epistemological level, intersectionality theory aligns with critical realism[7] in rejecting the quest for a universal pattern of inequalities; rather, intersectionality researchers seek to unpack the social processes of perpetuating inequalities, in particular sites, and to uncover the subjective meaning of living in an intersectional position.[8–10] Notably, although intersectionality theory was advanced by Black feminist scholars and activists to simultaneously account for the multiple forms of subordination in legal and political domains, intersectionality has gained increasing prominence in mental health care for various groups who are impacted by structural oppression or marginalization, directing our attention to within-group variations, complex structural inequalities, and between-group commonalities.[11,12]

In keeping with intersectionality theory, mental health practitioners should remain open to understand the experience of target populations and examine power relationships operating at individual, interpersonal, and structural levels.[13,14] Instead of treating social identities as fixed properties, intersectionality theory reminds practitioners to understand social identities as social processes that generate inequalities and calls for actions to challenge oppressive institutions.[10] Some scholars have recognized the value of the intersectional perspective in creating uniquely tailored, culturally appropriate services to meet clients' specific, yet complex, needs.[11,15,16] Taken together, intersectionality theory can guide professional practice to address the simultaneous social forces, decenter the exclusive primacy of a single dimension of disadvantage, and avoid simplifying people's experiences of being marginalized.[13,17]

In practice, intersectionality theory questions the ''one-size-fits-all'' approach[18] and encourages the development or modification of intervention programs to address clients' needs embedded in interlocking social locations.[19,20] Intersectionality research also sheds light on intersectional stigma and resilience. Recent studies with sexual minority people living with HIV have documented the operation and consequence of intersectional stigma constituted by HIV-related stigma, gender, race, sexual orientation, involvement in sex work, and socioeconomic status.[21–23] Their findings hence highlight a need for researchers and service providers to adopt an intersectional and multileveled approach to mitigate the effect of intersectional stigma. Notably, researchers who study stigma also draw a conceptual distinction between perceived and enacted forms of social stigma[24] and note that there may be occasions when an individual internalizes multiple forms of stigma (i.e., intersectional internalized stigma).[25,26] Although intersectionality theory has enriched knowledge about stigma, the responses of available interventions seem limited.[3]

Although intersectionality theory emphasizes the voice of people experiencing interlocking disadvantages, its critical feminist underpinnings also foreground the subjectivity and resilience among the oppressed.[8,9] With regard to Black women's experiences, Wing thus wrote ''our essence is also characterized by a multiplicity of *strength*, *love*, *joy*, … and *transcendence* that flourishes despite adversity.''[27] (p. 196) From an intersectional perspective, Rice et al.[22] offered strength-based accounts of how women living with HIV were afflicted with intersectional stigma while maintaining an optimistic outlook for the future and actively seeking resources and support such as self-affirmation, mental health services, and solidarity with peers having similar lived experiences. Likewise, in a study guided by intersectionality theory to explore the experiences of Chinese immigrant gay men living in Canada, a participant remarked on his unique intersectional position: ''If you think you are a minority … then you will really stand in a lower position…we all have some strengths.''[28] (p. 34) In this view, intersectionality theory does not confine research and practice focus to the experiences of suffering and oppression, but rather leads to the identification of resilience and resources existing in an intersectional social location.[23]

Intersectionality-informed practice

Several scholars[29,30] have recommended that an intersectional consideration can render interventions more culturally appropriate and responsive to clients' unique needs. Although the application of intersectionality in research across disciplines and statistical modeling is growing,[31–33] the integration of intersectionality into clinical interventions remains in its infancy.[17] Hankivsky[34] contends that a major challenge for those who aspire to utilize the intersectionality framework in health and mental health contexts lies in translating this theory into directives for clinical practice or interventions.[32,35]

To this end, several researchers have offered advice on moving toward intersectionality-informed practice. Focusing on children exposed to intimate partner violence, Etherington and Baker[17] suggested integrating the intersectional perspective into the process of practice, including agenda setting, evaluation, accessibility and inclusion, reflexivity, and education. Some researchers[17,36] consider an explicit use of intersectionality terms and framework to be a hallmark of intersectionality-informed practice. Weber suggests that an intervention to address health disparities is intersectional in nature when it seeks 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.[8] Meanwhile, according to Weber, ''intersectional and

other critical power-based research approaches seek a collaboration that privileges and supports the voices, insights, and actions of multiply subordinated groups.''[8] (p. 44) These works provide useful directions for intersectionality-informed practice.

The current study

Little research has investigated the extent to which mental health interventions for sexual minority people are informed by intersectionality. To the best of our knowledge, only two review studies[17,36] have examined whether an intervention was guided by intersectionality, both of which only considered an intervention to be guided by intersectionality if it explicitly used the intersectionality framework or terminology. In contrast, this review views the incorporation of intersectionality as a gradient (i.e., low, medium, and high) and develops intersectionality criteria to rate the degree to which a clinical intervention responds to participants' intersectional needs. This review aims to (1) assess how interventions for sexual minority people are informed by the intersectionality framework, and (2) identify the intervention characteristics that are instrumental in incorporating intersectionality theory.

Methods

Eligibility criteria

This review was conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidance, which requires a systematic review to demonstrate transparency and rigor by reporting a set of checklist items and a flow diagram to illustrate the rationale and process of the literature search.[37] To locate eligible academic journal articles, three inclusion criteria regarding types of reports, participants, intervention, and outcome measures were applied to screen the title and abstract of publications that (1) reported on a mental health intervention program for sexual minority people; (2) were published in a peer-reviewed journal; and (3) were published in English. Meanwhile, studies were excluded from the analysis if they (1) were review articles; (2) did not involve an intervention; (3) did not report empirical data on the outcomes; (4) only reported the process of intervention development; (5) did not assess psychological well-being as intervention outcomes; or (6) were conducted as case studies with small sample sizes. Given that the primary objective of this review was to investigate the degree to which intersectionality was integrated into an intervention, we included articles of diverse study designs, analytic techniques, and evidence quality.

Information source

The procedure of literature retrieval and selection is illustrated in a PRISMA diagram (Fig. 1).[37] We conducted a literature search using PsycINFO and PubMed. Previous analyses have identified PsycINFO as one of the principal databases through which to retrieve reports on high-quality psychological treatments[38,39] while PubMed is considered a useful database to identify literature concerning health interventions.[40] The combination of two reputable databases meets the guidelines of Assessing the Methodological Quality of Systematic Reviews critical appraisal tool[41] and yielded a significant volume of eligible literature.

Study selection and search strategy

According to a recent systematic review on interventions for sexual minority people,[3] the first intervention study was published in 2001. Thus, 2001 was designated as the start year for the literature search. Three sets of keywords were used in the literature search to specify (1) our population of interest (i.e., LGB, GLB, gay, lesbian, bisexual, homosexual, sexual minority, men who have sex with men [MSM], pansexual, asexual, queer, and questioning); (2) interventions (i.e., treatment, practice, intervention, counselling, psychotherapy, and therapy); and (3) mental health outcomes (i.e., mental health, mental disorder, depression, anxiety, psychological well-being, subjective well-being, self-esteem, and quality of life). In addition, the reference lists of reviewed publications were inspected manually to locate pertinent primary research which had not already been identified in our search; this procedure identified three additional publications.

A total of 2640 articles were found and screened by 2 independent reviewers to determine the relevance of the title and abstract. Seven hundred and sixty-three duplicate articles were found during the screening process and 1825 were excluded due to their study or intervention characteristics. Fifty-two articles were initially judged as eligible, although nine of these were subsequently excluded after discussion between the two reviewers for one of the following reasons: (1) they described intervention protocol; (2) they illustrated the process of developing an intervention without reporting empirical data; (3) they were case studies; (4) their sample was not exclusively sexual minority people; or (5) the primary objectives were irrelevant to mental health. Forty-three articles were therefore included for analysis.

Data collection process and data items

As a review of preexisting study reports, this review was deemed by the Ethics Review Board of the University of Hong Kong to be exempt from ethical approval. Data collection took place in July 2019. The following information from the included articles was collected and tabulated: authors, a brief description of the intervention, study site, study design, inclusion criteria, sample size, and intervention outcomes. Data extraction was carried out by one of the reviewers under the supervision of the team's principal investigator.

Analytic strategy

The included studies were analyzed by two independent coders to assess the incorporation of intersectionality. A coding framework (Table 1) was developed to evaluate each study. The operational logic of this coding framework regarded the recruitment of participants with diverse social identities as a potential for an intervention to be intersectional; however, an intervention could be regarded as truly intersectional only if the concept of intersectionality was integrated throughout the intervention process.[17,42] Specifically, in addition to the recruitment of participants with intersecting positions, the criteria for high intersectionality covered the following: (1) addressing the effects of intersecting positions in the intervention; (2) discussing the effects of intersecting positions in the study report; and (3) explicitly using ''intersectionality'' and some derivative of it as a theoretical framework.

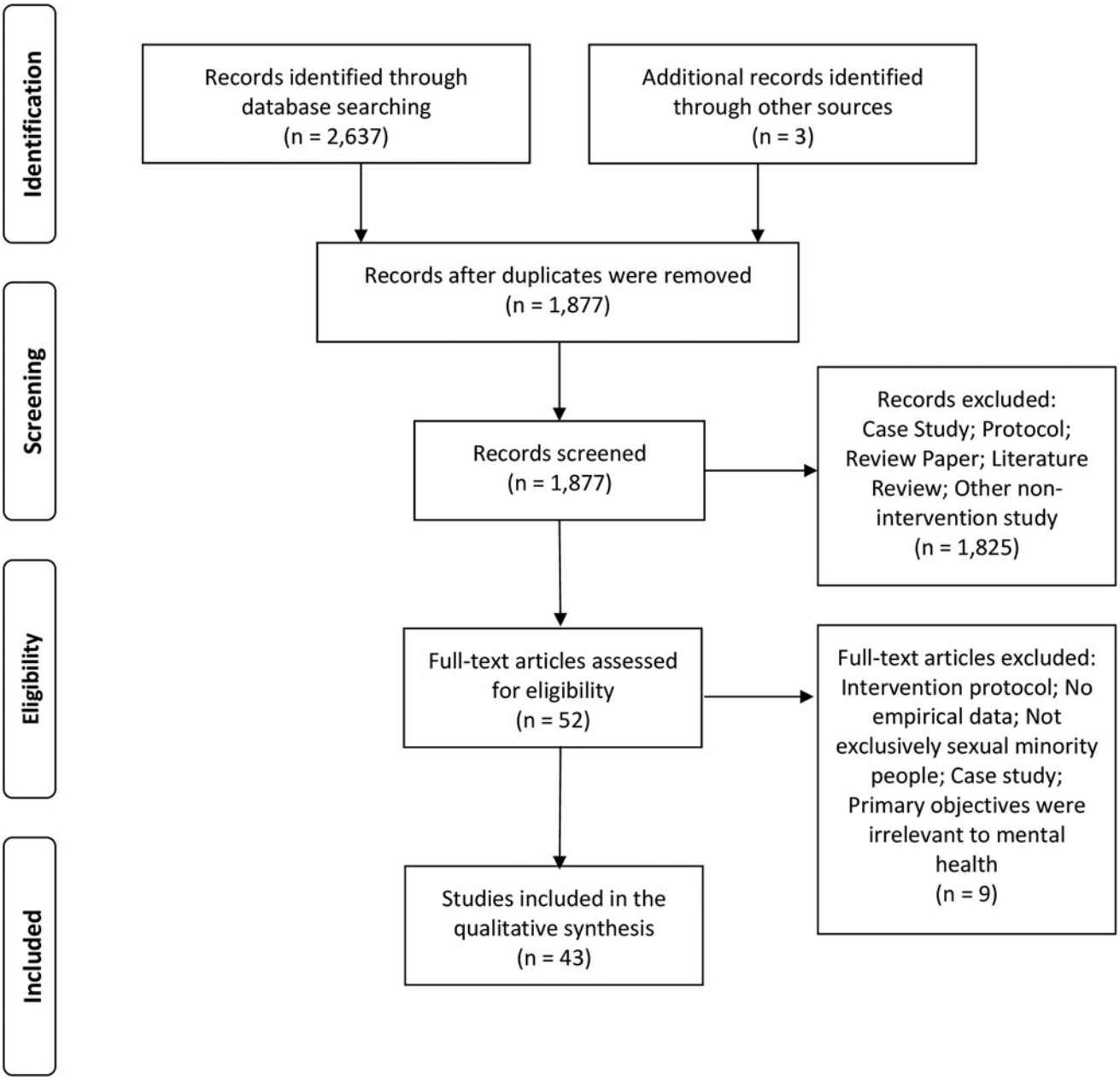

FIG. 1. PRISMA flow diagram of study identification and selection process. PRISMA, Preferred Reporting Items for Systematic Reviews and Meta-Analyses.

Applying these criteria, the two coders labeled each article as low (i.e., only including a homogenous group of participants), medium (i.e., reporting on participants' intersecting identities, yet without addressing the intersecting inequalities), or high (i.e., recruiting participants who occupied intersecting social positions and giving adequate attention to the social process of intersectional marginalization) in terms of adoption of the intersectional principle. In the initial coding process, the discrepancy rate between the two coders was 26.6%. All disagreements were resolved by the coreviewers through discussion and reexamination. The agreed coding results and summary of each article are presented in Table 2.[43–85] Each high intersectionality study is illustrated in detail in the Results section.

Results

Study characteristics

A majority ($n = 36$) of the 43 reported interventions designed to address sexual minority people's mental health were conducted in North America,[43–46,48–63,66,67,69–73,75–82,85] 3 in Europe,[47,65,84] and 1 each in Australia,[74] China,[83] New Zealand,[68] and South Africa.[64] The study designs ranged from 21 (48.84%) studies[45,53,54,56,57,59,61,62,64–68,70,72,73,75,77,78,80,84] reporting on within-group changes without a control group, 19 (44.19%) randomized controlled trials,[43,44,46–52,55,58,63,69,74,76,81–83,85] 2 (4.65%) quasi-experimental studies,[60,71] and 1[79] (2.33%) examining the correlation between the number of sessions attended and changes in the outcome variables

Table 1. Coding Framework to Determine Intersectionality

Level	*Criteria*
High	Addressing the effects of intersecting positions in the intervention; discussing the effects of intersecting positions in the study report; and explicitly using intersectionality and some derivative of it as a theoretical framework
Medium	Reporting intersecting identities of participants while; treating those intersecting identities only as demographic variables without addressing the intersections of structural inequalities and power relationships in the intervention; or not using intersectionality and some derivative of it as a theoretical framework
Low	Not reporting intersecting identities in the intervention and study report; treating the intervention participants as a homogeneous group

Intersecting identities refers to those other than sexual identities, such as socioeconomic status, religion, mental illness, HIV-positive status, homelessness, age, disabilities, and immigrant status.

(i.e., posttest only, no control group). The sexual minority sample sizes were between 7 and 762. In addition to LGB participants, some studies included participants who self-identified as asexual,[80] queer[53,59,60,66,67,70,73,75,79] pansexual,[59,66,70,80] or questioning.[60,70,73,79,81]

Result of intersectionality coding

Thirteen (30.2%) studies[53,55,57,59–61,64–67,69,72,75] were coded as low intersectionality because participants in these interventions were presented as homogenous sexual minority groups. Twenty-three (53.4%) studies were classified as medium because they added a recruitment criterion other than sexual orientation (HIV positive = 16[43,44,46–49,51,52,54,58,63,74,76,77,83,85]; age = 5[70,78–80,84]; substance use = 2[50,54]; and cancer diagnosis = 1[45]), but the interventions were designed as only focusing on stressors commonly endured by sexual minority clients, whereas the intersecting positions were relegated to descriptive demographics. Seven (16.3%) studies showed a high level of intersectionality to account for the intersection between membership as a sexual minority and HIV-positive status ($n = 3$)[56,62,82]; age ($n = 3$)[56,68,73]; disability ($n = 1$)[71]; homelessness ($n = 1$)[73]; or rurality ($n = 1$).[81]

Description of intersectionality-informed interventions

In this section, we described in greater detail the interventions that were rated as high intersectionality. Addressing the mental health outcomes and HIV sexual risk behavior among gay and bisexual men ages 40 and older, the intervention, 40 & Forward,[56] 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. In addition to the intervention's promising efficacy, participants also expressed their appreciation that the service catered to their unique social support needs as ''single guys in our forties.''[56] (p. 538).

In the Helping to Overcome Problems Effectively (HOPE) intervention,[62] although the initial objective was to mitigate unemployment among African American gay men living with HIV/AIDS, the research team also identified an array of challenges confronting this community, including low levels of job-seeking skills, lack of on-site support, inadequate treatment compliance, stigma and workplace discrimination, mental and physical health concerns, and lack of social support and public assistance. By addressing the intersection of these needs and marginalization, the HOPE intervention went beyond the employment issue to respond extensively to participants' diverse concerns arising from their intersecting positions.

Rainbow SPARX (smart, positive, active, realistic, x-factor thoughts) is a computerized cognitive behavioral therapy intervention that took account of ''the unique sociopolitical and interpersonal challenges'' (p. 203) faced by sexual minority youth.[68] Specifically, the program developers argued that young people were more likely to encounter anti-LGB attitudes and may feel that disclosure to their family renders them particularly vulnerable. They highlighted the advantages of this intervention specifically for sexual minority youth, including protection of privacy and overcoming geographical and social isolation.

In a study of a mindfulness program designed to improve mental health among lesbian and bisexual women, Ingraham et al.[71] explicitly recognized the ''particular intersectional oppression of race/ethnicity and sexual orientation, [so the program] added a group specifically for women of color. … Women who experience multiple forms of oppression may be particularly suited to a nonjudgmental, body acceptance approach to health.''(p. S59) The researchers suggested that future interventions should pay attention to the intersectional needs of lesbian and bisexual women of color and with disabilities.

The iTEAM program[73] was developed for homeless LGB, transgender, and queer/questioning or straight-allied youth who were at greater risk for drug abuse, victimization, truancy, and housing problems. The service developers recognized the necessity of ''a sensitive, coordinated, and effective system of care to address the constellation of issues they face.''[73] (p. 182) Researchers attributed the success of the iTEAM with regard to acceptability, retention, and efficacy to the effective responses to participants' complex needs.

Targeting rural sexual and gender minority people, a peer advocate intervention was implemented to address the social isolation stemming from the intersection of geographic distance, conservative gender norms, limited socialization opportunities, and identity concealment.[81] Viewing societal institutions as a source of minority stress, especially for rural sexual and gender minority people, a distinctive characteristic of this intervention was its advocacy orientation and training of peer advocates to effect changes for this community. This intervention addressed issues other than HIV and responded to different needs within rural sexual and gender minority communities.

Bogart et al.[82] reported on an intervention, Still Climbin', aimed at enhancing the coping abilities of Black sexual minority men living with HIV. The intersectional orientation of this intervention is evident from addressing multifaceted discrimination due to the ''intersectionality of multiple stigmatized identities.''[82] (p. 542) Notably, the intervention emphasized

TABLE 2. SUMMARY OF INTERVENTIONS DESIGNED TO IMPROVE THE MENTAL HEALTH OF SEXUAL MINORITY PEOPLE ($N=43$)

Name of intervention	*Description of intervention*	*Study site*	*Study design*	*Inclusion criteria*	*Sample size*	*Results*	*Intersectionality (intersecting identities)*
CBSM[43]	10-Week intervention incorporating multimodal relaxation training aiming to reduce participants' salivary cortisol and enhance their mood.	United States	RCT	Gay men aged between 18 and 49 years diagnosed with HIV at least 6 months before study entry; with at least one non-AIDS-defining, HIV-related symptom or a CD4 cell count between 200 and 700 cells/mm^3.	54 HIV+ gay men (experimental group = 30; control group = 24)	Participants' cortisol levels decreased across the 10-week period and were related to decreases in global measures of total mood disturbance and anxious mood.	Medium (HIV+)
CBSM[44]	10-Week program designed to help participants better manage life stress.	United States	RCT	At least an 8th grade education; ability to read and write fluently in English; at least one HIV-related symptom or to have a T-helper-inducer (CD4) cell count between 200 and 700 cells/mm^3.	100 Gay men (experimental group = 62; control group = 38)	Participants' mood disturbances and dysfunctional attitudes decreased significantly + changes in coping, perceived social support, and self-efficacy.	Medium (HIV+)
SEGT[45]	12-Week intervention focusing on the problems of a new diagnosis, coping with the illness and treatment, mood changes, coping responses and self-efficacy, improving relationships with family, friends, and physicians, impact of the illness on life, pain, and sleep, and changes in body image and sexuality.	United States	WSCWCG	A biopsy-confirmed diagnosis of primary breast cancer in stages I–IIIA within the past year; completion of initial surgical treatment; no detectable disease present.	20 Lesbian women diagnosed with breast cancer	Participants reported significant changes in social support and reduction in pain, instrumental and information support, conflict with family and better sleep.	Medium (breast cancer)
Coping Effectiveness Training[46]	Behavioral intervention designed to improve coping among depressed gay men living with HIV/AIDS.	United States	RCT	Self-identified gay or bisexual males; 21–60 years old; and self-reported CD4 levels between 200 and 700 cells/mm^3.	128 Gay or bisexual men (Experimental group = 46; control group = 82)	Those who completed the treatment showed significant decreases in perceived stress and burnout and significant increases in coping self-efficacy and positive state of mind.	Medium (HIV+)
SEGT[47]	9-Month intervention combining cognitive behavioral and supportive expressive therapies designed to reduce participants' distress and improve their social support and coping skills.	Netherlands	RCT	HIV+ Dutch and Belgian gay men between ages 18 and 65; diagnosed with HIV at least 6 months before beginning the study; have no problems with Dutch language; no current alcohol or drug abuse; no current psychotic symptoms.	85 Gay men (intervention group = 44; educational control group = 41)	No group differences found in the effects on distress, coping, or social support.	Medium (HIV+)
CBSM[48]	10-Week group treatment to improve psychosocial health and immunologic status.	United States	RCT	HIV-positive gay and bisexual men; have at least 8th grade education and the ability to read and write fluently in English; have at least one non-AIDS defining symptom and $CD3^+CD4^+$ cell counts >200 cells/mm^3 at study entry.	49 Gay or bisexual men living with HIV (treatment group = 31; wait-list control = 18)	The treatment group showed maintenance of intervention effects on dysphoria, perceived social support, and immunologic status.	Medium (HIV+)

(*continued*)

Table 2. (Continued)

Name of intervention	*Description of intervention*	*Study site*	*Study design*	*Inclusion criteria*	*Sample size*	*Results*	*Intersectionality (intersecting identities)*
CBSM[49]	10-Week group treatment to reduce depressive symptoms.	United States	RCT	Self-identified as homosexual; have at least 1 non-AIDS defining symptom; a T-helper-inducer cell count >200 cells/mm^3, at least 9th grade education and fluency in English.	129 Gay men living with HIV (treatment group = 83; comparison group = 46)	The treatment group reported previously observed effects on depression symptoms and perceived social support.	Medium (HIV+)
CBT and/or CM[50]	Participants randomly assigned to one of four treatment conditions: CBT, CM, CBT+CM, Gay-Specific CBT.	United States	RCT	Seeking treatment for current methamphetamine use; diagnosed with methamphetamine dependence; self-identified as gay or bisexual; aged 18–65 years.	162 Gay and bisexual male methamphetamine abusers	All participants reported significant decreases in depressive symptoms.	Medium (substance abuse)
CBSM[51]	10-Week group treatment to enhance coping skills and health-promoting behaviors.	United States	RCT	Gay and bisexual men aged 18–65 years living with HIV.	130 Gay and bisexual men living with HIV (experimental group = 76; control group = 54)	The treatment group reported decreases in depressed mood and denial coping.	Medium (HIV+)
Outpatient treatment[52]	16-Week outpatient methamphetamine treatment program to reduce depression, sexual risk behavior, and drug use.	United States	Four-armed RCT	Self-identified as gay or bisexual male; methamphetamine user; aged 19–57 years; seeking treatment for methamphetamine use; diagnosed with methamphetamine dependence.	145 Gay and bisexual men (CM = 38; CBT = 33; combined therapy = 36; tailored gay-specific version of CBT = 38)	Treatment recipients reported decreases in drug use, depressive symptoms, and sexual risk behavior.	Medium (HIV+)
Modified CBT Group Treatment for LGBT People with Depression[53]	14-Week group intervention based on antioppression principles to reduce participants' internalized homophobia.	Canada	WSCWCG	Self-identified as other than heterosexual and/or other than male or female; scored >8 on the 17-item version of the Hamilton Rating Scale for Depression.	23 LGB and queer individuals (including 1 transgender woman) completing the intervention	Participants demonstrated a significant decrease in depression severity and increase in self-esteem.	Low
CBT[54]	16-Week CBT-based therapy in combination with medication to reduce dependence on methamphetamine among gay men living with HIV.	United States	WSCWCG	Living with HIV; identified as gay; with a diagnosis of stimulant abuse or dependence.	10 Gay men completing the trial	6/10 Participants reduced their use of methamphetamine following therapy sessions.	Medium (HIV+; substance abuse)
Expressive Writing Intervention[55]	3 Days 20-minute sessions intervention aimed at improving participants' psychosocial functioning	United States	RCT	Self-identified as gay; college students.	77 Gay college students (experimental group = 52; control group = 25)	Intervention recipients reported significantly greater openness with their sexual orientation.	Low
40 & Forward[56]	Group intervention designed to reduce HIV sexual risk among gay and bisexual men aged 40 and older who self-reported problems with depression and social anxiety.	United States	WSCWCG	Gay and bisexual men self-reported having sex with another man in the past 2 months; aged 40 and older; reported engaging in unprotected sex; self-reported problems with depression, isolation/loneliness, and social anxiety; living in Massachusetts.	84 Gay and bisexual men	Participants demonstrated statistically significant reductions across all mental health outcomes including depressive symptoms, social anxiety symptoms, loneliness, and fear of negative evaluation, and increased condom use and self-efficacy.	High (age and HIV+)

(*continued*)

Table 2. (Continued)

Name of intervention	*Description of intervention*	*Study site*	*Study design*	*Inclusion criteria*	*Sample size*	*Results*	*Intersectionality (intersecting identities)*
Attachment-Based Family Therapy[57]	Intervention designed for depressed and suicidal adolescents to reduce isolation and increase self-esteem.	United States	WSCWCG	Self-identified lesbian, gay, and bisexual adolescents and their parents; reporting significant levels of suicidal ideation.	10 Lesbian, gay, and bisexual adolescents	Participants demonstrated a significant decrease in suicidal ideation, depressive symptoms, and material attachment-related anxiety and avoidance.	Low
Mindfulness-Based Stress Reduction[58]	Treatment aimed to facilitate mindfulness and improve psychological functioning.	Canada	RCT	Males aged 18–70 years; living within 1 hour of the hospital; and diagnosed with HIV.	117 Gay men (experimental group = 78; control group = 39)	Program participants demonstrated significantly lower avoidance and higher positive affect.	Medium (HIV+)
Strengths First[59]	The first strengths-based intervention designed specifically to promote self-esteem and self-efficacy among multiethnic sexual minority youth.	United States	WSCWCG	Multiethnic sexual minority youth.	162 Multiethnic sexual minority youth who self-identified as LGB, straight, queer/pansexual, and other	LGB and straight youth were included in the analysis and demonstrated significant increases in self-esteem and self-efficacy.	Low
Computer-based Intervention[60]	Online intervention designed to reduce internalized heterosexism for same-sex attracted males.	United States	Quasi-experimental; posttest only	Aged 18 years or older; self-identified as male; currently living in the United States; and have experienced some romantic/sexual attraction to other men.	367 Gay, bisexual, queer, same-sex attracted, straight/heterosexual, questioning, 2-spirit and "other" men completing the intervention (7.1% self-identified as queer; 0.8% self-identified as questioning)	Participants showed significantly lower internalized homonegativity.	Low
Integrated Behavioral Activation and Sexual Risk Reduction Counseling[61]	10 Group sessions to help participants reengage in life activities	United States	WSCWCG	Aged 18 years or older; self-reported one or more episodes of unprotected anal sex with a nonmonogamous male sexual partner while concurrently using crystal methamphetamine in the past 3 months; HIV negative.	16 MSM	Participants reported a significant reduction in unprotected sex, use of crystal methamphetamine, and depressive symptoms.	Low
HOPE[62]	Group intervention designed to improve mental health and employment outcomes of African American gay men living with HIV/AIDS.	United States	WSCWCG	Identified and agreed by the community partnership, including a confirmed diagnosis of HIV; receiving services at a community health center; 18 years or older; self-identifying as male, African American, and gay; understanding, conversing, and writing in English; unemployed.	7 Gay men	HOPE participants developed goal-setting skills, problem-solving skills, health-promoting behaviors, and employment seeking behaviors.	High (HIV+)
Project Enhance[63]	Proactive case management for psychosocial problems, counseling about living with HIV, and HIV sexual transmission-risk behavior risk reduction. Participants were followed every 3 months for 1 year.	United States	RCT	Self-identified MSM living with HIV; age of 18 or older; receiving primary care at Fenway Health for at least 3 months; engaged in at least one instance of HIV transmission-risk behavior in the 6 months before baseline; willing to be followed by a study case manager.	201 MSM living with HIV who have received HIV care	Participants reported reductions in HIV sexual transmission-risk behavior.	Medium (HIV+)

(*continued*)

Table 2. (Continued)

Name of intervention	*Description of intervention*	*Study site*	*Study design*	*Inclusion criteria*	*Sample size*	*Results*	*Intersectionality (intersecting identities)*
Community-based HIV-prevention program[64]	Intervention aiming to reach MSM in Cape Town to disseminate HIV-prevention information and promote use of condoms and HIV services.	South Africa	WSCWCG	Self-identified as MSM aged 18 years old or older in five Cape Town townships.	98 Gay, bisexual, and straight Black MSM	Participants reported gaining access to MSM-specific HIV-prevention information. Some reported a reduction in social isolation and improved self-efficacy.	Low
Blues-out[65]	Depression awareness campaign based on the European Alliance Against Depression targeting the gay/lesbian community in Geneva, Switzerland.	Switzerland	WSCWCG	Gay-identified men and other MSM who access meeting points in and around Geneva, Switzerland.	762 Gay men	Significant net decreases were seen in lifetime suicide plans, 12-month suicidal ideation, lifetime depression, and 4-week psychological distress between 2007 and 2011.	Low
ASSET[66]	LGBTQ-affirmative school-based group counseling intervention created specifically to promote resilience.	Canada	WSCWCG	Self-identified sexual minority; enrolled in high school.	263 Multiethnic gay, lesbian, queer/pansexual, and other-sexual-identity youth (3.8% self-identified as queer or pansexual) and transgender youth	Self-esteem and proactive coping increased significantly, whereas social connectedness remained constant.	Low
Queer Women Conversation Intervention[67]	Group-based psychoeducational HIV/sexually transmitted infection intervention tailored for lesbian, bisexual, and queer women.	Canada	WSCWCG	Self-identified women; aged 18 and over; lesbian, bisexual, queer, a woman who has sex with women, or same-sex attracted; committed to attending a weekend retreat and completing three surveys.	9 Bisexual, 13 lesbian, and 22 queer women	Participants reported reductions in sexual risk practices and sexual stigma, and increases in the use of self-efficacy and sexually transmitted infection knowledge.	Low
Rainbow SPARX[68]	7-Module computerized CBT program for depression.	New Zealand	WSCWCG	Sexual minority youth who were attracted to the same-sex, both sexes, or not sure of their sexual orientation; aged 13–19 years old with depressive symptoms at baseline; living in Auckland; sexual minority youth with severe depressive symptoms, at risk of suicide or self-harm.	21 Sexual minority youth	Participants showed significant reduction in depressive symptoms.	High (age)
ESTEEM[69]	Trans-diagnostic CBT treatment adapted to reduce depression, anxiety, and co-occurring health risks among young adult gay and bisexual men.	United States	RCT	Born male and currently identifying as a man; gay or bisexual identity; aged 18–35 years; English fluency; living in the New York City area; HIV-negative; engaging in HIV risk behavior; experiencing symptoms of depression and/or anxiety in the past 90 days; not currently receiving regular mental health service.	63 Gay/queer and bisexual men (experimental group = 32; waitlist control group = 31)	Participants reported significantly reduced depressive symptoms, sexual compulsivity, condomless sex with casual partners, improved condom use self-efficacy and. marginally significant greater improvement than the waitlist group in anxiety symptoms and heavy drinking.	Low

(*continued*)

Table 2. (Continued)

Name of intervention	*Description of intervention*	*Study site*	*Study design*	*Inclusion criteria*	*Sample size*	*Results*	*Intersectionality (intersecting identities)*
Affirmative CBT[70]	8-Module group CBT therapy designed to enhance cognitive behavioral coping with the impact of heterosexism and homophobia on well-being, and to explore and validate positive expression of sexual minority identities.	Canada/United States	WSCWCG	Aged 14–18 years; identify as nonheterosexual or transgender; able to converse in English; and agree to participate in a 2-day retreat.	30 Youth self-identified as lesbian, pansexual, queer, bisexual, gay, other, not-sure/ questioning, and/or two-spirit (26.7% self-identified as pansexual; 10% self-identified as not sure or questioning)	Participants showed a significant reduction in depression and increased reflective coping, and reported high levels of acceptability and skills acquisition.	Medium (age)
WHAM and DIFO[71]	WHAM aimed to improve lesbian and bisexual women's mental health, nutritional intake, and physical activity levels through mindfulness stress reduction and mindful eating tools. DIFO was a 12-session peer facilitator-led group counseling designed to promote intuitive eating with a mindfulness approach.	United States	Quasi-experimental	Lesbian or bisexual women; aged 40 years or older.	266 Lesbian/gay and bisexual, transgender women (experimental group = 160; comparison group = 106; 6% identified as other sexual orientation; 6% as other gender identity, including genderqueer, gender nonconforming or nonbinary)	Participants showed improvement in control overeating. Participants with a greater gain in mindfulness reported more significant improvement in health behavior and health outcomes.	High (disability)
LGB-Affirmative Psychotherapy[72]	10-Session individual intervention aimed to facilitate coping with minority stress.	United States	WSCWCG	Identifying as a gay or bisexual man born male; English fluency; aged 18–35 years; New York City residence; HIV-negative status; engaging in HIV risk behavior; experiencing symptoms of depression and/or anxiety in the past 90 days, though not currently receiving mental health services more than once a month.	54 Young gay/queer and bisexual men	Participants with higher implicit internalized homonegativity experienced greater reductions in depression, anxiety, and condomless anal sex with casual partners. Participants with higher explicit homonegativity experienced a greater reduction in heavy drinking.	Low
iTEAM[73]	Comprehensive project designed to provide intensive case management, substance abuse and mental health treatment, linkages to housing, and other supportive services for LGB, transgender, and queer/questioning and straight-allied youth experiencing homelessness.	United States	WSCWCG	Aged 15–24 years; self-identifying as LGB, transgender, and queer/questioning or straight-allied; experiencing or having experienced housing stress, mental health, and/or substance abuse treatment needs.	210 LGB, transgender, and queer/questioning or straight-allied youth (2.4% self-identified as another gender such as genderqueer)	Participants reported lower levels of substance use and improved mental health and increased engagement in employment and housing stability.	High (homeless; age)
Positive Outlook Program[74]	7-Week online self-management program to enhance the skills and confidence and abilities to manage psychosocial issues associated with HIV in daily life among gay men living with HIV.	Australia	RCT	Self-identified as gay, homosexual, or MSM; 18 years or older and living in Australia; had adequate English to enable participation; had access to a computer and the Internet; living with HIV.	132 Gay men living with HIV (experimental group = 68; control group = 64)	Participants demonstrated significant improvement in body change, social relationships, and emotional distress.	Medium (HIV+)

(*continued*)

Table 2. (Continued)

Name of intervention	*Description of intervention*	*Study site*	*Study design*	*Inclusion criteria*	*Sample size*	*Results*	*Intersectionality (intersecting identities)*
CBT- and DBT-skills-based hospital treatment[75]	Group therapy aimed to help individuals develop coping skills to improve their mood and ability to function in daily life.	United States	WSCWCG	Patients admitted to a partial hospital program in New England between January and November 2016.	84 LGB, queer, and gender minority (agender/nonbinary, prehormone/preop lesbian male to female) people; 357 heterosexual people (3% self-identified as queer)	Compared to heterosexual, gay-lesbian, queer, and gender minority individuals, bisexual individuals reported greater self-injurious and suicidal thoughts at the posttreatment assessment.	Low
CBT[76]	12-Session individual treatment integrating a single session on antiretroviral therapy adherence and CBT interventions for body image disturbance	United States	RCT	Living with HIV; reported oral or anal sex with men in the previous 12 months; self-identified as male gender; aged 18–65 years; prescribed antiretroviral therapy for the past 2 months or longer; significant body image disturbance.	44 Gay and bisexual men (experimental group = 22; control group = 22)	The experimental group showed significant improvements in body image disturbance, medical adherence, and global functioning.	Medium (HIV+)
Project ESTEEM-Sexual Compulsivity[77]	10-Session group intervention aimed to address and reduce symptoms of several syndemic conditions affecting gay and bisexual men living with HIV.	United States	WSCWCG	Born male and currently identifying as male; identifying as gay or bisexual; aged 18 years or older; fluent in English; residing in the New York City area; living with HIV; reporting recent (past 90 days) transmission risk behavior; reporting symptoms of sexual compulsivity; not currently receiving regular mental health services.	11 Gay and bisexual men living with HIV	Participants showed significant reductions in anxiety, depression, and obsessive-compulsive symptoms, and drug use.	Medium (HIV+)
Project PRIDE[78]	8-Session small group intervention to reduce negative mental and behavioral health outcomes resulting from minority stress.	Canada	WSCWCG	Identifying as a man; identifying as gay, bisexual, same-gender loving, queer, or another nonheterosexual identity; self-reported HIV negative or unknown HIV status; having at least one instance of condomless anal sex in the past 3 months; ability to read and write in either English or French; an ability to attend the intervention session.	33 Gay and bisexual men (39.4% self-identified as multiple sexual identities, including queer and pansexual, in addition to gay and bisexual)	Participants showed enhanced self-esteem and reduced loneliness, minority stress variables, alcohol use, and number of sex partners.	Medium (age)
Hatch Youth[79]	Group intervention providing services 4 nights per week for LGB, transgender, and queer youth to increase social support and potential to improve their health.	United States	Posttest only, no control group	LGB, transgender, and queer youth aged 13–20 years.	108 LGB, transgender, queer, questioning, and heterosexual youth (21.43% self-identified as transgender or gender queer)	Participants reported higher social support, increased self-esteem, improved coping ability and decreased depressive symptoms.	Medium (age)
Hatch Youth[80]	Drop-in program for sexual and gender minority youth providing social, educational, and youth-led support.	United States	WSCWCG	Sexual and gender minority youth.	12 Gay, lesbian, heterosexual, pangender, pansexual, agender, asexual youth (25% self-identified as either pangender, pansexual, agender, or asexual)	Participants perceived an increase in confidence and self-esteem through enhanced bonding with family, friends, and community.	Medium (age)

(*continued*)

Table 2. (Continued)

Name of intervention	*Description of intervention*	*Study site*	*Study design*	*Inclusion criteria*	*Sample size*	*Results*	*Intersectionality (intersecting identities)*
Peer advocate intervention[81]	Social support and services for sexual and gender minority people provided by lay providers undertaking specialized training.	United States	RCT	18 Years of age or older; identifying as LGB, transgender, queer, questioning, same-sex attracted "or troubled by or uncomfortable with one's gender"; meeting criteria for a DSM-IV-TR Axis I mental health disorder, as determined by the M.I.N.I. International Neuropsychiatric Interview.	47 LGB, transgender, questioning, and heterosexual individuals (experimental group = 22; control group = 25; including 8.5% self-identified as questioning and 4.3% as heterosexual)	Participants reported increased social bonding with LGB, transgender, queer/questioning community and self-advocacy skills; no significant improvement on psychiatric symptoms was found.	High (rurality)
Still Climbin'[82]	Intervention to improve coping with discrimination about their identities among Black sexual minority men living with HIV, comprising 8 weekly group sessions and a graduation session, based on CBT principles.	United States	RCT	18 or older; confirmed HIV diagnosis; biological male; identified as Black/African American; reported having sex with men in their lifetime.	64 Black sexual minority men living with HIV (experimental group = 38; control group = 26)	Participants showed significant improvement on coping in response to discrimination, including functional coping and cognitive/emotional debriefing.	High (HIV+)
Coping Enhancement Group Intervention[83]	4-Week intervention to improve well-being and adaptive coping strategies among MSM living with HIV in China.	China	RCT	Diagnosed with HIV/AIDS; MSM; aged 18–40 years.	60 MSM living with HIV (experimental group = 30; control group = 30)	The intervention group reported significantly increased problem-focused coping strategies and levels of posttraumatic growth and reduced posttraumatic stress disorder symptoms.	Medium (HIV+)
mHealth Intervention[84]	Mobile health HIV-prevention intervention.	Romania	WSCWCG	Aged 16–29 years; self-report an HIV-negative or unknown status; at least one condomless anal sex act with a male partner in the past 3 months; at least 5 heavy drinking days or one condomless anal sex act under the influence of alcohol in the past 3 months.	43 Young gay, bisexual, and sexual-identity-uncertain men	Significant increases in HIV-related knowledge and self-efficacy of condom use and reductions in anxiety and depression reported.	Medium (age)
Intervention for Promoting Sexual Health and Stress Management[85]	Intervention aimed to promote sexual health and stress management skills for MSM living with HIV.	United States	RCT	Male; living with HIV; reported having oral or anal sex with a man during the past year; medically, cognitively, and psychologically capable of participation; able to read and converse in English.	80 MSM experiencing HIV disparities (experimental group = 40; control group = 40)	Intervention participants reported greater HIV transmission knowledge, higher HIV disclosure self-efficacy, stronger intention to refuse unprotected sex, decreased frequency of unprotected sex, decreased perceived stress levels, and higher coping self-efficacy.	Medium (HIV+)

ASSET, Affirmative Supportive Safe and Empowering Talk; CBSM, cognitive behavioral stress management; CBT, cognitive behavioral therapy; CM, contingency management; DIFO, Doing It For Ourselves; DBT, dialectical behavior therapy; ESTEEM, Effective Skills to Empower Effective Men; HOPE, Helping Overcome Problems Effectively; LGB, lesbian, gay, bisexual; LGBTQ, lesbian, gay, bisexual, transgender, queer; MSM, men who have sex with men; PRIDE, Promoting Resilience in Discriminatory Environments; RCT, randomized controlled trial; SEGT, supportive-expressive group therapy; SPARX, smart, positive, active, realistic, x-factor thoughts; WHAM, Women's Health and Mindfulness; WSCWCG, within subject changes without a control group.

the development of flexible and contextual coping strategies to respond to distinct forms of discrimination across diverse situations. Moreover, the authors highlighted that ''structural-level interventions are needed in tandem that address social determinants of health disparities.''[82] (p. 549).

Community-based participatory research

All high intersectionality interventions involved close collaboration with diverse community partners. The development of the 40 & Forward program benefited from ''obtaining community advisory board and consumer input.''[56] (p. 527) In the HOPE program, ''CBPR partnership members, including African American gay men living with HIV/AIDS, were directly involved with development of the intervention and the section of the study design'' (p. 410)[62] The development of Rainbow SPARX also featured collaboration between researchers, clinicians, and sexual minority youth.[68] The mindfulness intervention program, Doing It for Ourselves, was ''developed using principles of community-based participatory research.''[71] (p. S55) Partnership between agencies and the research team enabled the iTEAM project to address ''the unique, varied, and complex needs'' of homeless LGB, transgender, queer/questioning, or straight-allied youth (p. 186).[73] In the peer advocate intervention for rural sexual and gender minority people, community-based participatory research (CBPR) proved instrumental in maintaining the intersectionality approach by involving community members ''who have close knowledge of local social realities, and can improve access to quality of care for underserved populations.''[81] (p. 396) Finally, the program Still Climbin' was a cognitive-behavioral therapy adapted through ''an iterative community-engagement process'' with input from community stakeholders[82] (p. 543).

Discussion

This review provides an overview of clinical interventions for sexual minority groups and suggests directions for future service development and research to move toward intersectionality. The review suggests a need to develop evidence-supported programs to assist sexual minority individuals in mitigating intersectional risks for mental health. The appraisal of intersectionality identified noticeable variability among the reviewed studies. Nearly one third of the reviewed studies were deemed to lack intersectionality because they neither addressed nor reported intersecting identities of the participants, thereby treating them as a homogenous group. Although 53.4% of the studies paid attention to the role of intersectional social positions in shaping participants' mental health, the presence and impact of intersectional disadvantages was not well considered. Moreover, a closer examination suggests that the majority of these medium-intersectionality interventions focused mainly on the interplay between sexual minority identity and HIV-positive status. Since disproportionate attention to HIV/AIDS has been criticized for reifying the stigmatization of sexual minority people,[86] future research and interventions should consider other social factors.[12]

Seven (16.3%) interventions that were examined demonstrated a thorough incorporation of intersectionality throughout their planning, implementation, and evaluation stages. Although their primary goal was to reduce sexual orientation-related disparities in mental health, the adoption of intersectionality theory along with CBPR afforded a critical space for their participants to highlight other types of disadvantage in their lives, thereby allowing the intervention to respond to their intersectional positions and unique needs. It is also important to note that the community engagement process of seeking participants' voices and concerns resonates with the empowering and strength-based principles inherent in intersectionality theory by privileging the perspectives of subordinate groups.[8]

Implications

Although emerging work has suggested useful strategies to collect and analyze empirical data using an intersectional approach,[17,32,87] there has been relatively little discussion on incorporating intersectionality into actual services.[88] Arguably, this stagnation of translating intersectional theory into clinical interventions may originate in the salience of establishing internal validity especially when mental health promotion for specific communities remains at a nascent stage.[89] Specifically, to determine whether an intervention yields intended effects on a prescribed set of needs for a target group, an intervention should be built upon a specific theoretical framework to pinpoint the causes of and possible solutions to a certain problem so as to be precise and parsimonious in its treatment component and participation criteria.[12,90] This quest for accurate identification of intervention effects in turn guides a researcher to recruit a homogenous sample to ''reduce confounding factors that might affect the dependent measures.''[44] (p. 377) Given that ''in its very definition intersectionality demands complexity,''[33] (p. 455) to fully consider the multiple forms of marginalization could inadvertently become counterproductive to the quest for internal validity by rendering an intervention and subsequent evaluation complex and unpredictable.

Intersectionality theory helps research, policy, and clinical interventions tackle the complexity of health inequalities.[7,91] As Dhamoon[92] suggests, intersectionality brings to the fore inherent instability and irreducibility in human behavior and experiences. Garran and Werkmeister Rozas[13] likewise mark intersectionality's dynamic, ambiguous, and open-ended properties as its core theoretical insights. In evaluation science, most researchers are invested in testing intervention efficacy (i.e., internal validity) through randomized controlled trials and usually call for further endeavor to establish generalizability (i.e., external validity) by recruiting a heterogeneous sample. However, these dominant implementation and evaluation strategies could counteract the development of intersectional, power-oriented, and community-based research. Weber also contends that from an intersectional perspective, the social processes of engendering health disparities are simultaneously dynamic and context-specific and can be best captured through the engagement of participants.[8] In this light, incorporating an intersectional approach entails a methodological shift and CBPR proves instrumental in ensuring intersectionality.

In practice, an intersectionality-informed intervention acknowledges multiple social determinants of health and avoids reducing a target population to unidimensional categorization. To this end, McCall delineates three complementary intersectional approaches that can be adopted in an intervention: (1) an intercategorical approach focuses on the combined influences and interactions of multiple identities; (2) an anticategorical approach follows a deconstructive method by questioning the universal representation of any

identity categories and relies more on personal narratives and interpretations of a mental health problem to inform the design of clinical interventions; and (3) an intracategorical approach operates through cross-classification to identify subgroup differences.[93] These distinct orientations enable researchers and clinicians to challenge the single-identity model and respond to the intersectional processes of marginalization. Importantly as well, the utilization of intersectionality should also guide us to unravel the coexistence of advantages and disadvantages, and challenges and resources that an individual possesses through intersecting social positions. However, this strength-based perspective has not been widely incorporated in the current body of literature on people facing intersectional marginalization.[94]

As elucidated by this review, several scholars have reiterated how community members' active engagement throughout the phases of intervention and evaluation can better ensure that clients' complex lived experiences and mental health needs are addressed holistically.[8,12,89] Despite substantial investment and prolonged commitment, CBPR allows us to strike a balance between delivering effective interventions and fully appreciating participants' concerns. Such insight can also contribute to the development of guidelines for intersectionality-informed practice and research.

Limitations

Some study limitations should be noted. The first limitation pertains to reliance on two databases only as the literature sources. Although these two databases provided a significant number of eligible articles, this study cannot be used as a scoping review because a minimal risk of omitting relevant studies still exists. Future reviews of mental health interventions for sexual minority people could extend to other databases to locate additional interventions[95] and to cover books, clinical guidelines, and training materials. Second, the coding framework used by this review was designed specifically to capture clients' characteristics and program components presented in the reports to determine their intersectionality. The noticeable intercoder discrepancies might be symptomatic of ambiguity inherent in this coding guideline; this, therefore, should be clarified and revised. Future studies can also consider establishing a broader set of criteria to increase correspondence with intersectionality theory. Finally, although this review focused on interventions for sexual minority individuals, participants in these interventions were diverse in their sexual and gender identities. This within-group diversity necessitates caution in interpreting the results of this review and warrants attention to the intersection of sexual and gender minority status in future research.

Conclusion

In this review, a promising progression toward intersectionality-informed intervention emerged as researchers and practitioners have become increasingly aware of the irreducibility of the experiences and complex needs of sexual minority individuals. Admittedly, the logic of well-defined grouping is important for intervention design, delivery, and evaluation. However, viewed through an intersectionality lens, a deliberate response to the nuances and the complex social forces in an individual's experience best enables an intervention to address entrenched health disparities and larger structural inequalities. Ongoing engagement in intersectionality, promotion of a community-based participatory approach, and concrete guidelines for intersectional intervention and evaluation represent vital steps forward.

Acknowledgments

The authors thank Professor Karen Grimmer for her useful comments and edits on the draft, as well as Professor Eric Blyth for his assistance in editing and proofreading the article.

Disclaimer

The content is solely the responsibility of the authors.

Author Disclosure Statement

No competing financial interests exist.

Funding Information

Y.T.M. and this study are supported by Research Grant Council Early Career Scheme number 27616418.

References

1. Plöderl M, Tremblay P: Mental health of sexual minorities. A systematic review. Int Rev Psychiatry 2015;27:367–385.
2. Lucassen MF, Stasiak K, Samra R, et al.: Sexual minority youth and depressive symptoms or depressive disorder: A systematic review and meta-analysis of population-based studies. Aust N Z J Psychiatry 2017;51:774–787.
3. Chaudoir SR, Wang K, Pachankis JE: What reduces sexual minority stress? A review of the intervention ''toolkit.'' J Soc Issues 2017;73:586–617.
4. American Psychological Association: Guidelines for psychological practice with lesbian, gay, and bisexual clients. Am Psychol 2012;67:10–42.
5. Davis K: Intersectionality as buzzword: A sociology of science perspective on what makes a feminist theory successful. Feminist Theory 2008;9:67–85.
6. Crenshaw K: Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. In: *Feminist Legal Theory: Foundations.* Edited by Weisberg DK. Philadelphia, PA: Temple University Press, 1993, pp 385–395.
7. Martinez Dy A, Martin L, Marlow S: Developing a critical realist positional approach to intersectionality. J Crit Realism 2014;13:447–466.
8. Weber L: Reconstructing the landscape of health disparities research: Promoting dialogue and collaboration between feminist intersectional and biomedical paradigms. In: *Gender, Race, Class & Health: Intersectional Approaches.* Edited by Schulz AJ, Mullings L. San Francisco, CA: Jossey-Bass, 2006, pp 21–59.
9. Collins PH: *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment, 2nd ed.* New York, NY: Routledge, 2000.
10. Bauer GR: Incorporating intersectionality theory into population health research methodology: Challenges and the potential to advance health equity. Soc Sci Med 2014;110: 10–17.
11. Cole ER: Intersectionality and research in psychology. Am Psychol 2009;64:170–180.

12. Rosenthal L: Incorporating intersectionality into psychology: An opportunity to promote social justice and equity. Am Psychol 2016;71:474–485.
13. Garran AM, Werkmeister Rozas L: Cultural competence revisited. J Ethn Cult Divers Soc Work 2013;22:97–111.
14. Anastas JW: *Teaching in Social Work: An Educators' Guide to Theory and Practice, 1st ed.* New York, NY: Columbia University Press, 2010.
15. Ohnishi H, Ibrahim FA, Grzegorek JL: Intersections of identities. J LGBT Issues Couns 2006;1:77–94.
16. Fredriksen-Goldsen KI, Simoni JM, Kim HJ, et al.: The Health Equity Promotion Model: Reconceptualization of lesbian, gay, bisexual, and transgender (LGBT) health disparities. Am J Orthopsychiatry 2014;84:653–663.
17. Etherington N, Baker L: From ''buzzword'' to best practice: Applying intersectionality to children exposed to intimate partner violence. Trauma Violence Abuse 2018;19:58–75.
18. Hankivsky O: *Intersectionality 101*. Vancouver, BC: Institute for Intersectionality Research and Policy, Simon Fraser University, 2014.
19. Bograd M: Strengthening domestic violence theories: Intersections of race, class, sexual orientation, and gender. J Marital Fam Ther 1999;25:275–289.
20. Pachankis JE: Uncovering clinical principles and techniques to address minority stress, mental health, and related health risks among gay and bisexual men. Clin Psychol (New York) 2014;21:313–330.
21. Logie CH, James L, Tharao W, Loutfy MR: HIV, gender, race, sexual orientation, and sex work: A qualitative study of intersectional stigma experienced by HIV-positive women in Ontario, Canada. PLoS Med 2011;8:e1001124.
22. Rice WS, Logie CH, Napoles TM, et al.: Perceptions of intersectional stigma among diverse women living with HIV in the United States. Soc Sci Med 2018;208:9–17.
23. Earnshaw VA, Bogart LM, Dovidio JF, Williams DR: Stigma and racial/ethnic HIV disparities: Moving toward resilience. Am Psychol 2013;68:225–236.
24. Herek GM, Gillis JR, Cogan JC: Internalized stigma among sexual minority adults: Insights from a social psychological perspective. J Couns Psychol 2009;56:32–43.
25. Earnshaw VA, Smith LR, Cunningham CO, Copenhaver MM: Intersectionality of internalized HIV stigma and internalized substance use stigma: Implications for depressive symptoms. J Health Psychol 2015;20:1083–1089.
26. Earnshaw VA, Reed NM, Watson RJ, et al.: Intersectional internalized stigma among Black gay and bisexual men: A longitudinal analysis spanning HIV/sexually transmitted infection diagnosis. J Health Psychol 2019. doi.org/10.1177/1359105318820101
27. Wing AK: Brief reflections toward a multiplicative theory and praxis of being. Berkeley Womens Law J 1990;6:181–201.
28. Huang YT, Fang L: ''Fewer but not weaker'': Understanding the intersectional identities among Chinese immigrant young gay men in Toronto. Am J Orthopsychiatry 2019;89:27–39.
29. Hankivsky O, Christoffersen A: Intersectionality and the determinants of health: A Canadian perspective. Crit Public Health 2008;18:271–283.
30. Dumas JE, Rollock D, Prinz RJ, et al.: Cultural sensitivity: Problems and solutions in applied and preventive intervention. Appl Prev Psychol 1999;8:175–196.
31. Hankivsky O: *An Intersectionality-Based Policy Analysis Framework*. Vancouver, BC: Institute for Intersectionality Research and Policy, Simon Fraser University, 2012.
32. Seng JS, Lopez WD, Sperlich M, et al.: Marginalized identities, discrimination burden, and mental health: Empirical exploration of an interpersonal-level approach to modeling intersectionality. Soc Sci Med 2012;75:2437–2445.
33. Warner LR: A best practices guide to intersectional approaches in psychological research. Sex Roles 2008;59:454–463.
34. Hankivsky O: Women's health, men's health, and gender and health: Implications of intersectionality. Soc Sci Med 2012;74:1712–1720.
35. Bird CE, Lang ME, Rieker PP: Changing gendered patterns of morbidity and mortality. In: *The Palgrave Handbook of Gender and Healthcare, 1st ed.* Edited by Kuhlmann E, Annandale E. London: Palgrave Macmillan, 2010, pp 125–141.
36. Mena E, Bolte G; ADVANCE GENDER Study Group: Intersectionality-based quantitative health research and sex/gender sensitivity: A scoping review. Int J Equity Health 2019;18:199.
37. Moher D, Liberati A, Tetzlaff J, et al.: Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. PLoS Med 2009;6:e1000097.
38. Eady AM, Wilczynski NL, Haynes RB: PsycINFO search strategies identified methodologically sound therapy studies and review articles for use by clinicians and researchers. J Clin Epidemiol 2008;61:34–40.
39. Brettle AJ, Long AF: Comparison of bibliographic databases for information on the rehabilitation of people with severe mental illness. Bull Med Libr Assoc 2001;89:353–362.
40. Bramer WM, Rethlefsen ML, Kleijnen J, Franco OH: Optimal database combinations for literature searches in systematic reviews: A prospective exploratory study. Syst Rev 2017;6:245.
41. Shea BJ, Reeves BC, Wells G, et al.: AMSTAR 2: A critical appraisal tool for systematic reviews that include randomised or non-randomised studies of healthcare interventions, or both. BMJ 2017;358:j4008.
42. Norris AN, Zajicek A, Murphy-Erby Y: Intersectional perspective and rural poverty research: Benefits, challenges and policy implications. J Poverty 2010;14:55–75.
43. Cruess DG, Antoni MH, Kumar M, Schneiderman N: Reductions in salivary cortisol are associated with mood improvement during relaxation training among HIV-seropositive men. J Behav Med 2000;23:107–122.
44. Cruess S, Antoni MH, Hayes A, et al.: Changes in mood and depressive symptoms and related change processes during cognitive-behavioral stress management in HIV-infected men. Cognit Ther Res 2002;26:373–392.
45. Fobair P, Koopman C, DiMiceli S, et al.: Psychosocial intervention for lesbians with primary breast cancer. Psychooncology 2002;11:427–438.
46. Chesney MA, Chambers DB, Taylor JM, et al.: Coping effectiveness training for men living with HIV: Results from a randomized clinical trial testing a group-based intervention. Psychosom Med 2003;65:1038–1046.
47. Weiss JJ, Mulder CL, Antoni MH, et al.: Effects of a supportive-expressive group intervention on long-term psychosocial adjustment in HIV-infected gay men. Psychother Psychosom 2003;72:132–140.
48. Carrico AW, Antoni MH, Pereira DB, et al.: Cognitive behavioral stress management effects on mood, social support, and a marker of antiviral immunity are maintained up to 1 year in HIV-infected gay men. Int J Behav Med 2005;12:218–226.

49. Carrico AW, Antoni MH, Weaver KE, et al.: Cognitive-behavioural stress management with HIV-positive homosexual men: Mechanisms of sustained reductions in depressive symptoms. Chronic Illn 2005;1:207–215.
50. Peck JA, Reback CJ, Yang X, et al.: Sustained reductions in drug use and depression symptoms from treatment for drug abuse in methamphetamine-dependent gay and bisexual men. J Urban Health 2005;82:i100–i108.
51. Carrico AW, Antoni MH, Duran RE, et al.: Reductions in depressed mood and denial coping during cognitive behavioral stress management with HIV-positive gay men treated with HAART. Ann Behav Med 2006;31:155–164.
52. Jaffe A, Shoptaw S, Stein J, et al.: Depression ratings, reported sexual risk behaviors, and methamphetamine use: Latent growth curve models of positive change among gay and bisexual men in an outpatient treatment program. Exp Clin Psychopharmacol 2007;15:301–307.
53. Ross LE, Doctor F, Dimito A, et al.: Can talking about oppression reduce depression? Modified CBT group treatment for LGBT people with depression. J Gay Lesbian Soc Serv 2007;19:1–15.
54. McElhiney MC, Rabkin JG, Rabkin R, Nunes EV: Provigil (modafinil) plus cognitive behavioral therapy for methamphetamine use in HIV+ gay men: A pilot study. Am J Drug Alcohol Abuse 2009;35:34–37.
55. Pachankis JE, Goldfried MR: Expressive writing for gay-related stress: Psychosocial benefits and mechanisms underlying improvement. J Consult Clin Psychol 2010;78:98–110.
56. Reisner SL, O'Cleirigh C, Hendriksen ES, et al.: ''40 & Forward'': Preliminary evaluation of a group intervention to improve mental health outcomes and address HIV sexual risk behaviors among older gay and bisexual men. J Gay Lesbian Soc Serv 2011;23:523–545.
57. Diamond GM, Diamond GS, Levy S, et al.: Attachment-based family therapy for suicidal lesbian, gay, and bisexual adolescents: A treatment development study and open trial with preliminary findings. Psychotherapy (Chic) 2012;49: 62–71.
58. Gayner B, Esplen MJ, DeRoche P, et al.: A randomized controlled trial of mindfulness-based stress reduction to manage affective symptoms and improve quality of life in gay men living with HIV. J Behav Med 2012;35:272–285.
59. Craig SL, McInroy L, Austin A, et al.: Promoting self-efficacy and self-esteem for multiethnic sexual minority youth: An evidence-informed intervention. J Soc Serv Res 2012;38:688–698.
60. Lin YJ, Israel T: A computer-based intervention to reduce internalized heterosexism in men. J Couns Psychol 2012; 59:458–464.
61. Mimiaga MJ, Reisner SL, Pantalone DW, et al.: A pilot trial of integrated behavioral activation and sexual risk reduction counseling for HIV-uninfected men who have sex with men abusing crystal methamphetamine. AIDS Patient Care STDS 2012;26:681–693.
62. Hergenrather KC, Geishecker S, Clark G, Rhodes SD: A pilot test of the HOPE intervention to explore employment and mental health among African American gay men living with HIV/AIDS: Results from a CBPR study. AIDS Educ Prev 2013;25:405–422.
63. Safren SA, O'Cleirigh CM, Skeer M, et al.: Project enhance: A randomized controlled trial of an individualized HIV prevention intervention for HIV-infected men who have sex with men conducted in a primary care setting. Health Psychol 2013;32:171–179.
64. Batist E, Brown B, Scheibe A, et al.: Outcomes of a community-based HIV-prevention pilot programme for township men who have sex with men in Cape Town, South Africa. J Int AIDS Soc 2013;16(Suppl 3):18754.
65. Wang J, Häusermann M, Berrut S, Weiss MG: The impact of a depression awareness campaign on mental health literacy and mental morbidity among gay men. J Affect Disord 2013;150:306–312.
66. Craig SL, Austin A, McInroy LB: School-based groups to support multiethnic sexual minority youth resiliency: Preliminary effectiveness. Child Adolesc Soc Work J 2014;31:87–106.
67. Logie CH, Lacombe-Duncan A, Weaver J, et al.: A pilot study of a group-based HIV and STI prevention intervention for lesbian, bisexual, queer, and other women who have sex with women in Canada. AIDS Patient Care STDS 2015;29: 321–328.
68. Lucassen MFG, Merry SN, Hatcher S, Frampton CMA: Rainbow SPARX: A novel approach to addressing depression in sexual minority youth. Cogn Behav Pract 2015;22: 203–216.
69. Pachankis JE, Hatzenbuehler ML, Rendina HJ, et al.: LGB-affirmative cognitive-behavioral therapy for young adult gay and bisexual men: A randomized controlled trial of a transdiagnostic minority stress approach. J Consult Clin Psychol 2015;83:875–889.
70. Craig SL, Austin A: The AFFIRM open pilot feasibility study: A brief affirmative cognitive behavioral coping skills group intervention for sexual and gender minority youth. Child Youth Serv Rev 2016;64:136–144.
71. Ingraham N, Eliason MJ, Garbers S, et al.: Effects of mindfulness interventions on health outcomes in older lesbian/bisexual women. Womens Health Issues 2016;26(Suppl 1):S53–S62.
72. Millar BM, Wang K, Pachankis JE: The moderating role of internalized homonegativity on the efficacy of LGB-affirmative psychotherapy: Results from a randomized controlled trial with young adult gay and bisexual men. J Consult Clin Psychol 2016;84:565–570.
73. Powell C, Ellasante I, Korchmaros JD, et al.: iTEAM: Outcomes of an affirming system of care serving LGBTQ youth experiencing homelessness. Fam Society 2016;97:181–190.
74. Millard T, Agius PA, McDonald K, et al.: The Positive Outlook study: A randomised controlled trial evaluating online self-management for HIV positive gay men. AIDS Behav 2016;20:1907–1918.
75. Beard C, Kirakosian N, Silverman AL, et al.: Comparing treatment response between LGBQ and heterosexual individuals attending a CBT- and DBT-skills-based partial hospital. J Consult Clin Psychol 2017;85:1171–1181.
76. Blashill AJ, Safren SA, Wilhelm S, et al.: Cognitive behavioral therapy for body image and self-care (CBT-BISC) in sexual minority men living with HIV: A randomized controlled trial. Health Psychol 2017;36:937–946.
77. Parsons JT, Rendina HJ, Moody RL, et al.: Feasibility of an emotion regulation intervention to improve mental health and reduce HIV transmission risk behaviors for HIV-positive gay and bisexual men with sexual compulsivity. AIDS Behav 2017;21:1540–1549.
78. Smith NG, Hart TA, Kidwai A, et al.: Results of a pilot study to ameliorate psychological and behavioral outcomes of minority stress among young gay and bisexual men. Behav Ther 2017;48:664–677.
79. Wilkerson JM, Schick VR, Romijnders KA, et al.: Social support, depression, self-esteem, and coping among LGBTQ

adolescents participating in Hatch Youth. Health Promot Pract 2017;18:358–365.
80. Romijnders KA, Wilkerson JM, Crutzen R, et al.: Strengthening social ties to increase confidence and self-esteem among sexual and gender minority youth. Health Promot Pract 2017;18:341–347.
81. Willging CE, Harkness A, Israel T, et al.: A mixed-method assessment of a pilot peer advocate intervention for rural gender and sexual minorities. Community Ment Health J 2018;54:395–409.
82. Bogart LM, Dale SK, Daffin GK, et al.: Pilot intervention for discrimination-related coping among HIV-positive Black sexual minority men. Cult Divers Ethnic Minor Psychol 2018;24:541–551.
83. Ye Z, Yu NX, Zhu W, et al.: A randomized controlled trial to enhance coping and posttraumatic growth and decrease posttraumatic stress disorder in HIV-infected men who have sex with men in Beijing, China. AIDS Care 2018;30:793–801.
84. Leluțiu-Weinberger C, Manu M, Ionescu F, et al.: An mHealth intervention to improve young gay and bisexual men's sexual, behavioral, and mental health in a structurally stigmatizing national context. JMIR Mhealth Uhealth 2018; 6:e183.
85. Brown JL, Vanable PA, Bostwick RA, Carey MP: A pilot intervention trial to promote sexual health and stress management among HIV-infected men who have sex with men. AIDS Behav 2019;23:48–59.
86. Van Voorhis R, Wagner M: Coverage of gay and lesbian subject matter in social work journals. J Soc Work Educ 2001;37:147–159.
87. Bauer GR, Scheim AI: Methods for analytic intercategorical intersectionality in quantitative research: Discrimination as a mediator of health inequalities. Soc Sci Med 2019;226: 236–245.
88. Rogers J, Kelly UA: Feminist intersectionality: Bringing social justice to health disparities research. Nurs Ethics 2011; 18:397–407.
89. Steckler A, McLeroy KR: The importance of external validity. Am J Public Health 2008;98:9–10.
90. Cougle JR: What makes a quality therapy? A consideration of parsimony, ease, and efficiency. Behav Ther 2012;43: 468–481.
91. Hancock AM: When multiplication doesn't equal quick addition: Examining intersectionality as a research paradigm. Perspect Politics 2007;5:63–79.
92. Dhamoon RK: Considerations on mainstreaming intersectionality. Polit Res Q 2011;64:230–243.
93. McCall L: The complexity of intersectionality. Signs 2005; 30:1771–1880.
94. Toomey RB, Huynh VW, Jones SK, et al.: Sexual minority youth of color: A content analysis and critical review of the literature. J Gay Lesbian Ment Health 2017;21:3–31.
95. Stevinson C, Lawlor DA: Searching multiple databases for systematic reviews: Added value or diminishing returns? Complement Ther Med 2004;12:228–232.

Address correspondence to:
Yu-Te Huang, PhD
Department of Social Work and Social Administration
The University of Hong Kong
RM515, The Jockey Club Tower
The Centennial Campus
Hong Kong

E-mail: yuhuang@hku.hk