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Structural stigma, gender and intersectionality. Implications for mental health care

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Original article

SUMMARY

The purpose of this paper is to describe the most common forms and expressions of structural stigma from the perspective of a group of people who attended four treatment centers as a result of having received a psychiatric or neuropsychiatric diagnosis (n=68) and a group of health care service providers engaged in these services in Mexico City (n=95). We adopted an approach, based on intersectionality, which involves the interplay between social determinants, including gender, in the processes of social exclusion in mental health. In this qualitative study, the in-depth interview technique was used, for which specific guidelines were designed for providers and users of psychiatric services. The interviews were audio recorded, transcribed, and subsequently encoded through a specialized program (Atlas ti, version 7.0). This paper examines the perceptions and experiences of stigma and discrimination related to psychiatric disorders, and other specific aspects related to the care process. Among the findings are the structural nature of discrimination not only directed at people affected by severe mental illness, but also at health care providers. Furthermore, the respondents' accounts reveal certain structural barriers that impact the quality of care, particularly for users who have multiple conditions of social vulnerability that go beyond the scope of these service providers, constituting dilemmas for the provider. Lastly, on the basis of the analysis of the various difficulties expressed by the study population in relation to the care services, the main challenges to improving the quality of services in the field of mental health are described.

Key words: Stigma and discrimination, gender and intersectionality, interaction between health care workers and users, health care services, mental health.

RESUMEN

El objetivo de este trabajo es describir las formas y manifestaciones más comunes del estigma estructural desde la perspectiva de un grupo de personas que acudieron a cuatro centros de atención por un diagnóstico psiquiátrico o neuropsiquiátrico (n=68), así como de un grupo de trabajadores del área de la salud, que laboran en estos servicios en la Ciudad de México (n=95). Adoptamos un enfoque basado en la interseccionalidad que comprende el interjuego que existe entre los determinantes sociales, incluyendo el género, en los procesos de exclusión social en salud mental. En el estudio, de carácter cualitativo, se eligió la técnica de entrevista a profundidad, para lo cual se diseñaron guías específicas en proveedores y usuarios de servicios de atención psiquiátrica. Las entrevistas fueron registradas en audio, posteriormente transcritas y codificadas por medio de un programa especializado (Atlas ti, versión 7.0). Entre los hallazgos destaca el carácter estructural de la discriminación, la cual tiene repercusiones tanto para las personas afectadas por trastornos mentales graves como para el personal de salud. Por otra parte, en las narraciones de los entrevistados se evidencian ciertas barreras estructurales que inciden en la calidad de la atención, particularmente en el caso de aquellos usuarios que presentan múltiples condiciones de vulnerabilidad social que rebasan el alcance de los proveedores de servicios, constituyéndose en dilemas para éstos. Al final se analizan los principales desafíos para mejorar la calidad de la atención en el ámbito de la salud mental.

Palabras clave: Estigma y discriminación, Género e interseccionalidad, interacción personal de salud y usuarios, servicios de atención, salud mental.

INTRODUCTION

Stigma towards mental illness is a complex phenomenon present in all societies, and over the last decade there has been a boom in research on the subject,[1,2] largely explained by the increase in mental disorders among the populations of different countries and the elevated cost of care that accompanies it.

Sigma itself was a concept originally proposed by Goffman, who defines it as a "deeply disempowering attribute"[3] or mark which places the subject in a state of inferiority and loss of status, generating feelings of shame, guilt, and humiliation. The process of stigmatization begins from a series of signals or markers, for example, skin color, ethnicity, gender, or social status. From these, the subjects adopt stereo-

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types based on prejudice which in turn provokes discriminatory practices or behaviors.[4]

Authors such as Link and Phelan[5] propose that much of the work in this vein has been centered on individual aspects of experience, pushing aside the analysis of structural aspects and social determinants that affect the processes of exclusion. These aspects make up "structural stigma", also called "institutional stigma", which tends to be related to a set of norms, policies, and procedures from public or private entities which restrict the rights and opportunities of people with mental illnesses,[6] legitimize power differences, and perpetuate inequalities and social exclusion.

For these authors,[5] stigmatization involves five interrelated psychosocial processes which include: 1. Labelling, 2. Assigning of stereotypes, 3. Separation, 4. Loss of status, and 5. Discrimination. All of these occur within an asymmetric power situation which facilitates said stigma components developing.

In this sense, structural stigma becomes a very useful concept to approach social groups with multiple conditions of vulnerability, such as: non-heterosexuals,[7] those with HIV,[8] women prisoners,[9] those displaced by migrations or conflict,[10] as well as rural and urban populations living in poverty.[11] Several social determinants influence these conditions and are expressed in social inequalities in terms of access to health care. One of these determinants –gender– is a crosscutting variable of a structural nature that offers a wider explanation of the different ways in which men and women become ill, considering the sociocultural context in which they develop, and the social system of relationships that is established from interaction between both, without favoring one or the other group. In this sense, the focus of intersectionality originally set out by Crenshaw[12] and developed by authors such as Hankivsky et al.,[13,14] propose that in order to give an account of the complexity of social phenomena, it is fundamental to analyze the simultaneous interaction of various social factors at different levels.

This perspective is interested in the inclusion of public policies in terms of social justice and recognizing relational constructs of social inequality, as well as constituting a useful theoretical instrument to examine the way in which power relationships are maintained and reproduced. One of the main achievements of this focus is that it distances itself from any type of generalization and proposes a new order of complexity in order to understand the way in which sex and gender interrelate with other dimensions of social inequality, specifically in historical and geographical contexts in which the individuals exist, in order to create unique experiences in the area of health.[13] In this sense, intersectionality does not reduce itself to the sum of conditions of vulnerability; rather, it is the dynamic relationship between the social determinants, the subjects, and their historical and social context.[13,14]

The aim of this work is to describe the commonest forms and manifestations of structural stigma from the perspective of a group of service users and providers at three treatment centers of third level. The focus is based on intersectionality, which includes the analysis of interplay between the social determinants, including gender as a crosscutting variable, in experiences described by participants in the study.

MATERIAL AND METHODS

The information analyzed comes from a wider transcultural study on the processes of stigmatization in different sectors of the population, using mixed methods. The methodological aspects are described in other works.[15-17] Informed consent forms were used, which guaranteed anonymity and confidentiality of information.

Participants

The data was based on a sample of health care providers from different disciplines (n=95), and a group of service users receiving outpatient treatment from four centers for psychiatric care located in Mexico City (n=68).

Psychiatric service users

Table 1 shows the sociodemographic characteristics of the participants, of which some 73% were residents in the Federal District. The ages ranged from 21 to 64 years (SD=11.8), with an average age of 36 for the men (SD=11.06) and 40 for the women (SD=11.9). Some 21% of the participants had a partner at the time of the interview,[4] and the majority were living with a friend or family member.

In terms of clinical characteristics, 90% had a diagnosis of a serious mental disorder (schizophrenia, bipolar disorder, obsessive compulsive disorder, or dual disorder) and a lesser proportion of epilepsy (10%).

The duration of the disorders ranged between less than one year and forty years, with a median of 13 years (SD=9.20). On average, the users had had nine years in treatment (SD=8.24) and only 10% of the sample had less than one year of receiving psychiatric care. Just under half (48%) received exclusively pharmacological treatment, while the remaining 52% used additional resources such as occupational therapy, partner or group therapy, support groups, orientation talks, or physical exercises.

Health care providers

Individuals participated from different disciplines, primarily psychiatrists, psychologists, nurses, and social workers who worked in various mental and addiction treatment centers in Mexico City. The majority worked in public health care institutions (72%) (Table 2). Table 3 shows data related with the working experiences of those interviewed in the

Table 1. Sociodemographic characteristics of the service users interviewed

	Female (n=37)		Male (n=31)		Total	
	F	%	F	%	F	%
Diagnosis						
• Serious mental disorder*	33	48.0	28	42.0	61	90.0
• Neuropsychiatric disorder (epilepsy)	4	6.0	3	4.0	7	10.0
Age						
• Years	(21-64)		(22-63)		(21-64)	
• Median	40		36		38	
Civil status						
• Single	28	41.0	26	38.0	54	79.0
• With a partner	9	13.0	5	7.0	14	21.0
Level of education						
• Elementary	3	4.0	1	1.5	4	6.0
• Secondary	6	9.0	7	10.0	13	19.0
• Technical school	14	21.0	11	16.0	25	37.0
• Degree	13	19.0	11	16.0	24	35.0
• Postgraduate	1	1.5	1	1.5	2	3.0
Living situation						
• Alone	5	7.0	–	–	5	7.0
• With other people	32	47.0	31	46.0	63	93.0
Occupation						
• Employed	27	40.0	22	32.0	49	72.0
• Unemployed	10	15.0	9	13.0	19	28.0
Monthly income	(100-10,000.00) 11 (16%)		(300-12,000.00) 17 (25%)		(0-12,000.00) 28 (41%)	

*Schizophrenia, addiction, bipolar disorder, obsessive compulsive disorder, and others.

area of care. In terms of perceived income, it is interesting to note that although the average hours worked by men and women per day or week are similar, income tended to be higher for men (T=0.16, p≤.05). This finding has implications from a gender perspective, as well as the tendency observed in women rather than men for working in areas related to health care such as nursing and psychology.

Methodological procedure

For the investigation, an approach was used which was based on mixed methods. The gathering of information was carried out by means of in-depth interviews with the population, which took place in the period between January 2009 and July 2010. The research team was made up of seven interviewers from various disciplines, primarily in the area of psychology, who received prior training in managing the data gathering techniques. Audio recordings were also made of the interviews and later transcribed for analysis.

For the purposes of this work, the following topics were analyzed. In the case of the service users: 1. Subject's perception of the event that triggered their disorder, 2. Experiences of stigma and discrimination associated with said disorder, 3. Primary sources of stigmatization, and 4. Suggestions to reduce stigma. In the case of health care providers, the topics analyzed were: 1. Perceptions of the most common dilemmas and difficulties linked with their working practice, 2. Perceptions of the sectors most affected by these types of disorders, 3. Experiences of stigma and discrimination, 4. Disorders most frequently encountered in their working practice, and 5. Suggestions to reduce stigma and discrimination.

Analysis of results

A thematic analysis was made of the interviews using an inductive method. The Atlas ti program (version 7.0)[18] was used to organize the qualitative analysis of the information. In addition was made a content analysis of open questions.

RESULTS

Perception of psychiatric service users around the event that triggered their disorder

We identified six broad interrelated categories, whose contents are shown in Table 4. As can be observed, the primary category is about conditions of social vulnerability, which refers to the coexistence of a series of factors perceived by

Table 2. Sociodemographic characteristics of the health care providers interviewed

	Gender					
	Female (n=61)		Male (n=39)		Total (n=95)	
	F	%	F	%	F	%
Profession						
• Unqualified personnel	6	6.3	–	–	6	6.3
• General medicine	2	2.1	1	1.1	3	3.2
• Social work	12	12.6	–	–	12	12.6
• Psychiatry	13	13.7	18	18.9	31	32.6
• Nursing	15	15.8	5	5.3	20	21.1
• Psychology	13	13.7	10	10.5	23	24.2
Level of education						
• Upper middle/technical level	10	10.5	1	1.1	11	11.6
• Degree	17	17.9	6	6.3	23	24.2
• Postgraduate	34	35.8	27	28.4	61	64.2
Area of work						
• Public	48	78.7	20	58.8	68	71.6
• Private	4	6.6	–	–	4	4.2
• Both	9	14.8	14	41.2	23	24.2
Age						
• Years			24–68			
• Median			(39)			

the informant. These are interrelated and they contribute to the disorder. Particularly notable are precarious living conditions, violence, substance consumption, and the lack of a support network, among others. Although men and women reported that they do not differ greatly in terms of this social vulnerability, gender does influence these experiences. For example, women are recognized as the victims of partner violence as much in men's reports as in women's.

Something similar occurs in terms of alcohol consumption, which is still a practice which is more socially acceptable in men than in women. What follows is a report that demonstrates the multiple conditions of vulnerability and the context in which these occur:

> "*…after a time working, my ex-husband said to me while the young girls were there, 'why did you study a degree? You are good for nothing and these things are marking you.' Yes, there is a moment when you just say, I am useless, I am worthless, I am going to hospital…(...) It makes you very insecure, that's what you lose with all this; alcohol, divorce, the children, joblessness, a dead father…*" (Service user)

Various conditions of social vulnerability can also be observed in the following testimony from an interviewee. In particular with regard to violence, even if the informant recognizes the impact of this experience on their disorder, given that his mother was abused by his father, he is not assumed as a direct recipient of the violence, as in the previously described case:

> "*Well, when I was little, my dad drank a lot, you know? And I took myself away and cried because my mom wasn't there. I'd cry till I was blue in the face. They say that once I had a seizure and that that could have affected me, not breathing for so long. After that, I remember my dad hitting my mom (…) Then, when I was 10, my dad developed a manic depressive psychosis. I started to work in the market and develop bad habits, you know? Like watching porn and stuff like that. I'd already started having problems at school and then when I was 16, my grandpa died, and that's when the trouble started. I was taking mushrooms and marijuana, and I got sick from there and started to have delusions, but it meant that I never recovered from it…*" (Service user)

We have identified a category called "individual characteristics" referring to attributes which, from the perspective of the individual, contributed to the disorder. For example,

Table 3. Variables related to the working experience of health care providers, comparison by gender (n=95)

	Women			Men			
Variables	Median	SD	Range	Median	SD	Range	p(t)
Experience in mental health (years)	11.65	8.37	0-30	13.60	9.02	2-39	ns
Time in current role (years)	9.63	8.02	0-29	10.59	8.53	0-28	ns
Daily care of service users (hours)	5.76	2.74	0-11	6.85	3.38	1-20	ns
Weekly care of service users (hours)	29.45	13.81	0-56	34.85	13.44	5-66	ns
Monthly income	14,526.67	9491.7	1,000-50,000	19,382.35	8861.6	8,000-40,000	0.01*

0= Less than one year. p≤.05.

feeling different to other people since childhood, having a strange behavior or isolating oneself from other people, or adopting habits that may be considered unsuitable around food, sleep, reading, etc. Even if genetic factors were identified as a trigger for the illness, it should be noted that cultural aspects related to magical/religious beliefs, esoteric practices, and relationship breakdowns can also have the same effect.

On the other hand, the category of "problems" included a series of difficulties at work, with partners, education, family members, or personally which, from the perspective of the interviewee, led to the emergence of the crisis. Another category was incorporated which grouped together specific events outside the direct actions of the subject: assaults, accidents, and blows to the head, as well as the loss of loved ones.

Experiences of stigma and discrimination referred to by service users

Some 91% of those interviewed recalled stigma and discrimination existing in society towards people with mental illness. Some 88% reported having experienced at least one example of social rejection due to their disorder:

> "*…people already have that mentality, and you can't get the idea out of their minds that you are crazy and won't stop being crazy. I am suffering that every day because I can't seek justice, I can't shout - I have that, and they won't even pay attention to me, let alone give me justice. So that's how they give it 20 nice names, and I think they'll never change their minds, crazy people don't have a right to anything*." (Service user)

The primary sources of stigma were family and health care providers, who would most commonly criticize, accuse, scold, provoke, joke, and use nicknames or descriptions. In particular with health care providers, some experiences referred to a lack of credibility or disqualification of which they are object, as well as certain fatalistic attitudes regarding the prognosis of the disorder:

> "*My sister said to me: 'you can't talk to me any more, you have no opinion, take your pill and get out of the way'.*" (Service user)
> "*Health care providers have these attitudes towards people with mental disorders, they don't believe what they say, they treat them with a lack of interest or even hostility, they are very devalued*." (Psychologist)

Table 4. Perception of event that triggered the psychiatric disorder, according to service users

	Women	Men
Conditions of social vulnerability (35 mentions)	• Domestic violence, alcohol and drug use, weight gain, and emotional problems within the family • Sexual abuse, lack of family support, and lack of financial resources • Loss (death, parental or partner separation) • Strange behavior in childhood which worsened with parental separation • "Traumatic experiences in childhood" • Family history of physical and mental illnesses • Abused by mother and brother had epilepsy • From a family background of depression and domestic violence	• Alcohol and drug use, grew up in an environment of consumption, conflict, and knowledge of dependency on parents • Experiences of neglect and abuse in childhood, conflict with family members, father was violent towards mother • Substance consumption in close family members • Other chronic disorders in the family • Negative experiences with care ("they injected him badly") • Pressure from parents and relationship problems • Traumatic experiences and abuse in childhood
Individual characteristics (18 mentions)	• Solitary personality • Strange behavior in childhood • Alcohol and drug consumption • "Not eating well"	• Behavior was always strange • Alcohol and/or drug consumption • The way he is • "I need to belong to a group of friends" • Psychological problems • Poor diet • Lack of exercise • Lack of reading
Genetic (17 mentions)	• History of psychiatric disorders • Biochemical alteration	• Family history of psychiatric disorders in the family • For a psychological reason as yet unknown • Due to statistical probability
Cultural aspects (11 mentions)	• Heartbreak • Witchcraft • After reading some cards which predicted bad luck	• Heartbreak • Esoteric experiences (Reading cards, tarot)
Working, family, academic problems (6 mentions)	• Problems which accumulated during lifetime and which they did not know how to manage	• Loss of employment • Family problems • Tensions at school, with partner, and with friends
Other	• Blows to the head • "Affected by assault" • Death of a loved one	• Fainting and blows to the head • Started having hallucinations and delusions of persecution • Complications at birth • Death of a loved one

The following is an extract from an informant who recalls participating in a group intervention with other women and remembers an experience of sexual abuse, which she did not report at the time because she feared she would not be believed. In this sense, it can be seen how suffering from a mental illness joins with gender to create a condition of 'double-discreditable':

> "*…when my friend said she had suffered abuse, I said it was true, because it had happened to me, and why did I keep quiet? Because if before, when I was younger - and let's say, had all my faculties - they didn't believe me, they'd believe me even less now. The truth is, it's not fair, but the social worker said that it wasn't true, that the girl made it up because of her illness, but that's not true because it happened to me and once again I felt dirty, lousy…*" (Service user)

As happens in other serious disorders involving psychotic episodes, in some cases, health care providers often have doubts regarding events described by patients in terms of whether they are a real event or a consequence of episodes or delusions. This could lead these people to becoming the object of double or even triple stigmatization.

Perceptions of health care providers around the primary mental health care demands and most affected sectors of the population

Depressive disorders, schizophrenia, personality disorders, bipolarity, anxiety, substance abuse, and alcohol abuse were considered by interviewees as the primary conditions treated in their field of work. They also mentioned other problems associated with them, such as violence, sexual abuse, poverty, and suicide.

Upon inquiring as to the providers' perception of the sectors of the population most affected by psychiatric disorders, 39% of those interviewed considered that any person could be susceptible to having this type of disorder, given that the cause of them is genetic, coupled with other environmental conditions such as insecurity, violence, and stress. Some 34% identified those from disadvantaged backgrounds as the sector most affected by implications of the disorder (e.g., difficulties accessing treatment, living in marginalized areas, and the elevated cost of medication and treatment, etc.). In particular they mentioned people in a state of abandonment living on the streets and lacking any kind of support:

> "*…that is the main problem, and as the means of communication and the political situation we currently have lead young people to have less interest in life, they want to kill themselves… There are conditions of poverty where you see prostitution, addiction, alcoholism, sexual violence or abuse by parents. So the situation in this country and all over the world is disgraceful and very sad; you have nowhere to go, you know? I feel that a lot, I feel very limited here with the people I work with.*" (Social worker)

It should be noted that 7% of those interviewed made reference to the gender difference in terms of prevalence of psychiatric disorders, according to which, depression and anxiety are most frequent in women, whereas alcohol and drug consumption was predominant among men. In this respect, one interviewee considered that the conditions necessary to provide care from a gender perspective do not exist in practice:

> "*…in my opinion, there is research into drug consumption, the problem of female drug users, but there is still not a specific model of treatment for them; so here we have a model thought out for the general population and that means for men. For example, women come and there is no room for the children to go into, that doesn't exist, there is no provision for the children while their mom is in treatment, that doesn't exist, and it is not enough for the children to go with their mom into the treatment area, she needs to ask a godmother or sister or someone to look after the kids in order for her to continue with the process. And who is going to take care of the costs? Who is going to watch the kids? Who is going to buy things? Who is going to cook for them? Who will even pick the kids up? The day she comes to treatment, she has to solve all of these day-to-day problems which make her treatment impossible.*" (Psychologist)

Female drug and alcohol users are usually indicated as responsible for the disorder; something similar occurs in victims of domestic violence in relationships. As one informant indicated:

> "*their complaints aren't considered reliable on the basis of gender.*" (Psychiatrist)

Dilemmas and difficulties in working practice

Working difficulties are conditions that health care providers perceive as obstacles to the development of their professional practice within the health care process, for example, lack of medical equipment, medications, or human resources. These are related to institutional problems which ultimately have to do with structural stigma, given that mental health occupies a marginal position compared to physical health in Mexico. Furthermore, these dilemmas imply the convergence of two possible solutions to a certain problem which are usually incompatible, placing the health care provider in a conflicting situation which could generate stress or unease. Table 5 shows some examples of the difficulties perceived, such as institutional barriers and their implications for health care providers carrying out their functions. Lack of human resources, materials, and finances while facing a growing demand for services, coupled with the scarcity of collaboration between health care providers and the vertical structure between disciplines are the primary sources of discontent for those interviewed:

> "*The communication networks between the mental health sectors are totally deficient, I would say almost non-existent… If hospital x did not want to take something, it is taken by hospital y, sometimes without even a reference sheet… and that is how we go on. So the community does not know what to do with that type of situation.*" (Psychiatrist)
>
> "*…there is not much communication, precisely because people are individuals, they want to do things independently and there is not the opportunity for that… I would say it's not the case everywhere, but unfortunately, in this country, this is how we've been shown to work, you know? Every man for himself.*" (Social worker)

The strategy to approach dilemmas was to ascertain

which had been the most difficult experiences they had faced during their professional career. As can be seen, the situations referred to were related to the intersection of different conditions which generated an effect of multiple vulnerability, for example: 1. Women in specific situations; pregnant, minors, without support networks, or living in conditions of violence, 2. Non-heterosexual or transgender people seeking care who may represent a transgression of the health care provider's own values and ideology, 3. Young people or teenagers with unwanted pregnancy, no support network, no financial resources, or intentions of suicide, 4. People with certain cognitive deterioration who are not receiving any type of care, living on the streets or in prison, 5. People from different ethnic groups or cultures who require specific conditions for care, such as linguistic or cultural interpretation in order to be understood and their symptomatology adequately managed. They may also lack economic resources and support networks, as illustrated in the following account:

> "*…I arrived on the floor and went to see a colleague. At that moment, a patient began to hit a colleague without a word. This patient was from Somalia and spoke no Spanish, in the little English we could understand, we interpreted him. He told us that there were voices in his mind telling him that the colleague wanted him to die because he had AIDS, so his reaction was to get very upset, but I am telling you, without a word he was hitting her all over. Fortunately I arrived and we contained him, talked to him, and calmed him down. Later, he was given medical care, medication, and physical restraint for two hours…*" (Nurse)

People with schizophrenia who live on the street or are destitute are a sector of the population forgotten by institutions. This is also the case with drug and alcohol users who are often subject to mistreatment and lack of care from institutions because they are in some way held responsible for their condition and socially, they are associated with the idea of promiscuity and a chaotic life. These people then have no choice but to start moving from place to place, channeled from one institution to another, most of the time without receiving care. These examples exceed the competence and abilities of health care providers, some of which derives from structural stigma and discrimination in such a way that makes mental health care very challenging.

DISCUSSION

The primary purpose of this work is to give an account of the structural nature of stigma and discrimination towards mental illnesses from the point of view of people affected by these disorders and the health care providers who work in various treatment centers in Mexico City.[5] In this sense, the focus based on intersectionality was extremely useful in approaching the dynamic relationship between the social subjects and certain social determinants, which in turn allowed difficulties which often present themselves in the process of psychiatric care to be identified.

Stigma and discrimination towards psychiatric disorders was the primary barrier occurring in care from the point of view of the participants, and it is present in various spheres at clinical, family, and social levels. Health care providers were reported as the second source of stigma and discrimination, which is congruent with previous studies.[19-21] In this regard, Szasz[22] reports that there are various gaps during the process of scientific-medical training for disciplines and specialties related with health, and that affective aspects are not usually approached, nor are prejudices or negative stereotypes associated with mental disorders. As a consequence, this leads to these practices continuing to be reproduced during doctor-patient interactions.

On the other hand, it is important to consider that due to working activity, health care providers are also subject to social rejection, both in medical circles as well as society in general, which is known in the literature as stigma by association.[20] This also has implications in the treatment process.

It was particularly notable that both service users and health care providers made reference in their interviews to the presence of multiple conditions of social vulnerability, and that even if they are not present in all cases, they represent an obstacle to care. Conditions of poverty, violence, lack of support networks, and comorbidity with physical and mental illnesses were some of the most common examples of social vulnerabilities. These are a series of social inequalities of a socioeconomic, political, and historical nature which form part of the subject's biographical context.

In this sense, adopting the paradigm of intersectionality[13,14] was extremely useful given that it is a theoretical tool to understand the processes of stigmatization towards psychiatric disorders from a more structural focus. It includes the analysis of social determinants such as gender, which offers the possibility of transcending the construction of isolated concepts which reinforce barriers and oppositions that contravene the social reality observed. The aim is to generate strategies derived from the reduction of unfavorable or risk conditions to which both genders are exposed.

From this perspective, gender is submitted to a series of social representations and practices under which male and female identities are defined and treated. This is true of both relational aspects and a particular social and historical context. In the case of health, this influences the configuration of different experiences of illness, in the way that public policies have traditionally used focuses which omit sociocultural diversity and which do not consider variations among the population in the configuration and expression of health needs.

In their testimonies, service users and health care providers referred to various conditions which are obstacles to care. As well as gender, conditions of poverty and lack of resources for care are structural variables that occur as crosscutting variables (e.g., experiences of sexual abuse and violence) in the manifestation of psychiatric disorders, accounting for their complexity.

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Table 5. Difficulties perceived in working practice, according to health care providers

Dimensions	Women	Men
Institutional barriers (57 mentions)	(41 mentions) • Lack of space and infrastructure • Conflict of interests in the care center • Lack of boundaries for staff functions • Lack of materials and human resources • Lack of staff training and supervision • True solutions are not offered for anxiety or family tension • Lack of mental health knowledge in primary care centers • No collaborative work; prevalent hierarchy in the health team • Lack of legal support • Insufficient time for consultations • Lack of inter-institutional collaboration	(16 mentions) • Lack of materials, financing, and human resources • Absence of an adequate treatment model (reception times, frequency, bureaucracy) • No integrated care • Lack of care training for health care providers • Delay in timely care as a result of previous care paths sought in the population • Lack of interest in staff mental health
User/Patient (39 mentions)	(23 mentions) • Resistance to receiving psychiatric care • Submissive attitude towards doctor • Lack of compliance with institutional regulations • Lack of adherence to, or abandonment of, treatment • Level of cognitive deterioration that hinders patient management • Lack of knowledge about mental health • Barriers due to lack of economic resources • Lack of family support for service user	(16 mentions) • Resistance to receiving psychiatric care • Lack of adherence to, or abandonment of, treatment • Weak or insecure self-perception • Physical and verbal violence • Anxiety caused by contact with other psychiatric patients • Delayed treatment • Lack of information and culture • Barriers due to lack of economic resources
Family (33 mentions)	(23 mentions) • Lack of family support • Lack of knowledge about service user's disorder • Non-compliance with institutional regulations • High demand for care • Non-compliance with medical instructions • Abandonment of service users • Hostile and critical attitude towards service user • Stress and emotional burden	(10 mentions) • Lack of family support • Lack of knowledge about service user's disorder • Lack of information and culture
Health care providers (27 mentions)	(21 mentions) • Favoritism towards colleagues • Lack of preparation • Lack of teamwork • Frustration experienced in care work • Lack of commitment or interest in work • Tensions and conflicts • Lack of sensitivity in care • No interest in training • Inadequate practices • Lack of knowledge about psychiatric disorders in primary care • Clash of egos • Doublespeak • Hierarchies, vertical care model	(6 mentions) • Individualized work, no coordination between areas and/or disciplines • Lack of training on approaching agitated patients • Disqualification between colleagues • Emotional and working exhaustion • Provider stigma towards service users • Incapacity to approach family and service users
Stigma and cultural aspects (27 mentions)	(16 mentions) • Underestimation of the general population towards the profession • Distrust of service users and families towards health care providers • Stigma and discrimination of some providers towards service users • Disqualification between care disciplines • Magical-religious ideas around mental illness in families and service users • Lack of information in the general population about mental illnesses and functions of a psychiatrist	(11 mentions) • Myths and prejudice around mental illness in society • Stigmatization of people with mental illness • Magical-religious ideas around mental illness in families and service users • Self-treatment as the first way of seeking help (witches, priests) which leads to a delay in medical care • Lack of information and interest in mental health in the population
State (21 menciones)	(14 mentions) • Lack of interest in mental health in public policies • Social inequality • Precarious financial conditions in the population • Insufficient resources for psychiatric care • Absence of specific programs for care of the psychiatric population (e.g. employment, homes) in vulnerable groups, primarily in families with low economic resources • Lack of social support	(7 mentions) • Conditions of poverty in the population • Health programs focusing more on figures than in solving health problems • Lack of employment, primarily among service users with addictions • Lack of specific treatment models for women that incorporate a gender focus into the practice • Centralization of psychiatric care services and abandonment of the most remote ones
User/provider interaction (9 mentions)	(4 mentions) • Mediation sometimes impedes communication with service user • Management of irritated or agitated patients (e.g. physical and verbal aggression) • Dealing with anger of family and service users • Dependence generated in the relationship with the service user	(5 mentions) • Lack of staff availability to listen to patients • Involvement in the patient's pathology due to lack of training or boundaries • Difficulty establishing adequate channels of communication with families and service users

Health care providers often feel powerlessness and uncertainty when facing complex cases where there are multiple conditions of social vulnerability such as teen pregnancy, substance abuse, and dangerous living conditions in the population. This often gives rise to neglect or indifference, especially when the health care provider has a number of years of emotional or occupational fatigue linked with their professional life.

Another important aspect lies in 39% of the health care providers interviewed considering that all sectors of the population are susceptible to having this type of disorder, alluding to genetic factors as the primary cause. In this respect, as indicated by Martínez-Hernáez,[23] even if the discourse included health care providers recognizing the multidimensional bio-psychosocial focus, it is certain that clinical practice would continue to tend towards treating mental illness from an exclusively biological and individual perspective, ignoring other aspects such as social inequality, power structures, and culture, as well as the way these affect and determine the appearance, development, and possible recovery from the illness.

As evidenced in the findings, a certain disagreement is noted in the relationship between health care providers and service users, while there is a sector of the latter that attributes certain magical/religious characteristics to the emergence of the psychiatric disorder. Health care providers consider that these cultural aspects are an obstacle to achieving the therapeutic adherence of patients, and because of this they often disregard these beliefs without considering that they form part of the symbolic and cultural universe of the population. For authors such as Kleinman,[24] this knowledge is crucially important in order for treatment to be culturally suitable for both doctors and patients. As such, it is important to increase staff awareness of attaching greater importance to cultural aspects. This would not only allow for an understanding of the complexity of psychiatric conditions, but would also provide a response that is more in accordance with the specific needs of the population using the service.

Further to the cultural aspects, gender plays a key role in the care process.[25,26] In this research, just 7% of the health care providers participants alluded to differences of gender, without accounting for the fact that in actual care practice, gender programs are not usually applied. Along the same vein, previous studies have reported that health care providers do not recognize gender violence,[27] and in this research it was identified that one of the possible risks for health care providers is attributing experiences of violence or sexual abuse exclusively to the psychiatric symptomatology without considering that it could be a legitimate complaint by the service user. This may be the case with those suffering a serious mental disorder such as schizophrenia.

It is interesting to observe that health care providers are also impacted by gender inequalities, such as the monthly income reported by the interviewees. This placed women's income below that of men, even when the time spent on care work was similar in both genders. Even if this information is taken with caution due to other aspects within the specific context of each discipline and of the activities and functions of the health care providers, these differences certainly do exist, and there was definitely a greater presence of women in areas related to health care.

Finally, it should be noted that even by means of a quantitative study, it is possible to identify a series of variables that affect psychiatric disorders. The input provided by the qualitative perspective stems from the possibility of giving an account not only of the aspects which intervene in the care process, but also to analyze articulations and the complexity of interaction between various social categories or dimensions. It also raises reflection of both the study population and other sectors involved, the health care providers, and even those who are interested in this area of study, valuing ideological and cultural aspects underlying social practices.

It should be pointed out that this work formed part of a broader study in such a way that it was not designed specifically to approach gender and mental health from an intersectional perspective. However, during the process of analyzing information obtained from the study population and in pursuit of theoretical references to interpret the findings, this focus was found to be very useful as it emphasizes the importance of the interrelationship between the social determinants, and how gender represents a fundamental transversal variable surrounding the health, illness, and care process. As such, we consider that this proposal could enrich research in this area, primarily in Latin American contexts where there are marked social inequalities that cannot remain on the sidelines when analyzing the health conditions of the population.

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