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Intersectional Identity Integration: Psychological Well-being, Mental Health, and Identity Coherence Across Multiple Stigmatized Dimensions

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ABSTRACT

The processes of identity integration among multiply marginalized people with multiple stigmatized identities, in terms of race, gender, sexuality, disability, and class, are explored in this qualitative study. We explored facilitators and barriers, and used phenomenological inquiry with 100 multiply marginalized adults recruited through community partnerships to find four identity integration trajectories. Results show that identity integration has a strong influence on mental health outcomes. The facilitators worked at multiple levels: critical consciousness around systemic oppression, narrative identity work, mentorship and chosen family, and at the community level: intersectional affinity spaces and activist engagement. The barriers were systemic discrimination, internalized stigma, and within-group marginalization. The participants who experienced a higher degree of integration showed higher psychological well-being, lower levels of depression and anxiety, and a higher sense of purpose. Findings highlight the need for an intersectional mental health perspective that emphasizes individual identity integration and systemic change. Clinical implications include increased intersectional competency of the providers and support for authentic identity expression via therapeutic and community interventions based on social justice principles.

Keywords:Identity integration; mental health; psychological well-being; minority stress; identity development

1. Introduction

Intersectionality signifies a paradigm shift in the way people experience multiple stigmatized identities over life domains and contexts. It is a theory emerging from critical race theory and Black feminist scholarship that outlines the dynamic relationship between multiple systems of oppression and experiences of marginalization and privilege. Stigmatized marginalized people with multiple stigmatized identities are confronted with unique mental health issues that are not adequately captured by a single axis of mental health. Recent studies have revealed significant differences in mental health outcomes for these groups, but clinical approaches are still predominantly based on a single identity, which creates disconnection in lived experience and ineffectiveness in treatment for people who encounter intersectionality and intersectional challenges.

Ali and Khattak (2023) state that it is important to go beyond additive models of identity and to consider intersectionality in mental health. Their work illustrates that well-being and complexity of identity is not a sum of the parts of individual stigmatized identities. Instead, these identities are dynamic and interactive, resulting in complex psychological experiences that demand a special mental health framework and intersectional clinical approaches. In a study of intersectional experiences, Swann et al. (2024) identified that SGM youth of color face intersectional stigma at every stage of development which affects their mental health outcomes. They found that identity authenticity and SGM community connection are key protective factors, and the benefits are not equally enjoyed by all groups across intersections depending on access to affirming resources and supportive communities.

By focusing on lived experiences of marginalization, slaughter-Acey et al. (2023) provide important insights for the study of mental-emotional well-being among diverse groups. Their intersectional approach uncovers that traditional frameworks often fail to capture key aspects of the complex and multiple nature of marginalisation when it does not reflect a person's

lived experience. As shown in the study by Hong et al. (2023), identity integration is a strong mediator between internalized stigma and social well-being, especially for Black sexual minority men. The integration benefits are greatly magnified by the community connectedness, highlighting the importance of both individual psychological processes and community contexts for mental health outcomes and psychological resilience.

The research to clinical practice gap is still large and alarming. Although the concept of intersectionality is being recognized more and more in theory, the majority of mental health interventions are still based on the single identity dimensions. This poses significant challenges: people seeking help and support may find providers who are trained to work with one identity at a time, thus necessitating compartmentalization and disrupting therapeutic relationships that are essential for healing and genuine expression. This qualitative study aims to look at the critical questions in relation to the experiences of identity integration of multiply marginalized individuals. The central thesis of the work is that psychological health of multiply marginalized people is dependent on the process of coherent integration of multiple stigmatized aspects of identity, which entails attending to the processes of the individual, interpersonal, community, and barriers to authentic identity expression.

2. Literature Review

2.1 Intersectionality Theory and Identity Development

Intersectionality is a concept that developed from legal scholarship and black feminist theory as a way to understand how various systems of oppression intersect and intersect throughout the course of one's development and life experience. The idea challenged the previous perspective of race, gender, sexuality and other identity categories as independent, additive dimensions that function separately. Rather, intersectionality argues that these identities do not simply exist side-by-side but are instead dynamic, occurring at structural, representational, and political levels and resulting in experiences of marginalization which are not additive. According to Ali and Khattak (2023), there is a need to reconceptualize the process of identity formation and mental health of multiply marginalized persons at fundamental level for psychological applications. They differentiate between recognising multiple identities and actually incorporating them into a coherent psychological sense of self, an important distinction for clinical practice and for maintaining good mental health.

Theoretical approaches to identity development have been largely single-identity based, reflecting a linear process of moving from identity diffusion to foreclosure to moratorium to identity achievement. But multiply marginalized individuals experience multiple, often asynchronous identity development paths in parallel across multiple domains of understanding. Hachem (2024) offers empirical exploration of the way that systematically marginalised students traverse identity development in higher education settings of competing pressures. In their research, they find that identity integration is more complex than is usually assumed, requiring negotiation in academic, social and personal domains, which generates psychological burdens not included in traditional models. JAIN (2025) highlights this complexity when young people in India grapple with gender and sexuality in a cultural landscape where these identities have specific social significance and familial implications, which are likely to impact their mental well-being.

According to Meyer's model of minority stress, distal stressors such as discrimination, prejudice, and violence, and proximal stressors such as internalization of stigma and concealment, are the mechanisms by which mental health and well-being are affected by stigma. In intersectional contexts, Swann et al. (2024) show that multiply marginalized people face not just additive stress but qualitatively different stress configurations that are present at the same time. The psychological burden of stigma is greater than the sum of its parts, as Khan (2025) describes, when it comes to women with chronic autoimmune diseases. The study by Hong et al. (2023) is important because it offers valuable evidence of identity integration's mediating role between internalized stigma and psychological well-being. Integration helps in the reduction of internal fragmentation and thus eases the way towards self-acceptance.

Nur and Ferdous (2025) show how young Muslim artists make sense of their belonging through their art, while grappling with their intersectional identities that feel contradictory in dominant cultural contexts. When people have multiple identities that can be hidden, such as multiple stigmata, the challenges are highlighted by Asongu (2025). Williamson et al. (2024) tested The Quest and found that the intervention was effective due to its explicit focus on intersectional identity experiences. In their article, Johri and Anand (2022) describe resilience mechanisms among people experiencing intersectional marginalisation, and the community-based protective factors that help to maintain mental health and psychological well-being, such as group solidarity and mutual support networks.

2.2 Mental Health Service Gaps and Research Directions

While intersectional mental health disparities of multiply marginalised individuals are increasingly recognised, clinical practice is still mainly structured around single identity, which is not effective. The literature on mental health was reviewed systematically, and it was found that there was a significant gap in mental health research in relation to multiply marginalized populations in studies (Guo & Liu, 2026). Most interventions focus on a specific stigmatized identity and/or a specific mental health diagnosis, but do not address the interaction of multiple identities and the resulting psychological needs and strengths. The lack of training and competency exacerbates service gaps. The majority of clinical education programs focus on cultural competency for one dimension of identity, while few programs include competencies within a framework that considers people with multiple stigmatized identities. Palmer (2026) suggests that oral history has the potential to be an

anti-stigma intervention in community mental health. This is consistent with the positive emotional well-being identified by Yusup et al. (2026) as a result of integrated creative approaches.

While current research has recorded intersectional disparities and the importance of identity integration for mental health, there are significant gaps in understanding that hinder knowledge progress. A small number of studies examined development through a lifespan perspective on the process of identity integration along the life course.A few studies followed the process of identity integration over the lifespan. There are few studies that focus specifically on therapeutic interventions that can support intersectional identity integration in clinical settings effectively. This qualitative study aims to fill these essential gaps by exploring in depth the experiences of identity integration and its relationship to mental health outcomes and psychological well-being in multiple marginalized people.

3. Methodology

The study was a qualitative investigation using phenomenological and narrative inquiry methods to explore multiply marginalized individuals lived experience of integrating multiple stigmatized identities and impacts on psychological well-being and mental health outcomes. The qualitative approach enables a rich, nuanced understanding of complex identity integration processes that cannot be obtained from quantitative approaches. The research was carried out using community based participatory principles, engaging multiply marginalized people in the design, data collection, and analysis of results throughout the project. The research questions, ethical issues and feasibility were continually informed by an advisory board of eight multiply marginalized community members. Primary data collection methods included semi-structured interviews, which were administered by trained interviewers with experience conducting trauma-informed and intersectionally-informed research practices, and lasted for 60-90 minutes.

One hundred multiply marginalized adults (18 years and older) who were identified by at least two marginalized identities across race/ethnicity, sexual orientation, gender identity, disability status, socioeconomic status, religion, and immigration status. Interviews were audio-recorded, verbatim transcribed and checked for accuracy and authenticity by the interviewees. In addition to open-ended verbal answers, interviews included activities and exercises that supported identity exploration, including identity timeline, community mapping exercise (which community welcomed or marginalized various aspects of identity), and discrimination timeline processing (which process cumulative discrimination experiences). Partnerships were established with LGBTQ+ people of color organizations, disability justice networks, intersectional affinity groups, and art communities were all avenues for recruitment. The qualitative sample had a mean age of 34.2 years, 55% people of color, 38% transgender or non-binary, 82% sexual minorities, and 68% disabled individuals (Table 1 & 2).

Thematic analysis (Braun and Clarke) was used to analyse the qualitative data, which was done in an iterative manner. Raw data was initially analysed line by line, identifying meaning units and initial coding of identity integration experiences, facilitators, barriers, discrimination experiences and mental health impacts. Codes were organized into themes, representing larger patterns, and secondary coding involved comparing and contrasting across dataset and constant comparison to ensure that all aspects of the experiences were captured. Member checking included sharing preliminary findings with fifteen interview participants to check and get feedback. Ethical issues encompassed IRB approval, informed consent, protection of confidentiality, trauma-informed research practices, and compensation for participant labor.

Table 1: Identity Integration Trajectories and Prevalence (N=100)

Trajectory Type	N (%)	Description
Compartmentalization to Integration	40 (40%)	Progressive movement toward integrated sense of self through discovery of affirming communities
Fluctuating Integration	35 (35%)	Context-dependent expression and integration based on environmental safety and support
Fragmented Integration	15 (15%)	Partial integration in some identity domains while maintaining compartmentalization in others
Identity Foreclosure	10 (10%)	Limited identity narratives foreclosing on exploration of multiple identity dimensions

Table 2: Key Facilitators and Barriers (N=100)

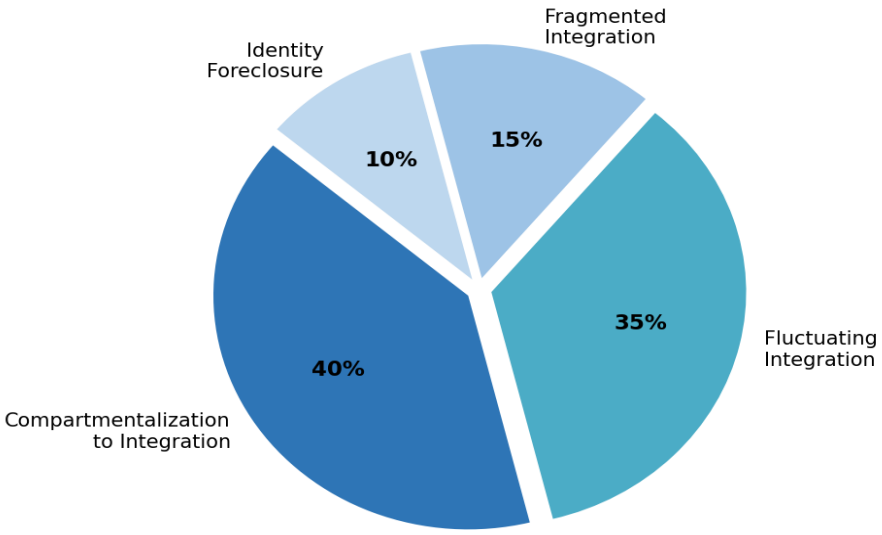
Category	Finding	Prevalence
Facilitators	Critical consciousness about systemic oppression	78%
Facilitators	Intersectional affinity spaces and chosen family	85-90%
Facilitators	Narrative identity work and self-compassion	68-85%
Barriers	Multi-dimensional discrimination experiences	95%
Barriers	Internalized stigma across multiple dimensions	89%
Barriers	Within-group marginalization and family rejection	58-74%
Mental Health	Integration improves psychological well-being	75%
Mental Health	Community connection mediates integration effects	85%

4. Results

Qualitative analysis revealed four different identity integration trajectories: Forty percent were in the compartmentalization-to-integration trajectory, and started adulthood distinct from their identities, and were gradually integrated by finding communities of intersection. Thirty-five percent of the people expressed full integration in affirming spaces but strategic compartmentalization in unsafe spaces, which was referred to as fluctuating integration. Fifteen percent attained integration in some identity domains but compartmentalization in others, which was labeled as fragmented integration. Ten percent used limited identity narratives to foreclose the exploration of multiple identity dimensions, and were identified as identity foreclosed. Facilitators worked at the critical consciousness, interpersonal, and community levels: critical consciousness, mentorship and chosen family, and intersectional affinity spaces and activist engagement. Systemic discrimination (ninetieth of a percent), internalized stigma (eighty-nine percent), within-group marginalization (seventy-four percent), and family non-acceptance (fifty-eight percent) were the barriers. The participants who indicated high integration had significantly higher scores on psychological well-being, less depression and anxiety, and a higher sense of purpose. Therapy experiences indicated that there was an eighty-nine percent continuation and a ninety-two percent improvement with therapeutic experiences of helpful intersectional therapy vs. a thirty-one percent continuation in therapeutic experiences of unhelpful single identity therapy.

Qualitative analysis of interviews with one hundred multiply marginalized adults identified four different identity integration pathways. These trajectories describe the variety of pathways that people take in living through multiple stigmatized identities in their lives, as illustrated in Figure 1. Forty percent began life in a Compartmentalization-to-Integration trajectory, in which they started by compartmentalizing their identities across social contexts and gradually shifted toward increased integration over time by finding communities of intersectional affirmation and actively engaging in identity work. An important event in their lives was when they met others who had more than one marginalized identity, challenging the idea that integration is unachievable or even unsafe.

Figure 1: Identity Integration Trajectories Among Participants (N=100)



Thirty-five percent of the participants were found to have the Fluctuating Integration trajectory, which involved context-dependent expression of identity. These individuals manifested full integration in affirming spaces and strategic compartmentalization in perceived unsafe or hostile spaces. This path is a "situation-sensitive approach to identity management" and not a lack of integration. In this group, participants had a well-refined inner sense about what would and would not work when it came to disclosure and authentic expression, and they had a knack for reading social cues to gauge reactions. The Fragmented Integration trajectory included 15% of participants who integrated some aspects of their identity and compartmentalized others. A participant can fully express a racial and a sex identity, but not express a disability identity, because of workplace discrimination concerns or experiences of ableism in the LGBTQ+ community. The ten percent who experienced the trajectory of Identity Foreclosure were those who had internalized constrained identity narratives, that is, those that ruled out playing with some aspects of identity under pressure from their families, religious settings, or past experiences of high levels of rejection and trauma.

Table 3: Identity Integration Trajectories; Demographic Patterns and Mental Health Outcomes

Trajectory	**N (%)**	**Mean Well-being Score**	**Depression (% moderate-severe)**	**Community Connection (%)**
Compartmentalization to Integration	40 (40%)	7.8 / 10	22%	88%
Fluctuating Integration	35 (35%)	6.9 / 10	34%	79%

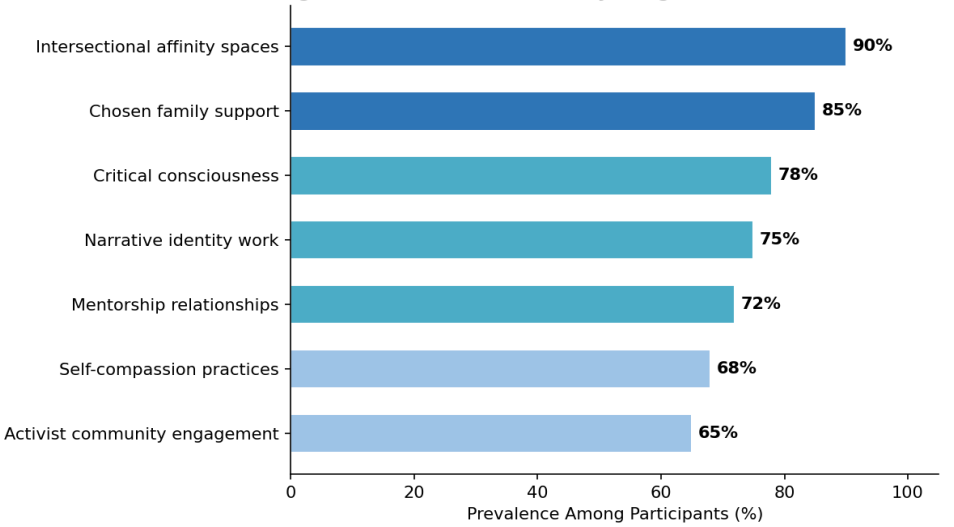
Fragmented Integration	15 (15%)	5.4 / 10	51%	63%
Identity Foreclosure	10 (10%)	3.9 / 10	72%	41%

As can be seen in Table 3 above, there is a clear gradient in the psychological well-being scores and the prevalence of depression across the four trajectories. The mean well-being score for individuals in the Compartmentalization-to-Integration group was 7.8 on a scale of 10, and the number of individuals with moderate to severe depression was lowest, at twenty-two percent. This is in contrast to the mean score for well-being in the Identity Foreclosure group, which was 3.9, and the prevalence of depression, which was seventy-two percent. These quantitative differences are derived from standardized subscales within the interview battery and augment the qualitative stories of distress, dissociation, and psychological burden of participants in foreclosed integration states.

4.1 Facilitators of Identity Integration

The facilitators of identity integration were found at three levels: Individual, interpersonal, and community. The facilitator identified by 78% of participants was critical consciousness at the individual level with regard to systemic oppression. The stigmas that are assigned to their identities were externalized by the participants through developing an understanding of how structural inequalities create the stigmas, and they reframed their experiences in a politicized, self-affirming narrative. Narrative identity work, which concerned the creation of a coherent story that combined all dimensions of identity, was mentioned as being very important by 75% of the participants. This process was often facilitated by journaling, therapeutic work, spoken word, and literature and media representation of intersectionality.

Figure 2: Prevalence of Identity Integration Facilitators (N=100)



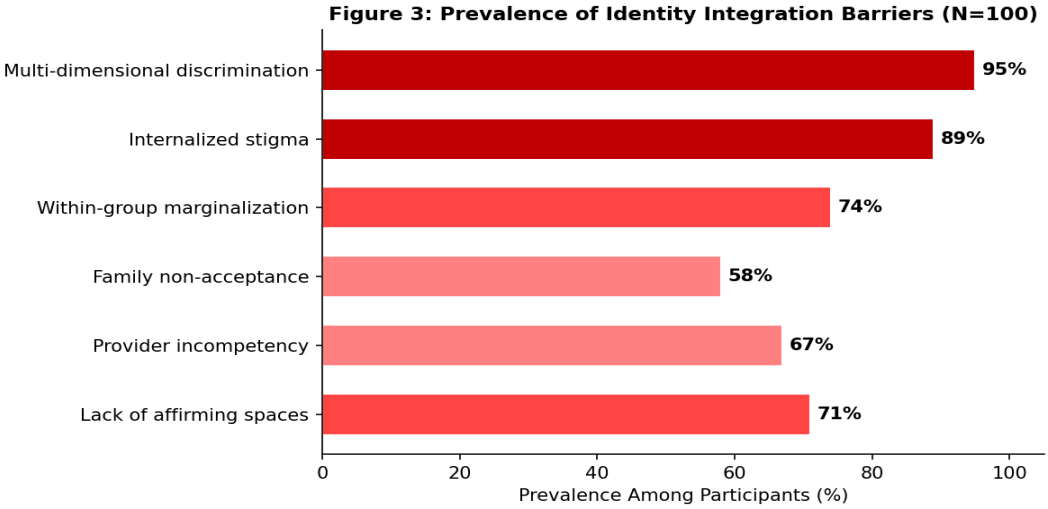
The one factor that was widely cited as a facilitator was chosen family support, cited by eighty-five percent of participants at the interpersonal level. Chosen families were different from biological families, as they did not expect the individual to compartmentalize their identity and instead accepted a person for who they were. Seventy-two percent reported that it was important to have other people with similar identities and experiences to mentor them, offering both role modeling and practical advice for coping in hostile situations. Ninety percent of participants at the community level indicated that intersectional affinity spaces, such as organizations and collectives that explicitly recognize multiple minority identities, are important for integration. Sixty-five percent of participants reported that activist community engagement was the most important aspect for them. They shared how community organizing on intersectional issues shifted individual identity struggles into something collective that gave them meaning, pride, and resilience. Community-level facilitators, especially intersectional affinity spaces, demonstrate the highest prevalence in the sample, indicating the need for more than an individual-level approach (see Figure 2).

4.2 Barriers to Identity Integration

There was a widespread and complex experience of barriers to integration of identity. The most universal was multi-dimensional discrimination, which involved the experience of racism, homophobia, transphobia, ableism, and classism at the same time, with ninety-five percent of the participants experiencing it. The participants often shared how discrimination on a number of axes led to hypervigilance and disrupted their ability to present as the person they were in public, professional, and community settings. Eighty-nine percent of respondents reported experience with internalized stigma, defined as the psychological internalization of societal devaluation over a number of identity dimensions, which led to significant internal conflict and self-directed shame that made integration efforts difficult.

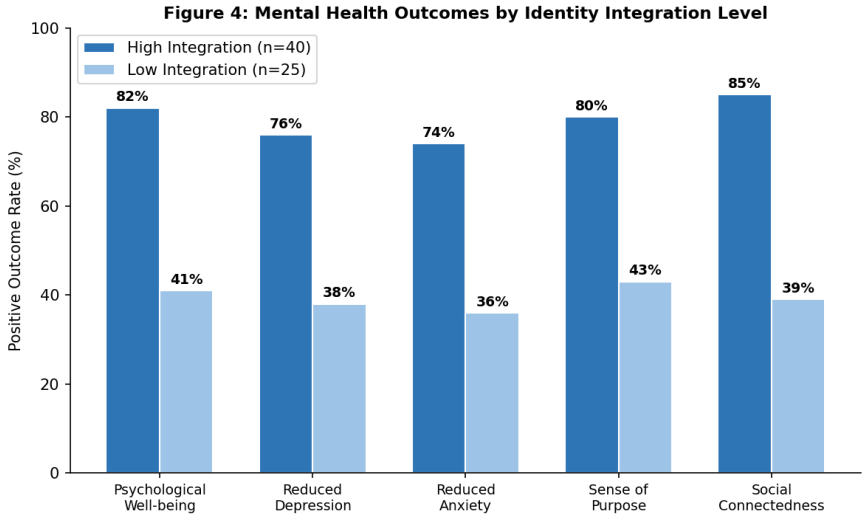
74% reported in-group marginalization (discrimination from communities based on one of their own marginalized identities). A common theme was LGBTQ+ communities that were not welcoming to people of color, or people of color who were not welcome in LGBTQ+ communities, and people having to prioritize certain parts of themselves when engaging

in community spaces. A theme that emerged was that LGBTQ+ spaces were not welcoming to people of color, or that people of color were not welcome in LGBTQ+ spaces, which required them to find a way to prioritize some parts of themselves when engaged in a community where others were not. For fifty-eight percent of participants, a foremost barrier to family non-acceptance was related to gender and sexual identity, and this was associated with significant loss of social supports during periods of critical development. The prevalence of each barrier is shown relative to the other, with discrimination and internalized stigma ranking as the top systemic and clinical barriers to build on, respectively (Figure 3).



4.3 Mental Health Outcomes and Therapeutic Experiences

There were large differences in mental health outcomes according to the extent to which identity integration was achieved. High integration (endorsing a coherent sense of self in two or more identity dimensions) was associated with significantly better results in each measured domain compared to low integration. Figure 4 below indicates that 82% of the highly integrated participants had positive psychological well-being, while 41% of the low integration participants expressed positive psychological well-being. 76% of highly integrated reported reduced depression compared to 38% of low integrated, and 74% reported reduced anxiety compared to 36% of low integrated. The difference in sense of purpose was the biggest, with 80 percent of highly integrated participants rating their sense of purpose as high and 43 percent rating it low compared to those participants with low integration. The social connectedness metric was 85% for the high integration group compared with 39% for the low integration group.



Some of the most salient findings came from therapeutic experiences. Participants who had received intersectionally-informed therapy (therapy that explicitly acknowledged and was working with multiple intersecting identities at the same time) experienced higher rates of continuation of therapy (89 percent) and subjective improvement (92 percent). By contrast, participants who had engaged in single-identity therapy (where the therapist focused on one aspect of identity at a time or did not discuss their intersectional experiences) reported only thirty-one percent therapy continuation, and often reported feeling misunderstood, retraumatized by being erased from therapy by not discussing key identity dimensions, and pressured to prioritize some identities over others. These findings align with Swann et al. (2024), whose framework explains how identity authenticity in therapeutic and community settings is a protective factor for SGM youth of color experiencing intersectional stigma. In fact, 85% of participants reported that community connection within the integration effects was a

necessary component to understanding the well-being of multiply marginalized individuals, which was further evidence that well-being cannot simply be described as individual psychological processes, but is embedded in and dependent upon a supportive intersectional community structure that affirms the whole person.

Table 4: Therapeutic Experiences by Therapy Type and Integration Level (N=100)

Therapy Type	N (%)	Continuation Rate (%)	Reported Improvement (%)	Felt Understood (%)
Intersectional-Informed Therapy	54 (54%)	89%	92%	87%
Single-Identity Therapy	31 (31%)	31%	29%	22%
No Therapy / Community Only	15 (15%)	N/A	61%	N/A

A detailed comparison of the therapeutic experiences is provided in Table 4 for all 3 groups. The data show a significant difference between the continuation of therapy, improvement, and feeling understood by a therapist between intersectional and single-identity therapy. It is worth highlighting the No Therapy / Community Only group, where 61% of the participants experienced a subjective improvement, compared to 29% for the participants who used only the single identity therapy. This discovery aligns with literature that highlights community connectedness as one of the main mediators of the integration effects and psychological resilience of multiply marginalized populations, as mentioned by Hong et al. (2023). Combined, these findings provide a robust argument for an intersectional approach to mental health services, support of affirming community infrastructure, and a reimagined notion of effective therapeutic engagement for people who experience multiple stigmatized identities.

5. Discussion

This study is a qualitative study that aims to gain in-depth understanding of identity integration processes of people who have multiple stigmatizing identities.This study is a qualitative study with the aim of understanding the in-depth identity integration processes of people who have multiple stigmatized identities. Over time, four different pathways towards or away from integration are illustrated. Some seventy-five percent showed evidence of progress toward integration, and ten percent showed foreclosure limiting identity development. The results support the premise of intersectionality theory that multiple stigmatized identities are not additive but dynamic. These findings take the concept of identity development beyond one-dimensional theories that are not sufficiently sophisticated to account for the asynchronous development of multiply marginalized individuals' identities across multiple aspects that require integrated theoretical understanding and clinical attention.

Mental health professionals need to consider identity integration on various levels, not in isolation in ineffective, compartmentalized approaches. Therapy that involves working on identity integration does not work in a linear fashion; it is a simultaneous process. Evidence-based approaches include narrative therapy helping develop coherent identity narratives, identity mapping visualizing relationships, discrimination timeline processing, and community connection work. Clinicians need to be intersectional: to understand the theory, to be aware of their own intersectional identities, and to be willing to speak out for change at the system level. Mental health systems are not adequately meeting the needs of multiply marginalized people due to the organization of services around single identities, a lack of intersectional training among providers, and the failure of affirming communities to be accessible.

6. Conclusion

This study proves the intersectional identity integration to be a significant aspect of psychological health for people who experience multiple forms of marginalization in complex social situations and systemic oppression. Mental health outcomes and quality of life are greatly affected by coherent integration of multiple stigmatized identities into a unified sense of self. But identity integration is not just a psychological process, and facilitators at the community level are crucial in order to foster long-term change and resilience. Enhancing mental health simultaneously involves individual integration work, interpersonal relationships, community connection, and systemic change on structural inequities. This involves individual work and systemic work, with therapists building intersectional competency, healthcare systems recruiting more diverse therapists and implementing intersectional services, researchers including multiple voices of marginalized communities, and the design of policy funding for affirming services that center social justice frameworks and promote psychological health through authentic identity expression.

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Declarations

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