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REVIEW ARTICLE
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Intersectionality in mental health diagnosis: implications for care equity and health services

Interseccionalidade no diagnóstico em saúde mental: implicações para a equidade no cuidado e para os serviços de saúde

Resistencia microbiana asociada a la IPCSL en unas UCI para adultos en Ceará

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ABSTRACT

Introduction: Mental disorder diagnosis is influenced by social determinants that permeate health systems and impact care access and quality. Structural inequalities related to race, gender, social class, and sexuality can interfere with psychological distress identification and diagnosis definition, producing inequities in mental health care. In this context, the intersectional approach contributes to understand how multiple social markers interact in the production of these inequalities. **Objective:** To analyze, through systematic literature review, how intersectionality influences the diagnosis of mental disorders and to discuss implications for care equity and health services. **Methods:** A systematic review was conducted according to the PRISMA 2020 guidelines, using the PEO strategy. The PubMed, SciELO, and VHL databases were consulted for studies published from 2000 to 2024. The selection was carried out in three stages: duplicate removal, screening by title and abstract, and then full-text reading. Methodological quality was assessed by two independent reviewers using instruments from the Joanna Briggs Institute. **Results**: It was evident that implicit biases, stigmas, and culturally limited diagnostic models influence accuracy, especially among negro women, transgender people, and individuals in situations of socioeconomic vulnerability. **Conclusions:** Incorporating an intersectional perspective can contribute to more sensitive diagnosis to social inequalities, strengthening equity in mental health care and improving professional practices, health training, and public policies.

Keywords: *Intersectionality; Mental health; Mental disorders; Social determinants of health; Diagnosis.*

RESUMO

Introdução: O diagnóstico de transtornos mentais é influenciado por determinantes sociais que atravessam os sistemas de saúde e impactam o acesso e a qualidade do cuidado. Desigualdades estruturais relacionadas à raça, gênero, classe social e sexualidade podem interferir na identificação do sofrimento psíquico e na definição de diagnósticos, produzindo iniquidades no cuidado em saúde mental. Nesse contexto, a abordagem interseccional contribui para compreender como múltiplos marcadores sociais interagem na produção dessas desigualdades. **Objetivo:** Analisar, a partir da revisão sistemática da literatura, como a interseccionalidade influencia o diagnóstico de transtornos mentais e discutir implicações para a equidade no cuidado e para os serviços de saúde. **Método:** Revisão sistemática conduzida conforme as diretrizes PRISMA 2020, utilizando a estratégia PEO. Foram consultadas as bases PubMed, SciELO e BVS com foco em estudos publicados entre 2000 e 2024. A seleção ocorreu em três etapas: remoção de duplicidades, triagem por título e resumo e então leitura na íntegra. A qualidade metodológica foi avaliada por dois revisores independentes utilizando instrumentos do Joanna Briggs Institute. **Resultados:** Evidenciou-se que preconceitos implícitos, estigmas e modelos diagnósticos culturalmente limitados influenciam a acurácia, especialmente entre mulheres negras, pessoas trans e indivíduos em situação de vulnerabilidade socioeconômica. **Conclusão:** A incorporação da perspectiva interseccional pode contribuir para diagnósticos mais sensíveis às desigualdades sociais, fortalecendo a equidade no cuidado em saúde mental e qualificando práticas profissionais, formação em saúde e políticas públicas.

RESUMEN

Introducción: El diagnóstico de los trastornos mentales se ve influenciado por determinantes sociales que permean los sistemas de salud e impactan el acceso y la calidad de la atención. Las desigualdades estructurales relacionadas con la raza, el género, la clase social y la sexualidad pueden interferir con la identificación del distrés psicológico y la definición de diagnósticos, produciendo inequidades en la atención de la salud mental. En este contexto, el enfoque interseccional contribuye a comprender cómo interactúan múltiples marcadores sociales en la producción de estas desigualdades. **Objetivo:** Analizar, a través de una revisión sistemática de la literatura, cómo la interseccionalidad influye en el diagnóstico de los trastornos mentales y discutir las implicaciones para la

equidad en la atención y para los servicios de salud. **Método:** Se realizó una revisión sistemática de acuerdo con las directrices PRISMA 2020, utilizando la estrategia PEO. Se consultaron las bases de datos PubMed, SciELO y BVS para estudios publicados entre 2000 y 2024. La selección se realizó en tres etapas: eliminación de duplicados, cribado por título y resumen, y lectura del texto completo. La calidad metodológica fue evaluada por dos revisores independientes utilizando instrumentos del Instituto Joanna Briggs. **Resultados**: Se evidenció que los sesgos implícitos, los estigmas y los modelos diagnósticos culturalmente limitados influyen en la precisión diagnóstica, especialmente entre mujeres negras, personas transgénero y personas en situación de vulnerabilidad socioeconómica. **Conclusión:** Incorporar una perspectiva interseccional puede contribuir a diagnósticos más sensibles a las desigualdades sociales, fortaleciendo la equidad en la atención de la salud mental y mejorando las prácticas profesionales, la formación sanitaria y las políticas públicas.

Descriptores: *Interseccionalidad; Salud Mental; Trastornos Mentales; Determinantes Sociales de la Salud; Diagnóstico.*

INTRODUCTION

Intersectionality, a concept developed by Kimberlé Crenshaw, refers to the overlap of different forms of discrimination and oppression experienced by individuals due to the combination of social identities, such as gender, race, class, and sexuality[1]. In societies marked by structural inequalities, these dimensions intertwine in a complex way, producing unique experiences of vulnerability and social exclusion. In this sense, intersectionality has consolidated as an important analytical tool to understand social inequalities and it guides debates on social justice and equity in health[2,3].

In the mental health field, this approach becomes particularly relevant to understand how social and structural factors influence the psychological distress recognition, diagnostic process and healthcare access. In the Brazilian context, mental health care is organized within the Unified Health System (SUS) framework, which is guided by the universality, comprehensiveness and equity principles, and it was also strengthened from the Psychiatric Reform and legal frameworks that ensure care at liberty[4,5]. Despite these institutional advances, mental health diagnosis is not a neutral or strictly objective practice, but produced in social and cultural contexts that can make the complexity of the trajectories and identities of the subjects not visible.

Thus, in practice, factors such as racism, sexism, socioeconomic inequality and stigma related to sexuality and gender expression can interfere with suffering recognition, diagnostic category definition and therapeutic conduct. These dynamics can result in barriers to health services, underdiagnosis or overdiagnosis and lower care effectiveness, especially among socially marginalized populations[6,7]. By considering multiple identity dimensions, the intersectional approach allows for a more comprehensive understanding of how these social markers interact and modulate the mental suffering experience[8].

Evidence indicates that negro women, transgender people and individuals in greater socioeconomic vulnerability face additional difficulties to obtain adequate clinical assessment and timely access to mental health services[9,10]. In addition, social exclusion processes and structural inequalities can influence both the symptom manifestation and the way these signs are interpreted in health services[11].

Therefore, understanding mental health diagnosis from an intersectional perspective makes it possible to question the strictly biomedical approach limits and recognize how psychological suffering is crossed by historical, social and cultural dimensions[1,6,8,12]. In this context, the following questions emerge from this research: how do the multiple dimensions of social identity influence mental disorder diagnosis?

And, how can this understanding contribute to qualify the clinical practice, strengthen mental health services and guide public policies that are aimed at promoting equity in health?

To answer these questions, this study aimed to carry out a systematic literature review, with narrative synthesis and reflexive analysis, in order to identify and analyze how intersectionality impacts mental disorder diagnosis, while highlighting challenges faced by socially marginalized groups and discussing implications for mental health care organization.

METHODS

It is a systematic literature review, with narrative synthesis and reflective analysis, carried out according to the recommendations of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA)[13]. The formulation of the research question was guided by the PEO (Population, Exposure, Outcome) strategy, defined as follows: P = socially marginalized populations with mental suffering; E = intersectionality as a social determinant; O = implications in mental disorder diagnosis.

Eligibility criteria

Peer-reviewed studies were included, which explicitly addressed the relationship between intersectionality and mental disorder diagnosis; which discussed clinical, social, or care access implications arising from that relationship; which presented empirical, qualitative, quantitative or mixed data, or systematic reviews with critical analysis of the diagnostic practice; and full text available in Portuguese, English, or Spanish, and published from 2000 to 2024.

Editorials, letters to the editor, comments, reviews and purely theoretical essays without empirical basis were excluded, as well as studies that did not directly addressed intersectionality in mental health diagnosis, publications without access to the full text and duplicate records identified in the screening step.

Information resources

The bibliographic search was carried out in the PubMed, SciELO and Virtual Health Library (VHL) databases. Additionally, manual screening of the reference lists with the included studies was carried out in order to identify potentially relevant publications not retrieved in the initial search.

Publications from January 2000 to December 2024 were considered, and the last search was carried out in December 2024. No records of clinical trials were consulted, since the review focus concentrated on observational, qualitative, conceptual studies and systematic reviews about the relationship between intersectionality and mental health diagnosis.

Search strategy

The search strategy was developed based on DeCS/MeSH controlled descriptors and keywords related to the concepts of intersectionality, social inequality, mental health and diagnosis. The terms were combined by Boolean operators, generally using the following structure: ("Intersectionality" OR "Social Inequality" OR "Marginalization") AND ("Mental Disorders" OR "Mental Health") AND ("Diagnosis"). On the SciELO and VHL bases, the strategy was adapted for Portuguese and Spanish, with equivalent combinations, namely: ("interseccionalidade" OR "desigualdade social" OR "marginalização") AND ("transtornos mentais" OR "saúde mental") AND ("diagnóstico").

When available, filters were applied for publication period and document type. The complete search strategies can be presented in supplementary material, as recommended by the PRISMA[13].

Study selection process

The selection process was carried out in three stages. Initially, the retrieved references were exported to Rayyan software, which was used for organizing and sorting records. In the first step, duplicates were identified and removed. Then, the screening was carried out by title and abstract. Finally, the potentially eligible studies were submitted for full reading, with a final decision for inclusion or exclusion.

The selection was conducted independently by two reviewers, blindly to each other's initial decisions. In situations of disagreement, a third reviewer was consulted for consensus. Rayyan was used exclusively as a tool to support the organization and tracking of the screening stages.

Data extraction process

The data extraction was carried out independently by two reviewers, using a standardized form that was developed for this study. The following variables were collected: author and year of publication, country, methodological design, population or contemplated social identities, analyzed intersectional markers, care context, main findings related to mental disorder diagnosis and implications for clinical practice, health services and public policies.

In cases of ambiguous or incomplete information, the data were discussed between the reviewers until consensus was reached. There was no contact with the authors of the original studies to supplement information.

Methodological quality assessment

The methodological quality of the included studies was assessed with instruments from the Joanna Briggs Institute (JBI), which were selected

according to the design of each study[14,15]. Specific instruments were used for qualitative and quantitative studies, systematic reviews, experience reports and conceptual tests.

The assessment was conducted by two independent reviewers, considering criteria such as clarity of objectives, theoretical coherence, methodological adequacy, analytical transparency and result consistency. The studies were classified as high or moderate quality. Studies with low methodological rigor were excluded from the final synthesis.

Data synthesis

Due to design heterogeneity, the studied populations, the care contexts and the used diagnostic instruments, it was not possible to perform a meta-analysis. Thus, a narrative synthesis of the findings was chosen.

Initially, the included studies were organized into descriptive matrices, allowing for the comparison of methodological and contextual characteristics. Then, the results were grouped into thematic axes: intersectional marker influence in the diagnosis production; stigma, implicit prejudices and discriminatory practices in mental health services; formative gaps and limitations in hegemonic diagnostic models; and implications for public policies and the mental health care organization.

This review was registered on PROSPERO, under the number ID 1066008, with a view to transparency and traceability of the adopted methodological protocol.

RESULTS

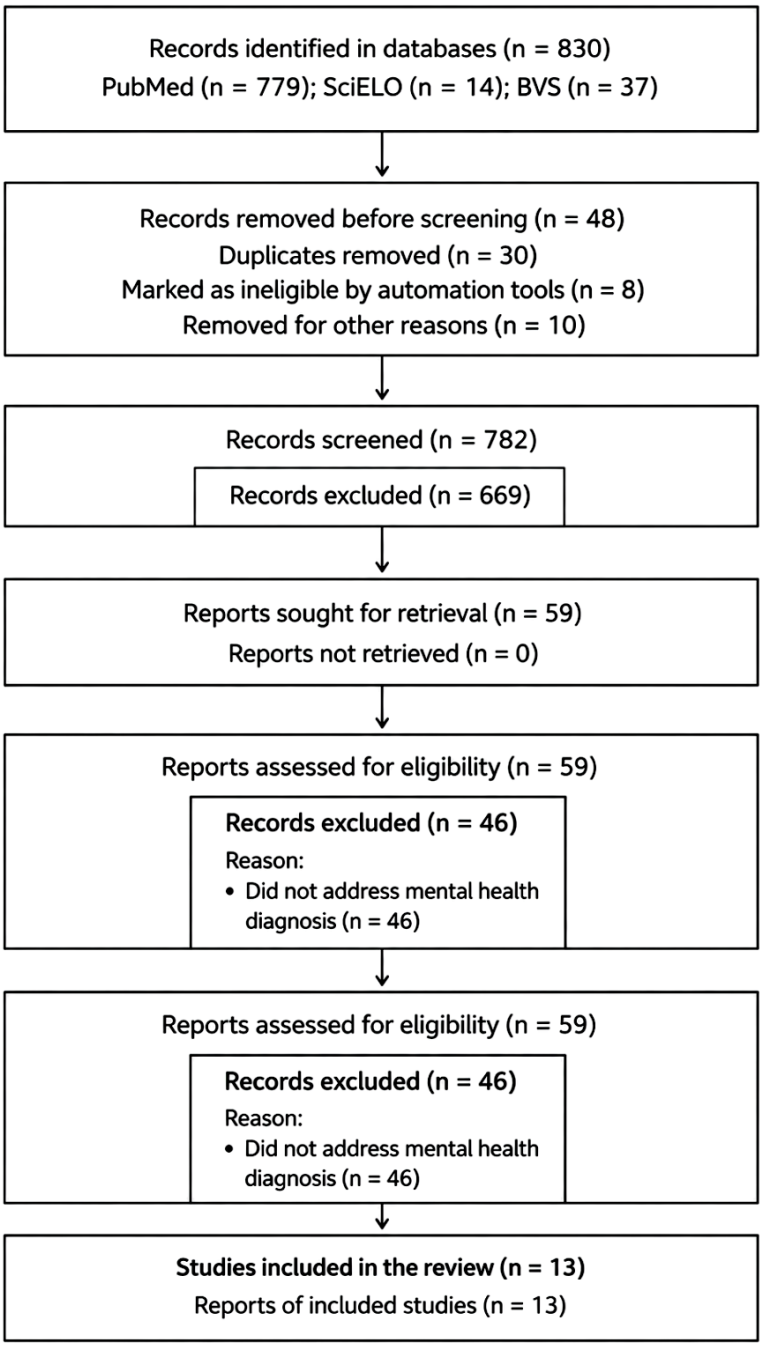
A search in the databases identified 830 potentially relevant records, from which 779 came from PubMed, 37 were from the Virtual Health Library (VHL) and 14 were found on SciELO. Before the screening step, 30 duplicate records were removed, plus 8 records were identified as ineligible by automation tools and 10 records excluded for other reasons, resulting in 728 records eligible for the title screening step.

In the initial screening, 236 studies were excluded after title reading, and 546 records for abstract analysis were left. After this phase, 487 studies were excluded, but 59 articles for full reading remained.

During the eligibility phase, 46 studies were excluded because they did not directly address the relationship between intersectionality and mental health diagnosis, resulting in 13 studies included in the final synthesis in this review.

The complete identification process, screening, eligibility and inclusion of studies are presented in the PRISMA flow chart (Figure 1)[13].

Figure 1 – PRISMA 2020 flow chart for the identification process, screening, eligibility and inclusion of studies in the systematic review.



Source: prepared by the authors.

Characteristics of the included studies

Chart 1 presents the synthesis of the studies that were included in the review, as well as author and year of publication, country where the study was carried out, methodological design, population or social identities analyzed and main findings related to the influence of intersectionality in mental health diagnosis.

The selected studies were conducted in different geographic contexts, including Brazil, the United States, Germany and Australia, highlighting the international relevance of the debate on intersectionality and inequalities in mental health diagnosis.

In relation to the methodological designs, a diversity of approaches was observed, including qualitative and quantitative studies, systematic reviews, theoretical essays, experience reports, and public policy analyses.

The investigated populations included negro women, young LGBTQIA+ people, individuals in socioeconomic vulnerability, mental health professionals and students in the health area, as well as other socially vulnerable groups in different sociocultural contexts.

In general, the studies showed that social markers such as race, gender, class, territory and sexuality influence mental suffering recognition, diagnostic accuracy and health service access, often resulting in inequalities in mental health care.

Chart 1 – Article distribution in the final sample.

Author/Year	Country	Study Design	Population/ Social identity	Main findings
Giacomini & Rizzotto (2022)	Brazil	Theoretical-reflective study	Mental health professionals and users	Diagnosis reflects symbolic disputes and disregards cultural pluralities.
Ream (2024)	USA	Theoretical-analytical study	Young LGBTQIA+ people	Minority stress and intersectionality intensify inequalities.
Amorim et al. (2021)	Brazil	Qualitative study	Negro women and racialized groups	Racism and sexism interact and influence diagnosis.
Paula (2024)	Brazil	Theoretical essay	Different social groups	Intersectionality as a tool for understanding inequalities.
Anyigbo et al. (2024)	USA	Qualitative study	Racial and social minorities	Implicit biases affect diagnosis and access to care.
Pereira et al. (2022)	Brazil	Experience report	Medicine students	Stigma in teaching affects mental distress understanding.
Vieira & Delgado (2021)	Brazil	Field study	APS doctors	Formative gaps perpetuate stigma and diagnostic exclusions.
Maldonado et al. (2023)	Brazil	Systematic review	Health professionals and family	Courtesy stigma reinforces exclusionary perceptions.
Brown et al. (2022)	USA	Conceptual essay	Vulnerable populations	Intersectional model in genomics and psychiatry.
Oliveira et al. (2020)	Brazil	Qualitative study	Young men in urban poverty	Gender, class and territory mold care and suffering.

Faissner et al. (2024)	Germany	Qualitative study	Mental health professionals	Discriminatory practices make diagnosis and inclusion difficult.
Filia et al. (2022)	Australia	Quantitative study	Vulnerable young people	Unequal access to services and diverse outcomes.
Paes-Sousa (2025)	Brazil	Public policy essay	Vulnerable populations	Need for inclusive and intersectoral policies.
Barbo (2024)	USA	Theoretical-evaluative analysis	Children with a refuge history	Intersectionality theory highlights structural and cultural barriers in mental health service access.

Source: prepared by the authors.

Methodological quality assessment

Chart 2 presents the methodological quality critical assessment of the included studies, based on the instruments by the Joanna Briggs Institute (JBI)[14,15].

In general, the qualitative and conceptual studies, and systematic reviews presented high methodological rigor, evidenced by the coherence among objectives, methodological procedures and analysis of results. On the other hand, theoretical studies and experience reports were predominantly classified as moderate quality, due to the absence of empirical data or limitations in the description of analytical procedures.

Despite the methodological differences, all the included studies contributed to understand the relationship among intersectionality, social inequalities and mental health diagnosis, allowing to identify recurring patterns related to diagnostic bias, institutional stigmas and educational gaps.

Chart 2 - Methodological rigor assessment of the included studies according to the criteria by the Joanna Briggs Institute (JBI).

Author/Year	JBI Applied Instrument	Quality Classification	Comments on methodological rigor
Giacomini & Rizzotto (2022)	JBI – Theoretical/ Reflective Studies	Moderate (🟨)	Good theoretical basis, but no empirical data collection.
Ream (2024)	JBI – Conceptual Studies	High (🟩)	Consistent analysis and clear alignment with the research goals.
Amorim et al. (2021)	JBI - Qualitative Studies	High (🟩)	Adequate description of the participants and robust analysis.
Paula (2024)	JBI - Theoretical Studies / Policies	Moderate (🟨)	Relevant analytical contribution, but limited to theoretical propositions.

Anyigbo et al. (2024)	JBI - Qualitative Studies	High (🟩)	Well-described method and interpretative triangulation.
Pereira et al. (2022)	JBI - Reports/Experiences	Moderate (🟨)	Important practical application, but with potential institutional bias.
Vieira & Delgado (2021)	JBI – Field Study	Moderate (🟨)	Limited description of the observed diagnostic process.
Maldonado et al. (2023)	JBI - Systematic Reviews	High (🟩)	Good systemization and critical analysis of the courtesy stigma.
Brown et al. (2022)	JBI - Conceptual Essays	High (🟩)	Innovative approach with a strong interdisciplinary basis.
Oliveira et al. (2020)	JBI - Qualitative Studies	Moderate (🟨)	Sample limitations and finding generalization.
Faissner et al. (2024)	JBI - Qualitative Studies	High (🟩)	In-depth discussion about discriminatory practices.
Filia et al. (2022)	JBI - Quantitative Studies	High (🟩)	Appropriate sample and statistical consistency.
Paes-Sousa (2025)	JBI – Public Policies/ Essay	Moderate (🟨)	High social relevance, but lack of direct empirical validation.
Barbo (2024)	JBI - Theoretical and Evaluative Studies	High (🟩)	Rigorous application of intersectional theory for mental health access analysis; consistency among objectives and theoretical discussion.

Source: prepared by the authors.

DISCUSSION

The results of this review indicate that mental health diagnosis is not a neutral or strictly objective practice, but crossed by social and structural dynamics that influence both mental suffering recognition as well as the way professionals interpret the symptoms presented by the individuals. Studies included in this review show that psychiatric diagnosis can reflect symbolic and normative disputes present in contemporary societies, which often make cultural pluralities and distinct social trajectories not visible[16].

In this context, intersectionality emerges as a relevant analytical tool to understand how different social markers such as race, gender, social class and sexuality are articulated in the production of mental health inequalities. Evidence indicates that the intersection between racism and sexism, for example, may influence clinical interpretation of behaviors and emotions, contributing to distorted or disproportionate diagnosis in certain population groups, especially among negro women[17].

Similar results have been observed in international contexts. LGBTQIA+ youth often experience psychological distress associated with so-called minority stress, stemming from ongoing processes of stigmatization and social discrimination. This context can influence both symptom manifestation and clinical interpretation, affecting mental health care[18] access and quality.

Similarly, studies conducted in urban poor scenarios indicate that gender, social class and territory have a significant influence on mental illness experiences and health service access[19].

Another relevant aspect that was identified in the literature refers to the presence of implicit prejudice in the diagnostic process. Even in health-care systems that have formal policies of equity, implicit biases can influence clinical decisions which result in more superficial or less sensitive assessment to cultural specificities of certain social groups[20]. In this sense, discriminatory practices can contribute to the underdiagnosis or overdiagnosis of certain disorders, reproducing structural inequalities in mental health care[21].

Moreover, the literature points out that professional background gaps also play an important role in this process. Studies indicate that students and health professionals may internalize stigma and negative social representations about certain population groups throughout their education, a phenomenon often associated with the so-called hidden curriculum[22]. These background gaps may compromise professionals' ability to recognize and adequately interpret mental suffering manifestation in diverse sociocultural contexts[23].

In the public health area, such evidence reinforces the need to expand approaches that integrate health social determinants to mental health diagnostic processes. Traditional biomedical models often treat social factors only as contextual elements, without considering their structural dimension in the production of mental suffering[24]. Incorporating the intersectional perspective can contribute to a more comprehensive understanding of health inequalities and to the development of diagnostic practices that are more sensitive to the multiple dimensions of human experience[25].

In the Brazilian context, the discussion assumes special relevance within the framework of the Unified Health System (SUS), which is based on the universality, comprehensiveness and equity principles. The integration of an intersectional approach in mental health care practices can contribute to strengthen the performance of the Psychosocial Care Network (RAPS) teams, expanding the capacity of services to recognize and respond to the multiple forms of social vulnerability that go through the experience of mental suffering[26].

From the point of view of public policies, the findings, in this review, also indicate the need for intersectoral strategies aimed at reducing social inequalities in mental health. The promotion of public policies that are sensitive to the dimensions of race, gender, class and territory can contribute to reduce barriers to services and to qualify the care offered to the population[27].

Despite the contributions that were identified in the literature, important gaps remain in scientific production about intersectionality practical operationalization in clinical contexts and health services. Many studies still address social markers in isolation, without fully considering the interactions between different social inequality dimensions. Thus, future research should seek to deepen empirical investigations that explore in an integrated way the multiple identity dimensions and their impacts on mental health diagnostic process.

CONCLUSION

The findings in this systematic review show that mental health diagnostic process goes through social determinants that influence the psychological distress manifestation and its clinical interpretation. The analysis of the included studies demonstrated that social markers such as race, gender, social class, sexuality and territory can interfere in symptom identification, diagnostic formulation and care access, contributing to the production and reproduction of mental health inequalities.

In this perspective, the intersectional approach proved to be a relevant analytical tool to understand how different social inequality manners are articulated in inequity production in the mental health field. Proving that discrimination experiences, socioeconomic vulnerability and social exclusion can influence the recognition and interpretation of mental suffering, the perspective broadens the understanding of diagnostic processes and favors care practices that are more sensitive to different sociocultural realities.

In public health, the results of this review reinforce the importance of integrating the perspective of social determinants into mental health diagnosis and care practices. In the Brazilian context, this integration can contribute to strengthen the service performance by the Unified Health System, especially in the Psychosocial Care Network, favoring approaches that are more sensitive to the social inequalities that cross territories and different population groups.

In addition, the findings point to the need for advances in health professional background, with greater articulation between clinical knowledge and critical approaches that consider the social, cultural and political dimensions in the health-disease process. The intersectional perspective incorporation in the background process can contribute to reduce diagnostic biases and promote professional practices more aligned with the principles of equity, integrality and social justice in mental health care.

Finally, it is important to promote the research production that investigates intersectionality operationalization in mental health services, especially in Latin American contexts. The deepening of these investigations could contribute to care strategy development and public policies which are more sensitive to structural inequalities, which strengthen mental health practices that are committed to foster equity in health.

Studies conducted in the Brazilian context indicate that mental health diagnosis and care are strongly related to social conditions and health service organization. Evidence from Primary Care and Psychosocial Care Centers shows a high presence of socioeconomic vulnerabilities among users, as well as difficulties in the diagnostic definition and continuity of treatment[28,29]. These findings reinforce that mental health diagnostic process is crossed by social and institutional factors, highlighting the importance of approaches that are sensitive to organization in the Psychosocial Care Network and care practices.

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Conceptualization: DJB, AMSG; **Methodology:** DJB, MPG, AMSG; **Investigation:** DJB, SRZ; **Data curation:** DJB, SRZ; **Formal analysis:** MPG; **Supervision:** AMSG; **Validation:** MPG, SRZ, AMSG; **Writing – review and editing:** DJB, MPG, SRZ, AMSG.

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Conflict of Interest

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