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ORIGINAL RESEARCH

Experiences of Mental Health Challenges among Vulnerable Groups in Indonesia

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Abstract

Background: Despite growing global recognition of mental health needs, qualitative evidence on how different vulnerable populations in Indonesia experience mental health challenges and navigate help-seeking within the same sociocultural context remains limited. This knowledge gap may result in unrecognized psychosocial needs, underutilization of mental health services, insufficiently tailored interventions, and persistent inequities in mental health service provision.
Purpose: This study explored the experiences of mental health challenges among vulnerable populations, including adolescents, university students, pregnant and postpartum women, and caregivers of individuals with severe mental illness.
Methods: A qualitative descriptive design was employed. Data were collected through five focus group discussions (FGDs) with 18 participants recruited through purposive sampling in the Special Region of Yogyakarta: three pregnant women, three postpartum women, four caregivers of individuals with severe mental illness, four adolescents, and four university students. Source triangulation was conducted through an additional FGD involving five mental health care providers. Verbatim Indonesian transcripts were analyzed using thematic analysis with manual coding supported by Microsoft Excel. Trustworthiness was enhanced through peer debriefing and cross-verification among the research team.
Results: Three overarching themes emerged: (1) root causes of mental health vulnerability, encompassing family- and perinatal-related stressors, developmental and identity-related stress, and caregiving burden and social exclusion; (2) coping and help-seeking practices, shaped by emotional disclosure preferences, support systems, and mental health literacy; and (3) structural gaps in mental health services, including inadequate service integration, logistical barriers, and mistrust of care quality. Help-seeking preferences varied across vulnerable groups and were influenced by stigma, concerns about confidentiality, and perceived accessibility of mental health services.
Conclusion: Vulnerable populations experience mental health challenges through distinct psychosocial stressors, coping strategies, and help-seeking behaviors. These findings underscore the need for person-centered, culturally responsive, and population-specific mental health services that address the diverse needs of vulnerable groups.

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1. Introduction

Mental health is increasingly recognized as a fundamental component of overall well-being and human development. Globally, an estimated one in eight people lives with a mental disorder, with anxiety and depression being the most prevalent conditions (World Health Organization [WHO], 2022c). However, in middle-income countries like Indonesia, mental health issues remain underprioritized within health systems, with limited service availability, persistent

stigma, and fragmented policy implementation (Basrowi et al., 2024; Rahvy et al., 2020). Addressing these challenges is essential to achieving equitable, effective, and sustainable mental health care for all and reducing the burden of mental disorders in Indonesia.

In Indonesia, the burden of mental disorders remains substantial. According to the Indonesian Health Survey (Ministry of Health of the Republic of Indonesia, 2024), approximately 2% of individuals aged 15 years and older experienced mental health problems, 1.4% had depression, and 4 per 1,000 households had at least one family member living with schizophrenia. Despite the enactment of the Mental Health Law No. 18/2014, significant implementation gaps remain, particularly in integrating mental health into primary care and community-based services (Rahvy et al., 2020; WHO, 2022a). Moreover, the mental health workforce remains insufficient, with only 0.31 psychiatrists and 2.52 mental health nurses per 100,000 population, far below recommended levels (WHO, 2022b). These gaps underscore the urgent need for systemic reforms and stronger community-based approaches to address the growing mental health burden, particularly among vulnerable populations.

Vulnerable populations, including pregnant and postpartum women, adolescents, university students, and caregivers of individuals with severe mental illness (IWMI), face compounded risks arising from social, cultural, and structural determinants. These groups often encounter heightened stigma, limited autonomy in help-seeking, and multiple barriers to accessing appropriate mental health care, particularly in decentralized health systems (Daniels et al., 2022; Laranjeira & Querido, 2024). Adolescents and young adults, for example, frequently report concerns about confidentiality and fear of being judged by parents or educators, which discourage them from seeking professional support (Radez et al., 2021; Velasco et al., 2025). Meanwhile, caregivers of individuals with severe mental illness often experience considerable emotional, physical, and financial burdens that are further exacerbated by limited formal support and inadequate mental health services (Daliri et al., 2024; Fitryasari et al., 2025).

These groups were included in this study because they are particularly vulnerable to mental health problems, although the underlying sources of vulnerability differ across populations. Pregnant and postpartum women are at increased risk because of hormonal changes and psychosocial stressors. Adolescents and university students face developmental transitions, academic pressure, and identity-related challenges, whereas caregivers of individuals with severe mental illness experience substantial emotional, social, and financial burdens. These distinct risk profiles justify their inclusion as key vulnerable populations in this study.

Qualitative research is particularly valuable for capturing the lived experiences of individuals navigating mental health challenges, especially in culturally diverse and resource-constrained settings (Fitryasari et al., 2025; Wells & Giacco, 2024). It provides a deeper understanding of how stigma, family dynamics, service accessibility, and cultural beliefs shape experiences of psychological distress, coping processes, and help-seeking behaviors (Laranjeira & Querido, 2024; Radez et al., 2021; Subandi et al., 2021; Velasco et al., 2025).

Although previous studies in Indonesia have examined mental health among adolescents, postpartum women, university students, and caregivers separately, little is known about how these vulnerable groups experience mental health challenges within the same sociocultural context or how their experiences converge and diverge. In the Indonesian context, these experiences are likely to be further shaped by strong collectivist family values, religious and cultural beliefs surrounding mental illness, persistent stigma, and considerable regional disparities in the availability and accessibility of mental health services. Most existing studies have focused on prevalence estimates or risk factors, whereas qualitative evidence comparing lived experiences, coping strategies, help-seeking behaviors, and expectations for mental health services across vulnerable groups remains limited. Without such evidence, mental health policies and community-based interventions may remain fragmented and inadequately address the specific needs of different vulnerable groups.

This study sought to address that gap by exploring the experiences of vulnerable groups in Yogyakarta, Indonesia. Through focus group discussions, we examined the perceived causes of psychological distress, coping strategies, barriers to accessing mental health services, and participants' expectations for service improvement. By amplifying the voices of vulnerable populations, this study contributes to the growing evidence base needed to support equitable, person-centered, culturally responsive, and community-integrated mental health care in Indonesia and other middle-income settings. Specifically, this study addresses the following

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research question: How do vulnerable populations experience mental health challenges and navigate help-seeking within the sociocultural context of Yogyakarta, Indonesia?

2. Methods

2.1 Research design

This study used a qualitative descriptive design to explore the experiences of vulnerable populations regarding mental health challenges and care-seeking behaviors. A qualitative descriptive approach was selected because it enables rich, contextualized accounts of participants' perspectives without imposing a priori theoretical frameworks (Sandelowski, 2000). The study was guided by established principles of qualitative inquiry in mental health research, emphasizing reflexivity, contextual sensitivity, and participants' voices (Peters, 2010). Consistent with this approach, the study used no predefined theoretical framework, allowing participants' experiences to emerge inductively from the data and keeping the analysis grounded in their accounts.

2.2 Setting and participants

Data collection was conducted through focus group discussions (FGDs). The FGDs were selected because the study sought to explore shared experiences, as well as similarities and differences in mental health challenges within each vulnerable population. Group interaction enables participants to build on one another's experiences, generating richer and more nuanced discussions than might have been achieved through individual interviews.

Participants were recruited using purposive sampling to achieve maximum variation in age, educational background, and lived experiences within each vulnerable group. Although the target sample comprised 25 participants (five from each group), adverse weather conditions during the data collection period substantially affected attendance in several groups. Consequently, 18 participants (three pregnant women, three postpartum women, four caregivers of individuals with severe mental illness, four adolescents, and four university students) took part in the FGDs. Despite the smaller sample, the data were considered adequate because the discussions generated rich and diverse accounts, and no substantially new concepts emerged during analysis. Data adequacy was therefore determined by the depth and breadth of the information obtained rather than by participant numbers alone. Eligible participants were residents of the Special Region of Yogyakarta, were willing to participate in the FGDs, and were able to communicate effectively. Individuals with hearing or speech impairments were excluded.

Separate FGDs were conducted for each participant group to facilitate in-depth exploration of group-specific experiences. Recruitment strategies were tailored to each population to ensure diverse yet contextually relevant perspectives. Pregnant and postpartum women, as well as adolescents, were recruited with the assistance of community mental health nurses from primary health care centers *(Puskesmas),* whose established relationships with community members facilitated trust and engagement. Caregivers of individuals with severe mental illness were identified through referrals from a psychiatric hospital, supported by research assistants with prior field experience. Meanwhile, university students were recruited through campus counseling, which distributed study flyers across university counseling units.

To enhance data credibility through source triangulation, an additional FGD was conducted with five mental health professionals, including one psychiatric hospital nurse, two community mental health nurses from primary health care centers, and two university counseling psychologists. A psychiatrist from the psychiatric hospital was invited but was unable to attend on the scheduled date. Eligible mental health professionals had at least one year of experience providing mental health services and expressed willingness to participate in the FGD. Mental health professionals were recruited through direct invitations from the principal investigator and research team, delivered both in person and via WhatsApp to facilitate participation. Researchers had no prior relationships with any of the participants before recruitment.

2.3 Data collection

Data were collected through five focus group discussions (FGDs) conducted between 7 and 14 November 2024. One FGD was conducted for each vulnerable group to facilitate in-depth exploration of group-specific experiences. This design was appropriate because the study aimed to identify both shared and population-specific mental health challenges across multiple vulnerable groups rather than to generate an exhaustive understanding of any single population.

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Participants were purposively selected to maximize variation in demographic characteristics and lived experiences within each group. Data adequacy was evaluated based on the richness, diversity, and relevance of the information obtained in relation to the study objectives rather than solely on the number of FGDs conducted. An exception was made for source triangulation, in which a single mixed-group FGD was conducted with mental health professionals from different practice settings. This discussion aimed to provide complementary perspectives and clarify and validate issues raised by participants from vulnerable groups.

Questions for the vulnerable groups explored perceived contributors to mental health challenges, experiences of psychological distress, coping strategies, help-seeking behaviors, and barriers and facilitators to accessing mental health services. For the mental health professionals, the discussion focused on clarifying and contextualizing the findings from the vulnerable groups, including why mental health concerns among pregnant and postpartum women were often not identified during routine antenatal care (ANC) and child health services despite participants reporting such experiences.

Each FGD lasted between 45 and 90 minutes and was facilitated by the first author (SW), a university lecturer with a doctoral degree and extensive experience in qualitative and mental health research. Discussions were conducted in private and comfortable settings. For example, FGDs involving pregnant/postpartum women were held at a community health center to ensure participants' comfort and accessibility. All sessions were audio-recorded, with backup recordings made using mobile devices. A semi-structured FGD guide, developed collaboratively by the research team, was used to ensure consistency across discussions. The guide was not pilot-tested because the research team had extensive prior experience conducting qualitative interviews and FGDs. Field notes were recorded during each session to capture non-verbal communication, group dynamics, and contextual observations.

To enhance reflexivity, the primary researcher engaged in ongoing self-reflection throughout data collection and analysis. Emerging interpretations were regularly discussed with co-researchers to challenge assumptions, minimize subjective bias, and strengthen the credibility of the findings.

2.4 Data analysis

Data were transcribed verbatim in Indonesian and analyzed using thematic analysis following the approach of Braun and Clarke (2006). The transcripts were read repeatedly to achieve familiarization with the data, after which meaningful units were identified, coded manually, and organized into categories and overarching themes. Coding was conducted independently by two researchers (SW and MS), followed by collaborative discussions to resolve discrepancies and refine the coding framework. A coding tree was developed to document the analytic process and enhance transparency.

Data from vulnerable groups were analyzed collectively first, followed by a separate analysis of the mental health professionals' discussions. The findings from the professionals were subsequently integrated with those of the vulnerable groups to enrich the interpretation of barriers to mental health care and expectations for service improvement. Microsoft Excel was used to organize codes, categories, and themes throughout the iterative analytic process. Consistent with the qualitative descriptive design, data adequacy was evaluated based on the richness, relevance, and explanatory value of the information in addressing the research objectives rather than on the number of FGDs conducted. The inclusion of multiple vulnerable populations, together with source triangulation involving mental health professionals, provided sufficient information to generate comprehensive and credible findings. The final themes were translated into English after completion of the analysis. Member checking was not undertaken due to time constraints. However, confirmability and credibility were strengthened through regular discussions among the research team, independent coding by two researchers, source triangulation, cross-verification of coding decisions, and ongoing researcher reflexivity throughout data collection and analysis.

2.5 Trustworthiness/rigor

To enhance methodological rigor and ensure the credibility of the findings, this study adhered to the trustworthiness framework proposed by Lincoln and Guba (1985). Credibility was strengthened through several strategies, including peer debriefing among co-researchers to

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discuss and refine emerging codes and themes, source triangulation involving mental health professionals, and ongoing researcher reflexivity throughout data collection and analysis. Transferability was facilitated by providing a thick description of participants' backgrounds, recruitment settings, and the sociocultural context. To establish dependability, the research team maintained comprehensive documentation of study procedures, analytic steps, and decision-making processes throughout the research cycle. This audit trail ensured transparency and consistency. Confirmability was enhanced through researcher reflexivity and cross-verification of coding decisions among researchers.

2.6 Ethical consideration

Ethical approval was obtained from the Ethics Committee of Universitas Airlangga (No. 3371-KEPK) and Ghrasia Psychiatric Hospital (No. 40/EC-KEPKRSJG/IX/2024). All participants received information about the study and were informed that participation was voluntary and that they could withdraw at any time without consequence. Confidentiality and anonymity were maintained throughout the study. All participants in the adolescent group were younger than 18 years of age. Hence, written informed consent was obtained from their parents or legal guardians, and written informed assent was obtained from the adolescents before participation. The FGDs were conducted only after both parental consent and adolescent assent had been secured.

3. Results

3.1 Characteristics of the participants

This study involved 18 participants across five vulnerable population groups: pregnant and postpartum women, adolescents, university students, and caregivers of individuals with severe mental illness (IWMI). Participants ranged in age from 15 to 58 years and represented diverse educational and occupational backgrounds. In addition, five mental health professionals, comprising nurses and psychologists, participated in a separate FGD for source triangulation. Participant characteristics are presented in Table 1.

Table 1. Characteristics of the participants

Participants	Age (years)	Gender	Occupation	Education background
Pregnant women				
P1	31	Female	Teacher	Bachelor
P3	38	Female	Laborer	Bachelor
P4	28	Female	Housewife	Bachelor
Postpartum mothers				
P2	24	Female	Housewife	Senior high school
P5	33	Female	Teacher	Postgraduate
P6	43	Female	Housewife	Junior high school
Caregiver				
P7	25	Male	Merchant	Senior high school
P8	58	Female	Housewife	Senior high school
P9	43	Female	Self employed	Diploma
P10	23	Female	Teacher	Senior high school
Teenager				
P11	15	Female	Senior high student	Junior high school
P12	16	Male	Senior high student	Junior high school
P13	16	Female	Senior high student	Junior high school
P14	16	Male	Senior high student	Junior high school
University students				
P15	21	Female	College student	Senior high school
P16	20	Male	College student	Senior high school
P17	21	Female	College student	Senior high school
P18	22	Male	College student	Senior high school
Triangulation participants: Mental health professional				
T1	52	Female	Public health nurse	Bachelor
T2	45	Female	Public health nurse	Bachelor
T3	49	Female	Psychiatric nurse	Bachelor
T4	33	Female	Psychologist	Postgraduate
T5	31	Female	Psychologist	Postgraduate

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3.2 Overview of themes

The analysis generated 72 codes, which were grouped into 14 categories and three overarching themes. These themes were: (1) root causes of mental health vulnerability, (2) coping strategies and help-seeking behaviors, and (3) structural barriers and expectations for mental health services. Table 2 presents how the themes developed. The detailed coding matrix, including the distribution of codes across participant groups, is provided in Supplementary Table S1.

Table 2. Development of the themes

Coding	Category	Theme
Lack of family support after childbirth	Causes of mental health problems in pregnant and postpartum women	Root causes of mental health vulnerability
Lack of role/assistance from husband in household chores and baby care		
Intergenerational conflict regarding infant care (plans)		
Pressure from the neighbors/society		
Uncontrollable postpartum conditions		
Triggers for psychological problems during pregnancy and after childbirth (condition of the fetus/baby, no breast milk production)		
Emotions felt during pregnancy and after giving birth		
Family triggers mental health problems	Causes of mental health problems in young people (adolescents and college students)	
School environment triggers mental health problems		
Bad social interactions among teenagers trigger mental health problems		
Love problems among teenagers		
Teenagers' search for self-identity		
The impact of technology and social media		
Overthinking		
A new phase of life that is complex and full of stressors		
Negative emotions in response to challenges		
Academic burnout		
Poor family support during patient treatment and its impact on caregivers	Caregiver burden related to caring for patients with mental disorders	
Difficulties faced by caregivers due to patient behavior		
Impacts arising from the patient's illness/treatment		
Need for ventilation	The urgency of sharing feelings	Coping strategies and help-seeking behaviors
Share the burden/story with someone you trust after you have calmed down		
Considerations for not telling the problem to a significant other	Preferences for disclosing psychological problems faced	
Prefer to share with peers		
The influence of gender in the mode of venting		
Prefer to tell problems to a particular teacher		
Reasons for not telling the problem to the counselor at school		
The person being avoided knows the problem they are facing and the reasons why.		
Consequences that arise when families are not informed		
The first response when encountering a problem: harbor feelings	Problem-solving efforts	
Coping by managing emotions		
Doing activities to distract your mind		
Spiritual coping		
Find our own solution		
Seeking professional help		
Right time to go to a professional		
Actively acquire mental health literacy (from books, articles, leaflets, and/or seminars)	Efforts to gain mental health knowledge	

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Table 2. Continued

Coding	Category	Theme
Search via the internet		
Follow professional and survivor social media accounts		
History of alternative medicines and reasons	Caregiver considerations for bringing patients to mental health services	
Reasons for going to a psychiatric hospital		
The importance of husband's support for the psychological health of pregnant and breastfeeding women	The importance of support systems in dealing with psychological problems	
Family support		
Peer support		
The need for family cooperation when caring for patients		
Neglect of psychological problems by health workers	Disintegration of mental health programs	Structural barriers and service expectations
There is no mental health topic in the school curriculum		
Neglect of college students' mental health on campus		
Health promotion from the government is minimal		
Educational videos from the Ministry of Health do not reach the public		
Mental health service efforts at Community Health Centers through integrated antenatal care	Mental health services at community health centers and their problems	
Obstacles to implementing integrated antenatal care		
Implementation of adolescent mental health programs in community health centers and its obstacles		
Solution to the limited number of psychologists in Community Health Centers		
The role of midwives in mental health programs at community health centers		
School-based mental health program efforts		
Barriers to the Community Health Center		
Adolescent health problems encountered in campus counseling services	Dynamics of mental health services on campus	
Urgency and obstacles to mental health screening		
Benefits of psychoeducational classes on campus		
The key to the success of mental health programs on campus		
Barriers and challenges to reaching out to a psychologist		
Challenges faced by students in accessing mental health services		
Barriers to the psychiatric hospital	Mental health services at psychiatric hospitals and their problems	
Need for mental health counseling	Hope for improved mental health services	
Need for psychological care assistance: during pregnancy and postpartum periods		
Proposed topic		
Expected counseling settings		
Potential involvement of cadres and students in psychological assistance programs in the community		
Expectations for improvement in Community Health Center services		
Obstacles faced by caregivers when using BPJS (healthcare social security) for people with mental disorders		
Hope for a free service program for people with mental disorders		

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3.2.1 Root causes of mental health vulnerability

Participants across all vulnerable groups described a range of psychosocial stressors that contributed to their mental health challenges. Three subthemes were identified: (1) family-related stressors, (2) developmental and identity-related stress, and (3) caregiving burden and social exclusion.

The first subtheme, family-related stressors, was primarily reflected in the experiences of pregnant and postpartum women. Participants frequently described intergenerational conflict, unsolicited advice, and lack of spousal support as key sources of emotional distress. One participant shared, "*I had to argue with my mother about baby care… but I couldn't do that with my mother-in-law. It was exhausting*" (P1, pregnant woman, 31 years old). Another recalled feeling judged by her community: "*The neighbors said, 'How come your belly is still small at 8 months?' It made me feel insecure*" (P4, pregnant woman, 28 years old). These accounts suggest that family dynamics, particularly intergenerational conflict and inadequate spousal support, substantially shaped emotional distress during the perinatal period by limiting women's autonomy in household decision-making.

The second subtheme, developmental and identity-related stress, emerged from the experiences of adolescents and university students. Participants described academic demands, family conflict, and social comparison as major sources of psychological distress. A 15-year-old adolescent explained, "*It could be from school, from home, or just from myself—too much pressure from everywhere*" (P12, adolescent, 16 years old). University students expressed similar concern, often linking their distress to the transition into adulthood and uncertainty about the future. These findings indicate that mental health challenges among young people are closely intertwined with developmental transitions, during which academic expectations, identity formation, and social comparison converge.

The third subtheme, caregiving burden and social exclusion, was unique to caregivers of individuals with severe mental illness. Participants described the cumulative emotional burden of long-term caregiving, compounded by stigma, social isolation, and limited family support. One caregiver stated, "*My husband's family distanced themselves… I felt alone in this*" (P8, caregiver, 45 years old). Another recounted a traumatic incident: "*My brother once punched a neighbor. After that, we were evicted from the village. I'm always on edge, afraid it'll happen again*" (P10, caregiver, 38 years old). These narratives illustrate how caregiving responsibilities extended beyond practical demands to include emotional distress, social exclusion, and fear of future crises.

Across the vulnerable groups, the nature of mental health challenges differed considerably. Emotional distress among pregnant and postpartum women was predominantly rooted in family relationships and household dynamics. Adolescents and university students were primarily affected by developmental transitions, academic demands, and social expectations, whereas caregivers experienced persistent psychological and social burdens associated with long-term caregiving responsibilities.

3.2.2 Coping strategies and help-seeking behaviors

Three subthemes were identified: (1) emotional suppression and delayed disclosure, (2) selective trust and help-seeking preferences, and (3) pathways to information and care.

The first subtheme, emotional suppression and delayed disclosure, reflects participants' initial responses to psychological distress. Many participants described suppressing their emotions and delaying disclosure to significant others, preferring to manage their distress privately before seeking support. Many participants initially chose to remain silent about their struggles. As one postpartum woman noted, "*Usually I stay quiet first, then I try to distract myself with hobbies or pray*" (P2, postpartum mother, 24 years old). However, when distress intensified, some participants sought support from trusted individuals or mental health professionals. These accounts suggest that emotional suppression served as an initial coping strategy, reflecting cultural norms that discourage the open expression of psychological distress.

The second subtheme, selective trust and help-seeking preferences, illustrates how participants carefully considered whom they trusted, whom they chose not to confide in, and the types of support they preferred to seek. Decisions about disclosure were influenced by trust, confidentiality, and expectations regarding others' responses. Preferences differed across participant groups. Adolescents and university students were reluctant to involve parents or school counselors because of concerns about judgment and breaches of confidentiality. A student

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explained, "*I don't want my parents to know… they either overreact or dismiss it*" (P18, college student, 22 years old), while an adolescent added, "*I'm afraid the school counselor will tell my parents. Then everyone will know*" (P13, adolescent, 16 years old). In contrast, pregnant women and caregivers emphasized the importance of family involvement. One woman shared, "*If my husband is supportive, I feel like I can handle anything. But if he's indifferent, even small things feel overwhelming*" (P5, postpartum woman, 33 years old). These findings indicate that help-seeking preferences are shaped by age and social context, with younger participants prioritizing confidentiality and peer support, whereas adults relied more on family-based support systems.

The third subtheme, pathways to information and care, describes how participants sought mental health information and decided where and from whom to seek help or support. Most participants obtained mental health information through informal sources, including social media, online resources, and discussions with peers. A university student remarked, "*I follow mental health accounts on Instagram or YouTube. That's where I learn the most*" (P17, college student, 21 years old). Participants also identified campus-based psychoeducation as a valuable source of information. These findings suggest an increasing reliance on digital and informal sources of mental health information, potentially reflecting limited accessibility or perceived relevance of formal mental health services.

Caregivers described a more complex help-seeking pathway. Many initially sought assistance through traditional or spiritual healing practices, often influenced by cultural beliefs or family expectations. One caregiver recounted, "*We tried everything—dukun, ruqyah, pesantren. But nothing worked until we went to the hospital*" (P7, caregiver, 25 years old). Over time, most caregivers transitioned to biomedical services after observing limited improvement with alternative treatments. These experiences demonstrate how cultural beliefs shaped initial help-seeking decisions, with traditional and spiritual practices frequently serving as the first response before formal mental health services were accessed.

Across participant groups, distinct patterns of coping and help-seeking were evident. Adolescents and university students prioritized confidential, peer-based support, whereas pregnant women and caregivers relied more on family support. Caregivers also exhibited a more complex help-seeking trajectory, typically transitioning from traditional or spiritual healing to formal mental health care.

3.2.3 Structural barriers and service expectations

Three subthemes were identified: (1) system-level barriers in service delivery, (2) perceived quality and trust in services, and (3) expectations for service improvement.

The first subtheme, system-level barriers in service delivery, captures participants' experiences of structural obstacles to accessing mental health services. Participants identified fragmented service delivery, limited service hours, long wait times, and perceived indifference from healthcare staff as major barriers. A pregnant woman shared, "*I went to the Puskesmas, but the queue was too long, and the staff didn't even smile. I never went back*" (P1, pregnant woman, 31 years old). Mental health professionals acknowledged these challenges, attributing them to workforce shortages and inadequate coordination across sectors. These findings indicate that structural inefficiencies, including limited resources and fragmented service delivery, play a critical role in discouraging initial access to mental health services.

The second subtheme, perceived quality and trust in services, reflects how participants' perceptions of service quality influenced their trust in mental health services and confidence in the care they received. University students appreciated the availability of campus counseling services but expressed dissatisfaction with the quality of therapeutic interactions. One participant noted, "*Sometimes the psychologist just gives generic advice. It doesn't feel personal*" (P18, college student, 22 years old). Concerns about stigma and potential academic repercussions further discouraged help-seeking. These findings suggest that the availability of services alone does not ensure their acceptability, particularly when interactions are perceived as impersonal or insufficiently responsive to individual needs.

In contrast, caregivers reported a different experience. They described considerable logistical and financial challenges in accessing psychiatric hospital services. One caregiver explained, "*We leave at dawn just to get a queue number. It's exhausting*" (P9, caregiver, 23 years old). Despite these barriers, many preferred hospital-based care over primary care because they had greater confidence in specialist providers and the consistent availability of medication. These accounts

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illustrate a trade-off between accessibility and perceived quality of care, with participants willing to endure logistical burdens in exchange for services they considered more comprehensive and trustworthy.

The third subtheme, expectations for service improvement, reflects participants' recommendations for enhancing the quality, accessibility, and responsiveness of mental health services. Across all groups, participants suggested extending service hours, reducing waiting times, expanding community-based psychoeducation, and providing free mental health care for individuals with severe mental illness. As one pregnant woman put it, "*We need mental health education in every neighborhood, not just in hospitals*" (P1, pregnant woman, 31 years old). These expectations underscore the need for more accessible, responsive, and community-based mental health services that better address the diverse needs of vulnerable populations.

Distinct differences were observed across participant groups. University students primarily emphasized the quality of interpersonal interactions within mental health services, caregivers highlighted logistical and financial barriers, whereas pregnant and postpartum women focused on accessibility within primary health care settings.

4. Discussion

This study sought to illuminate how vulnerable populations experience and navigate mental health challenges within the context of Indonesia's evolving, yet fragmented mental health system. Drawing on the perspectives of adolescents, university students, pregnant and postpartum women, caregivers of people with mental illness, and frontline healthcare providers, this research reveals that mental health vulnerability in Indonesia is deeply shaped by the interplay of sociocultural norms, structural inequities, and gaps in service provision. These findings are consistent with evidence from other low- and middle-income countries (LMICs), where mental health systems are frequently fragmented, under-resourced, and insufficiently responsive to community needs (Sarikhani et al., 2021; WHO, 2022c). Therefore, these findings can be interpreted through stigma theory and help-seeking frameworks, which propose that perceived stigma, social norms, and structural barriers influence both the experience of psychological distress and decisions about seeking care. From this perspective, mental health vulnerability emerges not solely as an individual condition but as a socially and structurally produced experience.

The first major theme, root causes of mental health vulnerability, highlights that psychological distress arose not only from individual factors, but also from the accumulation of social, familial, and contextual stressors. Among pregnant and postpartum women, distress was associated with intergenerational conflict, unsolicited advice, community judgment, and limited support from spouses. These findings are consistent with qualitative studies from Southeast Asia showing that socio-cultural expectations surrounding motherhood, together with limited partner involvement, contribute to depressive and anxious symptoms (Basrowi et al., 2024; Low & Bono, 2023; Nuraini & Mulyana, 2024; Pebryatie et al., 2022; Sainuddin et al., 2023). Collectively, these patterns indicate that restricted autonomy within family structures, gender-related social expectations, and mental health stigma contribute to the development of psychological distress during the perinatal period.

Similarly, adolescents and students described academic demands, pressures to meet performance expectations, and developmental transitions as major sources of emotional distress. These findings are consistent with previous research demonstrating that educational pressures and identity-related challenges are closely associated with poorer mental health among young people (Steare et al., 2023; Wuthrich et al., 2020; Zimmer-Gembeck & Skinner, 2024). In parallel, caregivers of individuals with severe mental illness described the psychosocial burden of long-term caregiving without adequate family or community support. This finding is consistent with the evidence from Indonesia and other Asian countries showing that prolonged caregiving responsibilities, combined with stigma and limited social support, substantially increase caregivers' psychological burden (Phoeun et al., 2023; Subandi et al., 2021).

The second theme, coping strategies and help-seeking behaviors, reflected both resilience and restraint. While some participants sought emotional release through religious practices, hobbies, and conversations with peers, many adolescents and university students hesitated to disclose their distress to family or formal support services due to fear of stigma, breaches of confidentiality, and diminished autonomy. The use of religious coping, recreational activities, and

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peer support identified in the present study is consistent with the systematic review by Muslimah et al. (2024), which highlighted these strategies as important protective resources for managing psychological distress. Similarly, participants' selective disclosure of emotional difficulties aligns with the findings of Cox et al. (2024) and Sheikh et al. (2025), who reported that individuals carefully choose trusted sources of emotional support. However, these findings differ from those of Velasco et al. (2025) and Radez et al. (2021), who identified parents as primary sources of support and key gatekeepers to professional mental health services. This discrepancy may reflect the Indonesian sociocultural context, where persistent mental health stigma, concerns about family reputation, and limited mental health literacy may discourage adolescents from openly discussing psychological distress with their families. Consistent with the findings of Williams et al. (2024) and Sheikh et al. (2025), stigma also emerged as a major barrier to formal help-seeking in the present study. By contrast, Crockett et al. (2025) demonstrated that school-based mental health literacy and anti-stigma interventions can significantly improve adolescents' willingness to seek professional help or support. These findings highlight the need for culturally responsive interventions that simultaneously reduce stigma, strengthen family communication, and improve trust in mental health services.

The reluctance to seek help observed in this study is not unique. Evidence from international studies suggests that internalized stigma, anticipated judgment, and limited access to confidential support consistently discourage adolescents from seeking professional mental health care (Laranjeira & Querido, 2024; Octavia et al., 2025; Velasco et al., 2025; Wahdi et al., 2025). This suggests that help-seeking is not only determined by need or severity of psychological distress, but also by perceived psychological safety, confidentiality, and anticipated stigma.

Furthermore, participants' increasing reliance on digital platforms and peer networks for mental health information reflects broader shifts in health information-seeking behaviors among young people in Indonesia (Mukti & Putri, 2021). Although digital resources may enhance access to mental health information, dependence on informal sources also increases the risk of misinformation and reinforces the need for credible, youth-friendly mental health education delivered through accessible digital and community-based platforms (Lahti et al., 2024; Wang & Togher, 2024).

The experiences of caregivers added an important cultural dimension to the findings, illustrating how spiritual interpretations of mental illness, including beliefs in *"guna-guna"* and curses, influenced initial treatment decisions. These findings are consistent with anthropological research demonstrating that traditional belief systems and biomedical models often coexist and sometimes conflict within Indonesian mental health practices (Subandi et al., 2021; Subu et al., 2022). Although many caregivers eventually transitioned to psychiatric care, this process often required considerable time, financial resources, and changes in beliefs about mental illness. These findings highlight the importance of integrating culturally sensitive psychoeducation into community-based mental health services to facilitate earlier access to appropriate care.

The third theme, structural barriers and expectations for service improvement, illustrates how systemic shortcomings, particularly within primary health care and campus-based mental health services, continue to reinforce health inequities in access to care. Participants reported logistical barriers, including limited service hours and long waiting times, together with low provider responsiveness and inadequate coordination across health and education sectors. These challenges are characteristic of under-resourced settings where mental health remains a relatively low policy priority, and frontline services often operate with limited capacity (Patel et al., 2018; WHO, 2022a).

Although mental health services were available in schools and universities, participants expressed mixed views about their usefulness. Students appreciated having access to counseling but questioned the quality of therapeutic interactions and reported that academic demands often limited opportunities to seek support. This tension between service availability and acceptability has also been reported in other Southeast Asia settings, where high levels of psychological distress coexist with relatively low rates of professional help-seeking among university students (Dessauvagie et al., 2022). These findings underscore the need for culturally responsive and youth-friendly mental health services that extend beyond service availability to foster trust, high-quality care, and timely access within educational institutions.

Participants' recommendations, ranging from expanding psychoeducation, improving service accessibility, reducing waiting times, and providing free mental health services for people

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with severe mental illness, are broadly consistent with the priorities outlined in the WHO Mental Health Action Plan (WHO, 2013) and the Lancet Commission on Global Mental Health (Patel et al., 2018). Both frameworks emphasize decentralized services, multisectoral collaboration, and sustained investment in contextually appropriate mental health systems. The lived experiences captured in this study demonstrate how policy gaps are experienced in everyday practice and highlight the value of incorporating service users' perspectives into mental health system reform (Laranjeira & Querido, 2024).

Methodologically, this study contributes to the literature by incorporating the perspectives of multiple vulnerable populations and mental health professionals, thereby situating mental health experiences within interconnected familial, sociocultural, and systemic contexts. The use of thematic analysis, source triangulation, independent coding, and reflexive discussions strengthened the credibility and trustworthiness of the findings (Braun & Clarke, 2006; Peters, 2010). Differences across participant groups further illustrate how mental health experiences and help-seeking behaviors are shaped by life stage and social roles. Adolescents and university students tended to prioritize confidentiality and peer-based support, whereas perinatal women and caregivers relied more heavily on family involvement. Caregivers also followed more complex help-seeking pathways, often transitioning from traditional or informal practices to formal mental health services.

5. Implications and limitations

Compared with previous studies, the present findings suggest that mental health challenges in Indonesia are strongly shaped by sociocultural norms and characteristics of the health system. The prominent influence of family dynamics, mental health stigma, reliance on informal and traditional sources of support, and the limited integration of mental health services into primary health care may help explain why participants' experiences differ from those reported in many high-income countries. These findings underscore the importance of developing culturally responsive, community-based mental health services that are tailored to Indonesia's unique sociocultural and health system context. Strengthening collaboration among primary health care providers, schools, universities, families, and community organizations may facilitate earlier identification of mental health problems, reduce stigma, improve mental health literacy, and enhance timely access to appropriate care. Such an integrated, community-based approach is likely to promote more equitable and responsive mental health services for vulnerable populations.

For nursing practice, the findings emphasize the importance of delivering population-specific mental health care that reflects the distinct needs and help-seeking preferences of different vulnerable populations. Nurses play a central role in the early identification of psychological distress, provision of psychoeducation, and development of trusting therapeutic relationships within primary health care and community settings. For adolescents and university students, this includes providing confidential, youth-friendly services, and delivering mental health education through digital and peer-supported approaches. For pregnant and postpartum women, routine mental health screening and psychoeducation should be integrated into antenatal and postnatal care with active involvement of spouses and family members whenever appropriate. For caregivers of individuals with severe mental illness, nurses should provide structured psychoeducation, emotional support, and practical guidance on accessing formal mental health services. In addition, nurses should advocate for coordinated, person-centered care and contribute to improving service responsiveness and continuity across community and health care settings.

This study has several limitations. First, the study was conducted in a single province (Yogyakarta), which may limit the transferability of the findings to other regions in Indonesia with different sociocultural and health system contexts. Second, although participants were recruited from several vulnerable population groups, the relatively small number of participants within each group may not have captured the full diversity of experiences. Third, data were collected through focus group discussions, a method that may have limited participants' willingness to disclose highly personal or stigmatized experiences because of group dynamics and social desirability. Fourth, although reflexive discussions, independent coding, and collaborative data analysis were undertaken, researcher involvement in data collection and interpretation may still have introduced some degree of interpretive bias. Fifth, the absence of formal member checking

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may have reduced the credibility of the findings. Finally, the findings were derived primarily from participants' self-reported experiences and were not triangulated with other data sources, such as service utilization records or observational data, which may have limited the breadth of contextual understanding. Future research should include multiple study sites across Indonesia, recruit larger and more diverse samples, and consider mixed-methods or longitudinal designs to provide a more comprehensive understanding of mental health experiences among vulnerable populations.

6. Conclusion

This study demonstrates that mental health challenges experienced among vulnerable populations are shaped by distinct psychosocial stressors, coping strategies, and help-seeking behaviors. At the same time, important shared challenges emerged across participant groups, particularly regarding stigma, barriers to accessing care, and the need for more responsive mental health services. Recognizing both common and group-specific experiences is essential for developing person-centered, culturally responsive, and population-specific mental health interventions that more effectively address the diverse needs of vulnerable populations. By capturing the perspectives of groups often underrepresented in mental health research and policy, this research contributes to the growing evidence supporting more equitable and contextually responsive mental health systems in Indonesia. The findings highlight the need for stronger intersectoral collaboration, greater integration of mental health into primary health care and educational settings, and expanded community-based psychoeducation. Ultimately, improving mental health care requires not only strengthening health systems but also ensuring that policies and services are informed by the lived experiences of the populations they are intended to serve.

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Author contribution

SW, RF, and MM contributed to the conception and/or design of the study. SW conducted data collection. SW and MSK conducted the data analysis. SW, MSK, and MM drafted the manuscript. All authors contributed to refining and/or critically reviewing the manuscript. All authors agreed with the final content of the manuscript.

Conflict of interest

The authors declare no conflicts of interest.

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Declaration of Use of AI in Scientific Writing

The authors used a large language model (Gemini, https://gemini.google.com/) to assist with language refinement during the preparation of this revised manuscript. All AI-generated suggestions were thoroughly reviewed, verified, and edited by the authors, who assume full responsibility for the final content of this manuscript.

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