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CASE REPORT

Stigma on Mood Disorders in Indonesia: A Culturally-Informed Analysis of Three Cases and a Proposed Intervention Framework

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ABSTRACT

Background: Mental health stigma is a major barrier to psychiatric care in Indonesia, deeply influenced by sociocultural and religious factors. **Objective**: To analyze stigma through three clinical cases of mood disorders and propose a culturally adapted intervention framework. **Cases**: Three anonymized cases are presented: a 56-year-old male with severe depression refusing care due to shame; a 44-year-old female with bipolar disorder experiencing marital stigma; and a 24-year-old male facing workplace discrimination due to his diagnosis. Stigma in Indonesia is shaped by collectivism, *malu* (shame), family reputation, and spiritual attributions. These lead to public, self, and structural stigma, causing treatment avoidance. Indigenous strengths such as gotong royong (mutual assistance) and kekeluargaan (familial harmony) offer potential counter-strategies. **Conclusions**: Direct use of Western anti-stigma models may be ineffective. We propose the 'Jujur-Terbuka-Berdaya' (JTB) program, a culturally adapted version of the Honest-Open-Proud (HOP) intervention, leveraging local values to empower individuals within Indonesian sociocultural norms.

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Highlights

1. This manuscript analyzes mental health stigma through three clinical cases of mood disorders in Indonesia, demonstrating how cultural factors such as collectivism, shame (*malu*), family reputation, and spiritual beliefs contribute to public, self, and structural stigma that hinders treatment-seeking.;
2. The culturally adapted 'Jujur-Terbuka-Berdaya' (JTB) intervention framework as an alternative to Western models, modifying the Honest-Open-Proud (HOP) program to align with Indonesian social norms through collective decision-making, indirect communication, and faith-based resilience narratives.

BACKGROUND

Mental health stigma—defined broadly as a set of negative beliefs, attitudes, and behaviors that lead to prejudice, discrimination, and social exclusion of individuals with mental health conditions—represents one of the most formidable challenges in global public health (Thornicroft et al., 2016). Despite advances in psychiatric treatment and increased awareness campaigns worldwide, stigma continues to impede help-seeking behaviors, reduce treatment adherence, delay recovery, and perpetuate social isolation for millions of people living with mental illness. In low- and middle-income countries like Indonesia, where mental health resources are already limited, the additional burden of stigma creates a particularly devastating cycle that exacerbates disability and diminishes quality of life for affected individuals and their families (Minas and Diatri, 2008).

The global prevalence of mental disorders has increased significantly in recent decades, with depression alone affecting approximately 280 million people worldwide. In Indonesia, epidemiological studies suggest that approximately 6-9% of the population experiences some form of mental health condition, with mood disorders representing a substantial portion of this burden (Brooks et al., 2022). However, treatment gaps remain alarmingly wide, with fewer than 10% of Indonesians with mental disorders receiving adequate care. While multiple factors contribute to this treatment gap—including limited healthcare infrastructure, economic constraints, and geographical barriers—research increasingly identifies stigma as the most significant and persistent obstacle to mental healthcare utilization in the Indonesian context (Andrade et al., 2014).

What makes stigma particularly complex in Indonesia is its deeply cultural nature. Unlike biological aspects of mental illness that may show cross-cultural consistency, the experience, expression, and social response to mental distress are profoundly shaped by local cultural values, beliefs, and social structures (Yang, 2007). Indonesia, as the world's fourth most populous nation and largest archipelagic state, encompasses remarkable cultural diversity with over 300 ethnic groups and numerous linguistic traditions. Yet despite this diversity, certain cultural themes—particularly collectivism, religious worldview, and face-saving behaviors—show remarkable consistency in shaping how mental illness is perceived and responded to across different Indonesian communities.

The collectivist orientation of Indonesian society, where group identity and social harmony traditionally take precedence over individual needs, creates a distinctive context for understanding stigma (Kim et al., 1994). In such societies, an individual's behavior reflects not only on themselves but on their entire family, clan, or community. This interconnectedness means that a mental health diagnosis carries implications far beyond the individual, potentially affecting marriage prospects for siblings, business relationships for family members, and the social standing of the entire kinship network. Within this collectivist framework, the concept of *malu*—often translated as "shame" but encompassing meanings of embarrassment, social discomfort, and loss of face—functions as a powerful social regulator (Menaldi et al., 2024). The prospect of experiencing *malu* or causing *malu* to one's family can be so

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aversive that individuals may choose to endure significant psychological suffering rather than seek help that might expose their condition to public view.

Religious and spiritual interpretations of mental distress further complicate the stigma landscape in Indonesia. With approximately 87% of the population identifying as Muslim (making Indonesia the world's largest Muslim-majority nation), Islamic perspectives significantly influence popular understanding of mental health issues (Wahyuni et al., 2025). Additionally, indigenous belief systems and syncretic practices blend with formal religious traditions to create complex explanatory models for psychological suffering. Mental illness is frequently attributed to non-medical causes including spirit possession (*kesurupan*), black magic (*santet* or *guna-guna*), ancestral curses, moral transgressions, or weak faith (Subu et al., 2022). While these attributions provide culturally meaningful explanations for distress, they often direct help-seeking toward religious leaders (*kyai*, *ustadz*) or traditional healers (*dukun*, *balian*) rather than mental health professionals, potentially delaying access to evidence-based treatments (Lloyd and Hartog, 2010).

Despite growing recognition of these cultural dimensions, mental health interventions in Indonesia—including anti-stigma programs—have largely followed Western models with minimal adaptation to local contexts. This disconnect between imported interventions and local cultural realities may explain the limited effectiveness of many mental health initiatives in the country. There is an urgent need for culturally grounded approaches that recognize and work within Indonesian worldviews rather than replacing them with foreign paradigms.

OBJECTIVE

This article addresses this critical gap through three interconnected aims. First, it provides a nuanced, narrative exploration of how mental health stigma manifests in contemporary Indonesia through detailed presentation of three clinical cases of mood disorders. These cases were selected to represent different facets of stigma experience—public shame, interpersonal rejection, and structural discrimination—within the Indonesian cultural context. Second, the article offers a systematic analysis of these cases through established cultural frameworks relevant to Indonesia, elucidating the specific mechanisms through which cultural values shape the lived experience of stigma. Third, building on this analysis, the article proposes a culturally adapted intervention framework called 'Jujur-Terbuka-Berdaya' (JTB), which modifies the evidence-based Honest-Open-Proud (HOP) program to align with Indonesian sociocultural norms while preserving the core therapeutic elements that make disclosure interventions effective.

Through this integrative approach—combining clinical case illustration, cultural analysis, and intervention development—this article contributes to the emerging field of cultural psychiatry in Indonesia and offers practical guidance for mental health professionals working in this complex cultural landscape. By demonstrating how Western evidence-based practices can be thoughtfully adapted rather than simply transplanted, this work supports the development of culturally-competent mental healthcare that respects local values while effectively addressing the debilitating impact of stigma.

CASE(S)

All cases presented in this article were drawn from clinical practice at the Department of Psychiatry, Dr. Soetomo General Academic Hospital in Surabaya, Indonesia, between 2022 and 2024. Informed consent was obtained from all patients for the publication of their anonymized cases in accordance with the ethical guidelines of the *Jurnal Psikiatri Surabaya* and the Committee on Publication Ethics (COPE)

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(Subu et al., 2022). To protect confidentiality, all identifying details—including names, specific locations, and potentially recognizable characteristics—have been systematically altered while preserving the essential clinical and cultural dynamics of each case. The cases were selected not for their rarity but for their representative illustration of common stigma-related challenges faced by Indonesians with mood disorders.

Case 1: Mr. D – Public Stigma, Shame (*Malu*), and Threatened Masculinity

Mr. D, a 56-year-old Javanese businessman, was referred to psychiatric services following hospitalization for a suicide attempt in which he stabbed himself in the abdomen with a kitchen knife. As the owner and director of a moderately successful family-run manufacturing company in Surabaya, Mr. D occupied a respected position in both his business community and extended family network. His admission to the surgical ward followed emergency intervention that saved his life but left him with significant abdominal injuries requiring weeks of recovery.

The precipitating event, as gradually revealed during clinical interviews, was Mr. D's discovery of his wife's five-year extramarital relationship with a business associate. What made this discovery particularly devastating was the simultaneous realization that this infidelity had been "open knowledge" among his employees and business contacts for an extended period. In Mr. D's words: "Everyone knew but me. I was the laughingstock of my own company." This dual betrayal—both marital and social—triggered a severe depressive episode characterized by pervasive guilt, profound shame, insomnia, appetite loss, and eventually suicidal ideation that culminated in his self-harm attempt.

During his postoperative recovery, Mr. D's hospital room became an extension of his workplace. Employees visited continuously to obtain signatures, deliver reports, and show respect to their recovering boss. This public setting—where business and personal boundaries dissolved—became the crucible for his psychological crisis. When the attending surgeon, recognizing the severity of Mr. D's depressive symptoms, formally requested a psychiatric consultation, the patient's demeanor transformed dramatically. Previously withdrawn and despondent, Mr. D became agitated and confrontational, adamantly refusing to see a psychiatrist despite clear medical indication.

His stated reason—"After all, consulting a psychiatrist will not bring my wife back"—initially appeared as logical rationalization. However, deeper exploration revealed more fundamental cultural anxieties. Mr. D expressed extreme *malu* (embarrassment/shame) at the prospect of a psychiatric consultation occurring in front of his staff. He articulated fears that word would spread through business networks that he was "weak," "crazy," or "unable to handle his affairs." Most poignantly, he described how the psychiatric consultation represented not merely a medical intervention but a public performance of failure that would compound the humiliation already experienced through his wife's infidelity.

From a cultural psychiatry perspective, Mr. D's case illustrates several key dynamics. First, it demonstrates how the collectivist context transforms individual mental health issues into public concerns with implications for social standing. Second, it reveals the potent regulatory function of *malu* in health decision-making, where avoidance of social shame can override recognized medical need. Third, it highlights gender dimensions of stigma, where mental illness threatens culturally-constructed ideals of masculine strength, rationality, and emotional control. Finally, it shows how help-seeking itself can become stigmatized when conducted in socially visible contexts, creating barriers even when individuals recognize their need for care.

Case 2: Mrs. IS – Interpersonal and Internalized Stigma in a Marital Dyad

Mrs. IS, a 44-year-old Sundanese woman, presented with a five-year history of bipolar disorder characterized by recurrent depressive and hypomanic episodes. Her treatment history included multiple

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medication trials with partial response and two previous psychiatric hospitalizations. Beyond her diagnostic picture, Mrs. IS's clinical presentation was notable for significant self-stigma and a complex history of domestic conflict, including episodes of verbal aggression and emotional neglect within her marriage.

The therapeutic breakthrough in understanding Mrs. IS's stigma experience emerged through an innovative integration of expressive writing and narrative therapy techniques. As part of her treatment, Mrs. IS maintained a structured journal where she documented interactions with her husband, emotional responses to these interactions, and reflections on how her illness affected family dynamics. Over six months, this journal revealed a consistent pattern of stigma reinforcement within her primary intimate relationship.

Mrs. IS described how her husband's responses to her mood episodes—which she perceived as "dismissive," "impatient," and "uncomprehending"—consistently triggered intense feelings of worthlessness and self-blame. During depressive phases, when she struggled with low energy and motivation, her husband's comments about "laziness" or "lack of effort" reinforced her belief that she was failing in her roles as wife and mother. During hypomanic periods, his irritation with her increased energy and decreased need for sleep translated in her mind as rejection of her authentic self. This pattern of perceived judgment and emotional withdrawal from her primary support figure became internalized as a pervasive self-stigma, which she articulated as: "I am broken. I am a burden. I don't deserve care." This internalized stigma in turn fueled cognitive distortions that exacerbated her mood symptoms. Believing herself to be fundamentally flawed and undeserving, she would often skip medications, cancel therapy appointments, or disengage from potentially supportive social interactions. These avoidance behaviors predictably worsened her symptoms, creating a vicious cycle where illness severity reinforced self-stigma, and self-stigma impeded recovery.
A critical therapeutic turning point occurred when Mrs. IS, through guided reflection, began to consider alternative explanations for her husband's behavior. With therapeutic support, she gradually recognized that his emotional withdrawal might reflect his own feelings of helplessness, cultural scripts about masculine emotional restraint, or lack of mental health literacy rather than personal rejection. She began to differentiate between his need for personal space after demanding workdays (a common stress response) and intentional abandonment. This cognitive reframing—though challenging—marked the beginning of disentangling her self-worth from perceived stigma and developing more adaptive coping strategies.

Mrs. IS's case illuminates the interpersonal dimensions of stigma within Indonesian families. It demonstrates how close relationships can become conduits for stigma transmission, especially when cultural expectations about family harmony (*kekeluargaan*) conflict with the realities of mental illness management. The case also highlights the transformative potential of narrative approaches in helping individuals reconstruct stigmatized identities and develop more empowered self-narratives.

Case 3: Mr. NA – Structural Stigma and the Disclosure Dilemma

Mr. NA, a 24-year-old Chinese-Indonesian man, presented with a complex history of bipolar disorder characterized by early onset (age 17), multiple treatment interruptions, and significant functional impairment despite evident intellectual and creative abilities. His educational trajectory was marked by discontinuation—first from an oceanography program, then from cultural studies—with a recurring theme of feeling "out of place" in structured academic environments despite strong academic performance in selective admissions processes.

Mr. NA's case particularly illustrates the challenges of structural stigma in Indonesian workplace settings. As he transitioned from university to employment, he faced repeated discrimination when seeking positions in creative industries aligned with his talents in graphic design and animation. On

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three separate occasions, he progressed through initial interview stages for promising positions at established animation studios, only to receive immediate rejections following disclosure of his bipolar diagnosis during medical screening processes. These experiences followed a consistent pattern: enthusiastic initial responses to his portfolio, positive interview interactions, then abrupt cessation of communication after health disclosures.

These repeated experiences of discrimination led Mr. NA to develop what he termed a "closeted professional identity." He learned to strategically conceal his mental health history, carefully managing self-presentation to avoid any suggestion of psychological vulnerability. This strategy proved effective in at least one sense: by omitting his diagnosis from applications, he secured freelance contracts with a prestigious international media company affiliated with Marvel Entertainment, where his work received positive recognition. However, this success came at high psychological cost. Mr. NA described living with constant anxiety about potential "exposure," meticulous self-monitoring to hide any mood fluctuations, and isolation from potential workplace supports he might have accessed through openness. Currently at a career crossroads, Mr. NA contemplates applying for a full-time senior position while grappling with what he calls the "disclosure dilemma." He articulates competing desires: to work in an environment where he can be authentic about his mental health journey, versus the pragmatic need to avoid discrimination in a competitive job market. He expresses particular frustration that legal protections against disability discrimination (notably Indonesia's Act No. 8 of 2016 Concerning Persons with Disabilities) seem to have minimal impact on workplace attitudes and hiring practices.

Mr. NA's case exemplifies structural stigma—systemic patterns of discrimination embedded in organizational policies and practices. It demonstrates how stigma operates not only through interpersonal prejudice but through institutional barriers that limit opportunities regardless of individual competence. The case also highlights the complex risk-benefit calculations involved in disclosure decisions, particularly in employment contexts where mental health history may trigger exclusion regardless of formal qualifications. Finally, it illustrates the gap between legislative progress and social change, where anti-discrimination laws exist but implementation remains inconsistent.

DISCUSSION

The three cases presented—Mr. D, Mrs. IS, and Mr. NA—collectively provide a multidimensional view of how mental health stigma operates within contemporary Indonesian society. While each case highlights distinct aspects of stigma experience (public shame, interpersonal rejection, and structural discrimination, respectively), together they reveal interconnected cultural mechanisms that sustain stigma across different domains. This discussion section analyzes these mechanisms through established cultural frameworks, identifies indigenous strengths that could counter stigma, and proposes a culturally-adapted intervention model.

3.1. The Cultural Anatomy of Stigma: An Integrated Analysis

Mr. D's vehement refusal of psychiatric care, despite life-threatening depression, powerfully illustrates what anthropologist term "shame culture" in action (Subu et al., 2024). In such cultural contexts, social regulation operates primarily through external sanctions (shame, embarrassment, loss of face) rather than internalized guilt. The visibility of help-seeking becomes problematic because it exposes vulnerability to social judgment. For Mr. D, the psychiatric consultation represented not merely a medical appointment but a public declaration of weakness that threatened his carefully maintained identity as competent patriarch and business leader. This case demonstrates how preserving social face (*harga diri*) can literally become a matter of life and death, with avoidance of *malu* taking precedence over addressing severe psychiatric symptoms.

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The collectivist dimension of this dynamic deserves particular emphasis. In individualistic societies, health decisions typically prioritize personal well-being. In collectivist contexts like Indonesia, health decisions inevitably consider implications for the entire social network (Kim et al., 1994). Mr. D's refusal reflected not only personal shame but protective instincts toward his family's reputation (*nama baik keluarga*). His reasoning implicitly acknowledged that his "mental breakdown" would diminish marriage prospects for his children, damage business relationships for his siblings, and potentially affect the social standing of his extended clan. This interconnected view of self and family transforms mental illness from an individual medical condition into a collective social concern with far-reaching consequences.

Mrs. IS's experience reveals how stigma operates within the foundational unit of Indonesian society: the family. Her husband's responses—while potentially understandable as expressions of frustration or helplessness—functioned as powerful stigma reinforcements because they came from her primary attachment figure. The cultural premium placed on family harmony (*kekeluargaan*) creates particular challenges when mental illness disrupts domestic equilibrium (Taufik, 2023). Without adequate mental health literacy, family members may interpret symptoms as intentional disruptions or moral failings rather than manifestations of illness. Mrs. IS's husband, lacking a biomedical framework for understanding her mood swings, likely perceived them as willful violations of household harmony, prompting responses of frustration and emotional withdrawal.

This dynamic becomes particularly damaging when combined with culturally ingrained scripts of self-blame, especially for women in traditional gender roles. Mrs. IS internalized her husband's perceived judgment as evidence of her failure as wife and mother—core identities in Indonesian feminine ideals. This intersection of gender expectations and mental illness stigma created what she described as "double shame": shame about her illness compounded by shame about her perceived inadequacy in fulfilling gendered social roles. Her case illustrates how stigma doesn't merely affect how individuals are treated by others, but how they come to view themselves, with internalized stigma potentially causing more psychological harm than external discrimination.

Underpinning both cases is the pervasive influence of non-biomedical explanatory models for mental distress (Wahyuni et al., 2025). While neither patient explicitly endorsed supernatural attributions, their narratives existed within a cultural milieu where spiritual interpretations remain prevalent. In many Indonesian communities, unusual behaviors associated with mental illness are more likely to be interpreted as spirit possession (*kesurupan*), effects of black magic (*guna-guna*), ancestral punishment, or tests of faith than as symptoms of medical conditions (Subu et al., 2022). These explanatory frameworks, while culturally coherent, create significant barriers to psychiatric care by directing help-seeking toward traditional or religious healers rather than clinical professionals. They also contribute to stigma by associating mental illness with moral or spiritual deficiency rather than health conditions.

Mr. NA's experience shifts focus from interpersonal to structural dimensions of stigma, demonstrating how discrimination becomes institutionalized in organizational practices. His repeated job rejections following disclosure illustrate what sociologists term "statistical discrimination"—employers using mental health history as a proxy for presumed unreliability or productivity concerns, regardless of individual capabilities (Corrigan et al., 2022). This form of discrimination is particularly pernicious because it operates through seemingly neutral organizational procedures (medical screenings, HR policies) while systematically excluding qualified individuals.

The persistence of such discrimination despite legal protections highlights the implementation gap common in mental health policy. Indonesia's disability law (UU 8/2016) formally prohibits discrimination based on disability, including psychosocial disabilities. However, as Mr. NA's experience shows, formal rights don't automatically translate to changed attitudes or behaviors in workplace settings. This gap between legislation and lived experience underscores that reducing

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structural stigma requires more than legal reform—it necessitates cultural change within organizations and professional communities.

Collectively, these cases reveal stigma as a multilayered phenomenon in Indonesia, operating simultaneously at psychological, interpersonal, and structural levels while being shaped by distinctive cultural values. Effective anti-stigma interventions must therefore address multiple levels while remaining culturally congruent.

3.2. Indigenous Resilience: Cultural Strengths as Stigma Counterweights

An important insight emerging from this analysis is that the same cultural values that sometimes amplify stigma also contain potential antidotes. Rather than viewing Indonesian culture solely as a source of stigma, a more nuanced perspective recognizes cultural strengths that could be mobilized in anti-stigma efforts. Two concepts particularly merit attention: *gotong royong* and *kekeluargaan*.

Gotong royong, traditionally translated as "mutual assistance," represents a deeply ingrained Indonesian ethic of collective responsibility and shared burden-bearing(Dewantara, 2017). Historically manifested in communal agricultural work, neighborhood clean-ups, or collective building projects, *gotong royong* embodies the principle that community challenges should be addressed through cooperative effort rather than individual struggle. In mental health contexts, this ethic could be reframed to transform how communities respond to mental illness.

A community that practices *gotong royong* in relation to mental health might organize rotating meal delivery for a family coping with a member's psychiatric hospitalization, provide childcare respite during treatment appointments, or simply maintain social inclusion when someone experiences symptomatic periods. Such practical support not only addresses concrete needs but communicates powerful anti-stigma messages: that mental health challenges are collective concerns rather than individual failings, and that community solidarity extends to psychological as well as physical needs. Modern manifestations might include peer support groups conceptualized as *gotong royong* circles, where individuals share coping strategies and recovery burdens. This reframing helps transform help-seeking from an admission of individual deficit into an opportunity for communal solidarity, potentially reducing the shame associated with accessing mental health services.

Kekeluargaan, often translated as "familism" or "family spirit," emphasizes harmonious interdependence within extended family networks (Taufik, 2023). While breakdowns in family harmony can exacerbate stigma (as seen with Mrs. IS), the shared cultural value placed on maintaining or restoring harmony provides a potential entry point for family-focused interventions. Rather than approaching families with the Western therapeutic frame of "dysfunctional dynamics requiring correction," practitioners might frame engagement around the culturally valued goal of restoring family equilibrium.
Family therapy could be presented not as "fixing a broken individual" but as a collaborative process of "strengthening family bonds" or "restoring household harmony." This reframing aligns with cultural values while addressing the same therapeutic targets. By working within rather than against the cultural ideal of *kekeluargaan*, interventions may achieve greater family buy-in and sustainability. This approach recognizes that in collectivist societies, healing often occurs through relational repair rather than solely through individual insight.

Religious and spiritual communities, often overlooked in biomedical approaches, represent another potential resource. Given the significant role of religious interpretation in shaping attitudes toward mental illness, engagement with religious leaders and faith communities should be integral to anti-stigma efforts. Collaborative initiatives between mental health professionals and religious figures could help develop theological frameworks that support rather than stigmatize help-seeking, perhaps

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emphasizing concepts like compassion (*rahmat*), patience (*sabar*), and community responsibility (*tanggung jawab bersama*).

These cultural strengths—*gotong royong*, *kekeluargaan*, and religious community—provide foundations upon which culturally-congruent anti-stigma interventions can be built. Rather than importing foreign concepts of "community support" or "family therapy," effective programs might work through these pre-existing cultural frameworks, increasing relevance and acceptability for Indonesian participants.

3.3. A Culturally-Adapted Intervention: From 'Honest-Open-Proud' to 'Jujur-Terbuka-Berdaya' (Honest-Open-Empowered)

Building on this cultural analysis, we propose the 'Jujur-Terbuka-Berdaya' (JTB) framework as a culturally-adapted version of the evidence-based Honest-Open-Proud (HOP) program. The original HOP intervention, developed primarily in Western individualistic contexts, is a peer-led program designed to help individuals make strategic decisions about disclosing mental health conditions, with the goal of reducing self-stigma and improving social integration (Rüsch and Kösters, 2021). While the core mechanisms of HOP—particularly its focus on empowering individuals through controlled disclosure decisions—have demonstrated effectiveness across various contexts, its cultural assumptions require thoughtful adaptation for the Indonesian setting.

The most immediately apparent cultural mismatch involves the program's final component: "Proud." In Western individualistic contexts, developing pride about one's mental health journey represents an important step in combating internalized stigma. However, direct translation to *bangga* in Indonesian carries potentially problematic connotations of arrogance, self-promotion, or excessive focus on individual achievement—all of which conflict with cultural values of humility (*rendah hati*) and collective orientation. The alternative term *berdaya* (empowered) better captures the intended outcome while remaining culturally congruent. *Berdaya* emphasizes agency, resilience, and capacity to contribute to the collective—concepts that resonate with Indonesian values while addressing the empowerment goals central to disclosure interventions.

Beyond terminology, more substantive adaptations are needed regarding the program's underlying assumptions about self, relationships, and communication. Western disclosure models typically emphasize individual autonomy, direct verbal communication, and personal narrative control. Indonesian contexts, by contrast, often prioritize relational harmony, indirect communication styles, and collective decision-making. The JTB framework addresses these differences through systematic modifications to all three core HOP modules, as detailed in Table 1.

Table 1. Cultural Adaptation Framework: From HOP to Jujur-Terbuka-Berdaya

Component	Original HOP (Western Context)	Jujur-Terbuka-Berdaya (Indonesian Context)	Cultural Rationale
Module 1: Disclosure Decision-Making	Individual cost-benefit analysis focusing on personal goals, authenticity, and self-esteem. Participants weigh how disclosure might affect their personal relationships, employment, and self-image(Corrigan et al., 2023).	***Menimbang Rasa* (Weighing Collective Feelings):** Analysis expands to consider collective consequences. Participants examine how disclosure might affect family harmony (*kekeluargaan*), community reputation, marital prospects for relatives, and business relationships. The goal shifts from "what's best for me" to "what's wisest for our collective well-being."	Aligns with collectivist values where major decisions inherently consider impact on the social network. Respects Indonesian relational orientation while preserving the analytical approach to disclosure decisions.

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Component	Original HOP (Western Context)	Jujur-Terbuka-Berdaya (Indonesian Context)	Cultural Rationale
Module 2: Disclosure Strategies	Focus on direct, though cautious, verbal communication. Participants practice identifying "safe" individuals based on direct feedback and explicit conversations. Techniques include rehearsed statements and gradual revelation(Corrigan et al., 2023).	***Seni Komunikasi Tidak Langsung* (The Art of Indirect Communication):** Emphasizes high-context communication strategies appropriate for Indonesian social norms. "Testing the waters" involves using allegory, third-person stories, seeking advice (*minta nasihat*) from respected elders, or observing reactions to related topics. Direct confrontation is minimized in favor of reading subtle social cues.	Recognizes that directness may be perceived as rude or aggressive in many Indonesian contexts. Works with rather than against prevailing communication styles while achieving similar disclosure assessment goals.
Module 3: Personal Narrative Development	Participants craft and practice telling their "recovery story" with emphasis on personal empowerment, overcoming illness, and achieving individual potential. The narrative arc typically moves from illness to health, vulnerability to strength(Corrigan et al., 2023).	***Kisah Ketangguhan dan Iman* (Story of Resilience and Faith):** Narrative is framed as a journey of patience (*sabar*), acceptance (*ikhlas*), gratitude (*syukur*), and spiritual growth. Emphasis shifts from individual achievement to lessons learned, relationships strengthened through struggle, and reliance on family, community (*gotong royong*), and divine support(Supratman et al., 2024). The individual is positioned as a resilient member of the collective rather than a heroic individual.	Aligns with cultural values of humility, spiritual framing of life challenges, and collective orientation. Maintains the therapeutic function of narrative reconstruction while using culturally resonant themes and story structures.

The JTB framework offers practical pathways for individuals like those in our case studies. For Mr. D, the *Menimbang Rasa* approach would allow him to process his disclosure decisions in a way that honors his roles and responsibilities as family patriarch and business leader, rather than forcing a confrontation with his cultural identity. He might consider limited disclosure to selected family elders who could provide support while protecting family reputation, or explore how his business leadership could model strength through vulnerability in culturally-appropriate ways.

For Mr. NA, the skills developed in *Seni Komunikasi Tidak Langsung* would provide culturally sophisticated tools for navigating disclosure in professional settings. Rather than the binary choice between full disclosure and complete concealment, he might learn to gauge workplace cultures through indirect means, share aspects of his experience through metaphorical language, or identify allies through careful observation before making targeted disclosures.

For Mrs. IS, crafting a *Kisah Ketangguhan dan Iman* could help her reframe her experience from a narrative of shame and failure to one of resilience and spiritual growth. By emphasizing how her journey has deepened her patience (*sabar*), strengthened her marriage through challenge, or increased her compassion for others, she might develop a self-narrative that reduces internalized stigma while resonating with cultural and spiritual values.

The JTB framework represents what cultural psychologist term "cultural accommodation"—modifying evidence-based interventions to align with local cultural patterns while preserving active therapeutic ingredients. This approach recognizes that effective interventions must be both evidence-based and culturally congruent, with adaptation occurring at the level of techniques and delivery while maintaining core change mechanisms.

Limitations

This study has several limitations that should inform future research. First, its reliance on three cases, while providing rich qualitative data, limits generalizability. Second, the cases all involve mood

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disorders; stigma experiences may differ for other mental health conditions. Third, the analysis focuses primarily on Javanese and urban Indonesian contexts; experiences in other ethnic groups and rural areas may vary. Fourth, the proposed JTB framework requires empirical testing to establish feasibility and effectiveness.

Future research should address these limitations through mixed-methods studies with larger, more diverse samples. Priority should be given to developing a manualized JTB program followed by feasibility studies and randomized controlled trials to evaluate its impact on stigma reduction, help-seeking behaviors, and mental health outcomes in Indonesian populations. Longitudinal research could examine how stigma experiences evolve with changing social conditions, including Indonesia's rapid urbanization and digital transformation. Comparative studies across different Indonesian ethnic groups could identify both universal and culture-specific stigma mechanisms.

Beyond research, several policy and practice implications emerge from this analysis. Mental health training programs in Indonesia should incorporate cultural competence modules that address stigma's cultural dimensions. Clinical guidelines should recommend culturally-adapted assessment tools that evaluate stigma experiences within cultural context. Mental health campaigns should collaborate with cultural and religious leaders to develop messages that resonate with local values while challenging stigmatizing beliefs. Workplace mental health initiatives should address structural stigma through both policy change and cultural transformation within organizations.

Ultimately, reducing mental health stigma in Indonesia requires a balanced approach that recognizes both the challenges posed by cultural values and the resources contained within them. By developing interventions that work with cultural grain rather than against it, mental health professionals can help build a more inclusive society where individuals with mental health conditions receive not only effective treatment but also the dignity, respect, and belonging that are fundamental to recovery and well-being.

CONCLUSION

This detailed analysis of three mood disorder cases demonstrates that mental health stigma in Indonesia is not a monolithic phenomenon but a complex, multilayered experience deeply intertwined with cultural values of collectivism, shame avoidance (*malu*), family reputation preservation (*nama baik keluarga*), and spiritual attributions of distress. The experiences of Mr. D, Mrs. IS, and Mr. NA collectively illustrate how these cultural forces shape public stigma, internalized self-stigma, and structural discrimination, creating significant barriers to care access, treatment adherence, and social inclusion.

The cases reveal stigma operating through multiple interconnected mechanisms: the regulatory power of *malu* in health decision-making; the transformation of individual health issues into collective family concerns; gender-specific stigma expressions; the internalization of interpersonal rejection as self-stigma; and the institutionalization of discrimination in workplace practices. These mechanisms collectively create what might be termed a "stigma ecosystem" in Indonesia—a self-reinforcing system where cultural values, social structures, and individual psychology interact to sustain stigmatizing attitudes and behaviors.

However, the analysis also identifies potential pathways for stigma reduction through strategic engagement with cultural strengths rather than cultural replacement. Indigenous concepts such as *gotong royong* (mutual assistance) and *kekeluargaan* (familial harmony)—while sometimes implicated in stigma perpetuation—also contain the seeds of potential antidotes. These cultural frameworks provide foundations for community-based support systems that could reduce isolation, share recovery burdens, and reframe help-seeking as collective responsibility rather than individual failing.

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The 'Jujur-Terbuka-Berdaya' (JTB) framework proposed in this article represents a practical application of this cultural strength perspective. By thoughtfully adapting the evidence-based Honest-Open-Proud program to align with Indonesian cultural norms—emphasizing collective decision-making (*Menimbang Rasa*), indirect communication strategies (*Seni Komunikasi Tidak Langsung*), and spiritually framed narratives of resilience (*Kisah Ketangguhan dan Iman*)—the JTB model offers a culturally congruent pathway to empowerment. This approach seeks to reduce stigma not by extracting individuals from their cultural context but by strengthening their position within it, working with rather than against the sociocultural frameworks that give their lives meaning.

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Conflict of Interest

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Patient Consent for Publication

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