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Structural and Sociocultural Determinants Barriers to Digital Mental Health Care in Qatar: A Qualitative Study of Provider Perspectives

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Abstract

Background

Despite substantial investment in mental health system development, equitable access to services remains uneven globally and within high income contexts. In Qatar, rapid health sector modernization has expanded service capacity and tele mental health care (TMHC), yet sociocultural stigma, institutional processes, and structural determinants may continue to shape disparities in access.

Objective

This study examines mental health professionals' perceptions of sociocultural, structural, and institutional barriers to care in Qatar and explores the equity implications of TMHC implementation.

Methods

A qualitative descriptive design was employed. Twenty-eight licensed mental health professionals representing psychiatry, psychology, social work, nursing, and medicine were recruited through purposive and snowball sampling. Semi structured interviews were conducted with 28 mental health providers. Data were analyzed using Braun and Clarke's reflexive thematic analysis within a structural health equity framework informed by stigma theory and intersectionality.

Results

Stigma operated across structural, institutional, interpersonal, and psychological domains influencing help seeking. Participants identified workforce shortages, centralized service organization, linguistic hierarchies, insurance limitations, and documentation fears as structural determinants shaping unequal access. Institutional processes, including confidentiality concerns and referral bottlenecks, were perceived to increase risk in seeking care. Interpersonal dynamics, particularly family mediated decision making and reputational concerns, situated help seeking within kinship and community networks, while internalized stigma contributed to delayed engagement. TMHC was viewed as potentially reducing visibility related stigma and geographic barriers; however, concerns were raised regarding digital literacy, privacy, infrastructure capacity, and the risk that digital expansion could reproduce socioeconomic and gender inequities.

Conclusions

Mental health inequities in Qatar reflect interactions between sociocultural norms, governance structures, service organization, and digital transformation. Expanding service availability alone is

unlikely to ensure equitable access. Policy responses must prioritize culturally responsive stigma reduction, equitable workforce and language capacity, and integration of mental health services within community and primary care settings. In addition, digital mental health initiatives require explicit equity safeguards, including attention to digital literacy, accessibility, and accountability mechanisms. Without such measures, tele-mental health expansion risks reproducing existing social and structural disparities rather than functioning as a tool for equitable mental health system reform.

Background

Access to mental health care remains a major global equity challenge. The World Health Organization (WHO) estimates that nearly one billion people worldwide live with a mental disorder, yet the majority do not receive adequate treatment, with treatment gaps exceeding 70% in many countries [1]. Consistent with these treatment gaps, nearly half of the global population lives in countries with fewer than one psychiatrist per 200,000 people, and access to essential psychotropic medicines remains limited in many settings [2]. These disparities are shaped by structural determinants, including income inequality, labor market stratification, migration status, and gender norms, which generate systematic differences in exposure, access to care, and health outcomes [3, 4]. Such inequities are not confined to low- and middle-income countries; high income countries also demonstrate uneven distribution of services across socioeconomic, gender, and migrant populations [3, 4].

Within Qatar, expanding equitable access to mental health services has become both a public health and policy priority. National reforms, including the National Health Strategy 2024–2030, emphasize community-based care and the integration of mental health services within primary health systems [5]. Ongoing national mental health initiatives and service expansion within Hamad Medical Corporation and the Primary Health Care Corporation have further increased service availability and strengthened the integration of mental health care within primary care settings [5]. Despite these developments, systemic barriers and cultural stigma continue to constrain service accessibility and effectiveness. Stigma operates not only at the interpersonal level but also through institutional practices and service design, shaping help-seeking behavior and contributing to unequal patterns of utilization [6–8].

These challenges are not unique to Qatar but reflect broader patterns observed across the Middle East and North Africa (MENA) region. Mental health systems in the region face persistent challenges related to workforce shortages, centralized service delivery, and sociocultural stigma surrounding mental illness [9–11]. Studies across the region indicate that concerns about family reputation, gender norms, and social labeling frequently influence help-seeking behavior and delay engagement with formal mental health services. These sociocultural dynamics intersect with structural conditions, including migration patterns and uneven distribution of health resources, which shape access to care in many Gulf countries.

In Gulf states, concerns about reputational harm, confidentiality breaches, and potential documentation consequences can disproportionately affect women and migrant populations, reinforcing patterned inequities in mental health service utilization [12, 13]. These dynamics highlight how sociocultural

expectations and institutional practices can interact to influence patterns of help-seeking across the region.

Persistent structural and sociocultural barriers have prompted increasing interest in alternative service delivery models that may expand access to mental health care. Within this context, tele mental health care (TMHC) has emerged as a strategy to address geographic and logistical barriers. Evidence from multiple contexts indicates that TMHC can improve service reach and continuity of care, particularly during public health emergencies such as the COVID 19 pandemic [14–16]. By enabling remote consultation and reducing the visibility associated with attending mental health facilities, digital modalities may also mitigate some stigma related barriers to help seeking. However, digital solutions do not automatically resolve inequities in access. Variations in digital literacy, privacy concerns, gendered mobility, and access to technology can reproduce or intensify existing disparities in mental health care utilization [17, 18]. In Qatar and the wider Gulf region, telepsychiatry has expanded as part of national digital health initiatives, yet its implications for equitable access to mental health services remain insufficiently examined [19, 20].

Accordingly, this study examines mental health professionals' perceptions of sociocultural, structural, and policy-level barriers to mental health care in Qatar and explores how TMHC may either reduce or reproduce inequities in access to services.

Determinants of access to mental health care

Mental disorders remain among the leading contributors to global disability, with depressive and anxiety disorders accounting for substantial years lived with disability and showing little reduction since 1990 [21]. The World Mental Health Report underscores that large treatment gaps persist across income settings, reflecting enduring inequities in access to care [1]. These disparities are not randomly distributed; patterns of exposure, service utilization, and treatment continuity vary systematically by gender, age, migration status, and socioeconomic position [3, 4].

In Qatar, epidemiological data indicate substantial mental health burden. Findings from the WHO World Mental Health Qatar Survey show that approximately one in four adults meets criteria for at least one lifetime mental disorder [22, 23]. Treatment delays are considerable, with only a minority seeking care within the first year of symptom onset and average delays exceeding five years [22]. Earlier population-based studies similarly reported prevalence rates exceeding 36.6%, with depression and anxiety among the most common conditions [24, 25]. Together, these findings highlight both significant burden and gaps in timely engagement with care.

Service organization further shapes access. Although reforms have aimed to integrate mental health into primary care, services in Qatar remain predominantly hospital based, with limited community and outpatient infrastructure [6, 26]. Globally, service coverage for mental disorders remains below one third of estimated need, and workforce shortages constrain system capacity [2, 27]. Centralization of services

and uneven workforce distribution contribute to spatial and social inequities, disproportionately affecting migrant populations and those residing outside major urban centers [3, 4].

Stigma operates as a cross-cutting determinant of access. Cultural and religious interpretations may frame mental illness as a moral or spiritual failing, reinforcing public stigma [9, 10]. Individuals may internalize these narratives, resulting in self-stigma and delayed help seeking [8, 28]. Structural stigma is reflected in institutional practices, confidentiality concerns, and limited culturally responsive services [7, 29]. Gendered expectations intensify these dynamics: women often face heightened concerns regarding reputation and marriageability [12, 30], while men may delay care due to norms surrounding masculinity and emotional restraint [31]. Across Arab and Muslim majority contexts, the intersection of gender, culture, and broader systems of marginalization shapes differentiated patterns of service engagement [10, 11, 32, 33].

In response to persistent barriers, TMHC has gained attention as a mechanism to expand reach and continuity of services. Evidence suggests that digital modalities can reduce geographic constraints and offer greater privacy for individuals concerned about stigma [15, 16, 34]. In the Gulf region, telepsychiatry has been incorporated into national digital health strategies and primary care reforms [19, 20]. However, digital innovation does not inherently resolve inequity. Differences in socioeconomic status, device access, digital literacy, and gender control over resources may reproduce existing disparities [17, 18, 35]. Moreover, while TMHC may reduce visibility related stigma, it does not independently address deeper cultural anxieties or structural inefficiencies within service systems [11, 37].

Collectively, the literature demonstrates that mental health inequities in Qatar emerge from the interaction of epidemiological burden, service organization, stigma, gendered norms, and digital transformation. Yet existing research has largely focused on patient level experiences and utilization patterns [22–25]. Less attention has been directed toward mental health professionals' perspectives on how sociocultural and institutional dynamics shape equitable access, a gap this study seeks to address.

Theoretical Framework

This study is grounded in a structural health equity framework that conceptualizes unequal access to mental health care as the product of interacting systems of power, institutional organization, and socially patterned stigma. Guided by a structural health equity lens, this study conceptualizes access as the product of interacting macro, institutional, and sociocultural determinants (Fig. 1).

Consistent with health equity scholarship, health and health care are understood as socially distributed goods shaped by policy environments, resource allocation, labor structures, and social hierarchies rather than individual choice alone [3, 38]. Within this framework, inequities in mental health access reflect structural gradients that systematically advantage or disadvantage population groups across gender, migration status, and socioeconomic position [4, 39].

Stigma is conceptualized as a central mechanism through which these gradients are reproduced. Drawing on Goffman's sociological theory, stigma is understood as a socially constructed process that produces "spoiled identities" and legitimizes exclusion from full social participation [40]. Corrigan's model further differentiates public stigma from self-stigma and identifies the "why try" effect, whereby internalized stigma reduces self-efficacy and discourages help-seeking behavior [28, 41]. From a health equity perspective, stigma operates not only at interpersonal or psychological levels but also as a structural force embedded in institutional policies, documentation practices, confidentiality norms, and service design [7]. It therefore functions as a pathway linking social stratification to unequal service utilization and outcomes [6, 8].

Intersectionality extends this analysis by demonstrating that stigma and structural disadvantage operate through overlapping and mutually reinforcing identities [32, 33]. In Qatar and the wider Gulf region, gender norms, migration governance systems, and reputational economies interact to shape differentiated risks and constraints in mental health disclosure and care-seeking behavior [9, 11, 12]. Inequitable access is therefore understood as the cumulative effect of layered vulnerabilities rather than isolated barriers [9, 30].

Tele mental health care (TMHC) is examined within this structural health equity lens. Digital platforms are conceptualized as socially embedded interventions whose distributive consequences depend on preexisting power relations and material conditions. While TMHC may reduce geographic barriers and visibility-related stigma, its equity impact remains contingent upon digital literacy, device access, privacy protections, labor regulations, and institutional trust [17, 18, 35]. Digital health equity research cautions that technological innovation can simultaneously expand access for privileged groups while deepening exclusion among populations experiencing socioeconomic or digital marginalization [34, 42].

By integrating sociological stigma theory, psychological stigma processes, intersectionality, and structural health equity scholarship, this framework enables a multilevel analysis of how policy reforms and digital transformation interact with sociocultural hierarchies to shape patterned access to mental health services in Qatar.

Figure 1 presents the multilevel conceptual framework guiding this study. The model illustrates how structural determinants, including governance, migration systems, and digital infrastructure shape health system organization, which in turn interacts with sociocultural dynamics and stigma mechanisms to influence access to care. Digital mental health is positioned as a socially embedded intervention with both equity pathways and equity risks, depending on institutional safeguards and social conditions. The framework emphasizes that equitable access emerges from the interaction of macro-level policy environments, institutional practices, and socially patterned stigma rather than from digital expansion alone.

Methods

Aim, Design, and Setting

This study aimed to examine mental health providers' perceptions of sociocultural, structural, and institutional barriers to accessing mental health care in Qatar and to explore their views on the equity implications of implementing tele mental health care (TMHC). A qualitative descriptive design using semi structured interviews was employed to capture in depth, contextually grounded interpretations of stigma, service delivery constraints, and digital transformation within Qatar's mental health system.

The study was conducted in Qatar, a high-income Gulf country undergoing rapid health system modernization, including expansion of digital health services. Data were collected across diverse institutional settings, including public hospitals, private clinics, academic institutions, and governmental agencies involved in mental health service provision.

Participants and Sampling

A purposive sampling strategy was used to recruit 28 licensed mental health professionals. Participants included psychiatrists, psychologists, counselors, social workers, psychiatric nurses, and physicians. Eligibility criteria required a minimum of two years of clinical experience in Qatar and current involvement in mental health service delivery.

Sampling aimed to capture variation across gender, nationality, professional discipline, and institutional setting to reflect differential positions within the health system and varied exposure to service access barriers. Snowball sampling was used to ensure representation from underrepresented professional groups. Participation was voluntary, and no financial incentives were provided. Written and verbal informed consent was obtained prior to data collection.

Data Collection Procedures

Data were collected between November 2023 and May 2024 through semi structured interviews conducted either in person or via secure videoconferencing platforms, including Zoom and Google Meet, based on participant preference. Offering modality choice was intended to enhance accessibility and accommodate professional schedules.

Interviews ranged from 45 to 75 minutes in duration and were audio recorded with participants' informed consent. Interviews were conducted in Arabic or English according to participant preference. All recordings were transcribed verbatim. Arabic transcripts were translated into English by a certified professional translator when required. To ensure accuracy, translations were reviewed for conceptual equivalence prior to analysis. All transcripts were de identified and assigned unique codes to protect confidentiality.

A semi structured interview guide was developed to elicit mental health professionals' perceptions of sociocultural, structural, and policy level barriers to care, as well as institutional practices and the role of tele mental health care in shaping access. The guide was informed by the study's structural health equity framework and stigma theory. Example prompts included:

1. “How do mental health professionals perceive sociocultural, structural, and policy level barriers that shape access to mental health care in Qatar?”
2. “How do mental health professionals evaluate the potential and limitations of tele mental health in promoting equitable access to services in Qatar?”

Data Analysis

Data were analyzed using Braun and Clarke’s six phase reflexive thematic analysis [44]. The analytic process involved iterative familiarization with the data, generation of initial codes, development of candidate themes, systematic review and refinement of themes, and analytic reporting.

While coding was inductive in that themes were generated from participants’ narratives rather than imposed a priori, the analysis was theoretically sensitized by the study’s structural health equity framework. Equity constructs were operationalized during analysis by examining how participants described:

1. Structural determinants, including policy design, migration governance, workforce distribution, and insurance or documentation practices.
2. Institutional processes, such as service organization, confidentiality procedures, referral pathways, and digital infrastructure.
3. Interpersonal dynamics, including public stigma, professional practices, and relational norms.
4. Psychological mechanisms, particularly self-stigma, perceived risk, and the “why try” effect.

Themes were therefore constructed not only around perceived barriers but around patterned gradients in access, identifying which groups were described as systematically advantaged or disadvantaged and through what mechanisms. Special analytic attention was given to intersectional processes, examining how gender, migration status, and socioeconomic position interacted to shape differentiated access to services.

Three researchers independently engaged in close reading and initial coding of transcripts. The team then convened regularly to compare interpretations, interrogate positional assumptions, and refine themes through reflexive dialogue. Consistent with reflexive thematic methodology, analytic divergence was treated as productive rather than resolved through statistical inter rater reliability metrics [43,44]. This approach strengthened conceptual coherence while preserving depth of interpretation.

Member checking with a subset of participants was conducted to enhance interpretive credibility and ensure that thematic interpretations reflected professional realities within Qatar’s service system. Data were managed manually to maintain immersion and contextual sensitivity. Artificial intelligence tools were used exclusively for organizational and language editing support and did not contribute to coding, interpretation, or theme generation.

As this study employed qualitative methodology grounded in reflexive thematic analysis, statistical testing and power calculations were not applicable.

Ethical Considerations

Ethical approval was obtained from the Institutional Review Board affiliated with the first author (XX IRB 23 045). Participants received detailed information regarding study objectives, procedures, confidentiality protections, and voluntary participation. Written informed consent was obtained prior to interviews.

All identifying information was removed from transcripts. Participants are referenced only by gender and age to preserve anonymity. Digital data were stored on password protected devices accessible only to the research team.

Researcher Reflexivity

Consistent with reflexive thematic analysis [44] and the study's structural health equity framework, the research team engaged in continuous critical reflection throughout data collection and analysis. The team consisted of three researchers with backgrounds in mental health, social work, and regional scholarship. Two members were bilingual and familiar with Qatar's sociocultural and institutional context.

Reflexive practice focused on examining how professional training, disciplinary orientation, cultural positioning, and institutional affiliations might shape interpretations of stigma, structural determinants, and digital health equity. Attention was given to how researchers' familiarity with regional stigma narratives, healthcare governance, and migration systems could influence theme construction. Reflexive engagement occurred through analytic memos, team debriefings, and documented discussions during theme development. These processes enhanced theoretical coherence and ensured that interpretations remained grounded in participants' accounts while critically attentive to power, hierarchy, and structural gradients.

Sample Characteristics

The sample comprised 28 mental health professionals representing diverse disciplinary, demographic, and institutional backgrounds. Females represented 53.6 percent (n = 15) and males' 46.4 percent (n = 13). Participants ranged in age from 25 to 56 years and reported a mean of 11.86 years of professional experience (range = 2–30 years), reflecting early, mid, and senior career stages.

Nine participants were Qatari nationals (32.1 percent), while 67.9 percent (n = 19) reflected the internationally staffed composition of Qatar's healthcare workforce. Participants identified across Arab, South Asian, Caucasian, Slavic, and mixed ethnic backgrounds. Most held postgraduate qualifications, and 75 percent were married (n = 21).

Professionally, the sample included psychologists (39.3 percent, n = 11), psychiatrists (28.6 percent, n = 8), social workers (21.4 percent, n = 6), and other mental health providers (10.7 percent, n = 3). Participants were employed across public hospitals, private clinics, academic institutions, and government agencies.

The demographic, professional, and institutional diversity of the sample strengthened the study's capacity to examine how perspectives on stigma, service organization, and TMHC are shaped by gender, age, nationality, professional role, and organizational setting. This variation supported an intersectionality informed analysis of how structural positioning within Qatar's healthcare system may influence interpretations of equity and access.

Findings

Three interrelated themes emerged. Participants described access to mental health care in Qatar as shaped by interacting sociocultural beliefs, institutional conditions, and technological adaptations rather than by availability of services alone. The first theme highlighted how stigma, late diagnosis, workforce shortages, cultural interpretations of distress, and financial constraints converge to delay or constrain engagement with care. The second Theme illustrated the cumulative impact of stigma over time, including delayed treatment-seeking, concealment within family systems, deterioration in quality of life, and the reinforcement of social shame through cultural norms. The third theme examined tele-mental health as a modality that expands flexibility and reduces visibility-related barriers for some individuals, while simultaneously raising concerns related to confidentiality, digital readiness, clinical suitability, and therapeutic limitations.

Across all themes, providers portrayed mental health access as socially mediated and contextually conditioned, with stigma, service capacity, cultural meaning systems, affordability, and digital implementation interacting to shape uneven care trajectories.

Theme 1: The Convergence of Cultural Silence and Systemic Invisibility

This theme reflects how cultural narratives and institutional arrangements operate synergistically to suppress mental health discourse and delay engagement with care. Rather than treating stigma, late diagnosis, and service gaps as isolated barriers, participants described a mutually reinforcing system in which mental illness becomes simultaneously culturally unspeakable and administratively deprioritized.

Through a reflexive analytic lens, stigma was interpreted not solely as an individual attitude but as embedded within bureaucratic processes, workforce limitations, and culturally sanctioned moral frameworks. Providers' narratives revealed how moral beliefs, structural bottlenecks, and institutional opacity collectively produce embodied consequences—prolonged suffering, delayed treatment, and unequal access. Mental illness thus emerges within this context as both socially concealed and structurally underserved, shaping inequitable pathways to care in Qatar's mental health system.

Stigma

Participants described stigma as a deeply embedded sociocultural force shaping whether and when individuals engage with mental health services. Rather than a peripheral barrier, stigma was framed as foundational to access. As one provider noted, *"Two things, stigma and accessing the right services,"* positioning stigma as inseparable from care pathways. Shame was repeatedly cited as a primary deterrent. One participant observed that *"patients with psychiatric disorders come very late… they are ashamed,"* while another emphasized, *"The biggest challenge is stigma; we face it a lot."* These accounts suggest that delayed presentation is not incidental but socially patterned.

At the interpersonal level, stigma operated through community judgment and relational expectations; at the psychological level, it manifested as shame and internalized fear that discouraged help-seeking.

Fear of institutional documentation emerged as a distinct dimension of stigma. A participant reflected, *"…their reaction was like, no, it would be documented. People always fear that something will be documented against them for the rest of their lives."* This concern extended beyond interpersonal judgment to perceived long-term structural consequences related to employment, marriage, and social standing. Analytically, such fears signal mistrust in institutional systems and illustrate how stigma becomes intertwined with bureaucratic record-keeping and perceived permanence.

This dimension reflects the intersection of psychological mechanisms, such as perceived risk, with institutional processes, including documentation practices and data permanence.

Stigma also operated through community visibility and generational norms. One participant stated, *"They suffer from stigma, especially older people,"* pointing to entrenched expectations around silence. Avoidance of mental health facilities was described as deliberate risk management: *"They don't want anybody to see them near any mental health center."* Here, stigma operates through social surveillance, where proximity to services carries reputational implications and access is mediated not only by availability but by anticipated social cost. These accounts demonstrate how culturally embedded interpersonal norms regulate disclosure and generate patterned gradients in service engagement.

Family systems were central to the regulation of disclosure. Participants described concealment as protective rather than pathological. As one explained, *"Families start hiding cases of mental illness out of fear of societal judgment,"* while another added, *"Families hide mental health issues to protect marriage prospects."* These narratives illustrate that stigma is relational and collective, extending beyond individual identity to family honor and social positioning. Interpersonal expectations intersect with structural determinants, including marriage markets and employment prospects, reinforcing concealment and producing patterned inequities in access to care.

Providers further linked stigma to clinical deterioration. *"If they had sought help earlier, there would be less damage. All psychosocial aspects are impacted,"* one participant noted, underscoring how delayed care amplifies functional impairment. Reflexively, we interpret these accounts as evidence that stigma

operates as a structural determinant of unequal timing of access, shaping trajectories of illness and recovery.

Participants' narratives position stigma as embedded within cultural norms, family systems, and institutional processes. It regulates disclosure, delays engagement, and contributes to differential clinical outcomes, thereby reinforcing inequitable pathways to mental health care.

Late Diagnosis and Access Barriers

Late diagnosis emerged as a recurrent concern, reported by nearly half of participants (46.4%, n = 13), and was described as both culturally mediated and structurally produced. Providers emphasized that individuals often enter formal care only after substantial clinical deterioration. As one participant explained, *"Late presentations occur because they first seek traditional healers or faith healers,"* indicating that pluralistic help-seeking practices precede psychiatric engagement. These pathways were not framed simply as cultural preference but as reflecting distrust in formal services and perceived social risk associated with psychiatric care. It also highlight how interpersonal belief systems and psychological hesitancy intersect with structural mistrust in formal institutions to shape delayed engagement with care.

Structural constraints further intensified delays. Long waiting lists, appointment gaps, and limited-service capacity were described as routine barriers. One provider noted, *"It's not easy to get an appointment; long waitlists delay treatment,"* while another added, *"Government services are available, but the problem is with dates and appointments; it may take months between two appointments."* These accounts suggest that institutional bottlenecks compound stigma-related hesitation, transforming delayed help-seeking into prolonged, untreated illnesses. Such delays reflect referral pathways and workforce distribution operating as structural determinants of unequal timing of care.

Participants also highlighted how symptom severity itself interacts with access barriers. As one explained, *"For some disorders, especially serious ones, motivation to seek treatment online or offline is very low."* Diminished motivation and executive functioning were described as clinical features that further impede navigation of complex systems. This dynamic reflects psychological mechanisms intersecting with structural complexity to reinforce inequitable access.

Technology-mediated services were not consistently viewed as corrective. Although telehealth expanded its reach, participants noted that structural capacity constraints persisted. As one provider stated, *"There might be many services available, but… the appointment might be far in the future."* This suggests that digital platforms do not resolve workforce shortages or scheduling limitations, and structural and institutional determinants remain operative despite technological adaptation.

Overall, these narratives position late diagnosis as the product of intersecting cultural, institutional, and clinical factors rather than individual delay. Stigma initiates postponement, system inefficiencies sustain

it, and symptom severity entrenches it, producing uneven care trajectories and reinforcing inequitable access within Qatar's mental health system.

Lack of Resources and Qualified Professionals

Workforce shortages and limited-service capacity were identified as structural barriers by approximately one-third of participants (n = 10, 35.7%). Providers described a system that has expanded in visibility but remains insufficiently resourced relative to demand, resulting in delayed appointments, constrained treatment options, and fragmented follow-up. As one clinician explained, *"You search for an expert but cannot find qualified professionals,"* capturing how institutional capacity gaps undermine timely access even when individuals are willing to seek care, reflecting structural determinants such as workforce distribution and service centralization.

Concerns extended beyond numerical shortages to the scope and quality of services. Several providers criticized what they perceived as a predominantly biomedical orientation, with limited integration of psychosocial or rehabilitative supports. One participant noted, *"There is no proper attention given to psychiatric patients. All they offer them is medication, nothing else,"* highlighting dissatisfaction with medication-centered models absent comprehensive therapeutic or community-based care. Similarly, another provider emphasized the absence of coordinated multidisciplinary teams, stating, *"There is no complete specialized team for treating patients who need complete rehabilitation."* These accounts suggest that recovery pathways remain fragmented, particularly for individuals requiring sustained, integrated support, reflecting institutional processes such as service design and model orientation that shape differential quality and continuity of care.

Resource constraints were also linked to provider burden and service centralization, contributing to long wait times and reduced continuity of care. In parallel, sociocultural fears continued to shape utilization even where services existed. One clinician reflected that *"if one family member is diagnosed with a mental illness, it could lead to rumors affecting the chances of other family members in employment or marriage,"* illustrating how structural insufficiency and social stigma operate interactively rather than independently.

Overall, participants framed resource scarcity not as a peripheral limitation but as a systemic determinant of unequal access. Workforce shortages, centralized delivery models, and limited interdisciplinary integration were described as reinforcing disparities in timely, comprehensive, and culturally responsive care.

Cultural Beliefs and Misinterpretations

Cultural interpretations of mental illness were identified by 12 participants (42.9%) as shaping how distress is understood and whether formal care is pursued. Providers described explanatory models grounded in spiritual or supernatural beliefs that often precede, delay, or substitute psychiatric consultation. As one clinician explained, *"There is an idea that sometimes people are possessed by jinn,*

or people are not praying enough… and therefore, they have these symptoms that we call mental health-related symptoms." Such narratives illustrate how symptoms are moralized or spiritualized rather than medicalized, redirecting help-seeking toward religious pathways and reflecting interpersonal belief systems that shape psychological appraisal and mediate entry into institutional care.

Several participants emphasized the role of religious authorities in reinforcing these interpretations. One provider noted, *"People usually see religious sheikhs who always diagnose the case as magic, evil eye, demonic possession, and the like,"* reflecting pluralistic systems of care in which spiritual consultation may precede formal assessment. These frameworks were described as socially legitimate rather than marginal, complicating efforts to promote biomedical engagement.

Intergenerational dynamics further influenced recognition of mental illness. As one clinician observed, *"Parents don't advise their kids to seek mental health care… They consider this not an illness, but envy, or an evil eye, or bewitched."* Providers described how such beliefs shape labeling practices within households, affecting whether symptoms are validated, concealed, or reframed. Another participant remarked, *"Many of them don't even realize they have a problem… [they attribute] their issues to external factors, like supernatural forces, magic, or just bad luck."*

In more severe cases, psychotic symptoms were interpreted through spiritual lenses, with one provider noting, *"If people see someone experiencing delusions or hallucinations, they might think they are cursed."* Participants suggested that these interpretations may contribute to delayed referral, ritualized responses, or social distancing.

Overall, cultural explanatory models were described not as isolated misconceptions but as socially embedded systems of meaning that influence recognition, timing, and pathways to care, functioning as interpersonal and psychological mechanisms that shape whether formal institutional services are activated.

Financial Barriers

Financial constraints were identified by nine participants (32.1%) as a structural determinant of unequal access to mental health care. Affordability was described as operating through insurance design, market pricing, and resource allocation, while also shaping individual psychological calculations of feasibility. As one clinician noted, *"If you are talking about private service, they're faced with financial constraints because it's quite expensive,"* underscoring how economic capacity mediates access pathways.

Private-sector psychotherapy was frequently described as cost-prohibitive. One participant explained, *"Each therapy session is very expensive… around 500 or 600 Qatari Riyals per session,"* while another added, *"A psychotherapy session costs 500 Riyals… so, it depends."* These costs were described as particularly burdensome for individuals without comprehensive insurance coverage, creating disparities in continuity of care. Providers suggested that out-of-pocket payment structures and uneven insurance benefits lead to differential treatment trajectories by socioeconomic position.

Participants also linked affordability to broader system design. As one provider stated, *"Accessibility and availability of resources is a big issue, especially if private services are expensive,"* indicating that cost intersects with service centralization and limited public-sector capacity. Another clinician emphasized, *"The financial aspect is a significant obstacle because of the high cost of the sessions,"* noting that financial barriers may redirect individuals toward informal or religious alternatives perceived as less costly.

High fees were further attributed to workforce scarcity and private market dynamics. One provider observed, *"Costs are very high at private centers… and even those who work with us here in the center charge high rates,"* suggesting that specialist shortages may drive up service prices.

Collectively, participants framed affordability as a structural gatekeeping mechanism. Financial barriers were described as shaping not only initial access but also treatment frequency, modality, and continuity, thereby reinforcing inequitable mental health care trajectories across socioeconomic groups.

Theme 2: The Impact of Stigma

Beyond limiting initial access, stigma was described as shaping long-term social, relational, and functional trajectories. Providers framed stigma as a structuring force influencing the timing of care, family responses, and the progression of untreated conditions. Rather than an isolated attitudinal barrier, stigma was depicted as producing cumulative disadvantage across individual and collective domains. It operated at the interpersonal level through social judgment, at the psychological level through internalized shame and perceived risk, at the institutional level through documentation and service processes, and at the structural level through its consequences for employment, marriage, and social positioning.

Delays in Seeking Treatment

Participants consistently reported that stigma delays help-seeking, often resulting in more severe clinical presentations. Fear of visibility was central. As one provider stated, *"They don't want anybody to see them near any mental health center, delaying treatment or avoiding it entirely."* Older adults were described as particularly affected by reputational concerns, with a clinician noting, *"They suffer from stigma, especially older people*." These narratives reflect interpersonal dynamics of surveillance and reputational monitoring that regulate public help-seeking behavior.

Providers emphasized the compounding effects of delay. One participant explained, *"They are in denial. They don't seek help, they feel ashamed, and when these patients are delayed... they might gradually be unable to go to their job."* Another observed, *"Stigma… [leads to] relapse stages, and affects both the patient and those around him."* These accounts illustrate how postponed engagement contributes to functional decline, relapse, and increased treatment complexity. Psychological mechanisms, including denial, shame, and diminished self-efficacy, reinforced avoidance and deepened inequitable care trajectories over time.

Internalized stigma further reinforced avoidance. A provider reflected, *"The person fears that society will look at them as crazy. The person may even consider themselves as crazy."* Anticipated institutional consequences also played a role, with one clinician noting, *"They fear that something will be documented against them for the rest of their lives."* Together, these narratives indicate that social labeling and perceived structural repercussions shape delayed entry into care. Psychological self-stigma intersects with institutional documentation practices and structural fears related to employment and social mobility, illustrating multilevel determinants of delay.

Impact on Family and Social Dynamics

Stigma was described as relationally embedded, extending its effects beyond individuals to family systems. Concealment was frequently reported as a protective strategy. As one provider explained, *"It affects family support because if they are not open… it causes the burden of hiding the problem."* These accounts underscore how interpersonal norms within family systems regulate disclosure and shape collective decision-making regarding care.

Concerns about family honor and marriageability were recurrent. A participant noted, *"You should pray more and be very cautious… protect the family's good name and not reduce the marital chances of other siblings."* Another added, *"If a young man proposed to a girl and knew later that she would get mental treatment, he would break up with her."* Providers interpreted these dynamics as shaping disclosure practices and treatment decisions within households. Such narratives illustrate how structural determinants, including marriage markets and gendered social expectations, interact with interpersonal stigma to constrain help-seeking.

Stigma also limited mobilization of external support. One clinician observed that fear and ignorance *"prevent him from seeking psychiatric treatment and benefiting from the available services."* These patterns perpetuated collective silence and shared burden within families, reinforcing inequitable access trajectories, as interpersonal dynamics and psychological fear mechanisms sustained patterned inequalities in engagement with institutional services.

Impacts on Quality of Life

Participants described stigma-driven avoidance as progressively eroding quality of life. Untreated conditions were associated with occupational disruption, social withdrawal, and relational strain. As one provider stated, *"If they could have sought help earlier, there would be less damage… all psychosocial aspects are impacted."* Another emphasized the cyclical nature of deterioration: *"Stigma… [leads to] relapse stages and affects both the patient and those around him."* These descriptions link psychological avoidance and institutional delays to structural consequences, including labor instability and social marginalization.

Social isolation was commonly noted. One clinician reported, *"Many people refuse to attend appointments due to the stigma… they fear what people might say about them."* In more severe cases,

delayed care is intersected with broader marginalization. A provider recounted, *"Some of them are imprisoned… their family doesn't find it agreeable to seek a psychiatrist because they think it is a sort of lunatic."* These accounts illustrate how interpersonal labeling and institutional exposure can escalate into structural exclusion from social and legal systems.

Overall, stigma was described as generating layered disadvantage, affecting not only access but also social participation, economic stability, and institutional exposure. Providers framed these trajectories as evidence that stigma functions as a determinant of inequitable life outcomes rather than merely a barrier to service entry.

Cultural Norms and Social Shame

Most participants (n = 18, 64%) described stigma as sustained by broader cultural norms and moral expectations. Providers emphasized that stigma is embedded within shared beliefs about illness, recovery, and social reputation rather than confined to individual prejudice. As one clinician explained, *"For cultural and social reasons, there is an understanding that if someone is diagnosed with mental illness, they will never recover."* Such fatalistic assumptions were described as shaping expectations about prognosis and discouraging early engagement with care, reflecting interpersonal belief systems that influence psychological interpretations of illness and mediate entry into institutional pathways.

Supernatural explanatory models were frequently referenced as reinforcing these norms. One participant noted, *"If society labels them… most of them prefer to believe they have an evil eye, sorcery, and lack awareness,"* illustrating how spiritual attributions can reframe psychiatric symptoms and redirect help-seeking pathways. Providers interpreted these narratives as socially legitimate belief systems that influence recognition, labeling, and treatment timing.

Participants also described how mental health services themselves may be viewed with skepticism or shame. A clinician reflected, *"I feel there aren't many good, solid, well-trained, and qualified therapists that can address the issue of stigma at the beginning of treatment,"* pointing to concerns about service adequacy and trust. Such perceptions reinforced avoidance, particularly when combined with fears of social judgment. Institutional trust and perceived service quality operated alongside interpersonal norms to shape differential engagement with care.

Beyond supernatural beliefs, mental illness was frequently framed as weakness or moral failure. Providers suggested that limited mental health literacy, combined with entrenched reputational norms, sustains silence around psychological distress. Within this sociocultural context, stigma operated through everyday expectations tied to family honor, morality, and social belonging.

Collectively, these accounts position stigma as culturally reproduced across social contexts, shaping differential recognition, disclosure, and engagement with services. Operating simultaneously at psychological, interpersonal, institutional, and structural levels, stigma reinforced patterned inequities in both access and long-term life trajectories.

Theme 3: Perspectives on the Use of Technology in Mental Health Services

Participants described digital mental health platforms as reshaping access, stigma management, and patient engagement while introducing new equity considerations. Technology was framed not merely as a technical adaptation but as a structural modifier of when, where, and under what conditions care is accessed. Providers emphasized that digital delivery may both mitigate and reproduce disparities depending on institutional safeguards, digital readiness, and sociocultural context. Across accounts, tele-mental health was understood as interacting with structural determinants such as digital access and socioeconomic resources, institutional processes including confidentiality and service design, interpersonal dynamics related to visibility and stigma, and psychological mechanisms such as perceived safety and autonomy.

Enhanced Accessibility and Flexibility

Most participants (n = 17, 60.7%) reported that tele-mental health expanded accessibility and flexibility. The COVID-19 pandemic was described as accelerating the integration of remote care. As one provider reflected, *"We saw many patients during that time using telehealth and telemedicine… we are still using phone calls to follow up with patients who do not turn up,"* indicating sustained incorporation into routine practice.

Telemedicine was described as reducing logistical and psychological barriers. A clinician noted, *"Telemedicine and telepsychiatry… have made it easier for patients to access services,"* while another added, *"Technology simplifies access… especially for those with social anxiety or those who cannot easily visit a treatment place."* Remote services were also perceived as accommodating work and caregiving responsibilities. One provider explained, *"Remote services offer flexibility in time for people who have morning commitments."* These accounts reflect institutional process adaptations, including remote follow-up and flexible scheduling and altered traditional referral and attendance pathways. At the psychological level, increased convenience and reduced exposure lowered perceived barriers to engagement.

However, participants noted that accessibility gains depend on digital literacy, reliable connectivity, and comfort with remote communication. Although technology was viewed as potentially democratizing, its equity impact was uneven across population groups. Structural determinants, including socioeconomic status, device ownership, and digital readiness, conditioned who benefited from technological expansion.

Reduction of Social Stigma

Half of the participants (n = 14, 50%) emphasized that digital platforms reduce stigma related to visibility. Providers highlighted anonymity and discretion as central advantages. As one clinician stated, *"Technology would help with stigma because it, to some extent, ensures anonymity."* Another observed,

"A lot of patients who don't want to come to the psychiatric hospital because of the stigma are now with us, following us over the phone."

Helplines and remote consultations were described as lowering exposure risk. One provider noted, *"Using a helpline has allowed patients to seek help without fear of their information being leaked."* Another added, *"Telemedicine made mental health services more accessible and normal in people's eyes; it removed some of the fear."* These narratives illustrate how digital platforms modify interpersonal dynamics by reducing public visibility and anticipated social surveillance, thereby influencing psychological perceptions of safety.

At the same time, participants emphasized that technology primarily addresses visibility, not underlying cultural narratives. Deep-seated beliefs about mental illness were described as persisting beyond digital adaptation. This distinction suggests that while institutional modalities can reduce surface-level stigma exposure, deeper structural and interpersonal norms remain operative.

Confidentiality and Privacy Concerns

Twelve participants (42.9%) raised concerns about privacy and data security. Trust in digital systems was described as central to equitable implementation. One provider stated, *"We need to ensure… confidentiality and privacy to prevent violations,"* while another emphasized, *"There must be high confidentiality and privacy, or people will not trust online services."* These concerns directly reference institutional processes, particularly data protection practices, regulatory safeguards, and system governance.

Fears of data breaches and unauthorized sharing were recurrent. As one clinician noted, *"Patients are afraid that their information might not be safe or might be shared."* In small or closely connected communities, even remote care was perceived as potentially exposing. One participant remarked, *"Some patients still fear that even using technology might expose them somehow."* Here, psychological mechanisms of perceived risk intersect with institutional trust, shaping differential willingness to engage with digital services.

Conversely, some providers viewed digital platforms as enhancing discretion. A clinician observed, *"Technology reduces… social stigma for many people by keeping their issues private."* Thus, confidentiality was framed as a double-edged dimension, dependent on perceived institutional competence and data protection safeguards. This ambivalence reflects how institutional design can either mitigate or reproduce inequities in trust and access.

5.3.4. Improved Patient Engagement and Compliance

Ten participants (35.7%) reported that tele-mental health improved engagement and adherence for certain groups. Flexibility was again emphasized, with one provider noting, *"Remote services offer flexibility in time…"* Participants described convenience as facilitating continuity. A clinician shared, *"A patient recovered from depression through these online sessions,"* while another stated, *"Technology*

gives patients a sense of control; they can choose when and how to engage without feeling judged." These accounts reflect psychological mechanisms of increased autonomy and perceived control, alongside institutional flexibility in scheduling and follow-up.

Generational familiarity with digital communication was described as influencing uptake. As one provider explained, *"For the younger generation especially, online communication is natural; therapy feels less formal and scary."* This observation suggests that structural determinants, including generational position and digital socialization, shape differential benefits from technological modalities.

However, engagement benefits were characterized as conditional. Participants cautioned that digital modalities may be less suitable for individuals with severe psychiatric conditions or limited technological familiarity. Accordingly, TMHC was framed as an adaptive complement rather than a universal substitute, with equity implications shaped by clinical complexity, age, and digital access. These limitations highlight how psychological capacity, structural access to technology, and institutional suitability criteria interact to produce uneven digital engagement patterns.

Challenges and Limitations of Technology

Nine participants (32.1%) emphasized that digital platforms cannot fully substitute in-person care. While tele-mental health was viewed as expanding access, it was also described as limited in therapeutic depth and clinical suitability. As one provider stated, *"Online therapy is limited… it cannot be as good as face-to-face sessions,"* reflecting concerns about relational nuance and embodied communication. These accounts reference interpersonal dynamics central to therapeutic alliance, which may be altered in virtual environments.

Technology was characterized by some as a "double-edged sword," with one clinician cautioning against self-diagnosis based on inaccurate online information. Others highlighted disorder-specific challenges. A provider noted, *"It is difficult to provide online services for some disorders; those people have no motivation to receive treatment,"* suggesting that symptom severity and engagement capacity shape digital feasibility. Here, psychological mechanisms such as motivation and symptom burden intersect with institutional service design, limiting universal applicability.

Reliance on telecommunication alone was also questioned. One participant warned that *"reliance on telecommunication alone might not always be beneficial,"* referencing screen fatigue and emotional disconnection. Consequently, several providers advocated hybrid delivery models. As one clinician emphasized, *"We can provide services through technology, but there must still be options for face-to-face care when needed."* These perspectives underscore the need for institutional flexibility and structurally responsive implementation to avoid reinforcing inequities among individuals who require in-person support.

Overall, participants framed tele-mental health as a conditional innovation that reshapes access but does not uniformly resolve structural, relational, or clinical inequities. Across structural determinants,

institutional processes, interpersonal dynamics, and psychological mechanisms, technology was described as capable of both mitigating and reproducing patterned gradients in access.

Comparative Analysis Across Age and Gender

To examine patterned variation, a comparative analysis was conducted across age and gender. Participants were grouped by age relative to the sample mean (M = 38.64 years) and by self-identified gender (15 male, 13 female). Using reflexive thematic analysis, differences emerged in how stigma, treatment hesitancy, and digital implementation were interpreted. These variations reflected generational positioning and gendered social roles within broader sociocultural contexts. Patterns were examined through the study's equity lens, assessing how age and gender intersected with structural determinants, institutional processes, interpersonal norms, and psychological interpretations of risk and care.

Comparative Thematic Analysis by Age

Participants were categorized as younger (≤ 38 years, n = 13) and older (> 38 years, n = 15). Generational differences were evident in how stigma and digital services were conceptualized.

Stigma was emphasized by both groups but more frequently and emphatically among older providers (86.7%) than younger providers (69.2%). Older participants described stigma as deeply entrenched, noting that *"They don't want anybody to see them near any mental health center,"* and emphasizing its persistence across generations. Younger providers acknowledged stigma but expressed cautious optimism regarding shifting attitudes, stating, *"They are in denial. They don't seek help, they feel ashamed,"* while suggesting change may be possible. These differences suggest generational variation in the interpretation of interpersonal stigma norms and psychological help-seeking barriers, with older providers more likely to frame stigma as structurally embedded and resistant to change.

Documentation concerns also differed. Among older participants, 66.7% referenced fears of permanent records and long-term reputational harm, with one noting, *"They fear that something will be documented against them for the rest of their lives."* Younger participants (38.5%) were less focused on institutional permanence and more concerned with digital privacy and cybersecurity. These patterns indicate generational differences in perceived institutional versus technological risk. This divergence reflects generational differences in perceived institutional processes versus technological systems as sites of risk, highlighting variation in how structural and digital determinants are interpreted.

Medication hesitancy followed a similar pattern. Older participants more frequently raised concerns about dependency and harm, describing fears that medications *"can cause addiction"* or *"harm the brain."* In contrast, 30.8% of younger providers referenced such fears and tended to frame pharmacological treatment as clinically indicated when properly managed. These distinctions suggest variation in professional socialization and psychological framing of treatment risk, rather than differences in clinical knowledge per se.

The most pronounced divergence emerged regarding tele-mental health. Younger providers (84.6%) described digital platforms as natural and effective, emphasizing that *"Technology simplifies access to services."* Older participants were more cautious (60%), noting that *"Online therapy is limited… it cannot be as good as face-to-face sessions,"* and referring to digital care as a "double-edged sword." These findings indicate generational positioning as a structural determinant influencing comfort with digital infrastructure, perceptions of institutional adequacy, and evaluations of interpersonal therapeutic depth.

These findings suggest that generational familiarity with digital systems, differing professional socialization experiences, and varied exposure to evolving mental health norms shape how stigma, medication, and tele-mental health are interpreted. Age-related patterns were treated as interpretive tendencies rather than statistically tested differences. Across age groups, differences were interpreted as patterned variations in how structural determinants, institutional processes, interpersonal expectations, and psychological mechanisms are prioritized and understood, rather than as fixed demographic divides.

Comparative Thematic Analysis by Gender

Gendered interpretive patterns were evident in how providers framed stigma, access, and digital care. These patterns are presented as thematic tendencies within this sample rather than essentialized distinctions. Female providers more frequently emphasized relational, cultural, and ethical dimensions of stigma, whereas male providers more often foregrounded structural constraints and system-level inefficiencies. Together, these perspectives illuminate how gendered social positioning may shape professional interpretation of mental health inequities. Through the equity framework, these differences were examined as variations in analytic emphasis across interpersonal dynamics, psychological interpretations, institutional processes, and structural determinants, rather than as categorical gender differences.

Female participants, largely in their 30s and 40s of age, articulated stigma through family-centered and moral frameworks. They highlighted pressures related to family honor, marriageability, and reputational risk, as well as the emotional labor involved in concealing mental illness within households. Providers referenced how women may be cautioned to protect family standing and avoid psychiatric labeling that could affect marital prospects. Supernatural explanations, including jinn possession or the evil eye, were also discussed in relation to how stigma is socially reproduced. These narratives suggest attentiveness to how stigma operates relationally and disproportionately affects women within gendered family structures. These accounts foreground interpersonal norms and psychological burdens associated with concealment, while also pointing to structural determinants such as marriage markets and gendered expectations that condition disclosure and access.

In contrast, male participants, many in mid- to late-career stages, more frequently framed stigma in terms of public visibility and institutional shortcomings. They cited long wait times, bureaucratic delays, and fragmented service delivery as primary barriers. Some attributed continued reliance on traditional healers to perceived deficiencies in formal service capacity. These accounts emphasized operational

gaps and structural inefficiencies rather than interpersonal concealment. Stigma was thus interpreted primarily through institutional processes, including service organization and referral delays, and structural

Gendered distinctions were also evident in perceptions of tele-mental health. Female providers emphasized confidentiality, therapeutic trust, and the ethical implications of remote care, while noting flexibility benefits for those balancing caregiving and mobility constraints. Male participants evaluated tele-mental health more pragmatically, focusing on logistical utility and questioning its capacity to sustain therapeutic depth. These differences reflected variation in emphasis on psychological mechanisms, including trust and perceived safety, interpersonal therapeutic dynamics, and institutional safeguards governing digital implementation.

These findings suggest that gender intersects with professional role and sociocultural context to shape interpretations of stigma and service inequities. Rather than fixed categories, these patterns reflect variation in analytic emphasis across relational and structural dimensions of mental health access. Interpretations differed in the relative prioritization of structural determinants, institutional processes, interpersonal expectations, and psychological risk, illustrating how professional positioning mediates understanding of inequitable access trajectories.

Overall, the comparative analysis across age and gender indicates that these variations were not opposed but reflected differing analytic emphases shaped by generational positioning and gendered social roles. Older providers more frequently foregrounded institutional permanence and entrenched stigma, whereas younger providers emphasized digital adaptation and evolving norms. Female providers highlighted relational and family-centered dimensions of stigma, while male providers underscored structural inefficiencies and service capacity constraints. Across groups, differences mapped onto the study's equity constructs, demonstrating how professional positioning shapes the perception and problematization of inequitable mental health access within Qatar's sociocultural and institutional context.

Discussion

Findings provide a contextually grounded equity analysis of how structural determinants, institutional processes, interpersonal dynamics, and psychological mechanisms intersect to shape mental health access in Qatar. Using Braun and Clarke's reflexive thematic analysis [44], the findings demonstrate that stigma operates not merely as an individual attitude but as a socially embedded and structurally mediated process influencing help seeking, family regulation, and institutional trust. Consistent with established health equity frameworks [3, 38], unequal access emerges as patterned rather than incidental, reflecting broader social gradients and institutional arrangements.

At the structural level, participants described workforce shortages, centralized service delivery, linguistic hierarchies, insurance limitations, and documentation fears as shaping differential access pathways.

These findings align with the social determinants of mental health framework [3, 39], which emphasizes that system organization and policy design distribute health opportunities unevenly.

The Lancet Commission on Global Mental Health and Sustainable Development similarly underscores that service capacity and workforce investment are core equity determinants [27]. In Qatar specifically, situational analyses [6] and recent epidemiological updates [22, 23] indicate that mental health system expansion has not fully resolved access gaps.

Recent scholarship on structural stigma further demonstrates how institutional systems embed disadvantage across healthcare contexts [7]. Findings indicate that fears and perceived permanence of psychiatric records illustrate how governance mechanisms can function as structural barriers rather than neutral administrative procedures.

At the institutional level, participants highlighted confidentiality procedures, record permanence, referral bottlenecks, and fragmented rehabilitation pathways. These findings extend Goffman's conceptualization of stigma as a "spoiled identity" [40], showing how identity management becomes intertwined with bureaucratic systems.

Systematic review evidence across Arab populations confirms that institutional opacity and stigma-related fears influence help-seeking behaviors [45]. Multinational population-based evidence from Arab countries further demonstrates persistent stigma gradients across gender and social strata [37]. Structural stigma theory reinforces those institutional environments shape health distribution patterns [7].

At the interpersonal level, stigma was described as relational and collective. Family concealment, marriageability concerns, and moral framing of mental illness positioned help seeking within kinship and reputational networks. Systematic review evidence demonstrates that help seeking in Arab populations is frequently mediated by family authority structures [45]. Qualitative analyses further highlight culturally embedded explanatory systems influencing care trajectories [9, 11]. Mental health literacy research in Gulf Cooperation Council states similarly underscores the role of collective belief systems [37].

Gender inequality scholarship provides additional context for how women may bear disproportionate reputational burdens associated with psychiatric disclosure [12, 13], particularly within honor-based social structures.

At the psychological level, internalized stigma, shame, and anticipated discrimination shaped delayed engagement and diminished self-efficacy. Corrigan and Rao's model of self-stigma [28] provides a framework for understanding how public stigma becomes internalized and produces the "why try" effect.

Intersectionality-informed equity research [32, 46] emphasizes that overlapping social identities amplify vulnerability to stigma and exclusion. These psychological mechanisms were inseparable from structural and institutional contexts, reinforcing that individual-level experiences cannot be detached from systemic gradients.

Participants' references to jinn possession, and the evil eye reflect culturally embedded explanatory models. Systematic reviews and qualitative cultural analyses confirm that pluralistic help-seeking pathways often precede formal psychiatric engagement in Arab contexts [9, 11, 45]. These findings suggest that biomedical systems must engage, rather than dismiss culturally situated epistemologies.

Tele-mental health was described as both enabling and limited. Regional research on digital mental health implementation in Gulf settings supports provider perceptions that digital platforms can expand accessibility [19, 20]. The effectiveness of tele-mental health has been documented in systematic evaluations [14, 15].

However, digital inequality scholarship demonstrates that technological expansion may reproduce stratification where digital literacy and infrastructure are unevenly distributed [17, 35]. International public health guidance further emphasizes that digital health reforms must address broader structural determinants to prevent widening inequities [42].

Age and gender differences in provider interpretation reflect socially situated positioning rather than essentialized distinctions. Intersectionality theory [32] and contemporary equity scholarship [38, 46] underscore that layered social identities shape exposure to structural disadvantage.

A central contribution oof the findings is that stigma functions simultaneously across structural, institutional, interpersonal, and psychological domains. Resource allocation, governance mechanisms, kinship norms, and internalized shame interact to produce differentiated access trajectories. This multi-level interpretation aligns with contemporary equity scholarship emphasizing interacting social determinants [3, 38].

Qatar represents a high-income, yet socially stratified context characterized by rapid development and demographic diversity. Epidemiological evidence [22, 23] underscores persistent mental health burden despite system expansion. The findings suggest that without culturally responsive implementation, workforce equity, and accountable digital safeguards, expansion alone is unlikely to reduce inequities.

Finally, reflexive thematic analysis [44] enabled examination of how stigma and inequity are co-constructed within layered sociocultural and institutional contexts. By analyzing provider narratives through structural determinants rather than individual deficit models, this study advances equity-oriented mental health scholarship highlighting the structural drivers of unequal access to care.

Implications for Practice and Policy

The findings carry implications for mental health practice and system development in Qatar and comparable sociocultural contexts. The entrenched nature of stigma, manifesting through social shame, supernatural attributions, and reputational fears, supports the need for culturally grounded anti-stigma strategies [8, 45]. Engagement with community leaders, educators, and religious figures may help reframe mental illness as a legitimate health condition rather than a moral failing [11, 45]. Educational

initiatives should be linguistically accessible and gender-responsive, aligning with local epistemologies and social structures. In Gulf contexts, where stigma intersects with gendered expectations and marital considerations [12, 13], outreach efforts may require engagement with family decision-makers and female professionals to enhance acceptability of help-seeking [30].

Integration of mental health into primary care and community-based platforms may reduce visibility-related stigma and facilitate earlier intervention [26, 27]. Discreet access through general health services could benefit women and youth navigating reputational scrutiny. Gender-concordant care may further mitigate disclosure-related barriers [12, 13].

TMHC offers potential but requires explicit equity safeguards. Although remote consultations may reduce public visibility, disparities in digital literacy, device access, privacy, and infrastructure must be addressed, particularly among lower-income and older populations [17, 18, 35]. Without investment in broadband access, clinician training, and data protection frameworks, digital expansion may reproduce existing inequalities [42].

System-level reforms remain critical. Addressing workforce shortages, service centralization, and fragmented rehabilitation pathways requires investment in interdisciplinary, team-based models incorporating psychiatry, psychology, social work, and peer support [27]. Workforce development should prioritize Arabic-language capacity and culturally adapted therapeutic approaches [39]. Decentralized community services may further reduce reliance on hospitals and enhance accessibility [6, 26].

An intersectional policy lens is warranted [32, 33, 46]. Gender, age, migration status, and socioeconomic position intersect to shape stigma exposure and access constraints. Policies premised on uniform need risk overlooking differentiated barriers, particularly for migrant workers and adolescent girls [12, 13].

Digital inequality must also be recognized as a structural determinant of tele-mental health access. Variations in digital literacy, connectivity, and control over technology may stratify those who benefit from remote services [35, 42]. Without explicit safeguards, tele-mental health risks reinforcing socioeconomic and gender-based disparities rather than mitigating them [42].

Overall, improving mental health access in Qatar requires coordinated attention to culturally responsive stigma reduction, workforce and language equity, infrastructure investment, and accountable digital integration.

Declarations

Ethics approval and consent to participate

Ethical approval was obtained from the Institutional Review Board affiliated with the first author (Protocol No. Adelphi University- IRB 23 045). All procedures were conducted in accordance with institutional ethical standards and the principles of the Declaration of Helsinki. Participants received

detailed information regarding the study objectives, procedures, confidentiality protections, and voluntary participation. Written informed consent was obtained prior to data collection.

Consent for publication

Participants provided informed consent for the use of anonymized quotations in publications and presentations. No identifying information is included in this manuscript.

Availability of data and materials

The qualitative datasets generated and analyzed during the current study are not publicly available due to confidentiality and ethical restrictions, as transcripts contain potentially identifiable professional information within a small national context. De identified excerpts may be available from the corresponding author upon reasonable request and subject to institutional approval.

Competing interests

The authors declare that they have no competing interests.

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Authors' contributions

Author Contributions: "Conceptualization, WAR.; methodology, WAR.; software, WAR & LBI.; validation, WAR. and LBI.; formal analysis, WAR and LBI; investigation, WAB and LBI; data WAR, LBI; writing—original draft preparation, WAR.; writing—review and editing, ED, LBI.; visualization, WAR supervision, WAR; project administration, LBI, ED. All authors have read and agreed to the published version of the manuscript."

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Authors' information

The authors are scholars and practitioners with expertise in mental health, social work, stigma research, and health equity within Middle Eastern contexts. Their work focuses on structural determinants of

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Figures

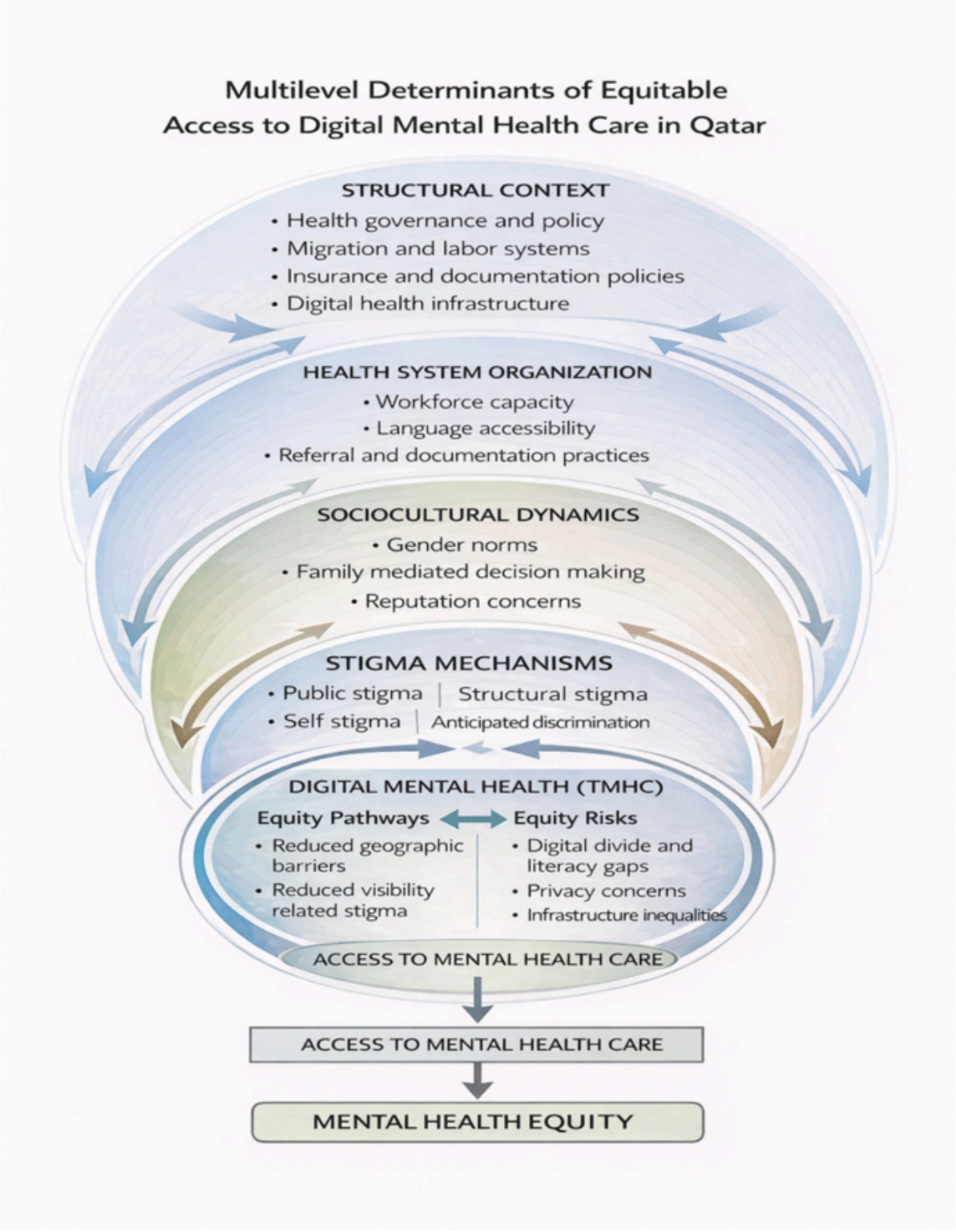


Figure 1

Multilevel determinants of equitable access to digital mental health care in Qatar.

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