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MENTAL-HEALTH VULNERABILITY AND EMOTIONAL DISTRESS AMONG YOUTH FROM DISRUPTED FAMILIES: AN EXTENDED SOCIAL SUPPORT MODEL

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ABSTRACT

This study examines the relationship between mental-health vulnerability and emotional distress among young people from disrupted families and extends the original model by introducing perceived social support as a moderator. A quantitative, cross-sectional survey was administered anonymously to 100 purposively selected respondents. The original instrument measured anxiety, sadness, low self-confidence, emotional dysregulation, insecurity, concentration problems, irritability, low motivation, social withdrawal, and sleep disturbance. The baseline results indicate a positive and significant association between vulnerability and emotional-distress scores ($B = 0.270$; $t = 3.215$; $p = 0.002$; $R^2 = 0.588$). Because the dependent items were negatively worded, higher scores represent poorer emotional well-being. The extended model proposes that support from family, friends, teachers, and other trusted adults can directly reduce distress and weaken the effect of vulnerability. Social support was not measured in the original dataset; therefore, its moderating effect is presented as a testable extension rather than a completed empirical finding.

Keywords: mental-health vulnerability; emotional distress; perceived social support; family disruption; youth.

INTRODUCTION

Adolescence and emerging adulthood are developmental periods marked by identity formation, expanding social roles, and a growing expectation to regulate emotions independently. During these stages, the family remains a major source of security, attachment, and everyday emotional support. Hurlock (2019) and Santrock (2018) explain that emotional development is shaped by relationships with caregivers, social experiences, and the individual's capacity to adjust to changing demands. When family relationships are unstable, young people may need to manage developmental pressures while simultaneously coping with conflict, separation, loss, or uncertainty at home.

The source study uses the term broken home to describe family conditions involving parental divorce, prolonged conflict, the death or departure of a parent, and the reduced functioning of caregiving relationships. In this English version, the less stigmatizing terms family disruption and disrupted families are used while retaining the source study's substantive meaning. Family disruption is not assumed to produce the same outcome for every young person. Its psychological impact depends on conflict intensity, the continuity of caregiving, economic changes, communication patterns, and the availability of supportive relationships (Gunawan, 2019; Cahyani & Hartono, 2019).

Young people from disrupted families may experience anxiety, sadness, insecurity, low self-confidence, difficulty controlling emotions, reduced motivation, sleep problems, and obstacles in building close relationships. Afdal and Sari (2020) associate family conflict with adolescent mental-health difficulties, while Irfan and Sulastri (2021) emphasize insecurity and anxiety among young people experiencing family disruption. However, vulnerability should not be equated with a clinical diagnosis. In this study, mental-health vulnerability refers to a heightened tendency to experience psychological symptoms when family-related demands exceed the coping resources available to the individual.

The original study tested a single direct relationship between mental-health vulnerability and emotional well-being. A measurement issue must be clarified before interpreting the results: all dependent-variable items describe negative experiences, including difficulty concentrating, irritability, low motivation, anxiety, interpersonal difficulty, feeling unsafe at home, withholding personal problems, and sleep disturbance. Consequently, a higher raw score indicates greater emotional distress and therefore poorer emotional well-being. The positive regression coefficient should be interpreted as higher vulnerability being associated with more emotional difficulty, not with improved well-being.

A second limitation of the original model is that it does not include a protective factor. The source manuscript repeatedly indicates that children and young people cope better when they receive attention and assistance from family members, friends, teachers, or the wider social environment. Lubis (2018) similarly highlights the role of the social environment in children's mental development. This observation provides a strong basis for adding perceived social support as a moderating variable. Social support can provide emotional reassurance, practical help, information, companionship, and access to trusted adults. These resources may not remove family disruption, but they can reduce isolation and improve coping.

Accordingly, this article has two purposes. First, it reports the empirical baseline from the original dataset: the direct relationship between mental-health vulnerability and emotional distress. Second, it develops a distinct extended model in which perceived social support is expected to reduce emotional distress directly and weaken the effect of vulnerability. This addition differentiates the manuscript from the original two-variable article while preserving the integrity of the available data. The added moderation effect is not assigned invented coefficients; it is presented as a hypothesis that requires a new social-support measure and a new analysis.

LITERATURE REVIEW

Mental-Health Vulnerability

Mental-health vulnerability is a condition of elevated susceptibility to psychological distress when individuals encounter persistent stressors, relational conflict, loss, or insufficient coping resources. It does not necessarily mean that a person has a diagnosed mental disorder. Rather, it refers to the likelihood that symptoms such as anxiety, sadness, stress, insecurity, emotional instability, and withdrawal will appear or intensify under adverse conditions (Arifin, 2017; Ningsih & Fatimah, 2020). This distinction is important because a survey of perceived symptoms cannot replace professional clinical assessment.

Within disrupted families, vulnerability may arise from repeated parental conflict, changes in residence or caregiving arrangements, economic uncertainty, reduced parental attention, and the loss of an attachment figure. Fauziah and Wibowo (2020) argue that family disruption can interfere with adolescent emotion regulation. Wulandari (2018) also links parenting patterns and incomplete family functioning with emotional stability. The source instrument represents vulnerability through anxiety about the family, sadness without a clear immediate cause, low

confidence in social interaction, difficulty controlling emotions, pressure at home, worry about the future, and reluctance to discuss personal problems.

Emotional Distress and Impaired Emotional Well-Being

Emotional well-being generally refers to the capacity to experience relative calm, understand and manage emotions, maintain motivation, build supportive relationships, and adapt to life changes. It is not merely the absence of negative feelings; it also includes the ability to recover from stress and continue daily functioning. In the source study, however, the dependent construct is operationalized through negative symptoms. For analytical accuracy, the observed score is therefore described in this article as emotional distress or impaired emotional well-being.

The eight validated dependent items include concentration difficulty caused by family problems, irritability, reduced motivation for school or hobbies, anxiety about family changes, difficulty developing close relationships with friends or teachers, discomfort or insecurity at home, withholding feelings, and sleep disturbance. A higher score on these items indicates a greater burden of distress. Maharani and Anggraini (2021) associate self-esteem with emotional well-being among adolescents from disrupted families, while Rahman and Sofyan (2020) describe emotional distress as a significant concern in this population.

Perceived Social Support as an Added Variable

Perceived social support refers to an individual's belief that reliable help, care, understanding, and companionship are available when needed. The perception of available support can be as important as the amount of support objectively received because it influences whether a young person feels safe enough to disclose problems and seek assistance. The multidimensional perspective distinguishes support from family, friends, and significant others or trusted adults (Zimet et al., 1988). In a school or community context, trusted adults may include teachers, counsellors, relatives, mentors, or religious figures.

Social support can influence emotional outcomes through two pathways. First, it may have a direct protective effect by increasing belonging, validation, and access to practical assistance. Second, it may buffer the impact of stress by helping individuals reinterpret problems, regulate emotions, and identify coping alternatives. The buffering hypothesis proposes that support is especially valuable when stress is high because it reduces the extent to which stressful experiences translate into psychological harm (Cohen & Wills, 1985). In the context of family disruption, support outside the immediate parental relationship may partly compensate for inconsistent emotional resources at home.

Hypothesis Development and Model Differentiation

Mental-health vulnerability is expected to increase emotional distress because recurrent anxiety, sadness, insecurity, and emotional dysregulation can interfere with concentration, motivation, sleep, and social adaptation. Dewi and Rahmawati (2021) identify an association between mental vulnerability and depressive symptoms in adolescents, while Setyowati (2021) positions family disruption as a relevant context for adolescent mental health. The baseline hypothesis is therefore: H1, mental-health vulnerability positively affects emotional distress among young people from disrupted families.

Perceived social support should reduce distress by providing emotional reassurance, information, and trusted channels for disclosure. Young people who feel supported may be less likely to carry family problems alone and more likely to seek constructive help. The second hypothesis is: H2, perceived social support negatively affects emotional distress. In addition, support is expected to weaken the positive vulnerability-distress relationship. The third hypothesis is: H3, perceived social support moderates the effect of mental-health vulnerability on emotional distress, such that the relationship becomes weaker at higher levels of support.

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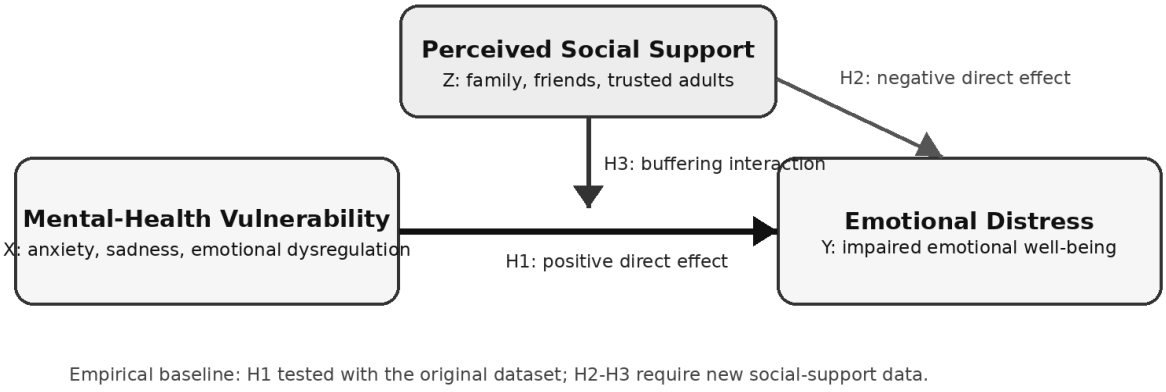
Table 1. Differences between the original and extended research models

Element	Original study	Extended STRAMER version
Predictor	Mental-health vulnerability (X)	Mental-health vulnerability (X)
Added variable	None	Perceived social support (Z)
Outcome	Emotional well-being score	Emotional distress / impaired well-being (Y)
Analytical model	Simple linear regression	Hierarchical moderated regression
Main contribution	Direct-effect evidence	Direct effect plus a testable protective mechanism
Evidence status	X→Y tested	X→Y reported; Z and X×Z proposed for new data

Source: Extended by the author from the original Ghifta Putri Famellya research model, 2026.

Figure 1. Extended conceptual model



Source: Author-developed model based on the original dataset and the proposed perceived-social-support extension.

METHOD

Research Design and Participants

The empirical baseline uses the original quantitative, cross-sectional, associative design. Data were collected through an anonymous online questionnaire from 100 purposively selected respondents who reported experience with family disruption. The sample included 78 female and 22 male respondents. The age profile extended from adolescence into emerging adulthood, with age 22 reported as the most frequent category. Because the source document does not provide a fully consistent age-frequency total, the profile is treated as descriptive rather than as a basis for subgroup inference.

Purposive sampling was used because the research required respondents with relevant family experience and willingness to answer sensitive questions. Anonymity was intended to reduce discomfort and encourage honest responses. Nevertheless, the survey did not constitute clinical screening and did not produce a psychiatric diagnosis. The findings describe self-reported vulnerability and distress within the participating sample.

Measurement

The questionnaire used a five-point Likert scale. The validated mental-health-vulnerability scale contained eight items in the instrument-quality tables, although the descriptive section and appendix show nine statements. The items reflect anxiety, sadness, low self-confidence, emotional-control difficulty, pressure at home, worry about the future, and reluctance to disclose personal problems. The emotional-distress scale contained eight validated items covering concentration problems, irritability, reduced motivation, anxiety about family changes, interpersonal difficulty, insecurity at home, withholding feelings, and sleep difficulty.

Perceived social support is the new variable introduced in this version. A future data-collection wave should measure perceived support from family, friends, and trusted adults. The Multidimensional Scale of Perceived Social Support offers a well-established structure for measuring these sources (Zimet et al., 1988). For the present article, the added variable is conceptually operationalized but not statistically scored because the original questionnaire did not include independent social-support items.

Table 2. Operationalization of the extended variables

Variable	Core indicators	Role	Measurement status
Mental-health vulnerability (X)	Anxiety; sadness; low confidence; emotional dysregulation; home pressure; future worry; disclosure difficulty	Independent variable	Measured in the original survey
Emotional distress (Y)	Concentration difficulty; irritability; low motivation; anxiety; interpersonal difficulty; insecurity; withholding feelings; sleep problems	Dependent variable	Measured in the original survey
Perceived social support (Z)	Family support; friend support; trusted-adult support; availability of emotional and practical help	Moderator and predictor	Added variable; requires new items/data

Source: Original instrument adapted and extended by the author, 2026.

Data Analysis

The original analysis used Orange Data Mining and included Pearson item-total validity, Cronbach's Alpha reliability, descriptive scoring, visual checks of normality and linearity, simple linear regression, a t-test, and the coefficient of determination. Items were considered valid when their item correlations exceeded the critical value of 0.195. Reliability was considered acceptable when Cronbach's Alpha exceeded 0.60. The direct hypothesis was evaluated at the 5% significance level.

To test the extended model in a future study, the predictor and moderator should be mean-centred, followed by hierarchical regression. The baseline equation is $Y = \beta0 + \beta1X + \varepsilon$. The extended equation is $Y = \beta0 + \beta1X + \beta2Z + \beta3(X \times Z) + \varepsilon$. A significant negative $\beta2$ would support

the direct protective effect of social support, while a significant negative β3 would indicate that social support weakens the positive relationship between vulnerability and distress. Simple-slope analysis should then compare the X→Y relationship at low, average, and high levels of perceived support.

RESULTS

Respondent Profile and Instrument Quality

The sample consisted of 100 respondents, with women representing 78% and men 22%. The source profile indicates that age 22 was the most frequent category. Respondents reported different forms of family disruption, including parental divorce, prolonged conflict, and the death or departure of a parent. Because the family-condition frequencies shown in the source do not sum to the full sample, the categories are not used for comparative statistical conclusions.

All reported instrument items exceeded the critical correlation value of 0.195. Mental-health-vulnerability item correlations ranged from 0.851 to 0.884. Emotional-distress item correlations ranged from 0.817 to 0.908. Cronbach's Alpha was 0.9822 for mental-health vulnerability and 0.905 for emotional distress. These values indicate high internal consistency, although extremely high reliability may also reflect close similarity among item contents.

Table 3. Respondent and instrument-quality summary

Aspect	Reported result	Interpretation
Sample size	100 respondents	Purposive, anonymous online sample
Gender	78 female; 22 male	Sample dominated by female respondents
Most frequent age	22 years (reported n = 40)	Late-adolescent/emerging-adult profile
Validity of X	r = 0.851-0.884	All reported items valid
Validity of Y	r = 0.817-0.908	All reported items valid
Reliability of X	Cronbach's Alpha = 0.9822	Very high internal consistency
Reliability of Y	Cronbach's Alpha = 0.905	High internal consistency

Source: Processed from the original survey output, 2026.

Descriptive Results

The average mental-health-vulnerability score was 319.33 out of 500, equivalent to 63.87% and categorized as moderate in the source study. The highest reported descriptive item was discomfort in discussing personal problems, at 66%. Anxiety about family conditions, sadness, low confidence, pressure at home, and future worry were also within the moderate range. This pattern suggests that many respondents experienced meaningful but varying levels of family-related psychological strain.

The average emotional-distress score was also 319.33 out of 500, or 63.87%, and was categorized as moderate. Irritability and discomfort or insecurity at home each reached 65.2%, while concentration difficulty, low motivation, anxiety, interpersonal difficulty, withholding feelings, and sleep disturbance were in the 63-64% range. Because these items describe problems rather than positive well-being, the moderate score indicates a moderate level of emotional difficulty rather than a moderate level of healthy well-being.

Table 4. Descriptive findings

Variable	Average score	Percentage	Source category	Substantive interpretation
Mental-health vulnerability	319.33/500	63.87%	Moderate	Moderate vulnerability symptoms
Emotional-distress score	319.33/500	63.87%	Moderate	Moderate impairment in emotional well-being
Added social support	Not available	Not available	Not tested	Requires a new independent scale

Source: Original descriptive recapitulation, reinterpreted according to item direction, 2026.

Baseline Regression and Hypothesis Testing

Visual inspection in the source study indicated approximately normal distributions and a linear relationship between the two measured variables. Simple linear regression produced an intercept of 25.138 and a slope of 0.270, yielding the equation Y = 25.138 + 0.270X. The positive coefficient means that each one-unit increase in mental-health vulnerability was associated with a 0.270-unit increase in the emotional-distress score.

The t-test produced t = 3.215, exceeding the reported critical value of 1.984, with p = 0.002. H1 was therefore supported: mental-health vulnerability significantly predicted emotional distress. The coefficient of determination was R^2 = 0.588, indicating that 58.8% of the variance in the measured distress score was explained by vulnerability in the sample, while 41.2% was associated with other factors outside the baseline model.

H2 and H3 were not tested because perceived social support was not measured separately in the original questionnaire. No coefficients, p-values, or effect sizes are assigned to the added variable. The extended model is therefore a research redesign that should be tested with new data rather than a retrospective claim about the existing sample.

Table 5. Baseline regression results and extended-hypothesis status

Test or hypothesis	Reported value/status	Conclusion
Regression equation	Y = 25.138 + 0.270X	Positive association with emotional distress
Slope for X	B = 0.270	Higher vulnerability predicts more distress
t-test	t = 3.215; p = 0.002	Direct effect significant
Coefficient of determination	R^2 = 0.588	58.8% of Y variance explained in the sample
H1: X→Y	Supported	Empirically tested
H2: Z→Y	Not tested	New social-support data required
H3: X×Z→Y	Not tested	Moderation analysis required

Source: Original Orange Data Mining output and the extended-model specification, 2026.

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DISCUSSION

The baseline findings show that greater mental-health vulnerability is associated with greater emotional distress among young people from disrupted families. This relationship is consistent with the descriptive pattern: respondents who reported anxiety, sadness, low confidence, emotional-control difficulty, home pressure, and future worry also tended to report concentration problems, irritability, reduced motivation, insecurity, interpersonal difficulty, and sleep disturbance. The statistical result therefore supports the substantive conclusion that family-related psychological vulnerability can interfere with everyday emotional functioning.

The direction of measurement deserves special attention. The source study labels the dependent variable emotional well-being, but the items are exclusively negative. If this issue is ignored, the positive coefficient could be misread as vulnerability improving well-being. The more defensible interpretation is that higher vulnerability increases an emotional-distress score and thereby reflects poorer well-being. Future research should either rename the construct emotional distress, as done here, or reverse-code negative items and supplement them with positively worded indicators of calm, optimism, emotional control, belonging, and life satisfaction.

The R^2 value of 0.588 suggests a substantial relationship in this sample. However, the result should not be interpreted as proof that vulnerability is the only major determinant of emotional outcomes. Both constructs were measured through self-report at the same time and include conceptually close negative symptoms. Common-method variance and content overlap may therefore increase the observed association. Longitudinal data, multiple informants, and a clearer separation between predictor and outcome indicators would strengthen causal interpretation.

The addition of perceived social support provides a theoretically meaningful way to explain the unexplained 41.2% of variance and to move the article beyond the original direct-effect model. Young people facing family disruption may have limited control over parental conflict or separation, but they can still benefit from reliable relationships. A supportive relative may provide stability; a friend may reduce isolation; a teacher or counsellor may identify risk and provide referral; and a trusted community figure may offer practical guidance. These resources can make emotional disclosure safer and reduce the tendency to carry problems alone.

Social support is also relevant because the highest vulnerability item concerned discomfort in discussing personal problems. The pattern suggests that some respondents may lack either a trusted person or confidence that disclosure will be received safely. A support-focused intervention should therefore not merely tell young people to speak up. It should create confidential, non-judgmental, and accessible channels; train adults to respond appropriately; and protect participants from blame or stigma. The quality of the response is central to whether support is experienced as genuinely helpful.

At the family level, parents and extended relatives should maintain consistent communication and avoid involving children in adult conflict. At the school level, counsellors and teachers can provide early identification, structured referral, peer-support activities, and psychoeducation on emotional regulation. Community organisations can provide mentoring and safe activities that strengthen belonging. These recommendations do not replace professional mental-health care. Respondents reporting persistent anxiety, sleep disturbance, severe withdrawal, or impaired daily functioning should be encouraged to access qualified psychological or medical services.

For researchers, the extended model can be implemented by adding a validated perceived-social-support scale and estimating direct and interaction effects. A meaningful buffering result would appear when the vulnerability-distress slope is steep among respondents with low support but weaker among those with high support. Researchers should also test whether support sources

differ: family support may be limited in highly conflicted homes, while friend or teacher support may remain available. Comparing these dimensions could produce more targeted interventions than a single total-support score.

CONCLUSION

The original dataset demonstrates that mental-health vulnerability significantly predicts emotional distress among young people from disrupted families. The reported regression coefficient was 0.270, with t = 3.215, p = 0.002, and R^2 = 0.588. Because the dependent items represent negative symptoms, the positive relationship means that greater vulnerability is associated with poorer emotional well-being. Respondents showed moderate vulnerability and moderate emotional difficulty, including anxiety, irritability, insecurity, disclosure barriers, concentration problems, and sleep disturbance.

This STRAMER version is differentiated from the original article by adding perceived social support as a protective moderator. The revised model proposes that support from family, friends, teachers, counsellors, and other trusted adults can reduce distress directly and weaken the effect of vulnerability. The direct vulnerability-distress result is empirically supported by the existing data; the social-support hypotheses require a new measurement wave and moderated-regression analysis. The main practical implication is that emotional support must be made reliable, confidential, and easy to access rather than treated as a general recommendation without an implementation mechanism.

LIMITATIONS

Several limitations should guide interpretation. First, the cross-sectional design cannot establish temporal causality. Second, purposive online sampling from 100 respondents limits generalisation. Third, all variables were self-reported in the same questionnaire, creating the possibility of common-method bias. Fourth, the dependent measure contains only negatively worded indicators, so it measures emotional distress more directly than positive emotional well-being.

Fifth, the source document contains administrative inconsistencies: eight vulnerability items appear in the validity and reliability tables, while nine statements appear in the descriptive section and appendix; the reported age frequencies and family-condition frequencies also do not fully account for the entire sample. Sixth, perceived social support was not independently measured in the original study. It has therefore been added as a transparent conceptual extension, not as a fabricated empirical result. Future research should use a consistent instrument, collect new support data, include positive well-being indicators, test moderated regression or structural-equation modelling, and consider longitudinal or mixed-method designs.

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