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Development of an Experience-Based Interpersonal Communication Model: A Qualitative Study of Non-Professional Caregivers in Indonesian Mental Health Rehabilitation

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Abstract

Interpersonal communication in non-clinical mental health rehabilitation is largely shaped by non-professional caregivers, yet existing therapeutic communication models emphasize clinical expertise and structured protocols. This study explores how experience-based relational practices emerge among Pramujiwa non-professional caregivers at Satpel Bina Laras Sakurjaya, Indonesia, through daily interactions with clients with mental disorders (ODGJ). Employing an intrinsic single-case qualitative design grounded in interpretivist and experiential learning perspectives, data were collected via unstructured interviews, participant observation, and document analysis with 10 key Pramujiwa informants, supporting staff, and an expert informant. Inductive thematic analysis identified four recurring interaction patterns: Initial Familiarization, Trust Negotiation, Daily Engagement, and Informal Continuity, which were synthesized into a three-phase conceptual model: Affectional, Adaptive, and Relationship Consolidation phases. Findings indicate that relational effectiveness is maintained through emotional attunement, situational adaptation, and continuity across everyday activities rather than formal clinical procedures. The Pramujiwa Interpersonal Relationship Model demonstrates that meaningful therapeutic-like communication can develop from sustained,

context-sensitive experiential practice. The study highlights the significance of non-professional, experience-based caregiving for psychosocial stabilization and relational continuity in resource-limited rehabilitation contexts, offering theoretical and practical insights for enhancing interpersonal communication frameworks in non-clinical mental health care.

***Keywords**: Experience-Based Communication, Non-Professional Caregivers, Mental Health Rehabilitation, Interpersonal Relationship Model*

1. Introduction

Mental health rehabilitation in non-clinical social service settings relies heavily on interpersonal communication, yet the dominant theoretical frameworks in this field remain rooted in clinical and professional paradigms. Classical therapeutic communication models, such as Peplau's Interpersonal Relations Theory and Stuart's therapeutic communication framework, were developed within institutional healthcare environments characterized by formal training, standardized procedures, and clearly defined therapeutic roles (Stuart, 2013). Although these models emphasize relational qualities such as empathy, warmth, and genuineness, their applicability in non-clinical rehabilitation contexts is increasingly questioned. Differences in role structure, relational intensity, and the absence of formal therapeutic mandates limit the explanatory power of clinically grounded communication theories when applied to everyday caregiving practices (McCabe & Timmins, 2013). This limitation suggests a structural mismatch between clinically grounded therapeutic communication theories and the communicative realities of non-clinical rehabilitation environments.

Figure 1. Daily Activities of Clients with Mental Disorders at Satpel Bina Laras Sakurjaya

In Indonesian social rehabilitation institutions, particularly Satpel Bina Laras under the Ministry of Social Affairs, daily interpersonal engagement with persons with mental disorders (ODGJ) is predominantly carried out by non-professional caregivers known as Pramujiwa. Unlike nurses or mental health professionals, Pramujiwa are not equipped with formal therapeutic training or standardized communication protocols. Their primary responsibilities involve daily supervision, emotional accompaniment, and sustained interpersonal interaction within routine activities. This situates Pramujiwa in a unique communicative position: they function as the main relational agents in rehabilitation processes while operating outside professional therapeutic frameworks. National rehabilitation guidelines emphasize psychosocial assistance and social functioning rather than clinical intervention alone (Kementerian Sosial RI, 2020), further reinforcing the centrality of everyday interpersonal interaction in these settings.

Similar caregiving roles performed by non-professional or lay caregivers have been acknowledged globally in community and residential mental health services, particularly in contexts with limited professional resources (World Health Organization, 2013). Existing therapeutic communication theories, however, inadequately account for this form of caregiving, as models developed within clinical paradigms typically assume structured therapeutic intent, explicit professional boundaries, and formalized communication techniques (Stuart, 2013).

However, studies have shown that when such models are applied outside clinical environments, caregivers often rely less on standardized techniques and more on situational judgment, relational familiarity, and experiential adaptation (Happell et al., 2014). This condition exposes a critical research problem. While interpersonal communication is widely acknowledged as essential for psychosocial stabilization, there is limited conceptual clarity regarding how effective interpersonal communication is constructed and maintained when it is not guided by formal therapeutic models. Existing communication theories implicitly assume professional competence, structured interactional stages, and explicit therapeutic intent. In contrast, non-professional caregivers rely primarily on experiential knowledge, situational judgment, and relational familiarity. As a result, the communicative logic underlying their practices remains theoretically underexplored and analytically underdefined.

A review of existing literature further reveals a clear research gap. Studies on therapeutic communication in mental health contexts predominantly focus on professional caregivers within clinical institutions, emphasizing technique mastery, therapeutic stages, and measurable

clinical outcomes (Fasya & Supratman, 2018; Azhari & Labela, 2022). These studies reinforce a professional-centric understanding of interpersonal effectiveness.

Conversely, research conducted in social rehabilitation settings tends to frame caregiver–client interaction through the lens of social support, emotional assistance, or caregiving roles, without conceptualizing communication as a distinct interpersonal process (Maisun et al., 2024; Cahyaningrum & Syafiq, 2022). While emotional closeness and accompaniment are acknowledged, the interactional patterns, relational phases, and communicative mechanisms through which these relationships are sustained remain largely unexplained. As a result, these bodies of literature remain analytically fragmented, developing in parallel without conceptual integration.

Consequently, there is an absence of an empirically grounded, experience-based interpersonal communication model that captures how non-professional caregivers develop relational competence through continuous, everyday interaction in non-clinical mental health rehabilitation settings. This gap is particularly evident in the Indonesian context, where Pramujiwa serves as the primary interpersonal actor in long-term social rehabilitation institutions. Existing communication theories have yet to adequately account for this form of relational practice, leaving a conceptual disconnect between clinical therapeutic communication models and the lived realities of non-professional caregiving.

To address this conceptual gap, this study offers an experience-based interpersonal communication model grounded in the everyday relational practices of non-professional caregivers. Rather than extending existing clinical therapeutic communication frameworks, the proposed model is inductively derived from the lived experiences of Pramujiwa within non-clinical rehabilitation settings. This model conceptualizes interpersonal communication not as a standardized therapeutic technique, but as a relational process that develops through repeated interaction, emotional attunement, and situational adaptation. The proposed model offers a conceptual solution to the mismatch between clinically grounded communication theories and the communicative realities of non-professional caregiving by reframing therapeutic-like communication as an emergent, relational, and experience-driven process rather than a standardized professional technique.

Empirically, this study identifies four recurring interaction patterns: Initial Familiarization, Trust Negotiation, Daily Engagement, and Informal Continuity, which collectively form a cyclical relational process.

These patterns are subsequently synthesized into a three-phase conceptual framework, namely the Affectional Phase, Adaptive Phase, and Consolidation Phase. By articulating these patterns and phases, the study generates a context-sensitive interpersonal communication model that captures how relational competence is developed and sustained through continuous experience in non-clinical mental health rehabilitation environments.

The main contribution of this study lies in the development of an empirically grounded interpersonal communication model that extends therapeutic communication theory beyond clinical and professional domains. By positioning non-professional caregivers as legitimate producers of communicative knowledge, this research challenges the assumption that therapeutic effectiveness is inherently dependent on formal training and standardized techniques. The experience-based model proposed in this study contributes theoretically by expanding interpretivist perspectives in interpersonal communication and practically by offering a relational framework that is responsive to the structural and emotional realities of non-clinical mental health rehabilitation settings, particularly within the Indonesian context.

The present study adopts an interpretivist qualitative approach to examine how interpersonal communication is enacted, negotiated, and sustained by Pramujiwa through experience-based relational practices. Rather than evaluating these practices against predefined clinical standards, this study seeks to inductively construct a conceptual model grounded in everyday interaction. By positioning non-professional caregivers as legitimate producers of communicative knowledge, this research contributes to the expansion of interpersonal communication theory beyond clinical domains and offers a context-sensitive framework for understanding relational processes in non-clinical mental health rehabilitation.

Interpretivism is particularly relevant for exploring non-standardized caregiving practices, as it acknowledges that social reality is constructed through subjective experience and relational interaction. In addition, experiential learning theory provides a foundational framework for understanding how interpersonal competence develops through concrete experience, reflective observation, and adaptive practice (Kolb, 1984). Methodologically, this approach is supported by qualitative inquiry traditions that prioritize contextual depth, reflexivity, and the co-construction of meaning between researcher and participants (Denzin & Lincoln, 2018).

Accordingly, this study is guided by the following research question: How is an experience-based interpersonal communication model constructed through the everyday relational practices of non-professional caregivers (Pramujiwa) in Indonesian mental health rehabilitation settings?

Finally, this study acknowledges several limitations. The qualitative design prioritizes depth over generalizability, and findings are contextually situated within a specific institutional setting. Researcher interpretation, participant self-reporting, and institutional norms may introduce bias; these risks are addressed through reflexive analysis, ethical safeguards, informed consent, and confidentiality procedures. Despite these limitations, the study offers a theoretically grounded and empirically informed contribution by articulating a communication model that reflects the realities of non-professional, experience-based caregiving within mental health rehabilitation contexts.

2. Method

This study employed a qualitative descriptive approach to explore and interpret the practice of interpersonal communication enacted by *Pramujiwa* in accompanying clients with mental disorders (ODGJ) at Satpel Bina Laras Sakurjaya. A qualitative approach was selected because it enables an in-depth examination of social phenomena within their natural settings and facilitates the exploration of meanings constructed through lived experiences and everyday interpersonal interactions (Creswell, 2018). Methodologically, this study views research procedures as a systematic framework guiding data collection and analysis to ensure rigor, transparency, and analytical accountability throughout the research process (Arikunto, 2006).

This study adopted an intrinsic case study design focusing on a single, context-specific phenomenon that holds particular significance and requires a holistic understanding (Creswell, 2018). The case under investigation is the interpersonal relationship between non-professional caregivers (*Pramujiwa*) and ODGJ clients within a social rehabilitation setting. Chosen for its suitability in exploring a unique, bounded social phenomenon, Pramujiwa's interpersonal practices in a non-clinical rehabilitation setting allow for an in-depth understanding of lived experiences without attempting generalization. A multiple case study design was not adopted because the role of Pramujiwa is institutionally exclusive to Satpel Bina Laras and does not exist as a comparable caregiving role across different rehabilitation settings; therefore, cross-case comparison would risk conceptual distortion rather than analytical enrichment.

Importantly, the role of *Pramujiwa* is institutionally specific to Satpel Bina Laras and does not exist as a formal caregiving designation outside the Bina Laras rehabilitation system. Pramujiwa are formally appointed non-professional caregivers whose responsibilities are shaped by the organizational structure, daily routines, and relational demands of Satpel Bina Laras services. Accordingly, the use of the term *Pramujiwa* in this study is analytically and contextually limited to Satpel Bina Laras and should not be equated with general care aides, peer support workers, or community volunteers in other mental health settings. This contextual specificity justifies the selection of an intrinsic single-case study design, as the phenomenon cannot be meaningfully detached from its institutional settings.

This study was grounded in a constructivist paradigm, which assumes that social reality is constructed through subjective experiences and interpersonal interactions (Creswell, 2018). From this perspective, knowledge is not viewed as an objective or fixed entity but as the result of continuous meaning-making processes shaped by individuals within specific social and cultural contexts. The constructivist paradigm aligns with the study's aim to understand how Pramujiwa interprets, negotiates, and enacts interpersonal communication through experiential caregiving practices rather than through standardized professional protocols.

The primary participants in this study were Pramujiwa, who engage in daily interpersonal interactions with ODGJ clients at Satpel Bina Laras Sakurjaya. Inclusion criteria for Pramujiwa participants included: (1) active involvement in daily caregiving and accompaniment activities, (2) a minimum of one year of experience as Pramujiwa, and (3) willingness to participate voluntarily. To enrich contextual understanding and analytical depth, additional informants included supporting staff (social workers, nurses, and structural officers) and one expert informant with a professional background in psychiatric nursing.

Participants in this study included 10 Pramujiwa as key informants, 4 supporting informants, and 1 expert informant. Informants were selected through purposive sampling to ensure their relevance to the research focus. The final number of participants was determined based on data saturation, which was reached when successive interviews no longer yielded new themes, conceptual categories, or variations pertinent to the development of the Pramujiwa Interpersonal Relationship Model (Gentles et al., 2015).

Table 1. Research Informants

No.	Name	Status	Tenue	Gender	Age	Description
1	Pramujiwa A	Pramujiwa	1	Male	24	Key Informant
2	Pramujiwa B	Pramujiwa	1	Male	24	Key Informant
3	Pramujiwa C	Pramujiwa	1	Female	27	Key Informant
4	Pramujiwa D	Pramujiwa	1	Male	24	Key Informant
5	Pramujiwa E	Pramujiwa	1	Female	29	Key Informant
6	Pramujiwa F	Pramujiwa	1	Male	28	Key Informant
7	Pramujiwa G	Pramujiwa	1	Male	23	Key Informant
8	Pramujiwa H	Pramujiwa	1	Male	30	Key Informant
9	Pramujiwa I	Pramujiwa	1	Female	23	Key Informant
10	Pramujiwa J	Pramujiwa	1	Female	23	Key Informant
11	Social Workers A	Social Worker	1	Male	24	Supporting informant
12	Nurses M	Social Service Nurse	1	Female	25	Supporting informant
13	Nurses N	Social Service Nurse	1	Female	25	Supporting informant
14	Structural Officer for Bina Laras	Structural Officer for Bina Laras	1	Male	45	Supporting informant
15	Expert A	Psychiatric Hospital Nurse	5	Female	28	Expert informant

Source: Researcher's Process, 2025

Data were collected through in-depth unstructured interviews, participant observation, and document analysis. Unstructured interviews

were conducted to allow flexibility and enable participants to articulate their experiences, meanings, and interactional practices in their own terms (Satori, 2017). Each interview lasted between 45 and 90 minutes and was conducted in multiple sessions where necessary to deepen exploration. Although unstructured, interviews were guided by thematic prompts focusing on daily interaction patterns, relational challenges, emotional engagement, and experiential learning processes.

Participant observation was conducted over an extended period within the rehabilitation setting to capture naturalistic interpersonal interactions between Pramujiwa and clients. The researcher adopted a non-participant observer role, observing caregiving routines, informal conversations, emotional exchanges, and situational responses during daily activities. Field notes were systematically recorded to document interactional contexts, behavioural cues, and relational dynamics. Document analysis included institutional guidelines, activity reports, and relevant policy documents to support contextual interpretation and data triangulation.

All data collection procedures adhered to ethical principles, including voluntary participation, informed consent, confidentiality, and respect for participants. Written informed consent was obtained prior to data collection, and participants' identities were anonymized to protect privacy.

Data analysis followed an inductive process based on the interactive model proposed by Miles and Huberman (1984), consisting of data reduction, data display, and conclusion drawing. Interview transcripts, observational notes, and documents were coded and categorized iteratively to identify patterns, themes, and relational phases underlying Pramujiwa's interpersonal communication practices. Member checking was conducted by informally confirming preliminary interpretations and thematic patterns with selected Pramujiwa participants to ensure that the findings accurately reflected their lived experiences and interactional meanings.

Source triangulation was employed by comparing data across interviews, observations, and documents. Discrepancies between data sources were examined through repeated reading, cross-checking with field notes, and interpretive comparison rather than forced convergence. This process enhanced analytical credibility and contextual validity (Creswell, 2018). Reflexive memos were maintained throughout the analysis to address the researcher's positionality and minimize interpretive bias. Findings were continuously reviewed to ensure coherence between empirical data and emerging conceptual interpretations.

To clarify the overall research procedure, a detailed research flowchart is presented in Figure 2, illustrating the sequential stages undertaken throughout the study.

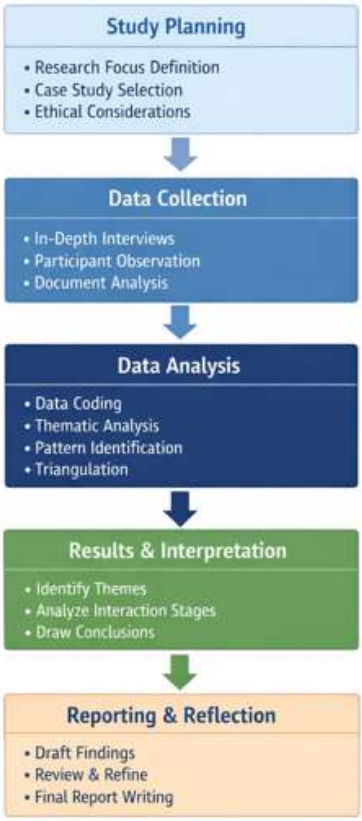

Figure 2. Research Flow Diagram

3. Results

3.1 Contextual Background of the Rehabilitation Setting

This study was conducted at Satpel Bina Laras Sakurjaya, a government-operated social rehabilitation unit for individuals with mental disorders (ODGJ) in Sumedang Regency, West Java, Indonesia. The facility adopts a holistic rehabilitation approach that integrates basic medical care with social, environmental, and community-based activities (West Java Public Relations Office, 2024). Physical infrastructure includes therapy rooms, shared activity spaces, gardening and livestock areas, and green open spaces that support psychological well-being and social engagement.

Figure 3. The atmosphere at the Bina Laras Sakurjaya Sumedang

As a long-term residential facility, the environment promotes continuous daily interaction between non-professional caregivers (Pramujiwa) and clients. This arrangement facilitates organic interpersonal communication, emerging from repeated routine activities rather than formal clinical sessions. The spatial organization of open communal areas, proxemic arrangements, and shared routines shapes relational dynamics, allowing repeated, informal encounters that foster emotional attunement, trust, and relational continuity (Gillard et al., 2015).

3.2 Emergent Patterns of Pramujiwa Client Interpersonal Relationships

Analysis of interview data, participant observation, and institutional documents indicates that interpersonal relationships between Pramujiwa and clients are formed through continuous, experience-based interaction embedded in daily routines. These relationships are shaped by repetition, emotional presence, and situational responsiveness rather than formal therapeutic planning. Across data sources, three interrelated relational tendencies consistently emerge: emotional attunement, situational adaptation, and relational continuity. These tendencies operate simultaneously and reinforce one another within everyday caregiving interactions.

These practices demonstrate an internally coherent relational logic grounded in lived interaction, as evidenced by recurring behavioral patterns, emotional orientations, and relational functions observed across participants and situations. Three interrelated relational patterns consistently appear across data sources: emotional attunement, situational

adaptation, and relational continuity. These patterns operate simultaneously and mutually reinforce each other, rather than functioning as discrete sequential stages.

Observational data show that non-verbal behaviors such as calm vocal tone, sustained proximity, flexible physical distance, and attentive bodily orientation play a central role in sustaining these relationships. Verbal communication tends to be brief, informal, and contextually embedded in activities such as meals, cleaning, gardening, or rest periods. Together, these practices form a relational process oriented toward emotional stability and trust maintenance.

3.3 Thematic Interaction Patterns between Pramujiwa and Clients

The term *relational phases* in this section refers to analytical groupings derived inductively from empirical interaction patterns, rather than predefined theoretical stages. To address analytical coherence, the empirical findings are reorganized into three emergent relational phases that synthesize recurring interactional patterns across the data. These phases are inductively derived from repeated behaviors, emotional orientations, and relational functions observed in practice, rather than imposed from clinical models.

To address redundancy and clarify analytical structure, the thematic findings are synthesized into a thematic matrix (Table 1). This matrix compares relational categories based on interaction focus, dominant practices, data sources, and relational outcomes, without employing clinical terminology.

Table 2: Thematic Matrix of Pramujiwa Client Interpersonal Practices

Interaction Pattern	Core Characteristics	Observable Practices	Non-verbal & Contextual Indicators	Primary Relational Function
Initial Familiarization	Emotional soft-entry	Casual greetings, humor, and name-based recognition	Relaxed posture, smiling, safe distance	Establish emotional safety
Trust Negotiation	Affective attunement	Listening, adaptive silence	Sustained eye contact, calm tone, gentle nods	Build interpersonal trust

Interaction Pattern	Core Characteristics	Observable Practices	Non-verbal & Contextual Indicators	Primary Relational Function
Daily Engagement	Relational maintenance	Shared routines, companionship, spontaneous support	Coordinated activity, attentive body language	Maintain emotional stability
Informal Continuity	Fluid relational presence	Gradual pauses, open-ended conversation	Reduced intensity, flexible physical distance	Preserve relational continuity

Source: Researcher's Process, 2025

The matrix shows that interpersonal relationships are maintained through relational consistency rather than procedural structure. Each pattern contributes to relational stability and remains active in daily interactions.

The findings suggest a cyclical relational flow shaped by cumulative cause-and-effect dynamics. Emotional attunement facilitates client openness and reduces interpersonal resistance. This openness enables situational adaptation, allowing Pramujiwa to respond flexibly to emotional fluctuations and behavioral changes. Successful adaptation reinforces relational continuity, which in turn strengthens emotional trust in subsequent interactions.

Over time, this cycle produces relational stability through accumulated emotional experience rather than formal evaluation or intervention. Conversely, disruptions such as emotional fatigue, institutional constraints, or client distress can weaken adaptive capacity and temporarily destabilize relational continuity. This interdependence highlights that relational effectiveness is contingent on both interpersonal sensitivity and structural conditions within the rehabilitation environment.

These interaction patterns demonstrate a progressive relational logic. Initial familiarization creates emotional safety, enabling trust negotiation through affective attunement. Once trust is established, daily engagement sustains emotional stability through shared routines.

This sequence reflects a cause–and–effect relationship: emotional safety facilitates trust, trust enables sustained engagement, and sustained engagement produces relational continuity. The process remains flexible,

allowing Pramujiwa to return to earlier patterns when clients experience emotional fluctuation.

Taken together, these findings indicate that Pramujiwa–client relationships are structured through experience-based interactional patterns rather than formal communication protocols. While the empirical data reveal four recurring interaction patterns, these patterns operate collectively to perform broader relational functions. The following Discussion section interprets these empirical findings by synthesizing them into a conceptual relational model grounded explicitly in the data.

3.3.1 Initial Familiarization

This pattern represents the entry point of interpersonal engagement, where Pramujiwa initiates contact with clients using informal, low-pressure strategies. Communication is characterized by casual greetings, humor, and basic personal recognition, establishing emotional safety without formal therapeutic framing. Participants greeted clients by name and made light jokes to reduce tension. Non-verbal cues included relaxed posture, friendly facial expressions, and maintaining safe interpersonal distance.

> *"At first, I just greet them, ask if they've eaten, and sometimes joke a little. Then they start opening up over time."* (Pramujiwa A, 3 Sept 2025)

Initial familiarization aligns with concepts of rapport-building and emotional attunement in non-clinical peer support (Sholihah & Iswahyudi, 2023), where establishing psychological safety is critical before deeper engagement. This stage emphasizes informal, humanistic relational entry, consistent with affective orientation theories in social care.

3.3.2 Trust Negotiation

Following initial familiarization, Pramujiwa engages in trust negotiation, a pattern aimed at deepening relational closeness through affective attunement. This phase involves active listening, adaptive silence, and non-verbal reassurance to signal presence, care, and reliability. Pramujiwa often paused to listen, allowed clients to speak without interruption, and used a calm tone and sustained eye contact. Situational adaptation included responding flexibly to emotional cues, such as moving closer when clients appeared anxious.

> *"First, I try to understand their mood… sometimes I just stay silent, listening. If they seem anxious, I sit next to them and smile."* (Pramujiwa B, 3 Sept 2025)

Trust negotiation reflects affective attunement and relational scaffolding in peer support literature (Satuhu et al., 2024). This pattern aligns with non-verbal relational strategies, emphasizing emotional responsiveness rather than clinical techniques. It serves as the foundation for sustained engagement, echoing findings from community-based mental health settings in Indonesia (Marpaung & Harahap, 2025).

3.3.3 Daily Engagement

Daily engagement encompasses routine, contextually embedded interactions, where Pramujiwa maintains emotional stability and reinforces relational bonds. Interaction occurs alongside shared activities such as meals, gardening, cleaning, or recreational exercises. Clients and Pramujiwa participated in shared routines, such as sweeping or preparing food, where casual conversation occurred naturally. Non-verbal coordination included mirroring movements, maintaining proximity, and empathetic gestures to facilitate comfort.

> *"We usually chat with clients while doing activities, like sweeping or morning exercise. They start talking on their own. If someone is angry, we try to calm them down, telling them to take it easy."* (Pramujiwa A, 3 Sept 2025)

Daily engagement aligns with relational maintenance theory (Stafford & Canary, 1991) and experiential empathy frameworks in non-clinical care (Sholihah & Iswahyudi, 2023). By embedding interactions in daily routines, Pramujiwa supports psychosocial stabilization, consistent with Indonesian rehabilitation studies emphasizing the role of contextual and repeated engagement (Riadi et al., 2024).

3.3.4 Informal Continuity

Informal continuity represents the ongoing, flexible nature of interpersonal relationships, emphasizing relational persistence without formal termination. Communication remains open-ended, allowing for spontaneous continuation across days, reflecting relational flexibility and continuity. Interactions were not time-bound; conversations resumed naturally in subsequent sessions. Non-verbal cues included reduced intensity, light humor, and attentiveness without structured routines.

> *"If you're comfortable, we can just continue yesterday's conversation tomorrow."* (Pramujiwa I, 11 Sept 2025)

This pattern reflects the relational consolidation phase of non-clinical care (Widianti et al., 2023), where continuity and emotional

presence are more impactful than formal closure. It supports the cyclical relational flow, allowing caregivers to revisit earlier patterns as client needs fluctuate.

3.4 Integrative Observations Across Patterns

These four interaction patterns, in initial Familiarization, Trust Negotiation, Daily Engagement, and Informal Continuity op, operate as a dynamic, cyclical process. Engagement typically begins with Initial Familiarization, where informal greetings and casual recognition establish emotional safety. This facilitates Trust Negotiation, characterized by attentive listening, adaptive silence, and non-verbal reassurance, allowing relational bonds to deepen. Once trust is established, Daily Engagement emerges through shared routines, companionship, and spontaneous support, consolidating emotional stability and normalizing social interaction. Informal Continuity ensures that these relational processes remain flexible and open-ended, allowing interactions to resume seamlessly over time in response to clients' fluctuating needs.

Across all patterns, non-verbal behaviors such as sustained eye contact, calm vocal tone, relaxed posture, and proxemics adjustments consistently reinforce relational functions, providing continuous cues of empathy, availability, and attunement. Empathy, situational responsiveness, and moral commitment act as cross-cutting mechanisms, mediating between verbal practices, contextual conditions, and client outcomes. Together, these factors create a self-reinforcing relational cycle, in which each pattern supports the emergence and maintenance of the next, demonstrating how non-structured, experience-based interaction achieves functional relational stability in long-term social rehabilitation contexts.

The phases interact causally: emotional safety, trust, sustained engagement, and national continuity, with verbal and non-verbal cues reinforcing these processes. Interactions remain flexible, allowing caregivers to revisit earlier patterns as client emotional or behavioral states fluctuate. These integrative observations remain grounded in empirical regularities identified across data sources; their broader theoretical implications are further elaborated in the Discussion section.

4. Discussion

The findings of this study differ from previous research on therapeutic communication in mental health contexts in both analytical focus and theoretical orientation. Prior studies predominantly examine professionally trained caregivers and conceptualize communication as a formal competency governed by standardized techniques, structured interactional stages, and clinically measurable outcomes (Fasya &

Supratman, 2018; Azhari & Labela, 2022). In contrast, the present study demonstrates that effective interpersonal engagement in non-clinical rehabilitation settings emerges through experiential learning, emotional familiarity, and sustained everyday interaction enacted by non-professional caregivers, rather than being evaluated against predefined clinical indicators. Relational competence in this context is constructed organically through adaptive, situational, and continuous relational practices.

This study, therefore, contributes a novel conceptual perspective to interpersonal communication theory in mental health rehabilitation by extending therapeutic communication beyond clinical and professional domains. The empirically grounded, experience-based communication model developed in this research challenges the assumption that therapeutic effectiveness is inherently dependent on formal training and standardized techniques. By positioning non-professional caregivers as legitimate producers of communicative knowledge, this study offers both a theoretical expansion of interpretivist interpersonal communication frameworks and a practical relational model that is responsive to the structural and emotional realities of non-clinical mental health rehabilitation settings, particularly within the Indonesian context.

4.1 Integration into Pramujiwa Interpersonal Relationship Model Design

The emergent relational patterns observed in this study provide empirical grounding for the Pramujiwa Interpersonal Relationship Model Design, which conceptualizes interpersonal engagement as a cyclical, experience-based, and non-structural process. Unlike formal therapeutic communication models, this framework emphasizes empathy, intuitive adaptation, and continuous relational presence, reflecting the lived experience of Pramujiwa rather than predetermined guidelines. To clarify the empirical grounding of the proposed model, the four interaction patterns observed, Initial Familiarization, Trust Negotiation, Daily Engagement, and Informal Continuity, are conceptually synthesized into three interrelated phases of the Pramujiwa Interpersonal Relationship Model: Affectional Phase, Adaptive Phase, and Consolidation Phase.

Table. 3 Integration into Pramujiwa Interpersonal Relationship Model Design

Empirical Patterns	Conceptual Phase	Core Function	Rationale
Initial Familiari	Affectional Phase	Emotional safety	Both patterns establish a safe & emotional entry and develop

Empirical Patterns	Conceptual Phase	Core Function	Rationale
zation + Trust Negotiation		relational readiness	affective attunement, forming the foundation for further engagement. Initial Familiarization provides casual, low-pressure contact, while Trust Negotiation deepens relational trust through attentive listening and adaptive responsiveness.
Daily Engagement	Adaptive Phase	Emotional stability & situational adaptation	Daily routines such as shared activities reinforce trust and provide a context for flexible, responsive interaction, allowing Pramujiwa to adjust strategies according to clients' emotional and behavioral states
Informal Continuity	Consolidation Phase	Relational continuity & psychosocial support	Where communication is no longer driven by situational adjustment but by relational consistency and sustained presence. Preserve psychosocial stability and reinforce the sense of relational security, enabling clients to experience continuity, predictability, and long-term emotional support within the rehabilitation environment.

Source: Researcher's Process, 2025

The mapping illustrates that while four patterns are empirically observable, they function dynamically within three conceptual phases. The Affectional Phase encompasses Initial Familiarization and Trust Negotiation; the Adaptive Phase corresponds to Daily Engagement; and the Consolidation Phase reflects Informal Continuity. This representation demonstrates causal and cyclical relationships among the patterns and phases. These phases exhibit a dynamic causal interaction, where emotional safety facilitates trust, trust enables sustained engagement, and sustained engagement reinforces relational continuity. Verbal and non-

verbal cues stabilize and guide these processes, while interactions remain flexible, allowing caregivers to revisit earlier patterns in response to clients' fluctuating emotional and behavioral states. This cyclical process reflects informal emotional labor, in which Pramujiwa continuously adjusts relational strategies based on lived experience.

While the model partially aligns with Stuart's (2013) four-phase interpersonal framework, it diverges in emphasizing emergent, practice-based processes rather than formalized theoretical steps. Similar patterns are noted in community-based rehabilitation literature, where continuous, non-clinical relational presence supports psychosocial stabilization (Riadi et al., 2024). Limitations include the single-site context, potential observational influence, and absence of formal evaluation. Despite these, the findings demonstrate that meaningful interpersonal relationships can be intentionally cultivated through empathetic, adaptive, and continuous engagement, providing a foundation for refining non-clinical mental health relational frameworks.

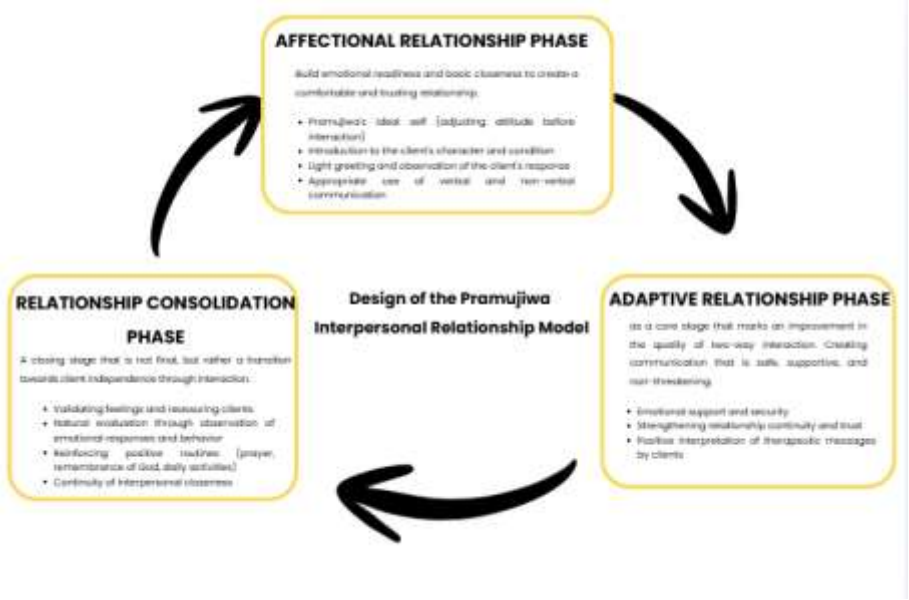

Figure 4. Design of the Pramujiwa Interpersonal Relationship Model

Figure 4 presents a visual diagram demonstrating the cyclical flow from empirical interaction patterns to conceptual phases. Arrows indicate causal and reinforcing relationships: emotional safety from Initial Familiarization facilitates trust, which supports Adaptive Phase engagement, and ultimately sustains relational continuity in the Consolidation Phase. The model also allows for flexibility, permitting

caregivers to revisit earlier phases in response to client needs. This visual emphasizes that the three-phase model is not strictly linear; instead, it captures the cyclical and responsive nature of interpersonal relationships. The empirical observations directly inform the conceptual phases, demonstrating how experience-based, non-structured interaction can be systematized into a coherent relational framework.

4.1.1 Affectional Relationship Phase

The affectional relationship phase constitutes the initial component of the Pramujiwa Interpersonal Relationship Model. Its primary function is to establish emotional readiness and relational closeness before deeper engagement occurs. This phase intentionally creates a sense of relational safety, which is essential for the effectiveness of subsequent interactions. Emotional safety and early relational acceptance are critical determinants of client engagement, particularly among individuals with mental disorders in non-clinical, long-term care settings (Widianti et al., 2023).

During this phase, Pramujiwa engages in emotional self-preparation prior to interaction, observing and recognizing client characteristics based on behavioral cues. Communication strategies are selected intuitively, balancing verbal and non-verbal approaches. Verbal engagement typically consists of gentle greetings, light questions, spontaneous affirmations, and brief exchanges designed to emotionally attune clients to the interaction. Non-verbal communication is dominant, characterized by soft eye contact, open and approachable posture, friendly facial expressions, calm vocal tone, and maintaining a safe interpersonal distance. These non-verbal cues have been shown to facilitate emotional regulation and reduce anxiety among ODGJ clients in Indonesian rehabilitation contexts (Marpaung & Harahap, 2025).

The affectional relationship phase is defined by spontaneity, intuitive responsiveness, warmth, and a strong human orientation. Even in the absence of formal professional procedures, this phase performs the essential interpersonal function of initial relational engagement through empathy and emotional awareness developed from daily practice. The mechanisms of empathy, emotional awareness, and experiential sensitivity enable relational openness and trust, reinforcing the relevance of experience-based interpersonal communication within social rehabilitation settings (Sholihah & Iswahyudi, 2023).

4.1.2 Adaptive Relationship Phase

The adaptive relationship phase represents the core interactional component of the model, marked by reciprocal engagement and flexible adjustment of verbal and non-verbal strategies according to clients' emotional, behavioral, and psychological states. This phase is crucial for

maintaining emotional stability and preventing behavioral escalation among clients in non-clinical settings (Jariyah et al., 2025).

Within this phase, Pramujiwa focuses on providing emotional support and safety while regulating client responses. They reinforce trust and relational continuity and facilitate positive interpersonal meaning-making. Verbal strategies involve gentle invitations, reflective responses, and affirming statements that validate client experiences. Non-verbal strategies include warm eye contact, open gestures, calm vocal tone, and appropriate physical distancing, which collectively reduce anxiety and enhance emotional regulation (Marpaung & Harahap, 2025).

The adaptive relationship phase is characterized by flexibility, empathy, affirmation, and non-confrontational communication. These qualities emerge from Pramujiwa's experiential emotional intelligence, allowing interpersonal engagement to proceed without provoking agitation or resistance. This phase demonstrates that recovery-supportive communication can emerge from relational consistency and responsiveness rather than reliance on formal techniques.

4.1.3 Relationship Consolidation Phase

The relationship consolidation phase represents the concluding yet non-terminal component of the model. Unlike formal termination procedures in clinical models, this phase functions as a transition toward client autonomy while maintaining relational warmth, empathy, and continuity. Emotional stabilization and reinforcement of positive meanings derived from prior interactions are key priorities, ensuring that clients remain emotionally secure and valued as they engage in daily activities. This approach aligns with findings from Indonesian social rehabilitation studies emphasizing the importance of relational continuity and emotional presence in promoting psychosocial stability (Riadi et al., 2024).

In practice, verbal communication during this phase consists of affirming and transitional expressions that implicitly reinforce relational continuity. Non-verbal communication manifests through gentle smiles, nods of acceptance, calm vocal tone, and supportive body language, promoting emotional regulation and preventing escalation. These practices are embedded in routine interactions, allowing implicit interpersonal agreements and mutual trust to emerge organically (Riadi et al., 2024). The relationship consolidation phase thus exemplifies how relational evaluation and closure can occur within everyday interactions, highlighting the distinctiveness of the Pramujiwa model in which relational maintenance is continuous and embedded in lived experience rather than structured procedures.

5. Conclusion

This study examined interpersonal relationship practices by non-professional caregivers (Pramujiwa) in a social rehabilitation setting for individuals with mental disorders (ODGJ) at Satpel Bina Laras Sakurjaya. The findings highlight that, despite lacking formal clinical training, Pramujiwa establishes effective relational engagement through experiential empathy, emotional attunement, and adaptive, context-sensitive interactions. These practices suggest that meaningful interpersonal relationships can emerge outside formalized clinical frameworks, emphasizing relational continuity and psychosocial support within daily routines.

The study proposes the Pramujiwa Interpersonal Relationship Model, consisting of three interrelated phases: the affectional, adaptive, and relationship consolidation phases. While the model provides a structured lens to understand experience-based relational practices, its contribution to interpersonal communication theory is contextually bounded; it highlights the role of non-professional experiential knowledge in social rehabilitation, complementing but not replacing existing clinical models.

Limitations of the study include the single-site context, small sample size, potential researcher influence, and limited client perspectives, which constrain the generalizability of findings. Ethical considerations regarding reliance on untrained personnel for emotionally intensive care warrant attention, particularly for scaling or institutionalizing such practices.

Future research should evaluate the model across multiple rehabilitation sites, including client-reported outcomes, and examine measurable variables such as emotional regulation, trust development, and relational continuity. Additionally, testing structured training programs for Pramujiwa could assess whether experiential relational practices can be systematized while maintaining ethical and psychosocial integrity. These steps would strengthen understanding of how non-clinical relational expertise contributes to psychosocial rehabilitation and informs evidence-based practice in resource-limited settings.

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