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Research Article

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Female undergraduate students' experiences and barriers in accessing mental health services: an interpretative phenomenological analysis

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Abstract

Female undergraduate students face academic and developmental stressors that may contribute to psychological distress, yet barriers to accessing campus mental health services remain. This study explored female undergraduate students' experiences of psychological distress, help-seeking behaviors, and perceived barriers to psychological services at a private university in Indonesia. A qualitative study using Interpretative Phenomenological Analysis (IPA) involved four purposively selected participants identified through Healthy Campus screening records and counseling service utilization. Data were collected through semi-structured, in-depth interviews and analyzed using the six-step IPA framework, with findings interpreted through the Stuart Stress Adaptation Model. Three themes emerged: clinical manifestations of psychological distress, psychosocial and behavioral impacts, and barriers to accessing campus psychological services. Participants reported interconnected cognitive, emotional, and physical symptoms, alongside behavioral and psychosocial consequences. Professional help-seeking was often delayed until distress intensified. Confidentiality concerns and overlapping academic and counseling roles further discouraged service utilization. These findings highlight the need for accessible, confidential, and independent campus psychological services. Dedicated counselors without academic evaluative responsibilities and private counseling facilities may encourage earlier help-seeking and improve psychological support for female undergraduate students.

INTRODUCTION

Female undergraduate students are currently in a critical developmental transition period, making them particularly vulnerable to high academic pressure and gender role expectations. Systematic epidemiological evaluations confirm that depressive symptomatology represents a pervasive global health burden among tertiary students, with reported prevalence rates escalating up to 69.5%. Female students consistently demonstrated significantly higher rates of depression

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(66.2%-805%) than their male counterparts (19.5% – 33.8%), suggesting greater vulnerability among women within university settings [1]. Consistently, female students exhibit higher rates of mental health problem compared to male students, with a significantly higher prevalence of depressive symptoms, anxiety, and emotional strain (22.7% in female compared to 6% in male). This pronounced disparity in psychological distress is heavily shaped by cumulative psychosocial demands, wherein female undergraduates encounter significantly higher severity levels of anxiety, stress, and depressive manifestations compared to their male peers within university environments [2]. Untreated emotional distress severely impacts academic engagement, driving down motivation, increasing absenteeism, and causing impaired learning performance. Furthermore, unaddressed psychological issues can escalate into social isolation, interpersonal dysfunction, risk-taking behaviors, non-suicidal self-injury (NSSI), and suicidal ideation [3].

Despite the alarming prevalence of emotional distress among female students, the utilization rate of professional campus mental health services remains surprisingly minimal. Prior studies demonstrate that social stigma, fear of negative evaluation, and doubts regarding data confidentiality act as major external barriers limiting professional help-seeking intentions [4] Additionally, limited emotional awareness frequently prevents female students from recognizing early clinical manifestations as actionable mental health issues, leading them to internalize emotional burdens or rely on inadequate informal support systems [5].

Although existing quantitative literature has mapped statistical relationships between perceived stigma, gender disparities, and help-seeking preferences, such broad methodologies remain inherently restricted in capturing the intricate, subjective emotional dynamics experienced during real-time interactions with campus psychological systems; specifically, a critical qualitative research gap exists regarding how female undergraduates subjectively interpret multi-system distress manifestations, navigate internal emotional conflicts prior to formal help-seeking, and experience relational and structural obstacles: such as spatial confidentiality deficits and dual-role counselor dynamics: during real-time service navigation. More specifically, existing qualitative research has predominantly remained focused on characterizing initial clinical manifestations and emotional symptom profiles, leaving the complex lived experiences and structural barriers encountered during actual navigation of campus psychological services under-explored [6].

Consequently, a deep qualitative investigation is required to illuminate the lived experiences, psychological transitions, and institutional obstacles encountered by female undergraduate students when seeking campus counseling services. Specifically, a critical qualitative research gap exists regarding how female undergraduate students subjectively interpret multi-system distress manifestations, navigate internal emotional conflicts prior to formal help-seeking, and experience relational and structural obstacles, such as spatial confidentiality deficits and dual-role counselor dynamics, during real-time service navigation. This making Interpretative Phenomenological Analysis (IPA) uniquely suited to bridge this empirical gap because its double hermeneutic framework allows researchers to examine the idiographic, deeply contextualized meanings participants assign to their psychological distress while critically interpreting how institutional environments constrain their help-seeking decisions.

One private university in Indonesia has a Healthy Campus program and counseling services for its students. Based on regular

screenings conducted by the Healthy Campus program, approximately 11.7% of female students experience depression, but only 9 access counseling services. This study aimed to explore in-depth the experiences of female undergraduate students in this university in responding to mental health clinical manifestations, help-seeking dynamics, and concrete barriers encountered when accessing campus psychological services.

METHODS

This qualitative research adopted IPA methodology, grounded in Smith's phenomenological and double-hermeneutic framework, to establish a transparent account of our interpretive approach. From an epistemological standpoint, the study operates within a contextual constructivist paradigm, recognizing that participants' lived experiences, internal personal meanings, and subjective perspectives regarding complex psychological manifestations and campus health service. Interviewers who are also students can actively understand and interpret how participants experience their own emotional stress because they have equal standing. The study was conducted at an Indonesian private university implementing the "Health Promoting University" program, which routinely provides bi-annual student mental health screening followed by psychologist counseling services. Data collection was carried out between July and August 2026.

Participants were selected through a multi-stage purposive sampling strategy based on specific inclusion criteria: active female undergraduate students aged 18–22 years, presenting with a documented history of psychological distress identified during routine campus health screenings, and having utilized institutional counseling services within the preceding six months. To ensure sampling adequacy and verify service engagement beyond minor transient issues, initial screening records evaluating depressive indicators were cross-referenced with counseling unit logs. Out of 552 total female students screening records reviewed from the Healthy Campus program, 11.7% experience depression. In the past six months, only 7 female students accessed counseling services on campus. These eligible individuals were approached via digital messaging invitations containing complete study disclosures. From these candidates who expressed initial interest, four participants (P1_S, P2_R, P3_N, and P4_Y), were deliberately selected using criterion-based purposive sampling to achieve qualitative depth, maximum variations in distress severity, and diverse counseling interaction histories.

Data were gathered using semi-structured, in-depth interviews guided by an open-ended interview protocol that utilized the Stuart Stress Adaptation Model purely as a conceptual and sensitizing framework. The protocol covered key domains including clinical symptoms, coping resources, help-seeking decisions, and evaluations of service access. To maintain methodological alignment with IPA, the Stuart Stress Adaptation Model served strictly to inform early topic generation during interview design rather than acting as a deductive matrix or constraining the inductive coding and thematic generation processes, thereby ensuring that participants' idiographic lived experiences and personal interpretations emerged freely during data analysis. This interview approach allows the researcher to explore participants' subjective experiences deeply through rich, detailed responses, enabling an extensive coding process to construct themes and sub-themes regarding their experiences using psychological services [7]. This technique also provides flexibility during interviews, allowing the researcher to adapt questions based on the participants' verbal responses and non-verbal cues from previous questions, ensuring that their experiences are comprehensively uncovered.

The researcher developed an interview guide to keep the session focused on the study objectives. The guide utilized several open-ended questions that could be expanded during the interview, covering topics such as: experienced mental health issues, perceived signs and symptoms, the decision to access psychological services, and overall experiences. Themes and sub-themes derived from the interviews were structured based on the Stuart Stress Adaptation Model. Within Stuart's concept, emerging mental health issues in students represent an appraisal of life stressors. This condition is responded to by accessing coping resources (specifically campus psychological services in this study) to foster adaptive coping mechanisms. Data saturation was achieved by analyzing each data collection from the first participant. The results of this analysis were then compared with the subsequent participants. No new themes were identified in the fourth participant, so data collection was stopped.

Transcripts were analyzed following Smith's six-stage analytical protocol for Interpretative Phenomenological Analysis (IPA): (1) repeated reading for data familiarization, (2) initial exploratory coding focusing on descriptive, linguistic, and conceptual notes, (3) generating emerging case themes, (4) mapping interconnections across emerging themes, (5) conducting idiographic cross-case analysis across individual accounts, and (6) synthesizing cross-case themes into a structured analytical narrative supported by verbatim participant quotes.

Rather than relying on conventional 'data saturation', which is epistemologically incongruent with IPA's idiographic commitment, sample adequacy was justified by the contextual richness, depth, and reflective nuance of individual accounts, wherein four cases provided sufficient idiographic detail to rigorously answer the research questions without diluting individual psychological accounts.

Methodological trustworthiness was operationalized through an interpretive triangulation process via two separate 60-minute Focus Group Discussions (FGDs) conducted in one month after the participant interviews were completed , one involving two clinical psychologists and two senior academic supervisors, another with three faculty dean and student service center coordinator. These FGD sessions presented, audited, and contextualized preliminary qualitative findings, generating consultative peer-debriefing data that refined structural barrier themes and verified institutional feasibility without overriding participants' primary accounts, alongside maintaining a transparent continuous audit trail.

Ethical clearance was formally granted by the UNRIYO Health Research Ethics Committee (Reference Number: 059.3/FIKES/PL/V/2026), and written informed consent was secured from all individual participants prior to data collection. Participant anonymity and data confidentiality were strictly safeguarded through the implementation of pseudonyms and anonymized institutional identifiers.

Given that disclosures involved sensitive topics such as non-suicidal self-injury (NSSI), intentional pharmacological toxicity, and acute suicidal ideation, a comprehensive multi-tiered participant safeguarding protocol was operationalized before, during, and after data collection. Prior to interviews, participants received pre-interview safety briefings outlining their right to pause or terminate the session at any moment without penalty. During disclosures of severe psychological distress or self-harm, real-time emotional grounding techniques and supportive check-ins were applied by the interviewer. Post-interview risk assessments were systematically conducted with every participant, backed by an established, active referral pathway to an independent external clinical psychologist to guarantee immediate

psychological support and continuity of care if acute distress flared.

RESULTS

The qualitative data analysis of in-depth interviews with four female undergraduate participants (P1_S, P2_R, P3_N, and P4_Y) yielded a structured account of their reported accounts and service experiences. The findings are organized into three primary master themes: (1) clinical manifestations of Mental Health Issues (2) reported psychosocial and behavioral impacts, and (3) Barriers to Campus Psychological Services. The detailed thematic structure, outlining the corresponding master themes and sub-themes derived from the qualitative interviews, is summarized in Table 1.

Table 1
Master Thematic Structure of Study Findings

Main Theme	Sub Theme
Clinical Manifestations of Psychological Strain	1. Psychological Distress 2. Cognitive Distress 3. Somatic Manifestations Disorders
Impact of Mental Health Issues	1. Spiritual Impact 2. Risk-Taking Behaviors, Non Suicidal Self-Injury (NSSI), and Suicidal Ideation
Barriers to Campus Psychological Services	1. Positive Perceptions of Services 2. Negative Perceptions of Therapeutic Efficacy 3. Facility and Counseling Room Constraints 4. Accessibility Obstacles and Duration Limits 5. Data Confidentiality and Leacturer-Psychologist Conflict of Interest

Clinical Manifestations of Mental Health Issues

Participants described their encounters with academic and psychosocial stressors as deeply intertwined with a complex spectrum of reported psychological distress, cognitive impairments, and somatic symptoms.

1. Psychological Distress

Two participants experienced anxiety during the learning process, manifested by crying and fear of specific things. One participant frequently cried for no apparent reason, and the other felt emotionally drained.

P1_S: "I have received a diagnosis of an anxiety disorder. In particular, I avoid swimming pools because the large volume of water triggers my fear. I have a past traumatic experience related to water."

P2_R: "I frequently experience anxiety, actually, very often. I feel nervous and afraid, and at times, after coming back from campus, I suddenly break down in tears. These episodes of crying occur unexpectedly, accompanied by irritability; even small mistakes made by others can provoke an angry reaction from me."

P3_N: "Over time, living with these ongoing feelings leaves me emotionally drained."

P4_Y: "I often find myself crying in that situation."

2. Cognitive Distress

Three participants described their cognitive distress through subjective accounts of persistent negative automatic thoughts, perceived peer scrutiny, reduced academic concentration, and feelings of powerlessness.

P1_S: "I find this difficult; I am afraid that people's responses will not be as I hope or will not match my expectations. When I notice that someone's facial expression changes, I immediately interpret it as a sign that I have done something wrong."

P2_R: "For example, if I see you remaining silent, I may assume that you are angry with me and start thinking, 'What did I do wrong?' In my perception, I might think, 'Why does the lecturer seem to dislike me?' I visualize a dark figure, black in color, human-like in shape, but entirely black. Yet the voice I hear belongs to my mother, my father, or other people who I feel dislike me."

P3_N: "In the past, I could focus quite easily, but now it feels different; it seems as though my ability to concentrate has diminished."

3. Somatic Manifestations and Physical Health Disorders

Unmanaged psychological stress among participants was expressed through a range of somatic symptoms, including repeated difficulty sleeping, marked weight fluctuations, gastrointestinal disturbances (such as peptic ulcers or severe acid reflux), episodes of shortness of breath, and disruptions to the menstrual cycle, including prolonged amenorrhea.

P4_Y: "It was extremely difficult to fall asleep in that situation."
P2_R: "The first time this happened; I immediately developed a gastric ulcer."
P1_S: "My menstrual cycle has been strongly affected. This is already the third month without menstruation. At one point, I did not menstruate for five to seven months. I also experienced severe shortness of breath."

P3_N: "I have difficulty sleeping."

Reported Psychosocial and Behavioral Impacts

Participant accounts indicated that severe psychological distress was frequently accompanied by reported spiritual strain alongside various high-risk coping practices. Within their lived narratives, female undergraduates described how persistent emotional suffering co-occurred with existential questioning and maladaptive behavioral responses.

1. Spiritual Impact

Sustained emotional distress can destabilize an individual's belief system and undermine spiritual coping. When hope and prayer no longer appear to bring about meaningful change, individuals become vulnerable to spiritual demoralization and disengagement.

P2_R: "I felt as though God was being extremely cruel to me by allowing such things to happen in my life."
P3_N: "I used to pray regularly. But I kept asking myself, 'Why do I still face such trials even though I pray?' Eventually, I thought, 'Maybe I should just stop praying."
P1_S: "There were times when we felt too exhausted to continue praying to God. We kept wondering, 'Why is there no progress? Why does everything remain the same?"

2. Risk-Taking Behaviors, Non-Suicidal Self-Injury (NSSI), and Suicidal Ideation

To manage overwhelming psychological distress, participants described engaging in non-suicidal self-injury (NSSI) as an affective regulation strategy, presenting through diverse self-directed behaviors such as forearm laceration (P2_R), cranial self-impact and thoracic striking (P1_S, P2_R), and intentional pharmacological toxicity (P3_N). Rather than reflecting a uniform or linear progression, the escalation from physical self-harm to acute suicidal ideation followed participant-specific trajectories: while certain participants described NSSI as an immediate physical release mechanism that subsequently co-occurred with or escalated into explicit suicidal ideation during peak emotional crises (P2_R), others reported self-harm practices or overdose incidents as distinct coping attempts without describing a uniform progression to active suicidal intent (P1_S, P3_N).

P2_R: "...I used to cut my wrist there... Sometimes I liked to bang my head against the wall... I punched my own chest and hit my head... as long as it provided a momentary sense of relief... I reached a point where I contemplated ending my life."

P1_S: "...It felt like an impulse driving us to engage in behaviors that should be avoided. The most overwhelming compulsion was actually to strike my head or chest..."

P3_N: "...It was an overdose, actually."

Barriers to Campus Psychological Services

When confronting severe psychological distress, female students actively attempted

to utilize university-administered counseling and mental health services. However, their navigation of these resources revealed a complex interplay between constructive experiences and systemic institutional obstacles.

1. Positive Perceptions of Services

Campus psychological services elicited favorable evaluations when digital administrative processes were streamlined via online registration, when mental health clinicians offered empathetic and non-judgmental containment, and when students received guidance to resolve pervasive feelings of guilt while gaining cognitive clarity regarding their academic stressors.

P3_N: "...On a positive note... I was relieved of that sense of guilt... through my conversations with him (the psychologist), he affirmed, 'That wasn't your fault; it was theirs,' which triggered a moment of realization for me."

P1_S: "...It helped me gain insight into my current clinical state, and he provided actionable strategies moving forward... it truly helped clarify my next steps..."

P2_R: “Regarding the positive impact, we feel heard and genuinely cared for. At times, it offers a sense of relief, making us realize that there are still people who truly care about us.”

P4_Y: "It feels much more effective when they actively listen to our concerns first before offering intervention strategies... The registration link was initially provided by a lecturer, so I just needed to complete the form."

2. Negative Perceptions of Therapeutic Efficacy

Conversely, participant dissatisfaction emerged when they perceived counseling interventions as unhelpful for their immediate needs, when an ongoing emotional distance persisted between the student and clinician, or when therapeutic conversations reactivated distressing memories without providing adequate containment or structured emotional resolution.

P2_R: "...However, the psychologist kept directing me, 'You should do this and that...' but it proved ineffective... It was completely insufficient... I continually felt an emotional distance between myself and the therapist."

P1_S: "...Visiting the psychologist felt like re-opening old wounds... like replaying an old traumatic documentary... For two days afterward, I experienced intense distress..."

3. Facility and Counseling Room Constraints

Substandard physical counseling environments represented one of the most frequently cited institutional impediments. Conducting therapeutic consultations within shared faculty offices or semi-enclosed venues that were excessively noisy and inadequately ventilated severely compromised student anonymity, thereby dismantling the essential psychological containment necessary for transparent self-disclosure.

P2_R: "...Recently, my therapy session was conducted inside a faculty office... where other professors were present... Even if they attempted to make it look empty, it was impossible. It was quite crowded..."

P1_S: "...Our session room was partially open and only half-partitioned, so if anyone walked by, our conversations could easily be overheard by third parties... which created a deeply uncomfortable atmosphere."

4. Accessibility Obstacles and Duration Limits

Systemic access barriers severely constrained participants due to restricted therapeutic session durations that collided with rigid academic schedules.

P1_S: "...Our consultations on campus were constrained by strict time limits aligned with class schedules, which restricted our openness...", "...there should be a proactive routine for follow-up meetings... it would be far better if campus

psychologists were more proactive in structuring continuous care schedules..."

P2_R: "The main constraint is having to strictly align with the psychologist's schedule. For instance, if the service is scheduled for Wednesday, but we have an exam at the exact same hour, it becomes very difficult to navigate."

5. Data Confidentiality and Lecturer-Psychologist Conflict of Interest

A key finding from participant accounts centers on students' heightened concerns regarding data confidentiality when accessing campus support. Participants described experiencing a perceived conflict of interest regarding clinical practitioners who simultaneously serve as university instructors. Consequently, participants reported persistent anxieties that disclosing sensitive trauma or psychological struggles might result in privacy breaches or adversely affect their academic evaluations.

P1_S: "...Since they are university lecturers, I believe students are hesitant... we worry that if we disclose our struggles, they might share our stories despite initial confidentiality assurances... It would be far better if they served purely as clinicians... if their role were strictly that of a psychologist, it would foster much greater trust..."

P2_R: "Furthermore, when leaving during class hours to visit the campus psychologist, lecturers inevitably inquire about our business. This triggers feelings of shame due to the fear of negative social stigma... I remain deeply anxious regarding privacy leaks and the possibility of unauthorized disclosure. Despite assurances of confidentiality, I still struggle with persistent trust issues."

DISCUSSION

Applying an IPA framework, this qualitative inquiry provided a granular, idiographic exploration into how female undergraduate students interpret clinical mental health manifestations, navigate internal help-seeking decisions, and encounter systemic institutional barriers within campus psychological services. The synthesized qualitative evidence yielded three central thematic pillars:

Clinical Manifestations

The pervasive emotional and cognitive strain reported by participants aligns with evidence from previous studies [3,8], who emphasized that female undergraduates demonstrate heightened vulnerability to psychological distress due to the complex interplay of biological fluctuations, societal gender-role expectations, and a higher propensity for ruminative coping styles. Furthermore, the observed cognitive distortions and executive dysfunction validate the self-reinforcing cycles of academic inadequacy and imposter phenomenon described by [5,9]. Regarding physical somatization, the high incidence of gastrointestinal distress and prolonged amenorrhea reinforces the empirical work of [10,11], demonstrating that female students in demanding academic environments frequently manifest chronic psychological stress through physical somatization.

Participants exhibited multi-system affective disruptions, including unprovoked anxiety, situational traumatic fears, severe emotional volatility, sudden weeping episodes, and profound emotional exhaustion. The heightened emotional vulnerability observed among female undergraduates can be attributed to the intersection of developmental transitions, gender role expectations, and a predisposition toward ruminative coping mechanisms. These empirical patterns mirror recent findings by [3], who reported that female students demonstrate significantly higher rates of anxiety and depressive symptoms than their male counterparts due to avoidant coping strategies and persistent cognitive rumination. Furthermore, [5] emphasized that gender disparities in social support and academic pressures exacerbate feelings of emotional isolation and acute panic among female university students.

Cognitive impairment presented as pervasive cognitive distortions, automatic

negative thoughts, hyper-vigilance toward perceived peer judgment, diminished executive function, and learned helplessness, which escalated to auditory and visual perceptual distortions during peak emotional crises. This cognitive decline reinforces the conceptual frameworks proposed by [5,9], illustrating a self-reinforcing cycle between psychological distress and the imposter phenomenon. Impaired information processing and concentration deficits intensify perceived academic inadequacy, thereby entrenching the student's psychological distress

From a qualitative standpoint, participants interpreted their somatic distress, such as gastrointestinal discomfort and secondary amenorrhea, not merely as isolated physical ailments, but as tangible, bodily manifestations of prolonged emotional strain and unmet psychological needs. While these somatic experiences can be tentatively situated within existing literature regarding Hypothalamic-Pituitary-Adrenal (HPA) axis dysregulation under chronic stress, any biomedical or neuroendocrine explanation remains strictly speculative. Because physiological biomarkers and hormonal levels were not empirically evaluated in this qualitative inquiry, the HPA-axis framework serves exclusively as a plausible theoretical lens rather than an established empirical finding, underscoring the necessity for future bio-psychosocial research to bridge these subjective lived accounts with objective physiological measures. The interaction between sustained stress, hormonal fluctuations, and physical somatization substantially undermines female students' overall physical health and capacity to engage academically [11]. These bodily symptoms function as an unacknowledged physiological early warning system, manifesting physical breakdown when psychological coping resources become entirely depleted. Furthermore, somatic manifestations frequently operated as an unacknowledged early warning system for the female students. The somatic expressions of their distress: ranging from gastrointestinal discomfort to body aches: frequently served as the initial physical indicators of their deteriorating mental health before they explicitly recognized their underlying emotional struggles [8]. Physical symptoms such as nausea, functional gastrointestinal disorders, and persistent muscle tension provided the first tangible indicators that their psychological coping capacities had been overwhelmed.

Hormonal fluctuations intersect with normative gender roles that simultaneously encourage emotional expressiveness and limit access to safe, supportive spaces for such expression, thereby accelerating the build-up of distress. Moreover, gendered coping patterns play a crucial role: although female students are more likely to seek emotional support, they also show a greater propensity for ruminative and avoidant strategies (e.g., social withdrawal, excessive social media use), which can entrench and prolong cycles of psychological suffering [3]. These findings underscore the need for gender-sensitive mental health interventions that address both emotional regulation skills and the structural conditions that constrain healthy coping among female students. Mental health and community health nurses operating within university health centers should prioritize early screening for anxiety and mood disturbances among female students, provide accessible counseling that normalizes help-seeking, and integrate psychoeducational programs focused on adaptive emotion regulation, stress management, and the creation of safe peer-support environments tailored to the specific needs of women in academic settings.

Reported Psychosocial and Behavioral Impacts

Unmanaged psychological morbidity severely compromised existential stability,

leading to spiritual demoralization (perceptions of divine abandonment, loss of faith, and cessation of religious rituals). Crucially, ineffective coping mechanisms escalated into high-risk behaviors, predominantly non-suicidal self-injury (NSSI) utilized for dysfunctional affective regulation (such as forearm laceration or "barcoding", cranial impact, thoracic self-striking, trichotillomania, and deliberate pharmacological toxicity/overdose) which systematically transitioned into acute suicidal ideation.

Cognitive distress in female students initiates a self-reinforcing cycle: slowed information processing and intermittent failures in memory retrieval intensify feelings of academic inadequacy and contribute to imposter phenomenon [9]. For female students, this cycle can erode confidence, reduce academic engagement, and heighten risk for longer-term mental health difficulties, underscoring the need for targeted cognitive and emotional support within university settings. When internal cognitive coping fails, existential demoralization sets in. As supported by previous study [12], severe psychological suffering erodes internal spiritual stability, causing students to interpret unanswered prayers as divine rejection or spiritual failure.

Sustained emotional suffering severely disrupted participants' existential and belief systems. When continuous prayer failed to alleviate psychological pain, female students experienced spiritual demoralization, perceived divine abandonment, and ultimately ceased religious engagement. This aligns with another study [12] who documented that extreme psychological distress erodes internal spiritual stability, causing individuals to reframe unanswered prayers as spiritual rejection and exacerbating existential disorientations.

While robust empirical evidence indicates that positive religious engagement generally acts as a protective buffer against psychological distress in young adults, the collapse of spiritual coping mechanisms under severe emotional crises inadvertently exacerbates existential disorientation and emotional [13]. To alleviate overwhelming emotional anguish, participants adopted dysfunctional affective regulation strategies, primarily non-suicidal self-injury (NSSI): such as forearm laceration ("barcoding"), cranial impact, thoracic self-striking, and deliberate pharmacological toxicity/overdose: which frequently transitioned into acute suicidal ideation. These behaviors corroborate the findings of [14,15], which indicate that high perceived burdensomeness and uncontained distress drive students toward self-harm as a physical release mechanism to externalize unbearable psychological pain, significantly increasing the risk of suicidal ideation. Consequently, maladaptive behaviors such as NSSI and suicidal ideation emerge as physical release mechanisms, wherein students inflict physical pain to externalize and temporarily relieve unbearable emotional anguish.

Barriers to Campus Psychological Services

While digital services and empathetic clinician attitudes created positive preliminary impressions, long-term service engagement was heavily hindered by structural obstacles. These included perceived therapeutic inefficacy (excessively directive/non-pragmatic advice, interpersonal distance, and re-traumatization without adequate emotional containment), physical facility deficits (non-soundproof, semi-partitioned, or shared faculty office spaces that dismantled spatial privacy), rigid session limits overlapping with academic timetables, lack of longitudinal follow-up protocols, and a profound conflict of interest caused by clinical providers holding dual roles as academic faculty lecturers.

In terms of institutional service navigation, while general quantitative literature predominantly attributes low service utilization to broad social stigma and negative public evaluation [3,4], the present qualitative findings highlight how participants experienced immediate physical and organizational structures, such as spatial confidentiality deficits and dual-role counselor dynamics, as prominent obstacles in their decision to seek and maintain campus psychological support. These lived accounts align with previous research confirming that non-soundproof consultation environments fundamentally undermine therapeutic trust [16,17]. Most notably, female undergraduates reported that counselor-lecturer dual roles created substantial reluctance, illustrating that in close-knit academic settings, fears of academic evaluation bias and potential breaches of confidentiality were experienced as primary deterrents to formal help-seeking [6,18].

Inadequate physical infrastructure was described by participants as a major structural impediment. Conducting counseling sessions in shared faculty offices or non-soundproof, semi-partitioned rooms was reported to compromise client anonymity, thereby undermining the spatial privacy necessary for authentic emotional disclosure. These lived accounts mirror broader institutional evidence indicating that university counseling facilities in developing regions often face severe spatial limitations, which can weaken therapeutic trust and deter student engagement [16,17].

Campus counseling services are perceived as highly beneficial when functioning as a safe space that validates female undergraduates' emotional suffering, alleviates internalized self-blame, and deconstructs societal stigma [15]. Proactive institutional interventions: driven by empathetic psychological support and accessible referral pathways: substantially assist female students in navigating acute mental health crises. By establishing a direct link between positive institutional perceptions and reduced help-seeking friction, research underscores that cultivating a supportive, stigma-free therapeutic environment empowers female students to overcome initial resistance and engage constructively with campus mental health infrastructure [16]. Furthermore, the integration of digital pathways and user-friendly technology platforms within educational settings significantly lowers administrative hurdles and enhances student readiness to utilize institutional support systems [17]. Initial positive evaluations of campus mental health services were driven by streamlined digital registration processes, clinician empathy, non-judgmental active listening, and guidance that helped students dismantle internalized guilt and gain cognitive clarity regarding academic stressors. An empathetic therapeutic alliance, low administrative friction, and a stigma-free environment are critical determinants that foster positive help-seeking attitudes and continuous service utilization [16,18].

Service dissatisfaction stemmed from interventions perceived as directive or non-pragmatic, lingering interpersonal distance between student and therapist, and premature exposure to past traumatic memories without adequate emotional containment or structured resolution strategies. Similar research observed that students disengage from psychological services when consultations remain purely reflective without delivering actionable behavioral strategies to manage immediate socio-academic pressures [4].

Regarding service barriers, the hesitation to utilize campus counseling stems directly from spatial and relational insecurity. Non-soundproof or semi-open consultation spaces heighten anxiety regarding public exposure and peer gossip, dismantling the essential psychological containment needed for self-disclosure. Furthermore, these structural deficiencies negatively impact student trust and institutional credibility.

As corroborated by previous study [19], university counseling infrastructure frequently suffers from severe spatial constraints, particularly non-soundproof and makeshift consultation quarters. In therapeutic contexts involving female students, spatial privacy is paramount; non-soundproof or improperly partitioned spaces intensify fears of accidental disclosure, ultimately violating clinical protocols, eroding trust, and deterring female students from accessing essential mental health care.

Female students typically enter therapeutic relationships anticipating concrete, actionable coping mechanisms to navigate complex psychological stressors [4]. Consequently, when clinical sessions remain predominantly reflective without providing pragmatic behavioral strategies, female students judge the intervention as therapeutically inadequate, thereby doubting its capacity to facilitate affective recovery. For female students, who frequently present with multi-faceted socio-academic distress, high affective severity, and co-occurring anxiety or depressive symptomatology-brief, time-limited interventions are clinically inadequate. Systemic access barriers included rigid session durations, scheduling conflicts with academic timetables, and the absence of structured, longitudinal follow-up protocols. In line with previous study [20], flexible scheduling options and proactive clinician-initiated follow-up care are essential to prevent premature treatment termination among university populations.

Most critically, the dual role of psychologists who also function as academic lecturers creates an inherent conflict of interest. Confidentiality breaches and dual-role conflicts of interest as major institutional impediments hindering female students from utilizing campus mental health care. Within conservative socio-cultural contexts; where psychiatric vulnerabilities are heavily stigmatized; privacy breaches carry severe social repercussions, threatening a female student's interpersonal standing and familial honor [6]. In conservative academic environments where academic standing, scholarships, and social reputation are closely interconnected, female students perceive a direct threat to data confidentiality, fearing that disclosing sensitive psychological struggles could compromise their academic evaluations or personal standing with faculty members. Institutional management must address dual-role conflicts of interest by separating academic instruction from clinical mental health delivery. Universities should recruit dedicated, full-time non-teaching clinical psychologists, thereby eliminating evaluator bias, safeguarding record confidentiality, and restoring student trust in campus healthcare systems.

To address these participant-reported challenges, university administrative bodies could consider policy adaptations that support the gradual improvement of campus mental health infrastructure. Where feasible, counseling facilities might be situated away from high-traffic faculty offices into more private, acoustically buffered spaces to better protect spatial confidentiality for student clients. Furthermore, institutions could explore integrating proactive psychoeducational initiatives and longitudinal care framework: such as adaptive stress regulation modules, peer-support networks, and structured follow-up mechanisms: to reduce treatment dropout and foster student safety. Drawing parallels from broader systematic health screening literature, establishing routinized diagnostic protocols may offer campus healthcare networks a structured approach to identifying high-risk individuals before severe distress escalates [21].

By utilizing IPA methodology, this study provides an idiographic, deeply contextualized understanding of the lived experiences, psychological distress, and structural barriers encountered by female university students. Rather than relying on broad assertions of rigor, data

trustworthiness was established through specific qualitative validation procedures. Credibility and dependability were supported through data source triangulation via FGD with campus psychologists and academic advisors, systematic audit trails documenting analytical decisions, and member checking via verbatim transcript verifications with participants. Regarding transferability, this study was conducted with a small, purposive sample (n = 4) from a single private university in Indonesia, which intentionally prioritizes contextual depth over direct statistical generalizability to broader student populations. Additionally, because the sample comprised exclusively female undergraduates, future multi-center qualitative inquiries across diverse institutional environments, genders, and academic disciplines are recommended to expand upon these findings.

CONCLUSION

This interpretative phenomenological inquiry synthesizes three interconnected dimensions of the participants' lived experiences: multi-system distress manifestations, complex institutional service navigation, and student evaluations of campus psychological support. Within this group of four female undergraduates, formal psychological help-seeking was described as occurring when emotional, cognitive, and somatic strain escalated alongside acute behavioral distress, including self-harm practices, suicidal ideation, or spiritual demoralization. While digital registration pathways and psychologist empathy were evaluated favorably by participants, sustained service utilization was constrained by spatial confidentiality concerns, limited consultation timeframes, and perceived conflicts of interest arising from dual counselor-lecturer roles. Situated within a single university context, these findings suggest that enhancing campus mental health support may benefit from acoustically private, dedicated counseling environments and clearer organizational boundaries between clinical care and academic evaluation.

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