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Therapeutic Communication and Post-Disaster Psychological Recovery Among Muslim Survivors

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Abstract

Post-disaster psychosocial support in Muslim communities is still poorly understood, especially regarding the role of religious-based therapeutic communication in psychological recovery. The study examined the relationship between therapeutic communication and post-disaster psychological recovery while exploring culturally specific recovery mechanisms among Muslim disaster survivors. The design of the sequential explanation mixture method is used. Quantitative data were collected from 60 adult flash flood survivors using validated measures of therapeutic communication and psychological recovery, followed by in-depth interviews with 12 informants who were randomly selected to explain the quantitative findings. Quantitative analysis showed a positive yet modest relationship between therapeutic communication and psychological recovery, with stronger associations observed in future orientation and social functioning than in emotional stability. The qualitative findings identified five interrelated themes that highlight the importance of empathic listening, Islamic spiritual communication, peer social support, avoiding non-empathic responses, and tawakal-based expectations in the recovery process. The integration of the two strands suggests that therapeutic communication provides a relational foundation for recovery, while Islamic spiritual communication and community social support serve as a culturally based mechanism that reinforces psychological adaptation. The study proposes a bio-psycho-social-spiritual therapeutic communication model with practical implications for culturally responsive post-disaster psychosocial interventions in Muslim communities.

Keywords: *Therapeutic Communication; Psychological Recovery; Islamic Spiritual Communication; Disaster Survivors; Mixed Methods*

Abstrak

Dukungan psikososial pasca bencana dalam komunitas Muslim masih belum cukup dipahami, terutama mengenai peran komunikasi terapeutik yang berlandaskan agama dalam pemulihan psikologis. Studi ini meneliti hubungan antara komunikasi terapeutik dan pemulihan psikologis pasca bencana sambil mengeksplorasi mekanisme pemulihan khusus budaya di antara penyintas bencana Muslim. Desain metode campuran penjelasan berurutan digunakan. Data kuantitatif dikumpulkan dari 60 penyintas banjir bandang dewasa menggunakan ukuran komunikasi terapeutik dan pemulihan psikologis yang divalidasi, diikuti dengan wawancara mendalam dengan 12 informan yang dipilih secara sengaja untuk menjelaskan temuan kuantitatif. Analisis kuantitatif menunjukkan hubungan positif namun sederhana antara komunikasi terapeutik dan pemulihan psikologis, dengan asosiasi yang lebih kuat diamati dalam orientasi masa depan dan fungsi sosial daripada stabilitas emosional. Temuan kualitatif mengidentifikasi lima tema yang saling terkait yang menyoroti pentingnya mendengarkan empatik, komunikasi spiritual Islam, dukungan sosial teman sebaya, menghindari respons non-empatik, dan harapan berbasis tawakal dalam proses pemulihan. Integrasi kedua untaian menunjukkan bahwa komunikasi terapeutik memberikan landasan relasional untuk pemulihan, sedangkan komunikasi spiritual Islam dan dukungan sosial masyarakat berfungsi sebagai mekanisme yang didasarkan pada budaya yang memperkuat adaptasi psikologis. Studi ini mengusulkan model komunikasi terapeutik bio-psiko-sosial-spiritual dengan implikasi praktis untuk intervensi psikososial pasca-bencana yang responsif secara budaya di komunitas Muslim.

Kata kunci: Komunikasi Terapeutik; Pemulihan Psikologis; Komunikasi Spiritual Islam; Penyintas Bencana; Metode Campuran

A. Introduction

Disasters are one of the most severe threats to people's mental health, resulting in far-reaching psychological consequences that can linger long after the event has settled. Indonesia, due to its geographical and climatological exposure, ranks among the most disaster-prone countries in the world. The flash floods that inundated five sub-districts in Aceh Tamiang Regency, Aceh, Indonesia, in November 2025 displaced thousands of residents to evacuation shelters and transitional housing, creating complex psychosocial and communication challenges during the recovery process. Beyond physical destruction, the event triggers acute and subacute psychological distress, including acute stress reactions, depressive episodes, anxiety, and early post-traumatic stress disorder. The [1] scale of this challenge is considerable.

Indonesia experiences hundreds of hydrometeorological disasters every year, and flash floods alone account for a substantial share of displacement events nationwide, with Aceh Province recording repeated flood-related emergencies in the years since the 2004 tsunami. Each such event results in not only an urgent physical need but also a surge in demand for psychosocial support that often exceeds the availability of trained mental health professionals, especially in rural and semi-urban districts such as Aceh Tamiang. This resource gap has driven a global shift toward a task-shifting model of psychosocial care, in which lay volunteers, public health workers, and religious leaders are trained to provide basic communication-based support rather than relying solely on scarce clinical personnel.[2]

Therapeutic communication a structured communication process that aims to promote the psychological well-being of distressed individuals is widely recognized as an essential component of psychological first aid and broader psychosocial support [3]frameworks. Stuart and Laraia's tripartite model [4] organizes therapeutic communication into phases of orientation (trust-building), work (active listening, empathic engagement, and intervention), and termination (closure and referral), each serving different but interdependent functions in moving survivors

[1] BPBD Aceh Tamiang, "Official Report of Flash Flood Disaster Events November 2025" (Aceh Tamiang, Indonesia: Aceh Tamiang Regency Regional Disaster Management Agency, 2025); Fran H Norris et al., "60,000 Disaster Victims Speak: Part I. An Empirical Review of the Empirical Literature, 1981–2001," *Psychiatry: Interpersonal and Biological Processes* 65, no. 3 (2002): 207–39, https://doi.org/10.1521/psyc.65.3.207.20173.

[2] Wietse A Tol et al., "Mental Health and Psychosocial Support in Humanitarian Settings: Connecting Practice and Research," *The Lancet* 378, no. 9802 (2011): 1581–91, https://doi.org/10.1016/S0140-6736(11)61094-5; Mark Van Ommeren, Shekhar Saxena, and Benedetto Saraceno, "Mental and Social Health during and after Acute Emergencies: An Emerging Consensus?," *World Health Organization Bulletin* 83, No. 1 (2005): 71–75.

[3] Gail W Stuart and Michele T Laraia, *Principles and Practices of Psychiatric Nursing*, 8th ed. (St. Louis, MO: Elsevier Mosby, 2005); Stevan E Hobfoll et al., "Five Essential Elements of Direct and Medium-Term Mass Trauma Interventions: Empirical Evidence," *Psychiatry: Interpersonal and Biological Processes* 70, no. 4 (2007): 283–315, https://doi.org/10.1521/psyc.2007.70.4.283.

[4] Stuart and Laraia, *Principles and Practices of Psychiatric Nursing*.

toward adaptive coping. This is based on [5] Rogers' explanation of congruence, unconditional positive attention, and empathic understanding as active ingredients of therapeutic change, and in Burleson's findings [6]

In the context of Aceh, communication in crisis cannot be separated from its Islamic substrate. The people of Aceh are firmly rooted in the Islamic tradition of mutual support (*ta'awun*), patience and patience (*sabr*), and the creation of transcendent meanings that interpret suffering as meaningful and navigable[7]. Social support is one of the most powerful protective factors in disaster psychology[8], and religious coping prayer, *dhikr*, Qur'anic reading, and consultation with religious leaders serves as a primary resource among Muslims[9], with *sabr* and *tawakal* providing culturally specific routes to meaning and hope[10]. The five [11] essential elements of Hobfoll et al.'s mass trauma intervention—safety, calmness, efficacy, connectedness, and hope map closely to this dimension, and in Indonesian Islamic counseling, therapeutic communication techniques have been documented as effective when embedded in religiously congruent guidance[12], although such research remains largely non-disaster and qualitative.

The study addresses this gap by examining therapeutic communication as a form of human communication behavior in post-disaster settings and by explaining how culturally embedded communication practices contribute to psychological recovery among Muslim

[5] "Necessary and Adequate Conditions of Therapeutic Personality Change," *Journal of Psychology Consulting* 21, no. 2 (1957): 95–103, https://doi.org/10.1037/h0045357.

[6] "The Experience and Effects of Emotional Support: What Studies on Cultural and Gender Differences Can Tell Us about Close Relationships, Emotions, and Interpersonal Communication," *Personal Relationships* 10, no. 1 (2003): 1–23, https://doi.org/10.1111/1475-6811.00033.

[7] Pargament, Koenig, and Perez, "Many Methods of Religious Copying: Early Development and Validation of RCOPE."

[8] Kaniasty and Norris, "Testing a Model of Decline in Social Support in the Context of Natural Disasters"; Aldrich, *Building Resilience: Social Capital in Post-Disaster Recovery*.

[9] Amber Haque, "Psychology from an Islamic Perspective: The Contributions of Early Muslim Scholars and Challenges for Contemporary Muslim Psychologists," *Journal of Religion and Health* 43, no. 4 (2004): 357–77, https://doi.org/10.1007/s10943-004-4302-z; Walaa M Sabry and Adarsh Vohra, "The Role of Islam in the Management of Psychiatric Disorders," *Indian Journal of Psychiatry* 55, no. S2 (2013): S205–14, https://doi.org/10.4103/0019-5545.105534.

[10] Qurotul Uyun and Evelin Witruk, "The Effectiveness of Sabr (Patience) and Salat (Prayer) in Reducing Psychopathological Symptoms After the 2010 Merapi Eruption in Yogyakarta Region, Indonesia," in *Trends and Problems in Interdisciplinary Behavior and the Social Sciences* (London, England: CRC Press, 2017), 165–73, https://doi.org/10.1201/9781315269184-28; Maila D H Rahiem, Steven Eric Krauss, and Husni Rahim, "Children of Aceh Tsunami Victims: Stories of Resilience, Overcoming and Moving Forward with Life," *Procedural Techniques* 212 (2018): 1303–10, https://doi.org/10.1016/j.proeng.2018.01.168.

[11] Hobfoll et al., "Five Essential Elements of Direct and Medium-Term Mass Trauma Interventions: Empirical Evidence."

[12] Grandchildren of Siti Rodiah, Isep Zaenal Arifin, and Hajir Tajiri, "Therapeutic Communication Techniques in Islamic Counseling Guidance Services for Handling Drug Abuse," *Al-Afkar, Journal of Islamic Studies* 7, no. 3 (2024): 1202–14, https://doi.org/10.31943/afkarjournal.v7i3.1602; Sri Widyaningrum and Siti Nur Fatonah, "Integration of Islamic Values and Therapeutic Communication Techniques in Group Counseling: A Case Study of MTs. Nurul Iman, Bandung City," *Al-Tazkiah: Journal of Islamic Guidance and Counseling* 14, no. 2 (2025), https://doi.org/10.20414/altazkiah.v14i2.13375.

disaster survivors. This study makes three main contributions. First, it provides the first mixed-methods examination of therapeutic communication and psychological recovery in post-disaster Acehnese Muslim communities, integrating validated quantitative measurements with theoretically saturated qualitative investigations in twelve informants. Second, it extends a standard model of religiously neutral therapeutic communication into an explicit bio-psycho-social-spiritual framework in which Islamic spiritual communication serves as a core therapeutic mechanism rather than peripheral cultural preferences. Third, through dimensional-level analysis identifies which communication phases and aspects of recovery are most closely related, resulting in actionable guidance for facilitator training. This research is guided by three research questions: (1) What is the level of quality of therapeutic communication felt by flash flood survivors? (2) What is their post-disaster psychological recovery rate? (3) What is the direction and magnitude of the influence of therapeutic communication on recovery, and how do qualitative findings deepen, expand, or challenge quantitative outcomes?

B. Research Method

This study adopts a sequential explanatory mixed method design [13], where the quantitative phase is followed by a qualitative phase that aims to explain and contextualize quantitative findings. This design was chosen because the research questions include explanatory (quantitative) and exploratory-contextual (qualitative) dimensions, and because the quantitative phase provides the basic data for the intended sampling in the qualitative phase; Integration occurs at the interpretation stage through the synthesis of joint views, allowing meta-inference beyond what a single strand alone can produce. Data was collected in five sub-districts of Aceh Tamiang Regency, Aceh Province, Indonesia Rantau, Sekerak, Karang Baru, Tamiang Hulu, and Bendahara between December 2025 and February 2026, approximately one to three months after the November 2025 floods. Face-to-face interviews were conducted in Tanjung Gelumpang Village, Sekerak District, Aceh Tamiang Regency, at evacuation centers, government transitional housing (*huntara*), community mosques (*meunasah*), and public health posts. This subacute time frame was chosen because acute symptoms are usually stable enough to allow for survey participation while recovery remains active and the effects of communication-based support are still close in survivor experiences.

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[13] John W Creswell and Vicki L Plano Clark, *Designing and Conducting Mixed Methods Research*, 3rd ed. (Thousand Oaks, CA: SAGE Publications, 2018).

Tamiang Regency, at evacuation centers, government transitional housing (huntara), community mosques (meunasah), and public health posts. This subacute time frame was chosen because acute symptoms are usually stable enough to allow for survey participation while recovery remains active and the effects of communication-based support are still close in survivor experiences. Quantitative data were collected by trained research assistants using self-administered questionnaires, with verbal assistance for participants with low literacy, after informed consent with guarantees of confidentiality, anonymity, and the right to opt-out. Qualitative data were collected through semi-structured interviews lasting 45-60 minutes, conducted in Indonesian and Acehnese per participant preference, audio recorded with consent, and complemented by field notes and structured observation checklists in six facilitated sessions, providing reinforcement of self-report behavior.

C. Discussion

1. Validity and reliability of the instrument

Both scales show good psychometric properties. For Variable X, all 24 items exceeded the critical r-(0.361; df = 28, α = 0.05), with a total-item correlation from r = 0.421 (X1.2) to r = 0.779 (X2.10) and a full-scale Cronbach alpha of 0.891 ("very high"; George & Mallery, 2003). For Variable Y, all 21 items exceeded r-critical, with correlations ranging from r = 0.376 (Y1.1) to r = 0.810 (Y3.2) and a full-scale alpha of 0.876. The reliability of the subscale level is certainly lower given the small number of items per subscale, ranging from 0.621 (X2) to 0.286 (Y3); the low Y3 coefficient reflects the heterogeneity of Islamic spiritual coping items and is reviewed as a limitation in Section 4.7. Table 1 summarizes these results.

Table 1. *Validity and Reliability of Study Instruments*

Variables/Subscales	*Item*	*R Range*	*α (subscale)*	*Verdict*
X – Therapeutic Communication (full)	24	.421–.779	.891	Reliable
X1 Orientation	6	—	.451	—
X2 Work	12	—	.621	—
X3 Termination	6	—	.495	—
Y – Psychological Recovery (full)	21	.376–.810	.876	Reliable
Y1 Emotional Stability	6	—	.443	—
Y2 Social Function	5	—	.325	—
Y3 Koping Spiritual	5	—	.286	—
Y4 Future Orientation	5	—	.530	—

Note. range r = item-total correlation range; All items exceeding R-Critical = 0.361. Full-scale reliability is very high; The subscale coefficient is lower as expected for a short subscale.

2. Demographic profile

Participants were spread across Rantau (n = 13, 21.7%), Bendahara (n = 14, 23.3%), Karang Baru (n = 12, 20.0%), Tamiang Hulu (n = 12, 20.0%), and Sekerak (n = 9, 15.0%). Educational attainment ranged from primary school (30.0%) to diploma/bachelor's degree (15.0%), and half worked in agriculture or fisheries. At data collection, 31.7% remained in shelters, 25.0% with relatives, 21.7% in transitional housing, and 21.7% had returned to damaged homes (Table 2).

Table 2. *Demographic Profile of Participants (n = 60)*

Variable	*Categories*	*n (%)*
Gender	Women	31 (51.7)
	Male	29 (48.3)
Age group	17–25	16 (26.7)
	26–35	19 (31.7)
	36–45	14 (23.3)
	≥ 46	11 (18.3)
Education	Primer (SD)	18 (30.0)
	Junior high school (SMP)	13 (21.7)
	Senior high school (SMA/SMK)	20 (33.3)
	Diploma/Bachelor (D3/S1)	9 (15.0)
Housing status	Evacuation shelters	19 (31.7)
	Relatives' houses	15 (25.0)
	Transitional housing (huntara)	13 (21.7)
	Return to a broken house	13 (21.7)

3. Descriptive statistics and dimension-level analysis

For Variable X, the mean total was 84.95 (SD = 7.75; range 69–107) against an ideal maximum of 120 (70.8%); 3.3% of participants scored "very high", 51.7% "high", and 45.0% "moderate", with none "low". For Variable Y, the mean total was 74.43 (SD = 6.77; range 57–91) against an ideal maximum of 105 (70.9%). At the subscale level, the average score of items is comparable across dimensions (3.48–3.59 out of 5), with the highest future orientation and the lowest social function (Table 3). Nearly identical X and Y outcomes (70.8% vs. 70.9%) signaled a simple but positive relationship reported next.

Table 3. *Descriptive Statistics by Dimension (n = 60)*

Dimensions	*Item*	*Sum M*	*Number of Elementary Schools*	*Item M*	*% Ideal*
X1 Orientation	6	20.88	2.53	3.48	69.6
X2 Work	12	42.82	4.26	3.57	71.4
X3 Termination	6	21.25	2.41	3.54	70.8
Y1 Emotional Stability	6	21.35	2.46	3.56	71.2
Y2 Social Function	5	17.58	2.15	3.52	70.3

Y3 Koping Spiritual	5	17.55	1.88	3.51	70.2
Y4 Future Orientation	5	17.95	2.30	3.59	71.8

4. Correlation and regression analysis

Pearson's correlation showed a positive association between therapeutic communication and psychological recovery (r = 0.206), consistent with theoretical predictions, but the relationship was modest (small effect; Cohen, 1988) and did not achieve significance at α = 0.05, double-tailed: t(58) = 1.600, p = 0.115. R^2 = 0.042 indicates therapeutic communication accounts for about 4.2% of the recovery variance, and the regression equation $\hat{Y}$ = 59.176 + 0.180X implies that each one-point increase in communication corresponds to the expected 0.180-point improvement in recovery. Dimension-level analysis localized associations meaningfully (Table 4): orientation (r = 0.203) and work (r = 0.204) showed small associations comparable to total recovery, while termination was negligible (r = 0.088); Communication was strongest associated with future orientation (r = 0.233) and social functioning (r = 0.188), weaker with spiritual coping (r = 0.155), and weakest with emotional stability (r = 0.065).

Table 4. *Correlation and Regression Results (n = 60)*

Relationships/Parameters	***r/value***	***t***	***p***
Orientation X1 → Total Y	.203	1.581	.120
X2 Works → Total Y	.204	1.586	.118
X3 Termination → Total Y	.088	0.670	.505
Total X → Y1 Emotional Stability	.065	—	—
Total X → Y2 Social Function	.188	—	—
Total X → Y3 Koping Spiritual	.155	—	—
Total X → Future Orientation Y4	.233	—	—
Overall: Total X → Total Y (r)	**.206**	**1.600**	**.115**
R^2 / b_1 / b_0	.042 / .180 / 59.18	—	—

Note. T-critical (df = 58, α = 0.05, two tails) = 2.002. Regression: $\hat{Y}$ = 59.176 + 0.180X.

5. Qualitative findings: Thematic analysis

Thematic analysis of 12 interview transcripts, triangulated with follow-up recovery phase interviews and six observational field notes, resulted in five overarching themes, each corroborated by four to seven independent informants (Table 5).

Table 5. *Theme × Informant Coverage*

Theme	***Types of informants***	***Different voices***
T1 Really heard	Survivors, facilitators, religious leaders	6 (INF-01, INF-03, INF-07, INF-09, INF-13, INF-14)
T2 Islamic spiritual communication	Survivors, ustaz, MH workers, religious leaders	7 (INF-01, INF-02, INF-04, INF-11, INF-12, INF-13, INF-14)
T3 Adverse non-empathic responses	Survivors, facilitators, religious leaders	6 (INF-01, INF-05, INF-07, INF-10, INF-13, INF-14)

T4 Peer social support	Survivors, MH workers, religious leaders	**6** (INF-01, INF-06, INF-08, INF-12, INF-13, INF-14)
Q5 Future orientation based on Tawakal	*Survivors, ustaz, religious leaders*	*6 (INF-01, INF-02, INF-06, INF-11, INF-13, INF-14)*

a. Theme 1: The Transformative Power of Being Truly Heard

Active listening is the most consistently valued component of therapeutic communication, restoring a survivor's sense of personality amid anonymous "victim" status. INF-01 recalled that the facilitator "sat next to me, asked my name first... I cried right away," while one facilitator independently described the same principle as a deliberate technique: "My principle, don't talk just yet... If we start with a lecture, they immediately close themselves" (INF-09). Recovery phase interviews reinforce that respectful presence and patience remain prerequisites for survivors' willingness to engage in counseling and religious activities later in life.

b. Theme 2: Islamic Spiritual Communication as a Healing Mechanism

All types of informants identify Islamic spiritual communications Qur'anic verses, sabr, tawakal, dhikr, and congregational prayers as centers of recovery. INF-01 anchored his stability in the remembered teaching: "I keep remembering the words of ustaz, if Allah will not test His servants beyond their abilities... don't feel alone," and one religious leader described a heart-centered method: "I hear their cries. Just slowly I bring a sentence... Religious communication must be through the heart first, then through the intellect" (INF-11). Importantly, mental health workers offer a clinical qualification that prevents overly romantic readings: "Survivors who are active in worship stabilize faster. But there are also those who feel that God is punished, that makes it worse" (INF-12) distinguishing positive religious coping from negative in line with the framework of Pargament et al. [14] Records of the recovery phase (INF-13, INF-14) confirm that religious leaders maintained this guidance well beyond the emergency through daily reminders and religious gatherings.

c. Theme 3: The Detrimental Psychological Effects of Non-Empathetic Responses

Survivors illuminate therapeutic communication with contrast. INF-01 illustrates minimization through comparison ("elsewhere it's worse... it feels like my feelings shouldn't exist"), while others report premature counseling and indifference; in particular, a facilitator honestly criticized himself for the same mistake: "I said that the patient yes, everything has its wisdom, too fast... I learned, don't rush to give

[14] Pargament, Koenig, and Perez, "Many Methods of Religious Copying: Early Development and Validation of RCOPE."

meaning" (INF-10). Religious leaders of the recovery phase (INF-13, INF-14) emphasize understanding the condition of survivors before offering advice, and use gentle language throughout.

d. Theme 4: Peer Social Support as a Parallel Recovery Mechanism

The informant differentiated formal facilitator communication from organic peer support, describing the two as complementary: survivors sharing narratives in posts ("It turns out I'm not the only one having trouble sleeping," INF-01) and the recovery of organized collective livelihoods (INF-06, INF-08). Mental health workers put formal support as a catalyst rather than a primary: "Most recover because of peer support... Our job is often just to spark, then the community that cares" (INF-12). Further recovery phase interviews show this support is underpinned by a wider network – families, volunteers, and outside donors (INF-13).

e. Theme 5: Future-Oriented Resilience Based on Tawakal and Agency

Future orientation emerges as the integration of active agents and theological acceptance: "Tawakal is not idle waiting, but effort and then surrendering the result" (INF-02), and one religious leader frames hope as a communal duty: "Despair is forbidden in Islam... We hope that we treat it together in the meunasah" (INF-11). The recovery phase account (INF-13, INF-14) reframes disaster as a test rather than a punishment, combining acceptance with sustained effort.

6. Therapeutic Communication and Post-Disaster Psychological Recovery Among Muslim Survivors

This simple and insignificant result requires careful interpretation rather than a literal reading as "no effect". Post-hoc power analysis showed that with n = 60 the study had only about 40% power to detect effects of this size, with approximately n = 197 required for 80% of the power [15]; Type II errors are therefore a more likely account than the absence of actual associations. Substantively, small effect sizes are consistent with the broader disaster mental health literature, where a single communicative intervention typically accounts for a limited portion of the variance in multiple-time defined outcomes [16], and the integrative review of Wang et al. [17] It found that psychological first aid-type communication reliably reduced acute distress and supported function but showed a

[15] Jacob Cohen, *Statistical Power Analysis for Behavioral Science*, 2nd ed. (Hillsdale, NJ: Lawrence Erlbaum Associates, 1988).

[16] Norris et al., "60,000 Disaster Victims Speak: Part I. An Empirical Review of the Empirical Literature, 1981–2001."

[17] "The Effectiveness and Implementation of Psychological First Aid as a Therapeutic Intervention after Trauma: An Integrative Review," *Trauma, Violence, & Harassment* 25, no. 4 (2024): 2638–56, https://doi.org/10.1177/15248380231221492.

weaker effect on established symptom level outcomes precisely the pattern found here, where communication tracks future orientation and social functioning but not emotional stability. Measurement considerations exacerbate this: Rogers [18] and Egan [19] argue that therapeutic communication operates through emergent relational dynamics that are not fully captured by aggregate Likert scores, limitations that qualitative findings help to correct.

The tension between simple quantitative signals and this rich qualitative explanation is itself methodologically instructive rather than just a limitation to be explained. Sijbrandij et al. [20] Similarly, it was observed that structured psychosocial interventions in humanitarian settings often produced statistically small aggregate effects while producing meaningful, individually reported changes differences they attributed to heterogeneity of trauma exposure and recovery trajectories in a single timepoint sample. The sequential explanatory logic of current design [21] is precisely constructed to accommodate this possibility: instead of treating weak correlations as the last word, a qualitative strand is tasked with explaining why associations take such forms. Hussain et al. [22] Likewise, be aware that measures of psychiatric outcomes given in the early to mid-recovery window may underestimate the unstable pressures into a measurable pattern, which may partly explain the wide variance observed around the mean of the Y Variable in this sample. Read together, these considerations suggest that a positive yet simple correlation, combined with a coherent and convergent qualitative account, constitutes stronger evidence for a real relational mechanism than one strand would provide independently.

Regarding Theme 1, this convergence of survivor experiences, facilitator intentions, and longitudinal continuity reflects [23] Rogers' empathic understanding and [24] Burleson's person-centered construct of support, and helps explain why orientation phase behavior brings the strongest phase-level association with recovery (r = .203) reinforces Stuart [25]and Laraia claims that alliances formed on the first contact scaffolding of all subsequent work, competencies that are now also documented in Indonesian Islamic

[18] Rogers, "The Necessary and Adequate Conditions of Therapeutic Personality Change."
[19] Egan, *Skilled Helpers: Problem Management Approaches and Opportunity Development to Help*.
[20] Sijbrandij et al., "Effect of Psychological First Aid Training on Knowledge and Understanding of Psychosocial Support Principles: A Cluster Randomized Controlled Trial."
[21] Creswell and Plano Clark, *Designing and Conducting Mixed Methods Research*.
[22] Hussain, Weisæth, and Heirs, "Psychiatric Disorders and Functional Disorders among Disaster Victims after Exposure to Natural Disasters: A Population-Based Study."
[23] Rogers, "The Necessary and Adequate Conditions of Therapeutic Personality Change."
[24] Burleson, "The Experience and Effects of Emotional Support: What Studies on Cultural and Gender Differences Can Tell Us About Close Relationships, Emotions, and Interpersonal Communication."
[25] Stuart and Laraia, *Principles and Practices of Psychiatric Nursing*.

counseling practices[26]. Regarding Theme 2, these findings expand on the Indonesian evidence of Uyun and [27] Witruk and Rahiem et al. [28] that sabr and prayer alleviate psychopathological symptoms, and support Koenig [29] and Haque's call [30] for a distinctively Islamic approach to psychological support – suggests that, in this community, religious content is not a peripheral cultural addition but a primary therapeutic mechanism. These findings also resonate with specific post-disaster trajectories documented in Aceh over the past two decades. Marthoenis et al. [31], reviewing mental health conditions in Aceh a decade after the 2004 tsunami, noted that religious coping consistently outperformed formal clinical referrals as society's default recovery pathway, largely because it was immediately accessible, socially approved, and did not carry the stigma associated with seeking psychiatric help. Stuart et al. [32]reports a parallel pattern among survivors of PTSD of natural disasters in different regions of Indonesia, where psychosocial and spiritual conditions improve simultaneously rather than independently, suggesting that the two domains are not only correlated but functionally intertwined in these cultural settings. The current findings extend this evidence from the 2004 tsunami and subsequent disasters to the 2025 Aceh Tamiang flash flood[33], which suggests that this is not a one-time cultural artifact but a lasting feature of how Acehnese people process disaster-related distress across different types of disasters and two decades apart.

Regarding Theme 3, this directly illustrates Burleson's finding [34] that position-centered support can worsen outcomes, and that providing Sphere/IASC standards does not jeopardize [35] concrete behavioral content: avoid minimizing comparisons, listen before advising, and maintain attentive attendance even in brief meetings. Regarding

[26] Rodiah, Arifin, and Tajiri, "Therapeutic Communication Techniques in Islamic Counseling Guidance Services for Handling Drug Abuse"; Widyaningrum and Fatonah, "Integration of Islamic Values and Therapeutic Communication Techniques in Group Counseling: A Case Study of MTs. Nurul Iman, Bandung City."

[27] Uyun and Witruk, "The Effectiveness of Sabr (Patience) and Salat (Prayer) in Reducing Psychopathological Symptoms After the 2010 Merapi Eruption in Yogyakarta, Indonesia."

[28] Rahiem, Krauss, and Rahim, "Children of Aceh Tsunami Victims: Stories of Resilience, Overcoming and Moving Forward with Life."

[29] Koenig, "Religion, Spirituality, and Health: Research and Clinical Implications."

[30] Haque, "Psychology from an Islamic Perspective: The Contributions of Early Muslim Scholars and Challenges for Contemporary Muslim Psychologists."

[31] Marthoenis et al., "Mental Health in Aceh – Indonesia: A Decade after the Devastating Tsunami of 2004."

[32] Suwarningsih Suwarningsih, Imas Muhafilah, and Tatan M Herawati, "Changes in Psychosocial and Spiritual Conditions in PTSD (Post Traumatic Stress Disorder) Victims After Flash Floods in Garut City, West Java," *Health Scientific Journal* 11, no. 1 (2019): 1–11, https://doi.org/10.37012/jik.v11i1.62.

[33] Tamiang, "Official Report of Flash Flood Disaster Events November 2025."

[34] Burleson, "The Experience and Effects of Emotional Support: What Studies on Cultural and Gender Differences Can Tell Us About Close Relationships, Emotions, and Interpersonal Communication."

[35] Football Association, *The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response*, 4th edition (Geneva, Switzerland: Practical Action Publishing, 2018).

Theme 4, this pattern is consistent with social capital theory [36] and reinforces communication-social-function associations (r = 0.188), suggesting programs should invest in enabling the formation of peer networks in addition to individual facilitation[37]. Regarding Theme 5, it offers a culturally specific extension of Snyder et al's theory of expectation. [38] and the element of "hope" in [39] the disaster intervention framework of Hobfoll et al. adding a third component beyond agency and pathway thinking: belief in benevolent divine agents and explaining why communication is most strongly related to the future orientation (r = 0.233) of all dimensions of recovery.

Further implications concern how facilitator training itself should be designed. [40] The relationship framework helps Carkhuff show that empathic communication is a sequential skill that can be trained attending, responding, and personalizing rather than an innate disposition, implying that brief, structured training modules can meaningfully improve facilitator performance even among lay volunteers without a prior counseling background. Saleebey's strengths perspective [41] further suggests that training should explicitly direct facilitators to obtain and affirm existing coping resources from survivors religious practices, family ties, job skills rather than treating survivors solely as recipients of standard intervention protocols.

Read together with these findings, it points in the direction of a specific training curriculum: facilitators should be taught not only the orientation-work-termination structure of therapeutic communication, but also how to recognize and validate the spiritual resources and Islamic social capital that survivors have tapped into, positioning formal communication training as a complement to, rather than a substitute, for these culturally embedded resources. The implications of this training also suggest a concrete direction for future research: longitudinal, adequately empowered trials, comparing facilitators trained under a strength-integrated curriculum with those trained under religiously neutral conventional communication protocols would allow the specific contributions of Islamic spiritual and social capital elements to be isolated from the effects

[36] Aldrich, *Building Resilience: Social Capital in Post-Disaster Recovery*; Kaniasty and Norris, "Testing a Model of Decline in Social Support in the Context of Natural Disasters"; Partelow, "Social Capital and Community Disaster Resilience: Post-Earthquake Tourism Recovery on Gili Trawangan, Indonesia"; Tentama, "Social Support and Post-Traumatic Stress Disorder in Adolescent Survivors of Mount Merapi."

[37] Van Ommeren, Saxena, and Saraceno, "Mental and Social Health during and after Acute Emergencies: An Emerging Consensus?"

[38] Snyder et al., "Wills and Means: Development and Validation of Individual Differences Expectation Measures."

[39] Hobfoll et al., "Five Essential Elements of Direct and Medium-Term Mass Trauma Interventions: Empirical Evidence."

[40] Carkhuff, *Helping and Human Relations: A Primer for Public Assistants and Professionals*.

[41] Saleebey, "Perspectives on Strength in Social Work Practice: Extensions and Warnings."

of common communication skills a test that could not be administered by the cross-sectional design today, but in which direction its findings are directly leading.

D. Conclusion

This study presents a mixed method-based empirical explanation of the role of therapeutic communication in the psychological recovery of Muslim disaster survivors in Indonesia. His main contribution is theoretical, showing that a religion-neutral communication model has not sufficiently explained the recovery process in the context of Muslim society. This research offers a bio-psycho-social-spiritual framework that places Islamic spiritual communication and community social capital as the primary healing mechanisms, while formal therapeutic communication serves as a relational foundation that supports the process. The findings of the study explain that the influence of communication on recovery is real, but it is more visible in strengthening expectations, social relationships, and adaptability than simply reducing emotional symptoms. Through qualitative data, this study identified important competencies for facilitators, such as active listening, the application of Islamic communication ethics, strengthening peer support networks, and preventing responses that underestimate the victim's experience. The resulting framework has practical relevance for the development of post-disaster psychosocial programs, as well as being applicable to community mental health services and da'wah-based counseling that integrates therapeutic approaches and religious values. Nonetheless, this study has limitations on a quantitative sample that is limited to a single location. Therefore, further research needs to test this model longitudinally with larger samples as well as develop validated Islamic spiritual coping instruments. More broadly, this study confirms that religious communication should not be seen only as a controlled cultural factor, but rather as an important mechanism that needs to be modeled directly in the development of psychosocial services that are evidence-based and aligned with the cultural context of Muslim society.

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