Amplifying Women's Voices: Women's Mental Healthcare Experiences and Social Media's Role in Promoting a Gendered Approach to Mental Healthcare

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Abstract

The present qualitative study explored whether women's lived experiences and perceptions of mental health services (MHS) reflect gendered biases, barriers, and inequalities within the provision of mental health care (MHC). It also explored women's views on social media use to promote a gendered approach to MHC. Women with prior experience in MHS (N = 15) were conveniently recruited and participated in one focus group discussion each, where they answered open-ended questions and actively engaged in conversation. Four focus group discussions were conducted in total. The gathered data were analyzed via the means of inductive thematic analysis which resulted in seven main themes with their related sub-themes. The findings indicated that participants did not have any personal negative experience that revealed gender biases or gender-based health inequalities within MHC provision. However, all participants shared similar expectations and perceptions that MHS and providers can fail to recognize and address the specific needs of women, potentially harboring gender bias against them, resulting in adverse MHC encounters. Furthermore, it was found that participants viewed social media platforms as powerful tools for raising awareness about women's mental health issues and advocating for gender-sensitive MHC. Despite some limitations, such as the lack of a more purposive sample consisting of women with lived negative MHS experiences, these findings can hold important implications for a university community like the University of Twente. They highlight the necessity of carrying out research to examine any potentially harmful gendered experiences among women using the university's MHS. Additionally, they emphasize the significance of putting into practice powerful initiatives like social media campaigns, to raise awareness of these issues and take steps to implement inclusive MHC for women, leading to positive wellbeing outcomes for them.

Keywords: women's mental health, mental health services, gender-based health inequalities, gender-sensitive healthcare system, social media use

Amplifying Women's Voices: Women's Mental Healthcare Experiences and Social Media's Role in Promoting a Gendered Approach to Mental Healthcare

The World Health Organization (WHO) estimates that one in four people will be affected by poor mental health or mental health disorders at some point in their lives (WHO, 2022). The latest World Mental Health Report, by WHO, showed that, globally, women have a 50% higher lifetime risk of mood and anxiety disorders than men (WHO, 2022). Similarly, the Global Burden of Disease (GBD) study found that in Europe, from 1990 to 2019, the prevalence of anxiety, depressive and eating disorders was higher in women than in men (Castelpietra et al., 2022). A large body of evidence from different countries reports on the risk and prevalence of mental disorders in women. For instance, according to Statista data from 2021, women in Germany reported a higher prevalence of mental health illness compared to men (YouGov, 2021). Patsali et al. (2020) found that female students in Greece were two times more likely to develop depression compared to male students in relation to the COVID-19 outbreak. The Netherlands Mental Health Survey and Incidence Studies showed that, in the period 2019-2022, women were more likely than men to have experienced a mental disorder in the past 12 months (Ten Have et al., 2023).

Considering these alarming rates of women's mental health issues and the multiple barriers they face in seeking and accessing mental health services (MHS) (Mcneish & Scott, 2014; Scholes et al., 2021; Sen & Östlin, 2008), this study aims to explore women's lived experiences of mental health care (MHC). The aim is to shed light on potential gender-based health inequalities and identify ways to address them to provide female patients with an inclusive MHC approach that meets their unique needs.

Explanations of Gender Differences in Mental Health

Psychological and Social Explanation. Differences between men and women in the prevalence, risk, and manifestation of mental health disorders can be attributed to an interplay of sex (i.e., genetic, and biological characteristics) and gender (i.e., social, and psychological factors) differences. Although biological mechanisms play a significant role in explaining such differences (Kuehner, 2017; Li & Graham, 2017), it is beyond the scope of this paper to provide a detailed examination of those. Nevertheless, research suggests that biological factors alone are not sufficient in explaining these differences, which underpins the necessity to look closer at psychosocial factors and their contributing role (Klose & Jacobi, 2004; WHO, 2001).

Psychological, social, and economic factors are deeply intertwined with an individual's gender, and to explore them further it is crucial to first understand gender as a social construct. Nevertheless, it has been widely accepted that gender is a fundamental social determinant of mental health (World Health Organization & Calouste Gulbenkian Foundation, 2014). *Gender* refers to "the characteristics of women, men, girls, and boys that are socially constructed" (WHO, 2019, Gender and Health section, para. 1). More specifically, these characteristics consist of:

> *Gender roles*: behavioral norms attributed to each gender, *gender identity*: individual's self-perception on the femininity-masculinity dimension, *gender relations*: how individuals interact with or are treated by others and *institutionalized gender*: distribution of power between genders in institutions in society justifying their different expectations and opportunities. ((Tannenbaum et al., 2016, p. 3)

As gender can be differentiated between all these facets, this illustrates its complex influence on the above-mentioned differences and how the different factors can intersect to impact women's mental health particularly.

Research shows that a wide range of distinct gender-related factors affects women's mental health in multiple directions. First, from a psychological perspective, among others, numerous studies have indicated that coping strategies contribute significantly to gender differences in psychological development and manifestation (Busfield, 2002; Casey, 2002; Kornstein and Wojcik, 2002 as cited in The Women's Health Council, 2005) and have also been particularly associated with gender differences in depression (Hänninen & Aro, 1996). In support of this view, it has been argued that women tend to have a more ruminative strategy for dealing with adverse feelings (Nolen-Hoeksema et al., 1993; Zwicker & DeLongis, 2010) and are more socially encouraged to internalize their stress (Sachs-Ericsson & Ciarlo, 2000).

Exploring women's mental health from a social perspective is more than necessary to understand the complexity underlying gender variations in the prevalence, risk, and expression of mental health problems. Associations between women's mental health and social determinants have been well-established over the years (Glynn et al., 2009; Holmshaw & Hillier, 2000; O'Neil et al., 2020; WHO, 2022b). Research has identified a strong and inevitable link between women's lower social status, deriving from cultural, economic, and political gender inequalities (e.g., gender pay gap), and mental health (Equality Authority, 2002; WHO, 1998; WHO, 2022b). Furthermore, women's mental health has been found to be significantly correlated with role overload (Boughton

& Street, 2007; Glynn et al., 2009), namely "the triple burden of productive (workers), reproductive (partners) and caring (carers) work that women are expected to perform at the same time" (WHO, 2001). Trying to live up to these societal expectations leads women to experience higher levels of stress, which in turn results in lower levels of well-being and a greater risk of suffering from mental health problems (Holmshaw & Hillier, 2000).

Stressful life events are another major social determinant of women's mental health. During their lifetime, women can be exposed to numerous stressful and even traumatizing experiences. Among others, some representative examples are gender-based physical, and sexual abuse (e.g., sexual harassment against women employees and students) and domestic or intimate partner violence (IPV) (Oram et al., 2017). The latest WHO study on the prevalence of violence against women, based on data from 2000 to 2018, found that 28% of women worldwide have experienced physical or sexual violence by a male intimate partner at least once in their lives (WHO, 2021). It has been clearly reported that all abuse and IPV are significantly correlated with increased rates of depression and a greater likelihood of developing post-traumatic stress disorder, self-harm, and suicidal attitudes (WHO, 2021).

Women and Mental Healthcare Services

Gender Barriers in the Mental Healthcare Services Use

Closer analysis and understanding of all the complex ways in which psychological and socioeconomic factors can contribute to women's mental health underlines the importance of adopting a gender-transformative and women-centered model of MHC (Judd et al., 2009; Morrow, 2002; Pederson et al., 2014; WHO, 2002). According to WHO (2011), a gender-transformative approach to health systems "addresses the causes of gender-based health inequities by including ways to transform harmful gender norms, roles, and relations" (p.136). The aim of such an approach to health is to promote gender equality and encourage positive changes in the power dynamics between men and women (WHO, 2011). Evidence suggests that healthcare interventions can be more successful when gender is considered during the design process (Boender et al., 2004). It has been strongly found that the implementation of gender-transformative interventions can have several positive implications resulting in significant improvements in mental health and maternal mental health (Raghavan et al., 2022).

However, exploring the available literature, evidence supports that healthcare systems may be failing to achieve gender equity in the way women use healthcare services (Sen & Östlin, 2008).

Although numerous studies have shown that women are considerably more likely to seek outpatient MHC (Kovess-Masfety et al., 2014; McManus et al., 2016), a variety of different barriers to women's access to and use of MHC services have been identified (Scholes et al., 2021; Sen & Östlin, 2008). For instance, services' inability to meet women's caring needs, responsibilities, and complicated social circumstances and its negative impact on the patient-provider relationship is one of many examples of such barriers (Mcneish & Scott, 2014)). Cost barriers are also important to mention, as they have been constantly identified as one of the most prevalent reasons why women do not access MHS (Diep et al., 2022; National Office of Mental Health Engagement and Recovery, 2023). Recognizing and understanding existing and additional gender barriers in the design and delivery of MHS emphasizes the need for a gendered perspective in the mental health system.

Women's Experiences in Mental Healthcare Services

To enable the adoption and implementation of gender-transformative MHC, it is indispensable to thoroughly identify, analyze, and understand the lived experiences and perceptions of women who engage with MHS. Existing literature has identified a wide range of said gendered and potentially negative experiences reported by women from different countries, indicating a significant degree of commonality, with manifestations varying in many ways.

For example, numerous studies have explored women's MHC experiences as mothers and caregivers. It has been shown that MHS often fail to adequately support women's caregiving roles and responsibilities both in practical terms (e.g., inflexible service provision and lack of opportunities to bring their children along) (Department of Health and Social Care (DHSC) & Agenda, 2018; MHER, 2023) and on a deeper level (e.g., disregarding their concerns about their children's wellbeing or overlooking the social pressures and expectations placed on them as caregivers) (Banerjee et al., 2021; Jack et al., 2022). Many women were found to be reluctant to seek help again due to such previous negative experiences with MHS (Jack et al., 2022). Another example of adverse gendered encounters can be observed in the lived experiences of women who are victims-survivors of gender-based violence (García-Moreno & Riecher-Rössler, 2013; O'Dwyer et al., 2019; Trevillion et al., 2016). MHS and professionals often fail to recognize and address the complexity of abuse and its serious consequences for women's well-being. MHS do not often adopt a trauma-informed approach, failing to ask essential questions that might reveal cases of abuse or resorting to harmful practices in inpatient care such as physical restraint, or

surveillance by male staff (DHSC & Agenda, 2018). In other cases, women who disclose sexual abuse often face healthcare providers who respond to such disclosures with disbelief, silence, trivialization, or denial (Graham, 1994; O'Dwyer et al., 2019).

Examining these examples of women's adverse encounters with MHS underscores the need for a gender perspective to MHC. However, it is evident that the existing literature places a prevalent focus on women's healthcare experiences in relation to their roles associated with men (e.g., as victims of IPV) (García-Moreno & Riecher-Rössler, 2013; O'Dwyer et al., 2019; Trevillion et al., 2016), or others (e.g., as mother/caregivers) (Banerjee et al., 2021; Higgins et al., 2016; Jack et al., 2022; Templeton et al., 2003). Women, though, are multidimensional individuals and their experiences and challenges extend beyond their interactions and relationships with others. Among the identified English language papers there is a lack of exploration regarding their MHC experiences independent of such roles. Therefore, this study aims to fill this gap and contribute to a more thorough understanding of women's specific concerns, gendered experiences and challenges within the healthcare system. Understanding women patients' perspectives on treatment disparities and barriers to quality care can provide a more holistic view of their needs and preferences for gender-sensitive or transformative MHC, and thus create opportunities for improvement.

Regardless, attempting such a significant transformation of healthcare services can be extremely difficult. However, in today's world, healthcare users have a powerful tool that can enable them to drive significant changes in healthcare provision: social media platforms.

Social Media and Women's Mental Health Care Experiences

Social Media Use and Mental Health. The relationship between social media and mental health is complex and multidimensional. Given the ubiquitous integration of social media into almost everyone's daily life, the effects of social media engagement and content consumption on mental wellbeing can be both negative and positive (Sadagheyani & Tatari, 2020; Sharma et al., 2020). However, the nature of such impact can be highly determined by the way in which individuals choose to use the different social media platforms (Kross et al., 2020; Smith et al., 2021). Looking at the potential of social media in terms of its positive impact on users' wellbeing and MHC related issues, a wide range of benefits can be identified. Firstly, social media platforms can be extremely powerful tools for providing valuable mental health education (Peek et al., 2015; Sadagheyani & Tatari, 2020). Online informational content such as videos, photos, posts, and articles about mental

health can cover a wide range of topics, including addressing mental health disorders and challenges, discussing advice and self-care tips, or providing mental health resources (O'Reilly et al., 2022). Strong evidence reports that very often many people who struggle with mental health illness use social media platforms to seek mental health information striving for a deeper understanding of symptoms and diagnosis, medication and side effects as well as ways to cope with an illness (Lal et al., 2016; Naslund et al., 2016).

In addition to mental health education and information-seeking, individuals facing mental health challenges use social media platforms to interact with peers or others who share similar difficult experiences, leading to a multitude of positive outcomes across various dimensions. Online social media platforms provide great opportunities for individuals struggling with mental health to connect with others and create communities by sharing personal experiences and stories, providing or seeking support, and learning from each other (Berry et al., 2017; Lal et al., 2016; Naslund et al., 2017; O'Reilly et al., 2022). Coming together in these ways, people with mental health problems can experience a profound sense of belonging alleviating feelings of loneliness while finding hope and support, and fostering meaningful relationships (Bucci et al., 2019; Naslund et al., 2016; O'Reilly et al., 2022). Furthermore, enabling this peer support through social media platforms can play a significant role in challenging the social stigma surrounding mental health by raising awareness and empowering people who are struggling with these challenges (Naslund et al., 2016; O'Reilly et al., 2022).

Apart from the previously highlighted significant advantages, social media platforms can also serve as powerful tools for spreading essential mental health awareness. Mental health awareness on social media has grown remarkably in recent years, with many individuals, organizations, and platforms around the world working together to shed light on various mental health issues, while reducing stigma and helping those in need (Latha et al., 2020; Saha et al., 2019). The available literature offers a wide range of research reporting the significant effectiveness of different social media campaigns aimed at raising mental health awareness (Alonzo & Popescu, 2021; Latha et al., 2020; Naslund et al., 2017; Saha et al., 2019). Latha et al. (2020) investigated three impactful mental health awareness campaigns on social media, highlighting the cost-effective, time-efficient, and audience-reaching nature of such campaigns. They emphasized social engagement, tailored feedback, and effective dissemination of mental health information as key benefits of using social media platforms.

Social Media Use in Promoting Gendered Approach to Mental Health Services. Social media platforms are not only powerful tools for raising mental health awareness and disseminating vital information, but they also provide spaces where people facing mental health problems can openly share their experiences and stories with MHS. Research has shown that a growing number of patients use social media platforms to communicate their experiences with healthcare providers or institutions (Antheunis et al., 2013; Greaves et al., 2013). Social media platforms offer patients the opportunity to amplify their voices, express their emotions freely, and openly discuss potential negative experiences with services (Chiu & Hsieh, 2012). The qualitative study of Shepherd et al. (2015) examined an online discussion on Twitter known as #dearmentalhealthprofessionals, where individuals with mental health conditions shared their experiences with services and discussed practical approaches to address their concerns. They found that the use of social media platforms in such way can serve as a valuable tool for mental health providers to gain insight and receive meaningful feedback from patients themselves. Evidence shows that enhanced use of patient-reported feedback can drive meaningful change in policy-making processes and stimulate quality improvement approaches within healthcare organizations (Flott et al., 2016; Kumah et al., 2017).

While the existing literature addresses the effectiveness of social media as a platform for patients to discuss their concerns and experiences with healthcare, there is limited evidence on women patients' perspectives on using social media to promote a gendered approach to healthcare. Harnessing social media platforms for women patients to share their negative experiences of MHS as a result of gender-based health inequalities, has the potential to be a powerful way to reflect the need for a gendered approach to MHC. Shedding light on these issues can provide a starting point for health organizations to act on this need and make meaningful improvements in services through a gender lens. This, in turn, lays the foundation for the implementation of gender-transformative health systems in the future.

The Aim of the Present Study

The previously analysed determinants of all the deeply rooted gender biases and inequalities in the provision of mental health can lead women to engage with a health care system that is not designed to meet their needs in relation to their psychological distinctiveness, social and economic position, and cultural background. This, in turn, leads to negative experiences of MHS and inadequate well-being outcomes. Nowadays, however, social media platforms hold great power for women patients to share their negative experiences with services and to advocate for improved

quality and gender-sensitive MHC, influencing policy-making processes. Considering this, the present study aims to explore underrepresented aspects of women's gendered experiences in MHS that are not solely related to their roles associated with others. It also aims to address the gap of women's views on using social media to promote a women-centered and gendered healthcare approach. Therefore, the following two-fold research question is aimed to be addressed: "(1) *Do women's lived experiences and perceptions of mental health services reflect gendered biases, barriers, and inequalities within the provision of care, and* (2) *how can social media use contribute to promoting a gendered approach to mental health care?*"

Methods

Research Design

The present study was approved by the BMS Ethics Committee of the University of Twente (request number 230633). To facilitate the exploration of the research question, a deliberate use of qualitative research design was implemented, with focus group discussions selected as the most appropriate method of data collection. Focus groups can be defined as "a way of collecting qualitative data, which involves engaging a small number of people in an informal group discussion, 'focused' around a particular topic or set of issues" (Wilkinson, 2004, p. 177). For the research design, focus groups were chosen as they can yield significant advantages in eliciting and discussing personal experiences, opinions, and perceptions (Krueger & Casey, 2015; Onwuegbuzie et al., 2009), and thus align well with the purpose of the study. Such discussions create a beneficial environment for participants to influence and inspire each other, encouraging active engagement and the sharing of valuable insights (Casey & Krueger, 1994). This dynamic process facilitates effective group interaction, which in turn promotes productive communication (Stewart & Shamdasani, 2014). By encouraging productive communication between participants, the aim was to help them inspire each other by hearing and potentially relating to others' personal stories, leading to more effective expression of their own experiences and perceptions and thus insightful findings. Additionally, productive communication was necessary to enable participants to motivate each other to exchange opinions and generate new perspectives and ideas for promoting a gendered approach to MHC as well as the value of using social media in this process.

Participants

The target population of the present study was individuals who identify as woman and who have engaged or are currently engaged with MHS across Europe. Therefore, these were the

inclusion criteria for recruitment. No specific age range was required. Participants were recruited through the use of opportunity sampling, and more specifically the method of convenience sampling. Recruitment was conducted by distributing flyers on the University of Twente campus targeting the relevant population, posting advertising banners on social media platforms, and leveraging personal networks. In addition, the study was made accessible to students of Psychology and Communication Science at the University of Twente through the use of the SONA subject pool system. Students were able to register and participate in the study via the SONA system and were rewarded with 2 SONA credits.

The sample consisted of 15 participants. Participants had an age range from 19 to 62 years old, with a mean age of 33.3. Five participants had German nationality, eight participants had Greek nationality, one participant had Dutch and one had Irish nationality. Of the total number of participants, eight reported that they had used MHS in the past, while seven reported that they were currently using MHS. All participants indicated using private or public outpatient mental health treatment, with no participants indicating using private or public inpatient or residential mental health treatment. Participants reported receiving MHC services primarily within the Greek and German healthcare system. Table 1 shows the demographics characteristics of all participants.

Table 1

Demographic Characteristics of Participants

Sample characteristics	*n*	%	M_{age}	*SD*
Nationality				
German	5	33.3	21.4	1.3
Greek	8	53.3	38	15.1
Dutch	1	7	25	
Irish	1	7	19	
Experiences with MHS				
MHS used in the past	8	53.3		
MHS currently using	7	47		
Type of MHS				
Outpatient treatment	15	100		
Inpatient treatment	0			

Note. $N = 15$.

Procedure

As mentioned previously, focus group sessions were conducted to collect the data for this study. In total, four focus group sessions were conducted where three to four women participated in each session. Once the participants had been successfully recruited, they were invited to the scheduled focus group sessions. The two sessions took place on the campus of the University of Twente on the 16th and 19th of May. The other two sessions were conducted online to accommodate the participants' location in Greece. Each focus group session lasted approximately 60 minutes.

Upon arrival, participants were welcomed by the researcher and given a brief overview of the study's purpose and session's procedure. First, participant information sheets were distributed to all participants (see Appendix A), explaining the purpose of the study, the benefits and risks of participation, and the rights of participants, to ensure that they were fully aware of the voluntary nature of their participation and their ability to withdraw from the study at any time. After reading this information, participants were asked to sign an informed consent form (see Appendix B). Next, participants were also asked to fill in a short demographics questionnaire (see Appendix C).

Once the preparatory phase was complete, the focus group session began. The sessions were moderated by the researcher of the present study who used a semi-structured interview guide. The interview guide consisted of open-ended questions designed to explore three main areas of interest related to the research question: (1) participants' gendered experiences and perceptions in seeking and receiving MHC, (2) participants' views in implementing a gendered and women-centered perspective in MHC provision, (3) participants' views on the value of social media activism in promoting a gender-transformative approach for women in MHS. The detailed interview guide containing all the questions can be found in Appendix D. Regarding to the role of the moderator, the main aim was to guide the discussion by posing the questions and maintaining control, intervening if necessary to steer the conversation back on track in case it deviated from the relevant topic, but refraining from actively participating in or influencing the discussion. The moderator encouraged all participants to actively contribute to the discussions, promoting an inclusive and respectful environment.

All focus group sessions were audio recorded, using high-quality recording equipment to guarantee an accurate record of the discussions. The audio recordings were transcribed verbatim by a digital transcription tool. The transcriptions have been checked for accuracy and completeness. All data in the transcriptions have been anonymized.

Data Analysis

The participant's data collected from the focus group sessions were analyzed inductively via the means of thematic analysis (TA). The TA approach developed by Braun and Clarke (2006) refers to "a method for identifying, analyzing and reporting patterns (themes) within qualitative data". Inductive TA is data-driven meaning it does not begin with theoretical frameworks and pre-existing coding frames, but rather "works 'bottom up' from the data and develops codes (and ultimately themes) using what is in the data as the starting point" (Terry et al., 2017, p. 11). This approach aligns well with the study's aim of gaining new perspectives on women's specific lived MHS experiences and their perceptions of social media use. Allowing the data to determine the coding themes enabled a more accurate representation of what women need, want, and value regarding a gendered approach to the MHC system. Lastly, a semantic approach was chosen for the TA as it focuses on the explicit and surface-level meanings of the data. This approach is well-suited for examining participants' narratives and how they interpret their experiences as well as the explicit meaning they attribute to social media use for advocating about inclusive MHC.

To analyze the gathered data, the six-phase TA was undertaken (Braun & Clarke, 2022). Starting with the first phase - *familiarising yourself with the dataset* - I became familiar with the dataset by closely examining the content of the transcriptions and attempting to make initial analytic observations to gain preliminary insights. During the second phase - *coding* -, I started identifying and giving code labels to segments of the data and that appeared to be interesting, meaningful, and relevant to the research question. For example, a code label that emerged in this phase was the "dual nature of social media activism on women's mental health relationship". In the third phase - *generating initial themes* – I attempted to compile clusters of codes that share the same main idea to start with the theme development process. By doing so, I identified candidate themes that described broader meanings and addressed the research question. Next, in phase four - *developing and reviewing themes*- I evaluated the suitability of the candidate themes in relation to both the coded data and the entire dataset. I tried to improve the themes by dividing, combining, or discarding them as necessary. During phase five - *refining, defining, and naming themes* - I analyzed each theme focusing on developing a solid core concept and constructing a coherent narrative around it. This phase also involved choosing a concise and informative name for each theme. Considering the example mentioned above, the initial code was further refined and transformed into distinct final themes, such as "Oversimplifying Mental Health Through Social

Media" or "You Are Not Alone". Lastly, during phase six - *writing up* -, the analytic narrative of the themes was integrated with vivid data extracts to communicate a coherent story while addressing all different aspects of the research question.

Results

After conducting a TA of the gathered data, the results are identified and available to be reported. From the findings, seven themes with their related sub-themes were identified, reflecting the two-fold nature of the research question. Table 2 provides a comprehensive summary of the different themes. The present section delves into a detailed description of all the themes.

Women's Mental Healthcare Experiences and Perceptions

In relation to the first aspect of the research question, whether the experiences and perceptions of the women who participated in this study reflected the previously discussed gender-based barriers and inequalities in MHC provision, the first overarching theme, along with its themes and sub-themes has been identified. It is referred to as *gendered and non-gendered negative experiences and perceptions of women engaging with mental health services.*

Theme 1: Being a Woman in the MHC System. As part of the first overarching theme, theme 1 highlights participants' personal experiences and perceptions of how being a woman has negatively affected, or can affect, their journey of seeking or receiving MHC. Subtheme 1.1: *non-gendered negative experiences* emerged as reflecting on their personal lived experiences, none of the participants reported any adverse situation with MHS that could be attributed to their gender identity. For instance, participant #7 (Greek, 23 years old) emphasized *"Personally, I would say that fortunately, I have not experienced any discrimination as a result of being a woman in MHS."* However, through participants' discussions, their perceptions and personal opinions revealed a common belief that being a female patient can potentially have a detrimental impact on one's encounters with MHS. Thus, subtheme 1.2: *gendered perceptions of women's negative MHC experiences* emerged, for example, participant #10 (German, 20 years old) mentioned:

> *I believe that it [being a woman] can affect someone [their experience] … I very much expect that. I can see why that would be a problem. Imagine you have a problem with your child. You can't take or leave your child anywhere. And if you are single, I guess then that would be very, very hard if they cannot reschedule an appointment for you and just ignore the fact that you are a single mother.*

Table 2

Theme Summary Table

Theme	Subtheme	Example
Being a Woman in MHC System	Non gendered negative experiences	"In my case, because of the nature of my illness [bulimia disorder], I felt safe within MHS and not discriminated against as a woman."
	Gendered perceptions of women's negative MHC experiences	"They minimized her distress and attributed it to her role as a mother, while she had an anxiety disorder and had been struggling for years."
	Discrepancies in assessing women patients' experiences	"Therapists who are older, not well informed might minimize your experiences [as a woman] because they have a different mindset."
Non-Gendered Barriers to MHC Accessibility	Financial barrier	"I didn't have the money for private services… I tried to access some public services … They could only take me once per month, and this couldn't work for my depression."
	Delayed help	"I am waiting for an appointment with a psychiatrist in Germany, but I only got an appointment in July, and I made it three to four months ago. It was hard."
	Substandard care	"They could only take me in once a month, and this couldn't work for my depression … I felt helpless"
Ideas for a Gendered Approach to MHS	Continuing education for professionals	"If you're a therapist who's not educated and up to date on these, it can be so hard to understand your client"
	Unbiased MHC	"Mental health professionals need to free themselves from their own biases to encourage women to feel confident about who we are as women and to acknowledge that in the therapy setting."
Over-simplifying Mental Health Through Social Media	Misconceptions about mental health problems	"There are so many videos portraying mental illness so simply and people go and self-diagnose… it is still a serious thing."
	Comparison	"When I saw somebody else being on medication and going well, while I wasn't at that stage yet … it affected me negatively, I felt a lot of pressure."
Gendered Social Media and Women's Mental Health Deterioration		"They're not going to give you advice on how become anorexic but they're going to call it 'How not to get bloated?', it's like they have rebranded it."
Social Media in Educating About Women's Mental Health		"The benefits of this content are very important…people are being told that it's OK to feel this way and that they're valid."
Social Media Support for Mental Health.	You are not alone	"To see that I'm not the only one helps so much. It gives me a boost to think I'm not crazy."
	Access to mental health advice	"There were posts that had tips, daily positive messages that were very comforting."

This view of the participants was consistently observed in all the focus group discussions and was further reinforced by some of the participants' stories. Participant #7 (Greek, 23 years old), who

herself has been diagnosed with anxiety disorder, shared a story to explain why she believes that women can face implicit gender-based inequalities within MHC.

> *I have an example in my family environment of a woman who have anxiety disorder since she was 18 years old, but the doctor diagnosed her now that she is 60 years old, and she just started taking medication and doing therapy. All her life, everyone, including doctors, told her and made her believe that it's normal to have anxiety because being a mother is difficult, stressful and she had too many responsibilities. They all attributed her distress to this, whereas it was a disorder and the woman had been struggling for years.*

Moreover, subtheme 1.3 emerged named, *discrepancies in assessing women patients' experiences*. For several participants, their perception that women patients can potentially encounter adverse experiences with services simply because of their gender identity stems from their belief that professionals may fail to understand and validate women's certain experiences and emotions. Particularly, they highlighted experiences in relation to female-based sexist behaviors. For example, participant #9 (Greek, 23 years old) mentioned:

> *I really think that sexism can play a huge role. While you are in therapy, in many cases with both men and women therapists, some people might not understand your problems and experiences of sexism. They just don't get it, so they're not going to make you feel safe or understood in any way. And therapists are normal people, so some of them are sexist. I think a lot of women have felt unheard by therapists about things like that…. There are also therapists who are older, not well informed, and aware of how people from younger generations think about these issues. It is then likely that you will go to a therapist and talk for example, about a verbal assault or a catcall, and they will say "Why is that a big deal?" and try to minimize your experiences, just because they have a different mindset and don't understand.*

Another participant #10 (German, 20 years old) shared her concerns about therapists potentially invalidating her personal experience of sexual assault:

> *If I think about it, if I were to go to another therapist and tell the same story [of being sexually assaulted by her boyfriend at the time], it might be that they would struggle to understand how he was when we were in a relationship and the assault itself, because I continued to be in a relationship with him for about a year after that. I think it could have happened that my experience could have been invalidated.*

Reflecting on these views and discussions, participants attributed this inability of mental health professionals to differences between them and the patients. More specifically, they mentioned discrepancies in their belief systems, attitudes, and generational gaps, which might contribute to these mindset differences. Therefore, this sub-theme aims to shed light on the challenges women expect to face in accessing appropriate and empathetic MHC.

Theme 2: Non-Gendered Barriers to MHC Accessibility. This theme encompasses participants' insights regarding the numerous, non-gendered, challenges that people may face when attempting to seek help and access MHC. Subtheme 2.1: *financial barrier* emerged when most participants, in all focus group discussions, mentioned and agreed that one of the most difficult challenges is the high cost to accessing adequate MHC, which can be a strong deterrent to seeking help. For instance, participant #10 (German, 20 years old) noted: *"Therapy is very expensive. One session, which is 45 minutes costs €70, at least at my therapist…So it is quite a lot of money."* Participant #15 (Greek, 48 years old) emphasized:

> *The cost of weekly therapy is very high. You must be able to afford it, which I am struggling to do, but for now, it is still possible. However, it is a big deterrent for someone who wants to attend individual sessions.*

Another participant #13 (Greek, 62 years old) noted how financially independent women have the privilege to choose the best services for themselves: *"It is a treatment that you pay dearly for. If someone didn't consider my role as a mother and my difficulties as a woman, I would have chosen someone else. I wouldn't continue with someone who doesn't understand me."*

Subtheme 2.2: *delayed help* highlights another barrier frequently addressed by the participants, the issue of extended waiting times and insufficient availability of MHC resources. It was consistently mentioned that such problems can have extremely harmful consequences for people in need of mental health help. Participant #4 (German, 20 years old) shared her own experience of long waiting times to schedule an appointment within the German healthcare system.

> *I am waiting for an appointment with a psychiatrist in Germany, but I only got an appointment in July, and I made it three to four months ago. It was hard. I am going there because I am struggling a lot with PMS. But because he's a man and he obviously can't feel what I'm feeling or what I'm going through, I'm a bit scared that maybe he won't understand what I'm going to explain. So, in that case, I have wasted the whole waiting time. But if I had the choice, I would rather choose a woman therapist, but he was the only one available.*

Subtheme 2.3: *substandard care* refers to the significantly poor quality of public MHS particularly within the Greek healthcare system. Participant #6 (Greek, 30 years old) shared the following about the lack of adequate availability and quality of care in the Greek public health system and the negative impact this had on her well-being.

> *I started seeking care in a public mental health organization because I didn't have the money to afford private services. The problem was that the sessions lasted only 30 minutes because it was public service and they had too many people to accommodate. Then I tried to access some services through the municipality, and they didn't have any availability. They could only take you in once a month, and this couldn't really work for my depression. I remember that the employee said to me, "If you've got something serious, I'm sorry, I can't help you. I think it won't work to come only once a month." The situation made me feel very bad because I was in desperate need of help. I felt helpless, that I had something that no one could diagnose, no one could help me with.*

Theme 3: Ideas for a Gendered Approach to MHS. Throughout all the focus group discussions, it became evident that while participants discussed the different barriers, gendered or not, to receive appropriate MHC, their ideas, and views on how to address such issues were also raised. Additionally, participants discussed and explored ways to promote a gendered perspective in MHC that recognizes women's complex social roles and considers their unique needs when providing help. Subtheme 3.1: *continuing education for professionals* entails participants' idea for continuing education for practicing professionals and accordingly, specialized training for students that focuses on keeping them abreast of current social changes and trends and how these may affect women's experiences. For instance, participant #1 (German, 22 years old) noted: *"I think education is a very important thing. And it is also very important that all professionals who are providing the help feel able to provide the help one specifically needs."* Another participant (German, 20 years old) emphasized:

> *If you're a therapist who's not educated and up to date on these [toxic social media content e.g., accounts promoting anorexia or self-harm behaviors], it can be so hard to understand your client and how easily available this content is on their phones.*

Moreover, subtheme 3.2: *unbiased MHC* emphasizes how several participants highlighted the crucial need for therapists to eliminate their personal social biases and stereotypes in order to ensure

the provision of services that prioritize women and address their unique needs in a way that is independent of societal norms. Participant #3 (German, 23 years old) mentioned:

> *Mental health professionals need to free themselves from their own biases to encourage women to feel confident about who we are as women and to acknowledge that in the therapy setting e.g., encouraging women to be authentically sensitive rather than how women's sensitivity might be perceived by society.*

Social Media Use and Women's Mental Healthcare

In relation to the second aspect of the research question, whether social media activism can contribute to promoting a women-centered approach to MHC provision, the following two overarching themes have been identified (1) *the negative direction of social media use and women's MHC relationship* and (2) *the positive direction of the social media use and women's MHC relationship*.

Theme 4: Over-simplifying Mental Health Through Social Media. This theme belongs to the first overarching theme and focuses on participants' views on how certain social media content can contribute to oversimplification and generalization of what mental health problems can appear to be. Subtheme 4.1: *misconceptions about mental health problems* shows how participants emphasized the serious consequences generalization can have, including consuming misleading information and misconceptions about the nature of mental health challenges as their full complexity is often overlooked. For instance, participant #10 (German, 20 years old) mentioned:

> *I think the conversation about mental health on social media is very important. But there are so many videos saying "If you have these five symptoms, you have depression." And then people say, "I saw this TikTok and now I have depression". No, you don't, you're sad! You can have normal emotions without it being a mental illness…. Also, it is still an illness, it's a serious thing, you can't just portray it so simply, and then people go and self-diagnose…. There are non-experts with limited knowledge who create content spreading misinformation that influences people.*

Furthermore, subtheme 4.2: *comparison* describes how some participants had negative experiences of engaging with content from people sharing their mental health journey and making generalizations, overlooking the diversity of individual experiences. Two participants with a diagnosis of anxiety and depression respectively highlighted the disadvantages of comparing their mental health journey online with others. Participant #7 (Greek, 23 years old), said:

> *There is a lot of generalization in social media and sometimes it has affected me negatively. I mean, there was a time when if I saw somebody else doing well or was on medication and going well, while I wasn't at that stage yet, I was still working on it, it affected me negatively, I felt a lot of pressure. It didn't help me.*

Theme 5: Gendered Social Media and Women's Mental Health Deterioration. As part of the first overarching theme, theme 5 focuses on participants' discussion regarding the detrimental effect of certain social media content on women's wellbeing and how it exacerbates existing mental health challenges. Such content is mainly related to women's body image and female gender stereotypes. For instance, participant #10 (German, 20 years old) noted *"back when I was in my early teens, the whole anorexia blogs on Tumblr and stuff were very prominent. I think it's less now, but I also feel like they've rebranded it."* Participant #9 (Greek, 23 years old) continued:

> *Yes, it still exists on Tik Tok. They're not going to give you advice on how to eat less and become anorexic but they're going to call it "That girl aesthetic" or "What do I eat in a day?" or "How not to get bloated?" it's like they're branding it in a different way. They also rebrand sexism and call it "female and male energy". These are still stereotypes!*

Theme 6: Social Media in Educating About Women's Mental Health. On the positive side of the relationship between social media use and women's MHC, theme 6 highlights participants' belief that certain social media content can have a positive impact on women who struggle with mental health. Such content aims in educating others and raising awareness of mental health problems to promote a better understating and positive view of mental health among people. Participants emphasized that this content could work towards humanizing and destigmatizing mental health experiences as well as validating the emotions of people who struggle. Participant #7 (Greek, 23 years old) shared *"The benefits are very important, that people are being sensitized, that they're being told that it's OK to feel this way and that it's valid. That's something very positive we've achieved on these platforms that we didn't have before."* Participant #8 (German, 22 years old) mentioned *"For example, people who create content can give you a 15% discount on online therapy app because of their brand deal and that's really cool. And it gives awareness and takes away the scary part of going to therapy."* Another one (German, 20 years old) said *"This content destigmatizes mental illness and gives the message that having one does not mean you are broken and that's extremely important."*

Theme 7: Social Media Support for Mental Health. This theme, also part of the second overarching theme, captures how social media platforms can serve as powerful tools for women who struggle mentally to find different kinds of support. Subtheme 7.1: *you are not alone* describes participants' view of social media as a safe online space to find emotional support and comfort by helping them to realize that they are not alone in their struggles. For them, social media also facilitate the creation of supportive communities by connecting users who share similar experiences, feelings, and concerns. For instance, participant #4 (German, 20 years old) noted *"When I see people share their experiences and struggles, it makes me feel less alone. It may not improve my situation directly, but it brings me some comfort."* Similarly, participant #7 (Greek, 23 years old) said *"To see that I am not the only one helps so much. It gives me a boost to think " I'm not crazy" and that's so important because you don't know how many times in my life, I felt like I was going crazy."* Additionally, participant #6 (Greek, 30 years old) said:

> *I follow a group on Facebook…. But it has become very supportive, and members share mental health advice, seek therapist recommendations or guidance on leaving abusive partners. And this has made me feel good, that I'm in a community where I can talk freely because you can also post anonymously. It has become a very safe space for me.*

Moreover, participants discussed another type of support that social media can provide, focusing on access to online mental health advice. Subtheme 7.2: *access to mental health advice* emphasizes participants' view that certain online content can serve as a helpful guide for individuals seeking to understand their own mental health experiences and gain advice on dealing with them. Many participants agreed that online platforms can provide easily accessible and valuable information about mental health advice such as simple tips, copings strategies and self-care practices. For example, participant #7 (Greek, 23 years old) shared: *"I follow different pages that have been very helpful, especially when I was struggling with my disorder during Covid-19. There were posts that had tips, daily positive messages that were very comforting. I often shared them to help others that might need them."*

Discussion

The aim of the present study was twofold: (1) to explore women's lived experiences and perceptions of mental health services, specifically investigating whether these reflect gendered biases, barriers, and inequalities within the provision of MHC and (2) to examine women's views in order to understand how social media use can contribute to promoting a gendered approach to

MHC. In this section, the insights that emerged from the focus group discussions will be thoroughly examined to illustrate the underlying factors contributing to these results.

Women's Experiences of Mental Health Services

The findings of this study showed that none of the fifteen women who participated had any personal experiences that revealed gender biases or a lack of gender recognition in the treatment they received from mental health providers (subtheme 1.1: *non-gendered negative experiences*). These results are not consistent with evidence that have substantiated that women struggling with mental illnesses frequently face adverse experiences within MHS attributed to biases and discrimination based on their gender identity (Borba et al., 2012; DHSC & Agenda, 2018; Mizock & Brubaker, 2019). The lived personal experiences of participants did not reflect a potential lack of MHS to acknowledge, address and support women's needs, complex social roles and gendered responsibilities when providing MHC (McNeish & Scott, 2014; MHER Office, 2023; Mowbray et al., 1992; Teh et al., 2008).

Privilege of Choice. Throughout the focus group discussions, it became clear that the participants had the financial means to afford high-quality MHC and were, therefore, able to choose the mental health providers, resources, or services they preferred. Individuals who have the privilege of financial stability experience greater options and flexibility in choosing mental health professionals, treatment modalities, and facilities. On the other hand, women encountering financial difficulties are often deprived of the privilege of choice in seeking and receiving MHC. As a result, they may be unable to terminate services that do not meet their specific needs as women (Andrade et al., 2014; Diep et al., 2022; Memon et al., 2016; MHER Office, 2023).

For the Greek participants of the current study, the financial privilege of choice holds significant relevance. The Greek healthcare system consists of a combination of the National Health System, compulsory work-related social insurance, and private healthcare (Ziomas et al., 2018). Although the National Health System provides free and equal access to healthcare for all citizens, the quality of MHS, particularly, is severely lacking. Greek public MHC suffers from chronic underfunding, organizational challenges, inadequate staffing, excessive waiting times, and an insufficient number of available appointments (Christodoulou & Kollias, 2018; (Vlassi et al., 2022). As a result, people with financial means have the opportunity to opt for private MHC instead.

Regarding the German participants, the absence of adverse gender-based encounters with services could also be attributed to their financial privilege of choice. In the German healthcare system, individuals are required to have statutory health insurance if their income does not exceed a certain threshold. However, those who earn above this limit have the option of choosing private insurance (Döring & Paul, 2012). Evidence has shown that the German healthcare system exhibits inequalities in healthcare based on individuals' insurance status (Klein & von dem Knesebeck, 2015), with privately insured patients experiencing shorter waiting times, longer treatment durations, and greater attention to their needs (Roll et al., 2012).

Considering this, it can be postulated that the women who participated in this study may have not experienced gender-biased MHC and treatment, mainly due to their financial independence to access private services or be privately insured. In this way, they were able to choose services that met their specific gender needs and if necessary, discontinue or seek alternative options. It is important to note that although all participants reported having the financial privilege to access adequate mental health care, they expressed a common expectation that financial limitations can significantly hinder women from seeking MHS. This expectation is rooted in their own perceptions shaped based on information they have gathered through others.

Women's Perceptions of Mental Health Services

While participants did not specifically report negative gendered experiences during their MHC journeys, they all shared a common perception that MHS and providers often fail to recognize and address the specific needs of women, potentially harboring gender biases against female patients (subtheme 1.2: *gendered perceptions of women's negative MHC experiences*). To begin with, as analyzed extensively above the participants' perceptions of gender bias and discrimination faced by women within services, as well as the lack of services to address their needs related to gender identity, are consistent with previous research findings (DHSC & Agenda, 2018; McNeish & Scott, 2014; MHER Office, 2023; Mowbray et al., 1992; Teh et al., 2008). Furthermore, such perception of women can be reinforced by the perspective of mental health professionals. Chandra et al., 2019 discovered compelling global evidence, indicating that even in the high-income countries, a significant majority of experts expressed high levels of dissatisfaction with the availability of gender-sensitive services for women.

An important aspect to explore is how participants rationalize their beliefs, despite not personally experiencing negative gendered encounters that could typically contribute to such a

perception (Moreland et al., 2018). In general, such belief can arise from a number of factors, including lack of trust or confidence in the mental health system which may be perpetuated by societal norms, personal experiences of others, or an awareness of the barriers women face in accessing services. While discussing, there was a clear consensus among the participants that their belief regarding female patients' experiences stems from the acknowledgment of significant mindset differences between mental health professionals and women patients. They attributed these differences to variations in belief systems, attitudes, and generational gaps (subtheme 1.3: *discrepancies in assessing women patients' experiences*).

Gendered Approach to Mental Health Services

To better understand participants views regarding women's gendered negative experiences within services, their ideas on how to promote a gendered perspective in MHC system were discussed. To begin with, participants agreed on the importance of implementing a gendered approach to MHC that prioritizes women's specific needs and actively addresses gender-based inequalities, biases, and gender-role stereotyping in service provision. Across all focus group sessions, participants discussed and highlighted the importance of continuous education and specialized training for mental health providers already working in the field or aspiring to enter it (subtheme 3.1: *continuing education for professionals*). Integrating continuing education and training for professionals that focuses on tackling female-based gender bias has consistently emerged in the available literature as a critical aspect that should be incorporated into healthcare interventions (Celik et al., 2011; Chandra et al., 2019; WHO, 2002; WHO, 2011). For instance, in 2011, WHO published an extensive manual for health managers focusing on developing skills in gender training and gender analysis. The aim was not only to raise awareness of gender-based health inequalities but also to facilitate effective action. By providing the tools needed to develop and implement gender-responsive health policies and programmes, the manual aimed to eliminate harmful gender norms, roles, and inequalities, thereby empowering women and improving their overall well-being (WHO, 2011). Furthermore, a recent systematic review that focused specifically on research on gender-sensitive training and education interventions for healthcare providers found that 37% of the studies indicated that following the training, practitioners' gender-related knowledge, attitudes and practices significantly improved (Lindsay et al., 2019). The participants' discussions clearly revolved around strategies for policy change in the health sector, indicating a

strong emphasis on addressing systemic issues. However, participants did not seem to view themselves as actively contributing to the solution.

Social Media Use and Women's Mental Healthcare

In relation to the second aim of the research question, the findings regarding participants' views on social media use for women to share their negative gendered experiences with MHS need to be examined. Reviewing the themes and subthemes identified for this aim, it becomes evident that participants exhibited mixed views regarding the use of social media to discuss mental health related topics. Across all focus group discussions, participants agreed that social media content centered around mental health can have both positive and negative impacts on individuals who consume it.

Participants identified several significant benefits associated with discussing mental health online and engaging with related content. An alignment was found between participants' views and existing studies, indicating consistency in understanding social media use in the context of mental health awareness. Participants highlighted the benefits of informative social media content in mental health education (theme 6*: Social Media in Educating About Women's Mental Health*), emphasizing its ability to offer accurate information and contribute to the destigmatisation of mental health disorders (Naslund et al., 2016; Peek et al., 2015; Sadagheyani & Tatari, 2020). Furthermore, in subtheme 7.1: *you are not alone* participants identified social media as means for receiving support and connecting with peers, ultimately leading to feelings of hope and belonginess (Bucci et al., 2019; Naslund et al., 2016; O'Reilly et al., 2022). Additionally, in subtheme 7.2: *access to mental health advice*, participants' view that social media can provide easily accessible resources for mental health advice to help individuals understand their experiences and deal with them is in line with findings from the available literature (O'Reilly et al., 2022). Participants' recognition of the potential of social media to raise awareness and be a means for patients to advocate for mental health reflects their positive view of using online platforms to advocate for women's negative gendered experiences in mental health, with the aim of driving change.

Apart from the benefits, participants in their discussions also acknowledge the negative side of talking about mental health issues online. They emphasized the risk of certain content oversimplifying and generalizing mental health problems by spreading misinformation and misconceptions about the nature of mental health challenges and failing to address their full complexity (Theme 4: *Over-simplifying Mental Health Through Social Media*). In their study,

Yeung et al. (2022) confirm such views by showing that over 50% of the analyzed TikTok videos about ADHD contained misleading information and approximately 15% oversimplified the disorder. In addition, participants expressed their concerns about toxic social media content related to women's body image and female gender stereotypes that can have serious consequences to women's well-being (Theme 5: *Gendered Social Media and Women's Mental Health Deterioration*). This is consistent with findings linking girls' body image dissatisfaction and lower self-esteem to appearance-focused social media engagement and use (Markey & Daniels, 2022).

Based on these findings, it can be concluded that social media platforms offer several benefits to individuals facing mental health challenges, leading to numerous positive effects. These benefits, among others, include educating and raising awareness about women's mental health issues, which can potentially include advocating for improved and more inclusive MHC as well. This, in turn, can contribute to promoting a more gendered approach to MHS for women. However, given the reported negative aspects of social media, it is crucial to highlight the importance of cautious communication for content creators, who need to be mindful of both the content of their message and the way in which they communicate it. On the other hand, people consuming such content need to be discerning about what they engage with and approach all information critically.

Implications of the Research Findings

The findings of the present study have significant implications emphasizing the crucial role of women's voices in gaining genuine insights into their experiences and expectations of MHS. Although the participants did not report any direct adverse gender-related experiences and thus, the research gap cannot be addressed, their perceptions, views, and expectations, as discussed, confirm the need for a gendered approach to MHC. An approach that addresses the specific mental health challenges faced by women and fully supports and integrates their needs, social roles and responsibilities in the design and delivery of healthcare. By amplifying women's voices, the lived experiences, thoughts, and feelings can be better understood and thus, the critical priorities that need to be addressed when implementing a gendered approach can be better recognized. The inclusion of both gendered and non-gendered barriers to women's MHC access from the present study contributes valuable insights to the existing literature on women-centered issues that require attention.

Although the sample used in the present study was not exclusively composed of university students, considering that this research is a bachelor thesis initiated by the University of Twente

(UT), the findings can carry important implications for the university itself. More specifically, the importance of amplifying women's voices in exploring such issues can serve as a guide for potential future research within the UT setting. Researchers at UT can consider the findings of the present study to initiate an investigation of the lived experiences, expectations, and views of the women students, employees and other patients utilizing MHS offered by UT. Such an initiative would provide valuable insights into the way MHS at UT function and assess the necessity of applying a gendered approach to them. Consequently, it would contribute to the decision of designing and implementing effective gender-sensitive MHC interventions, inclusive strategies, and guidelines, focusing on the specific gendered mental health needs and experiences of the women within the university community.

In relation to the effectiveness of utilizing social media platforms to advocate about more inclusive and gender-sensitive MHS, the findings carry another important implication for UT. Participants demonstrated an optimistic perspective regarding social media use to raise awareness about gendered negative healthcare experiences and gender-based health inequalities. UT can use such findings to create an online mental health awareness campaign focusing on promoting gender-sensitive approach to MHC. In such a campaign UT can leverage its network and recourses to organize and encourage women students and employees to share their experiences with MHS online. This can be accomplished through a coordinated effort, for example by using a specific hashtag or platform to make it easier for people to participate. By organizing and executing a successful social media campaign, UT can effectively raise awareness about the importance of implementing a gendered approach to MHC. Such campaign can attract the interest of key decision-makers in the healthcare industry, having a significant impact on their practices and policies regarding gender-sensitive MHC. As a result, the synergy between powerful social media use and insightful patient feedback can motivate policymakers and organizations to foster quality improvement processes driving meaningful changes on gendered approaches and women' mental health needs.

Study Limitations and Recommendations for Future Research

To fully leverage the findings and explore their potential implications, it is important to identify the limitations encountered in this study and consider recommendations for future research. The first limitation refers to selection bias. Regarding the sampling method, as with any study that uses a convenience sample, the generalizability of the current findings is limited, and the

introduction of bias is possible. Selecting participants who are readily available and easily accessible may result in non-representative sample that does not properly reflect the traits of the target population. Therefore, it is crucial for future research to consider using different recruitment methods and more specifically, random sampling. The robustness and generalizability of the research will be improved by utilizing random sampling and thus, obtaining a more diverse sample with a greater variety of distinct demographic characteristics.

The choice of population can present another limitation. In the context of the present study, the inclusion criteria focused on identifying women participants who had utilized MHS, regardless of their experiences. However, upon reflecting on the data collection process and examining the results, it became apparent that such criterion led in the inclusion of participants who had not experienced any gender-based inequalities and barriers to mental health use. As a result, the findings revealed participants' expectations and perceptions of these issues, rather than their lived experiences. Specifically selecting women who had negative experiences with MHS could offer deeper insights into the nature of such encounters. By including this subset of participants, the sample would yield more purposive and applicable results for this population. Future research might therefore benefit from considering the importance of selecting specific subgroups within the population based on their experiences, as this may lead to a more thorough understanding of the phenomenon under investigation. Researchers can improve the applicability and relevance of their findings by acknowledging these limitations and incorporating it into future research design.

Despite these limitations, the present study contributes to the existing body of evidence, demonstrating the need for a gender-sensitive, and ideally transformative, approach to MHS for women. Although the findings did not expand our understanding with different types of women's gendered MHC experiences, they did yield valuable insights into women's expectations of MHC provision. These expectations and perceptions reflect women's concerns about encountering non-gendered barriers such as financial stain, as well as gender-based bias and health inequalities, including sexist behaviors and biased assessments by mental health professionals. These findings could be combined with leveraging social media's power to effectively reach a wide audience and raise awareness about the need of adopting a gendered approach to MHS, aiming to eliminate gender-based health inequalities and change women's expectations about MHC. UT community could use these results in many ways including motivating women to actively engage with social

media platforms to advocate about their healthcare experiences, ultimately inspiring healthcare decision makers to consider real-life patient feedback and make steps towards meaningful changes.

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Appendix A

Participant Information Sheet

You are being invited to take part in the research study *"Amplifying Women's Voices: Women's Mental Healthcare Experiences and Social Media's Role in Promoting a Gendered Approach to Mental Healthcare"*. This study is being conducted by Angeliki Mantzana from the Psychology Programme of the Faculty of Behavioural, Management and Social Sciences at the University of Twente, as part of the Bachelor Thesis. Before you decided it is important for you to understand why the research is being done and what participation will involve. Please take time to read the following information carefully. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether you wish to take part. Thank you for reading this!

Purpose of the Study

The present study aims to investigate the lived experiences and perceptions of women who have used, are using, or have ever thought of using mental health services across Europe. Moreover, it aims to explore the role of social media use as a means of promoting a gendered perspective in mental health systems, which will enable services to recognize and address women's unique needs and responsibilities.

Benefits and Risks of Participating

By participating in this study, some participants may benefit. Sharing personal experiences and opinions can help participants to feel validated and to gain new insights into their own behavior, attitudes, and beliefs. Engaging in meaningful discussions with others who have similar experiences can help participants realize that they are not alone and that their feelings and experiences are valid and normal. It can also allow participants to connect with each other and build a support system as they share their challenges with others who understand and empathize with them.

The present study aims to avoid exposing participants to any discomfort, despite some sensitive topics discussed. Thus, certain measures are planned to minimize any risks. A safe and understanding environment will be created so participants can feel comfortable sharing their experiences. Moreover, apart from this information sheet and informed consent, participants will be given extra verbal information about privacy and confidentiality issues as well as any other

question they have. The present study has been reviewed and approved by the BMS Ethics Committee.

Rights of Participants

Participating in this study is entirely voluntary. Participants are free to decline to participate, omit any question, or they can withdraw from the study at any time without the need to give an explanation. Participants have also the right to request access to and rectification or erasure of personal data.

Usage of Data, Confidentiality and Anonymity

The data provided by participants will only be used for the purposes of the study. The data will be treated confidentially and will not be shared with any other parties than the researcher and their supervisor. All data will be anonymized and stored in a highly secure way with controlled access. After the completion of the bachelor's thesis, all the recordings will be destroyed. The anonymized transcripts will be stored for a longer period.

Appendix B

Informed Consent Form

Consent Form for "Amplifying Women's Voices: Women's Mental Healthcare Experiences and Social Media's Role in Promoting a Gendered Approach to Mental Healthcare".

	Yes	No
Please tick the appropriate boxes		
Taking part in the study		
I have read and understood the study information dated [19/05/2023], or it has been read to me. I have been able to ask questions about the study and my questions have been answered to my satisfaction.	□	□
I consent voluntarily to be a participant in this study and understand that I can refuse to answer questions and I can withdraw from the study at any time, without having to give a reason.	□	□
I understand that taking part in the study involves an audio recorded focus group. The audio recording will be transcribed as text to help us analyse the data and will be destroyed after the completion of the BSc Thesis.	□	□
Risks associated with participating in the study		
I understand that taking part in the study involves the risk of experiencing mental discomfort as sensitive topics might be discussed.	□	□
Use of the information in the study		
I understand that information I provide will be used for the BSc Thesis report.	□	□
I understand that personal information collected about me that can identify me, such as [e.g., my name or where I live], will not be shared beyond the study team.	□	□
I agree that my information can be quoted in research outputs.	□	□
Consent to be audio recorded		
I agree to be audio recorded.	□	□

Signatures

_____	_____	_____
Name of participant	Signature	Date

I have accurately read out the information sheet to the potential participant and, to the best of my ability, ensured that the participant understands to what they are freely consenting.

_____	_____	
Researcher name	Signature	Date

Researcher's contact details for further information:

Name: Angeliki Mantzana

Email address: a.mantzana@student.utwente.nl

Phone number: +306972435581

Contact Information for Questions about Your Rights as a Research Participant

If you have questions about your rights as a research participant, or wish to obtain information, ask questions, or discuss any concerns about this study with someone other than the researcher(s), please contact the Secretary of the Ethics Committee/domain Humanities & Social Sciences of the Faculty of Behavioural, Management and Social Sciences at the University of Twente by ethicscommittee-hss@utwente.nl

Appendix C

Demographics Questionnaire

Thank you for taking the time to complete this questionnaire.

1. Name: _____

2. Gender: _____

3. Age: ____

4. Nationality: _____

5. Please put an X in the box of one or more of the following statements that best describe your situation.

   I have used mental health services in the past. ☐

   I am currently using mental health services. ☐

   I have considered using mental health services in the past, but I did **not** do so. ☐

   Other
   If "other", please specify: _____

6. If you have used or are currently using mental health services, please put an X in the box for the type(s) of mental health services you have used or are currently using.

   Private/public **outpatient mental health treatment** (mental health treatment where participants visit the treatment center or therapist's office on certain days of the week e.g., individual/group psychotherapy sessions) ☐

   Private/public **inpatient or residential mental health treatment** (mental health treatment takes place in a residential facility on a 24/7 basis) ☐

   Other

If “other”, please specify:

_____

7. If you have used or are currently using mental health services, please indicate in which European country.

_____

8. If you have used or are currently using mental health services, please indicate for how long you have been or were under their care.

Appendix D

Interview Guide

Experiences Questions

1. How would you describe your overall experience with mental health services? (Positive, negative, neutral, other)
2. What exactly made your experience negative/positive/neutral? In what way was your experience negative/positive/neutral? Give specific examples.
3. How did this negative/positive/neutral experience affect you? How did it make you feel?
4. What are the problems with your experience? What gaps need to be addressed in mental health services to make the overall experience better?

Experiences as a Woman

5. Do you feel that being a woman has affected your (overall) experience of mental health services, the way you have been treated by professionals and the type (positive/negative) of experience you have had?

Opinions/Perceptions/Views

6. Do you believe that being a woman can in any way affect one's experience of mental health services and the way professionals can treat them?

Changes towards more gendered mental healthcare approach

Research supports that mental healthcare services often fail to achieve gender equity in the way they provide care, and they are unable to meet women's unique needs, responsibilities, and social roles. An example for this that mental health services often do not support women's roles as mothers/caregivers, by not being flexible to reschedule an appointment or even not recognizing how important is for women to have this role. Another example is that services often fail to recognize and address the gender-based violence (e.g., intimate partner violence) and its serious consequences for women's well-being.

7. How can we better address such needs (described above), women's specific needs and responsibilities within the mental health system? How can we establish an approach to mental health care that is more gender-sensitive and even women-centered when addressing women's needs?
8. What else matters to you as woman when it comes to mental health care?

Social media questions

Now we are moving on the next part of the discussion. Social media platforms can provide a powerful space for individual to engage with activism and eventually help in raising awareness about different social issues and potentially leading to positive change. Many people use their social media accounts to share experiences regarding mental health-related matters or to share personal stories with mental health services. They do that for many reasons: to raise awareness, educate others, find support, build community and other.

Example of social media activism regarding mental health services

- *A few years ago, there was this Twitter trend with #dearmentalhealthprofessionals, where people shared their experiences and stories with mental health professionals. For example, one tweet said → "#dearmentalhealthprofessionals ban 'attention-seeking' & 'manipulative'. People still need help, even if they been taught awkward ways of asking." Now I would like to ask you:*

1. Do you follow or engage with any social media account that created content about mental health?
2. If yes → How do you use it/engage with this content and for what purposes?
3. If yes → Do you think that consuming such content has any effect on you?
4. What do you think of this type of content? Do you find it beneficial or not? If yes, in what way such content is beneficial (e.g., you find comfort/support/connect with others)? If not, why such content is not beneficial?
5. What would you like to see as content on social media that could support your mental health journey?
6. Do you think that activist content on social media could address your negative experiences with services and help change the problems? If yes, in what way? If not, why not?
7. Since you have some negative experiences/perceptions views, would you be willing to create yourself social media content to share your experiences and try to make a change?
8. Was anything you wish I have asked, and I did not?