

Beyond Clinical Techniques: The Intersection of Culture, Faith, and Interpersonal Communication in Indonesian Student Counselling

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Abstract

Research on campus counselling has largely followed a clinical logic in which the conversation that delivers an intervention is treated as a neutral channel. This qualitative single-case study examines how interpersonal communication drives therapeutic work at a state university's Psychological Service Centre in Makassar, Indonesia, where counselling is embedded within Bugis-Makassar honour norms (*siri' na pesse*), familial obligations, and religious practice. Data were generated between October 2024 and March 2025 through five semi-structured interviews with two psychologists and two student clients, observation of the centre's public spaces and routines, and analysis of institutional documents. Findings reveal three recurrent communicative practices: tolerated silence as a safety condition, relational reframing of counselling as *curhat* (confiding) within a domestic space, and faith as a shared therapeutic idiom. Reinterpreting social penetration theory, the analysis shows that the costs of disclosure were governed by an imagined communal audience, above all the family, rather than by the immediate therapeutic dyad, and that depth was achieved through relational reframing instead of incremental exchange. The article introduces the concept of culturally and spiritually embedded therapeutic communication competence, arguing that communication theory must conceptualise culture and faith as constitutive elements of therapeutic discourse rather than as moderating variables. For practice, the findings suggest that training for campus counsellors in collectivist and religiously observant settings should treat reading silence, naming services in locally sanctioned language, and working within clients' faith as core competencies in their own right.

Introduction

Psychological distress among university students is now recognised as a public health concern across regions (Roy et al., 2025), and Indonesian students are no exception: many report mental distress, and self-compassion has emerged as the strongest predictor of their mental wellbeing (Kotera et al., 2022). Counselling has thus become ordinary infrastructure of student life rather than emergency provision for a troubled few (Perrella et al., 2026). Yet campus counselling scholarship follows a largely clinical logic, asking which intervention works for which presenting problem and measuring outcomes accordingly. Technique is tacitly assumed to do the work, and the conversation that delivers it is treated as a neutral channel. That assumption rarely survives contact with a counselling room. A cognitive restructuring exercise of the kind that performs well in outcome studies (Buana & Zulwidyaningtyas, 2025) can land as a lecture when a student does not yet trust the person offering it, and the same exercise can reorganise her account of herself after twenty minutes of unhurried listening. The technique is identical in both cases; what differs is the communication around it. In other clinical settings, too, the relational quality of talk has been shown to shape patient-centred outcomes in its own right (Sharki, 2023).

This article takes that difference as its object. It treats interpersonal communication as the medium in which the clinical work of student counselling succeeds or fails, and not merely as a preliminary to that work. It does so in a setting where textbook assumptions about therapeutic talk are under visible strain: Makassar, eastern Indonesia's largest city and the historic centre of Bugis and Makassar society.

Scholarship on these communities converges on a moral vocabulary of *siri'*, a compound of dignity, honour, and shame governing how persons and families present themselves to others, and its complement *pesse* (in Makassar, *pacce*) (Juhansar, 2020), the felt solidarity binding kin and neighbours to one another's fortunes. A psychological difficulty is thus potentially a matter of family face rather than a private fact, and family-centred research elsewhere likewise shows that the wellbeing of one member is held as a shared concern of the household (Reid et al., 2025). Stigma toward mental disorder remains widespread and continues to keep people from seeking help (Habebe et al., 2025). In Indonesia, mental health literacy is uneven even among community health workers (Marthoenis et al., 2026), and undergraduates report low willingness to seek counselling (Lukito Setiawan, 2006), citing their social network's anticipated reaction as the strongest deterrent. Religious practice, finally, is a primary idiom of coping in Indonesian life and cannot be treated as a background variable. Most outpatients in a Singaporean clinical sample described religion as important for coping with their illness (Cetty et al., 2022), and reviews of community-based recovery in Indonesia, Malaysia, and Thailand stress culturally relevant, holistic care (Hikmat et al., 2025).

The question, then, is not whether counselling techniques developed elsewhere can be used in Makassar; plainly they can. The question is how communication makes them usable (Beidas et al., 2013). What must a counsellor do communicatively for active listening to build trust, for confidentiality to be believed, and for a student's silence to become speech, in a setting where the audience that matters most is the family and help-seeking can read as a failure of self-command? And what does the answer imply for the way communication scholarship, theorised largely in Anglo-American settings, models therapeutic competence (Essel & Govender, 2025)?

I address these questions through a single instrumental case: the Psychological Service Centre of a state university in Makassar, studied through interviews, site observation, and documentary records between October 2024 and March 2025. The case is small by design, and its limits are set out in the Discussion. It nonetheless makes visible a set of communicative practices whose form will be familiar to counsellors anywhere but whose function and meaning are specific to their moral and religious setting, and the theoretical contribution lies there. Social penetration theory (SPT), the standard account of how relationships deepen through disclosure, assumes that the costs and rewards of disclosure are weighed within the relationship (Carpenter & Greene, 2015). In the Makassar case those costs were set outside it, by an imagined audience of kin and community, and depth was reached less by incremental exchange than by a change in the kind of relationship the student believed she was in. From this I develop the concept of culturally and spiritually embedded therapeutic communication competence and argue that culture and faith should be modelled as constitutive of therapeutic talk, not as moderators of it.

Therapeutic Communication Competence

Therapeutic communication has a long lineage in nursing and health communication. Peplau's interpersonal theory framed the practitioner–patient relationship as itself the therapeutic instrument, moving through phases of orientation, identification, exploitation, and resolution (Hagerty et al., 2017).

Rogers (1957) specified empathy, unconditional positive regard, and congruence as the relational conditions necessary and sufficient for change. Health communication textbooks have since codified a repertoire of therapeutic communication that includes active listening, empathic acknowledgement, open questioning, and attention to nonverbal cues (Segal, 2025). Spitzberg's (2013) model of competence adds a second criterion: communication is competent when it is appropriate by the standards of its context as well as effective. Therapeutic communication competence is therefore the capacity to enact that repertoire in ways that are both effective for the client and appropriate to the setting (Bhatt & Dayal, 2026).

This study takes hold at that second criterion. Most treatments of therapeutic communication list the behaviours and leave appropriateness to clinical judgment (Sriwijayanti et al., 2024). The list is readily exported to new settings, whereas the judgment is not. The Makassar case allows me to examine what appropriateness consists of in a specific moral and religious setting, that is, what makes a given behaviour appropriate here when the same behaviour might be inert, or even offensive, elsewhere. That content, I argue, belongs to competence itself and is not a modifier applied to it from outside.

Social Penetration Theory as an Analytical Lens

SPT describes relational development as a gradual, mutual movement from superficial to intimate exchange along two dimensions: breadth, the range of topics disclosed, and depth, their intimacy. In the theory's familiar onion image (Utz, 2015), outer layers of biographical fact and inner layers of feeling, value, and fear are penetrated in sequence as each partner judges further disclosure safe. The mechanism is a reward–cost calculus. Partners disclose more when the anticipated rewards (understanding, support, reciprocity) outweigh the anticipated costs (rejection, exposure, loss of control) (Boyd & Markowitz, 2026).

Although SPT was not built for clinical settings, it has repeatedly been read into them. Psychotherapy research uses it to explain how clients move from presenting complaint to core concern and how therapist self-disclosure can prime reciprocal openness, and health communication research treats provider–patient relationships as developing through the same logic of gradual, mutual revelation (Berg et al., 2020). Cross-cultural work finds that people disclose more to friends than to acquaintances, as SPT would predict, and that collectivism and the cultural identity of the partner shape how much is disclosed and to whom (Schwartz et al., 2011). Other comparative studies in collectivist settings have reported narrower breadth and slower movement toward depth, so the direction of cultural influence on disclosure is itself unsettled.

What these applications retain is the assumption that the calculus of disclosure is transacted between the two parties. On this view, the counsellor's task is to raise the rewards of disclosure and lower its costs within the room, by signalling warmth, guaranteeing confidentiality, and disclosing selectively (Chaikin et al., 1976). SPT is a productive lens for the present case precisely because it fits uncomfortably. The Makassar material shows disclosure governed by a third party who was never in the room, and depth reached by a route the theory does not describe. Applying SPT here therefore specifies

what a theory built for one relational world omits when it meets another. Exposing a tacit assumption in this way is among the strongest contributions a single case can make.

Communication privacy management theory sharpens the lens further. It reframes disclosure as boundary regulation: what a person tells is governed by rules about who will co-own the information afterwards, and a confidant's trustworthiness turns on the belief that those rules will be honoured (Hernandez & Petronio, 2019). This provides grounds for treating confidentiality as something the client feels, and not only as something the counsellor states.

Stigma, Culture, and the Constitutive View

Stigma research supplies the final element. Clement et al.'s (2015) systematic review identifies stigma as a consistent deterrent to help-seeking, with concerns about disclosure the most commonly reported stigma-related barrier and young people among the groups most strongly deterred. Most important for the present study is the argument that stigma draws its force from what matters most in a given moral world, threatening whatever locally constitutes a good life and a respectable family. In Makassar that includes family face and self-command, the standard against which a student's decision to enter a psychology centre is judged (Schug et al., 2010).

Health communication offers two ways of handling cultural texture. The cultural-sensitivity approach, exemplified by the LEARN model (listen, explain, acknowledge, recommend, negotiate), treats the client's framework of meaning as something to be elicited and accommodated (Ladha et al., 2018). Dutta's culture-centred approach goes further. It regards culture as the ground on which meaning is made, so that a community's own categories constitute both the health problem and its solution, instead of a variable to be managed within an intervention designed elsewhere (Dutta et al., 2024). Taking the culture-centred position as its premise, this study asks what that position implies at the micro-level of therapeutic talk. If culture and faith are constitutive, then reading a student's silence, choosing *curhat* (confiding) over the clinical word, and reframing a religious teaching to loosen self-blame are cultural acts performed communicatively (Lane et al., 2002). They are more than communicative acts with a cultural colouring, and they call for a competence that cannot be separated from the world in which they occur.

The Present Study

Drawing these strands together, the study treats the Psychological Service Centre as a case through which to examine how therapeutic communication competence is enacted where the costs of disclosure are shaped by collectively held face and where faith supplies a shared vocabulary of distress. Two research questions guided the inquiry:

RQ1. What do counsellors at the centre do communicatively to build trust, to make confidentiality credible, and to help students move from silence to speech, and how do student clients experience these practices?

RQ2. What do these practices imply for SPT's account of how disclosure deepens, and for the way therapeutic communication competence is conceptualised?

The first question is addressed in the Findings and the second in the Discussion.

Method

Research Design

The study is a qualitative single instrumental case study in Stake's (1995) sense. The case is of interest less in itself than as a means of understanding a practice that is otherwise difficult to isolate, namely the use of interpersonal communication in counselling students with academically related mental health difficulties. The case is the Psychological Service Centre (*Pusat Layanan Psikologi*, hereafter the centre), which operates within the Faculty of Psychology of a state university in Makassar. A case study was preferred to multi-site or survey designs because the question concerns how communication works in situ, not how widely a practice is distributed. In response to the routine criticism that single cases cannot be generalised, I follow Flyvbjerg (2006): the appropriate logic is analytic rather than statistical, and a case is selected for the information it can yield rather than for its representativeness.

Research Setting

The centre was established in 2003 by institutional decree and serves students, staff, and the public. Its documented provision includes psychodiagnostic assessment; individual, group, and family counselling; psychological examination; religious psychotherapy; and services for children with developmental or special needs. It was selected on three grounds bearing on the research questions. First, it is an established, information-rich site whose written procedures could be read against interview accounts. Second, its psychologists hold both clinical certification and teaching appointments, which allowed the counsellor–lecturer dual relationship typical of Indonesian campus services to be observed rather than assumed. Third, it lists religious psychotherapy as a named service, which made faith available for study as institutional practice rather than as individual improvisation. The centre serves students of any religious affiliation and offers religious psychotherapy within the client's own tradition.

Researcher Positionality

I carried out the fieldwork alone, coming to the centre from a background in communication studies. My familiarity with the languages of the setting gave me ready access to the centre's register and to terms such as *curhat* and *siri'*, but it also obliged me to guard against reading my own assumptions into what I observed. I kept field notes that separated description from interpretation, checked my understanding of the consultation procedure with the psychologists during fieldwork, and returned to the students' own words whenever my interpretation began to outrun them.

Consent and Confidentiality

All participants took part voluntarily and gave written informed consent. Before the interview, each read and signed a form setting out the purpose of the study, the audio recording, how transcripts would be handled, and the right to withdraw at any point without consequence. Students were approached only through the centre, which acted as gatekeeper, and only if they were adults who had completed counselling or were well advanced in it. Clinical history was discussed only as far as a participant chose to raise it.

Participation was confidential rather than anonymous: I know the identities of all four participants, and no one outside the research does. The psychologists appear as Ratna (head of the centre) and Sari (adult-counselling service), and the students as NS and SKT. With the centre's permission, its institutional character (written procedures, listed services, position within a faculty) is described in some detail, because these features are analytically important and could not be conveyed if disguised. Because the centre is a public institution with a small clinical staff, pseudonyms reduce but cannot eliminate the chance that a reader with local knowledge might infer a practitioner's identity; both psychologists were told this and consented on that understanding. No detail capable of identifying a student client is reported.

Participants

Participants were selected purposively, with snowball referral from the psychologists to the students, on the principle that depth rather than breadth governs case work (Table 1). The two psychologists, both also lecturers, were chosen as key informants because both held professional certification and current, hands-on responsibility for students presenting with mental health concerns. These inclusion criteria ensured that informants could both perform the practice and articulate it. The two student clients had been assessed at the centre with academically driven difficulties and had completed or were completing counselling there. The classification was settled after a preliminary site visit on 29 October 2024 and held open to revision.

Table 1
Participants, With Pseudonyms, Profile, and Interview Schedule

Pseudonym	Role	Profile	Presenting concern / remit	Interview(s)
Ratna	Psychologist; head of the centre	Age 44; 16 years of practice; background in organisational psychology; also a lecturer	Oversight of provision; direct counselling of students	30 Nov 2024; 15 Dec 2024 (≈ 1 hr each)
Sari	Psychologist; adult counselling	Age 32; 10 years of practice; also a lecturer	Direct counselling of students	14 Dec 2024 (≈ 1 hr)
NS	Student client	Age 22; female	Burnout; assessed and counselled at the centre	22 Mar 2025 (≈ 1 hr)
SKT	Student client	Age 22; female	Academic stress; initially cancelled, later completed counselling	19 Mar 2025 (≈ 1 hr)
Note. Names and initials are pseudonyms. Interview durations are approximate.				

Data Generation

Data were generated through three channels between October 2024 and March 2025: interviews, observation, and documents.

Interviews

Interviews were the primary source: five sessions of approximately one hour, two with Ratna and one each with Sari, SKT, and NS (Table 1). The psychologists were interviewed at the centre. The students were interviewed in March 2025, after counselling had run its course, so that their accounts could be gathered without pressure. A semi-structured guide ensured comparable coverage of the consultation procedure and of the communicative practices used at each stage, while open segments let participants follow their own reasoning. The psychologists' guide was anchored in the cases the centre most often sees: students describing extreme estrangement from their families and sometimes from themselves. The students' guide followed their own experience, from first considering coming to the centre to what the psychologist did that helped or did not help (Table 2). All interviews were audio-recorded with consent and transcribed in full in Indonesian; translations are the author's. Terms with no clean English equivalent (*curhat*, *siri'*) are retained in Indonesian or Bugis-Makassar and glossed.

Table 2
Representative Questions From the Two Interview Guides

Guide	Representative questions
Psychologists	Walk me through what happens from the moment a student arrives until the end of a first session. Many students who come here describe feeling cut off from their families and sometimes from themselves; how do you open that conversation? What do you do when a student cannot speak? How do you talk about this service to a student who is afraid of being labelled? Students here are often taught by the same people who counsel them; how do you handle that? Where does a student's religious background enter the work, and how do you raise it? What makes a student stop coming, and what have you tried?
Student clients	Tell me about the first time you thought about coming here. What made it hard, and what made it easier? What happened in your first session? Was there anything the psychologist did that made it possible to speak, or that made it harder? How did your family respond to your coming here? Did faith come up in your sessions, and if so how? If a friend were thinking of coming, what would you tell them?

Observation

Observation covered full days at the centre, from opening until close, during the preliminary visit in October 2024 and on the psychologists' interview days. I was able to observe the centre's public life: the reception and pre-assessment area, the observation room, the counselling rooms and their arrangement, the way staff greeted students, light conversation in the waiting space, and a student's movement from arrival through registration to the counselling-room door. I could not observe the confidential counselling session itself and did not attempt to do so; its private sequence was reconstructed from what I saw, together with the psychologists' step-by-step accounts and the students' retrospective descriptions. Observation was overt when I needed procedural information and unobtrusive when a quiet presence better preserved the ordinariness of the centre's routine. Field notes were written on site and expanded the same day.

Documents

Documents comprised the centre's written service descriptions, procedural records for a consultation, outreach material, and founding decree. They were used to check the consultation sequence described in interview and to establish the vocabulary the centre uses to present itself to students.

Data Analysis

Analysis followed Stake's (1995) four forms of case study analysis: categorical aggregation, direct interpretation, the establishment of patterns, and naturalistic generalisation. I first aggregated the material into broad categories (the consultation procedure, the communicative practices used at each stage, and the difficulties practitioners and students reported) and then moved to direct interpretation of single instances, where the analysis carries most weight. Instead of fragmenting transcripts into codes, I reconstructed each participant's account as a narrative, read it against my observations and the documents, and treated it as a story with its own internal logic before setting it beside the others. Only then did I look across accounts for patterns, in the form of recurring communicative moves and obstacles, and finally for naturalistic generalisations that readers can carry to settings they know. The findings are therefore organised around participants' stories rather than around comparison between them.

Trustworthiness

Credibility was pursued through triangulation of technique (interview, observation, documents) and of source (psychologists, students, records). Participants are the authorities on their own experience, and I have not used one source to correct another's account of what something felt like. Triangulation instead placed accounts in context. It allowed me to check a psychologist's description of the consultation sequence against the centre's written procedure and room arrangement, and to note where a student's experience diverged from the institutional description; such divergences are themselves findings. The students' retrospective accounts also served as member reflection on whether the dynamics identified from the psychologists' side matched the experience on the receiving end. Quotations were chosen as the fullest statements in the corpus of a recurring pattern and are given at length so that readers can judge my readings against participants' words.

Findings

The findings address the first research question. They begin with the setting the centre constructs, follow the two students' accounts, and then turn to the vernacular naming of the service, the place of faith, and the ordering of technique and relationship.

A Home, Not an Office: The Centre as Communicative Setting

A visitor's first impression is that the centre does not sound like an academic office. Students were greeted by name where known and with light, joking familiarity where not, in the register of a relative's front room rather than a faculty counter. Conversation in the waiting area was small talk about classes, food, and the weather, the kind that in Makassar precedes any serious matter. The architecture supports

this register. Students enter a pre-assessment area furnished as a sitting room; beyond it, the observation and counselling rooms have neutral colours, soft seating, ventilation, and a deliberately arranged quiet, in what Ratna calls *room setting*, so that the space itself communicates safety to a student who is uneasy in crowds or carrying something heavy. The arrangement is consistent with early analogue evidence that the physical environment of a counselling room affects what clients disclose (Chaikin et al., 1976).

Both psychologists described this as strategy rather than accident. Asked how the centre approaches students who feel profoundly cut off from their families and sometimes from themselves, Ratna answered with an image of place instead of a technique:

Our strategy is always to make the psychology service a home. Not a formal place that you come to with an official letter, but a home, a home with friends in it, and family, and lecturers who understand you. (Ratna, head of the centre, 30 November 2024)

The centre's documented procedure gives this image its working structure. A consultation opens with an initial assessment built on listening, an open conversation that works outward from small, everyday difficulties toward whatever lies beneath. Observation of nonverbal behaviour follows, then written instruments, and only then psychological intervention, with tele-counselling and hybrid formats used as circumstances require. In the centre's terms the conversation moves through three levels: a surface of light academic complaint, an intermediate level where social anxiety and personal conflict appear, and a core of vulnerable disclosure. At each threshold the psychologist must make the next level feel safe enough to attempt. On paper the sequence is familiar. The interviews show what it takes communicatively to make each step happen, and why the 'home' is a precondition of the procedure and not a decoration on it.

Sari described the skill at the heart of this sequence as reading, and insisted that it is learned:

The key is our ability to catch the small signals: an expression, the way they sit, even the way they answer. It is a skill, not merely intuition. (Sari, psychologist, 14 December 2024)

The insistence is significant. Clinical accounts tend to naturalise nonverbal attunement as instinct, whereas Sari treats it as a teachable competence, one the centre trains for instead of waiting to find. The same reading governs the transition from listening to intervention, where solutions are not simply dispensed:

We don't just hand them solutions; we invite them to think it through, we ask what they feel and believe. Students need to feel they are in control, and that only happens when our interpersonal communication is supportive rather than preachy. (Sari, psychologist, 14 December 2024)

Sari's word, rendered here as 'preachy', carries a particular charge in a setting where students are used to being addressed by lecturers, parents, and religious teachers as recipients of instruction. A counsellor

who declines that role and returns agency to the student communicates respect in a form the student recognises, and this loosens the deference that would otherwise keep her silent.

NS: The Long Silence

NS came to the centre with burnout. Her account of her first sessions is the fullest description in the corpus of what happens at the threshold between surface and core.

There were times when I couldn't speak at all. A pressure would come over me. I never knew how it came or when it would come, and it would come when I was sitting there with the psychologist. I just went quiet, and I cried, in silence. For the first thirty minutes of that first session I simply sat there. Then I cried, and I started to talk, though hesitantly. And it went on like that for a long time. In the sessions after that I still needed time before I could say anything. But that was also the reason I felt safe. I wasn't required to speak, and I wasn't required to produce anything in a particular session. I could stay silent for as long as I wanted, until I was ready. And in the end, I could talk. (NS, student client, 22 March 2025)

What NS describes is a state she could neither predict nor control, recurring across several sessions, and it should not be read as resistance to be worked around. The source of safety she identifies is precisely what a productivity-minded reading of counselling would count as failure: sessions in which nothing was said or accomplished. The psychologist's contribution was to let that happen, asking of NS neither speech nor a result (Ladany et al., 2004). NS herself described that contribution in terms of patience and reassurance:

The psychologist reassured me, gave me time, and convinced me that whatever I said would be kept confidential. (NS, student client, 22 March 2025)

A clinical vocabulary would tend to run together three distinct processes in this episode. The first is the withholding of demand over time. The psychotherapy literature recognises that tolerating silence can itself be an intervention; NS adds that the tolerance had to be sustained across weeks, its meaning accumulating as each silent session showed again that the room would exact nothing from her. The second is the conversion of confidentiality from a stated rule into a felt one. NS was told that her words would be kept confidential, but what convinced her was that the person telling her did not press. In the terms of communication privacy management theory, the psychologist demonstrated through conduct, more than through assurance, that she could be trusted to honour the boundary rules governing anything NS chose to disclose. The third concerns what the silence protected. NS did not say, and I did not ask, what the pressure was about. Where a student's difficulties are potentially her family's shame, however, the freedom not to speak is also the freedom not to expose, and a psychologist who does not press signals that she understands what speaking puts at stake.

SKT: The Lecturer Who Talked Like a Sister

SKT's account begins at home rather than in the counselling room, and it is the clearest statement in the corpus of how the decision to seek help is made, and unmade, by others.

I called off the consultation because my family was sure there was nothing wrong with me, that I could handle everything on my own, that I wasn't sick. And when I finally did want to go, it turned out the psychologist was my own lecturer. The problem wasn't really her; it was that I couldn't get past my own thoughts about how I would be judged for seeking help. (SKT, student client, 19 March 2025)

SKT folds two obstacles together here and then separates them carefully. The first is her family's reading of her distress. Their conviction that she was not sick expressed confidence in her ability to manage; it was not indifference. In a moral world organised around self-command that confidence is a compliment, and it left SKT no legitimate way to say that she could not manage without contradicting her family's account of who she was. The second obstacle is the dual relationship of a small academic community, familiar from the literature on small-community practice: the psychologist to whom she was referred also taught her. SKT is explicit that the lecturer herself was not the problem. The problem was an awkwardness that spread, as she put it, until she lost the confidence to open up at all. It combined awareness of a person who knew her in another capacity with the imagined judgment, standing behind that person, of her closest circle, her parents above all, for having sought help.

What changed was not the dual relationship but the kind of talk within it.

Then, in the sessions after that, my lecturer kept drawing me into conversation, just talking, until I forgot that I was sitting across from a psychologist. It was the way she communicated, like my own sister. Like *curhat*. (SKT, student client, 19 March 2025)

The comparison SKT reaches for is the key to the case. *Curhat*, a contraction of *curahan hati* (literally, an outpouring of the heart), is the ordinary Indonesian word for confiding in someone one trusts, such as a friend, a sibling, or a cousin. It is an everyday genre with its own norms: reciprocal, unhurried, and undemanding, and unstigmatised because everybody does it (Saraft & Pepper, 2020). SKT describes a change in the genre of the encounter. She still knew that the person across from her was a psychologist and a lecturer, but she stopped experiencing the conversation as one in which those roles mattered. On SPT's incremental account, the relationship would have deepened because she disclosed more and found the reception rewarding. Her account points elsewhere: the frame changed, and once she was in a *curhat* rather than a consultation, the disclosure that *curhat* licenses became available all at once.

Ratna's account of the same student confirms both the difficulty and the method.

That student found it very hard to come to the centre, precisely because of the stigma lodged in her mind, even though it lived only in her own thoughts. With a warm interpersonal approach, the assessment can still proceed well. (Ratna, head of the centre, 30 November 2024)

Ratna's phrase 'only in her own thoughts' should not be read as dismissal. It describes how stigma works in this setting: as an internalised audience whose judgment the student anticipates and which no reassurance from the psychologist can address, because the psychologist's opinion is not the one the student fears. The warmth Ratna describes cannot substitute for the family's recognition, which the

centre is unable to supply. What it does is change the kind of relationship the student is in, so that for the duration of the conversation the family's judgment is beside the point.

Renaming the Service: *Curhat*, Me-Time, and the Work of the Vernacular

SKT's word for what her sessions became is also the word the centre uses for itself. Its outreach material and its psychologists avoid the clinical vocabulary of counselling and present a session as *curhat*, or as me-time with a psychologist. Ratna was direct about the reason:

Students are often afraid to come because of social stigma. But we never run out of ideas. We start by introducing the programme in a persuasive, inviting way, stressing that the service isn't only for people with mental illness. Any student who simply wants to talk, to share, is welcome. (Ratna, head of the centre, 15 December 2024)

The move is lexical, but it is more than cosmetic. Naming the encounter in terms the culture already sanctions relocates counselling from the stigmatised category of treatment for the unwell into the unremarkable one of confiding in someone trusted. Clinical reassurance delivered in clinical language could not achieve this, because the clinical category itself carries the stigma. The relabelling works because the genre it invokes is real. As SKT's account shows, a session can actually become *curhat*, at which point the label describes the encounter instead of euphemising it. The centre extends this logic by enlisting former clients as peer agents who normalise help-seeking, and by designing low-pressure points of entry, such as open spaces and hybrid and online formats, so that approaching the service never requires the conspicuous act of walking through a door marked psychology.

Faith as a Shared Idiom

Measured against the Western literature, the centre's most distinctive feature is that religion is institutionalised as a named service instead of being handled at the edge of the clinical conversation (Bouwhuis-Van Keulen et al., 2024). Religious psychotherapy sits alongside psychological examination and family counselling in the centre's provision, justified by the observation that spiritual practice in this setting is interwoven with daily life and with how people understand their own coping. The centre describes itself as a medium for integrating clients' own beliefs into the work, including the reinterpretation of teachings they already hold. This work runs alongside conventional intervention, not in place of it, and within the student's own tradition.

Read through a communication lens, this amounts to more than accommodating a client's preferences. It elevates faith to a shared symbolic vocabulary through which distress can be named and reframed. A psychologist who helps a student reread a teaching so that it loosens self-condemnation is doing recognisably communicative work: offering an interpretation and negotiating meaning inside a system the student already trusts. This carries the final step of the LEARN model, negotiation, to its conclusion. Rather than the counsellor's framework politely acknowledging the client's, the client's framework becomes the channel of intervention. The practice also matters for the family. Where parents dismiss the secular language of mental illness, a religious account of a student's struggle, as a trial to be borne

with patience, may be more legitimate and more sayable at home than a clinical one. It may therefore become the account through which the family is brought back into the work instead of being left outside it.

Flexibility and the Ordering of Technique and Relationship

These threads converge on a practical style that both psychologists described as adaptive. The centre varies the form of sessions as well as their content, offering face-to-face, remote, and hybrid arrangements so that circumstance never disqualifies a student. Because dropout is a persistent threat, as SKT's cancelled consultation shows, psychologist and student set realistic goals together at the outset, which makes the student a partner in the work. Supportive techniques such as emotional labelling and visual aids serve as ways of making feelings speakable and are not treated as ends in themselves.

What unifies these practices is an ordering principle that the case states more clearly than the literature usually does. Clinical technique is necessary but not sufficient, and whether it succeeds depends on the communication around it. The centre's psychologists did not abandon psychological intervention; assessment instruments, cognitive reframing, and structured sessions all remained in use. Each, however, was carried into the room on the back of a relationship built first through tolerated silence, the recasting of the encounter as *curhat*, and a willingness to let faith carry meaning. Without that relationship, the same instruments would have met silence, denial, or absence.

Discussion

In answer to the first research question, the findings show that the counsellors' decisive work lay in tolerating silence, recasting the encounter as *curhat*, and speaking through students' faith, within a setting arranged to feel like home. The second research question concerns what these practices mean for theory. I argue below that the case calls for three respecifications of the received account, concerning where the costs of disclosure are set, how depth is reached, and the place of faith, and that together they yield a reconceptualisation of therapeutic communication competence. Limitations and implications for practice follow.

Disclosure With a Third Party in the Room

SPT locates the calculus of disclosure inside the relationship: I tell you more as I come to expect that telling you will be rewarded rather than punished. In the Makassar case the decisive costs were set by someone who was never in the room. SKT cancelled her consultation because seeking help would contradict her family's insistence that she was not sick, not out of any fear of the psychologist. She froze in her first sessions, not because the psychologist was unkind, but because the psychologist was also her lecturer, and behind her stood the anticipated judgment of her parents and closest circle. NS's

silence, likewise, protected something whose exposure would have cost her outside the room rather than within it.

This is the point at which SPT's individualist premise meets the moral economy of *siri'*. In Bugis-Makassar society honour and shame are held by the family and its network rather than privately, and an individual's conduct is judged by its effect on that shared standing. As argued in setting out the framework, stigma threatens what matters most, which here means the family's face and the individual's self-command. The reward–cost calculus of disclosure is therefore transacted with an imagined audience, and the counsellor's communicative work is directed as much at that audience as at the student. Unable to reassure the family, the counsellor can only alter the student's sense of what the conversation is, so that the family's judgment is, for the moment, out of play. SPT can be retained as an account of the trajectory of disclosure, from academic complaint to the matter underneath, but its mechanism needs respecifying where face is collectively held. Depth is reached when the counsellor lowers a cost that she does not control and that the student cannot name to her.

Depth by Reframing Rather Than by Increments

The second respecification concerns the route to depth. SPT models penetration as incremental, with each rewarded disclosure licensing a slightly deeper one. Both student accounts point in another direction. NS's disclosure was preceded by a long period in which nothing was disclosed at all, and it was the undemanding, unhurried character of that period, free of any expectation of result, that made speech possible when it came. SKT's disclosure was preceded by a shift in the kind of conversation she believed she was in. Once the talk became *curhat*, she was inside a genre in which confiding is expected, and disclosure followed from the genre instead of accumulating toward it. In both cases the counsellor's work lay less in rewarding disclosure than in changing the frame within which it would be judged, and depth was reached by a step rather than a slope.

The centre's practices are, in effect, moves that redefine the situation: the 'home', the *curhat*, the psychologist who talks like a sister, the me-time that is not treatment. Each alters what kind of encounter this is, and thereby what disclosing within it would mean to those whose opinion the student fears. This explains why techniques used everywhere, such as tolerating silence, reframing the service, and using everyday language, do something specific here. Their form is global, but their function is local, because the situation they redefine takes its meaning from *siri'*.

Faith as Constitutive, Not Moderating

The third respecification concerns religion. The culturally sensitive approaches outlined earlier treat a client's religious framework as something to be elicited, acknowledged, and negotiated with. The centre's practice goes further, in terms that Dutta's culture-centred approach supplies: the client's framework becomes the medium of the intervention instead of being consulted alongside it. Religious psychotherapy here is less a concession to religious clients than a recognition that the vocabulary in which a student already understands her suffering, her explanatory model of it, is religious (Anderson et al., 2015). Reframing that suffering in her own vocabulary is then the most effective and most

appropriate thing the counsellor can do, appropriate in Spitzberg's (2013) sense because the standards of the setting license it. The point is not confessional. The centre offers this work within whatever tradition the student holds, and the mechanism, meaning negotiated inside a system the client already trusts, is the same in each. The case thus offers the literature on religiously integrated psychotherapy a communicative description of integration: the choice of a shared symbolic code in which the counsellor can speak and be believed, as distinct from the insertion of religious content into a clinical protocol.

Culturally and Spiritually Embedded Therapeutic Communication Competence

Taken together, these three respecifications yield a concept. The literature models therapeutic communication competence as a portable repertoire of behaviours whose appropriateness is settled by clinical judgment. The Makassar case suggests that the repertoire is the smallest part of it. What the centre's psychologists possess, and what NS and SKT responded to, is the capacity to perform the repertoire in a way that (i) recognises that the audience governing disclosure is outside the room and collectively held; (ii) redefines the encounter, through setting, register, and naming, so that face is not at stake within it; and (iii) works inside the symbolic system, including the religious one, in which the student already understands herself. I call this culturally and spiritually embedded therapeutic communication competence. The qualifier carries two claims: that appropriateness in Spitzberg's (2013) sense forms part of the content of competence, not a constraint applied from outside, and that standard behaviours such as active listening, tolerated silence, and reframing acquire therapeutic meaning only when embedded in a particular moral and religious world.

Limitations and Directions for Future Research

The case is small, and I want to be exact about what it supports. Four participants at one centre in one city cannot show how widely these practices are distributed, whether they are typical of Indonesian campus counselling, or how they vary across the archipelago's religious and ethnic diversity; nor can two student accounts represent the range of experience even at this centre. Both students were women in their early twenties with academically related difficulties who had completed or nearly completed counselling. Theirs are therefore accounts of students for whom the relationship held; those who did not return, or whose distress was of another kind, are not heard here. Interviews were single sessions of about an hour, and longer engagement would have deepened the students' accounts. Finally, because I could not observe counselling sessions, my description of them rests on participants' accounts and on what the setting and documents allowed me to infer.

What the case can do, in Flyvbjerg's (2006) terms, is show that a theory's assumptions do not hold in a particular setting and specify what would have to change for them to hold. The claim is analytic rather than distributional. I do not claim that Indonesian counselling works this way. I claim that in this setting disclosure was governed by an audience outside the room, depth was reached by reframing rather than by increment, and faith operated as a shared code instead of a variable to be accommodated, and that these observations are inconsistent with the individualist premise of the theory most often used to

explain how counselling relationships deepen. Whether they hold elsewhere is an empirical question that the proposed concept is meant to make askable. Comparative work across Indonesian regions, across institutions with and without the counsellor–lecturer dual relationship, and across religious traditions is the natural next step. Following students who drop out would test the concept where it matters most.

Implications for Counselling Practice and Training

If the decisive skills are communicative and embedded, training for campus counsellors in settings such as this one should address them as explicitly as diagnostic skill. That means treating the reading of nonverbal signals as a learnable craft, as Sari insisted it is; naming the service in language the local culture already sanctions; working within students' religious commitments rather than around them; and handling the dual relationships of small academic communities by changing the register of talk within them, as SKT's lecturer did, since avoiding such relationships is often impossible.

Several of the centre's practices also translate into service design. Tolerating silence across sessions, instead of reading it as failed engagement, requires session expectations that do not demand a product from every meeting. Setting goals jointly at the outset, offering hybrid and online points of entry, and enlisting former clients as peer agents respond to dropout and to the conspicuousness of help-seeking, both of which the students' accounts show to be real risks. Where families are sceptical of clinical language, a counsellor who works within the student's own religious vocabulary may also open a way of involving the family that a clinical explanation would close. These implications are offered as naturalistic generalisations in Stake's (1995) sense. Practitioners elsewhere, including those who counsel students from collectivist and religiously observant backgrounds in other countries, are best placed to judge how far they carry over to settings they know.

Conclusion

Effective student counselling at the Makassar centre is less a clinical act that happens to be communicated than a communicative act, culturally and spiritually situated, that happens to be clinical. Recognising that order is the contribution of this article. It moves communication from the margin of the encounter, where it is treated as a delivery system, to its centre, where the work gets done. It also specifies what 'communication' must include, namely an audience outside the room, a redefined situation, and a shared symbolic code, if the standard repertoire of therapeutic behaviours is to do anything at all. The argument gives communication departments a stake in a problem usually ceded to clinical psychology, and it gives therapeutic communication theory a task largely left to clinical judgment: to say, for a given moral world, what appropriateness consists of.

Declarations

Author Contribution

K.A. conceived and designed the study, conducted the fieldwork and data analysis, and wrote the main manuscript. The author reviewed and approved the final manuscript.

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Ethics approval and consent to participate This study involved human participants and was conducted in accordance with the Declaration of Helsinki. Institutional permission and ethical approval were granted by the Institute for Research and Community Service (Lembaga Penelitian dan Pengabdian kepada Masyarakat, LP2M) of Universitas Negeri Makassar (Letter No. 3340/UN36.11/TU/2024, dated 29 October 2024), upon recommendation from the South Sulawesi Provincial Investment and One-Stop Licensing Office (Letter No. 25967/S.01/PTSP/2024, dated 12 October 2024). All participants took part voluntarily and provided written informed consent prior to data collection, with guaranteed confidentiality and the right to withdraw at any stage without consequence.

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