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The Co-Design of a Chat Telepsychotherapy Manual for
Indonesians with Minor Depression

A thesis presented in fulfilment of the requirements for the
degree of

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Abstract

The primary aim of this study was to address a gap found in the discipline of Psychology and mental health treatment in the Indonesian setting. Advances in technology and the changing lifestyle of Indonesians made distance mental health treatment a common practice. This study focuses on one of the few options for distance mental health treatment, Chat Telepsychotherapy, which has gained popularity among Indonesians, especially the Millennials and Gen Z in Indonesia. The main issue with the phenomenon was the unavailability of comprehensive, evidence-based guidelines on how to best execute such a therapy. Thus, this study aimed to create a manual that could help the community of Indonesian Clinical Psychologists to deliver Chat Telepsychotherapy to Indonesians. The study limits the scope to Indonesian Millennials and Gen Z who suffer from Minor Depression. This is because these generations are the primary users of such a service, and depression itself is found to be one of the most common mental health issues in Indonesia.

To achieve the goal of this study, I used a qualitative method that used Collaborative Design with the help of online-focused group discussion. I collaborated with Indonesian clinical psychologists, Indonesian millennials, and Gen Z with minor depression to design the manual. Thematic analysis was used to analyse the participants' answers.

The result of the study is a comprehensive manual that consists of nine chapters: 1) Introduction; 2) The Concept of Chat Telepsychotherapy; 3) Starting CT Practice; 4) General Guidelines for Conducting CT; 5) Specific Guidelines for Conducting CT; 6) Characteristics of Indonesian Millennials and Gen Z; 7) Minor Depressive Disorder; 8) Self-Harm; 9) CT Stages for Indonesian Millennials and Gen Z with Minor Depression. The main suggestion for future studies is to test the manual to assess its usability and effectiveness.

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I see that life, in general, is challenging; it is also unfair from time to time. Regardless, it gives me the opportunity to create and achieve my dreams. It allows me to find something meaningful and be meaningful. Through that, I learned that despite the downsides, life is beautiful and worth fighting for. The ups and downs of life are something that I cherish.

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Chapter 1 – Rationale of the Study

Advances in information technology (IT) are inevitable at this moment in time. The wave of new technologies is changing how people behave as they are now fully integrated into our everyday lives (Swingle, 2016; Wang et al., 2016). In the field of psychology, it is now possible to work therapeutically in the digital world (Weitz, 2018). There are several approaches to conducting digitally based therapeutic relationships. However, this study focuses on one specific approach: chat telepsychotherapy (CT).

During the 1920s, letter writing was an expected indirect communication medium between psychotherapists and clients before telephone counselling gained enormous popularity in the 1950s (Benjamin Jr & Dixon, 1996; Mohr et al., 2008). Email therapy has been used as a more modern type of letter writing with the help of an internet connection (Pier et al., 2008; Robinson & Serfaty, 2008). Various technology-based therapies have developed in response to dramatic rises in Internet usage.

Chat telepsychotherapy, often done via chatting applications, is one of these therapies that has started gaining attention as the younger generations, particularly millennials and Generation Z (Gen Z), are used to communicating through text. CT allows the client to directly contact the clinical psychologist (CP) and exchange chat messages in real time with the CP. CT has gained popularity in Indonesia for possibly several reasons. Firstly, chatting has become a common way of communicating in Indonesia. Over 78% of the population of 275 million Indonesians are recorded as active internet users who primarily use the internet to connect with others using social media and chatting applications (*Asosiasi Penyelenggara Jasa Internet Indonesia* [APJII, Indonesian Internet Provider Association], 2023). Secondly, chatting has been found to provide emotional relief for its users, even without being in a therapeutic setting (Dolev-Cohen & Barak, 2013; Steinkuehler & Williams, 2006). Thirdly, in a country with thousands of islands, 2,725 or 71.82 % of the 3,794 registered CPs in Indonesia are located on Java Island (*Ikatan Psikolog Klinis Indonesia* [IPK Indonesia, Clinical Psychologist's Association of Indonesia] (2023). Finally, although 16 million people in Indonesia experience depression as one of the most common mental health issues (*Kementerian Kesehatan Republik Indonesia* [Kemenkes R.I., The Ministry of Health of the Republic of Indonesia], 2018), the stigma surrounding mental health issues is still strong (Asti et al., 2016). This makes Indonesians reluctant to seek direct face-to-face therapy.

To date, even though there are Indonesian studies that focus on online therapy, no

Indonesian studies have focused on providing comprehensive guidance that could help Indonesian CPs conducting CT in general, let alone to treat specific mental health issues. This has been a significant gap since CT is what Indonesians appear to be seeking at the moment. Thus, this study focuses on creating a manual for CT to treat Indonesians with minor depression.

Chapter 2 - Literature Review

This chapter explores the current evidence related to the study. The discussion is divided into six main sections: 1) chat telepsychotherapy; 2) Indonesia; 3) Indonesian millennials and Gen Z; 4) CT in the Indonesian setting; 5) minor depression; 6) treating depression; and 7) evidence based manual. The chapter ends with a summary and research questions.

Chat Telepsychotherapy

This study might be the first to use the term "chat telepsychotherapy". Online databases of scholarly literature, including Google Scholar, EBSCO, and others, have used terms including "online counselling," "online therapy," "chat psychotherapy," "chat counselling," "e-counselling," "text-based therapy" and "text-based counselling" to describe a concept of a therapeutic relationship in which the practitioner provides an intervention to ease the mental illness via chat messages. The literature review is based on the literature retrieved using these terms.

What is CT?

Ideally, an explanation of a concept includes a definition. However, since the first use of the term chat telepsychotherapy might be in this study. A specific definition of CT has not been found in the literature; instead, it has been developed in discussion with the participants of this study (p. 98). This section provides an etymological approach to explain the concept of CT as a construct of three smaller concepts: "chat," "tele," and "psychotherapy."

Chat. Originally used to refer to small talk (Merriam-Webster, n.d.a), the term "chat" was adopted by the communication technology field to describe "a real-time, text-based online communications using the internet" (Derrig-Palumbo, 2016. p. 16).

Tele. The Greek word *têle* means distance, at a distance or operating over distance (etymonline, n.d.a; etymologeeek, n.d.; Wiktionary, n.d.)

Psychotherapy. The terms "psycho" and "therapy" originate from the Latin words *psukhê* and *therapeia*, with *psukhê* meaning breath, life, or soul, while *therapeia* means curing or healing (dictionary, n.d.; etymonline, n.d.b).

Therefore, from the etymological perspective, CT refers to a type of healing or curing intervention in a person's life that takes place over the internet using real-time, text-based communication.

Chatting Communication

As suggested in the previous discussion, the term chatting refers to “real-time, text-based online communications using the internet” (Derrig-Palumbo, 2016. p. 16). Although it is essentially a text-based communication method, chatting differs from traditional text messaging service that is often done via cellular phone. Traditional text messaging via cellphone is usually called Short Message Service (SMS) and is delivered between cellular phones via mobile service network (Church & de Oliveira, 2013). Chatting is considered mobile instant messaging (MIM), which is delivered via cellular phones using an internet data plan (Church & de Oliveira, 2013). Chatting is usually done via a third-party application that can be downloaded via the operating system store. Both services can send not only text but also photos or voices. However, the SMS service (or MMS when sending media) will charge extra fees to the user for every media sent, while sending multimedia in chatting consumes more internet data but has no additional cost.

In the Indonesian setting, APJII (2023) mentioned that most Indonesians (98.63%) use WhatsApp for chatting. Four other chatting applications were mentioned: Facebook Messenger (46%), Telegram (12.91%), Instagram Direct Messenger (10.72%) and Line (2/07%). In contrast, traditional SMS was only used by 0.13% of Indonesians. Furthermore, Indonesian online medical and psychological company such as Riliv, Halodoc and Alodokter have their own application to conduct chat sessions (Alodokter, n.d.a; Halodoc, n.d.b; Riliv, n.d.a)

Chatting as a Source of Emotional Support and Relief

It has been found that 90% of young adults tend to communicate with each other through text messages while preferring in-person communication with close relatives (Lenhart, 2015; Madell & Muncer, 2007). This means chatting is how the young adults communicate with each other. However, the type of communication also seems to provide emotional support and relief, just like in-person communication. A study by Dolev-Cohen & Barak (2013) examined the pre-and-post effect of instant messaging (IM) on the emotional state of distressed adolescents. The participants' distress level was measured using a positive affect-negative affect scale. The study found that IM messaging significantly decreased the level of distress experienced by the participants. It was argued that IM provides private, synchronous, interpersonal communication that facilitates disclosure and intimacy.

A study by Steinkuehler and Williams (2006) found that chatting with peers does not

need to be the primary goal of the activity. It was found that chatting could occur during the online gaming course of play. Players often communicate with other players using multiple chatting channels, such as public, private, and various groups embedded in the game. The researcher then argued that this activity was one reason why gaming online became the third place of informal sociability. Online gaming seemed to provide spaces for social interaction and relationships beyond the workplace and at home.

The same findings are found in Indonesian literature, where young adults make friends through online gaming (Firdaus & Aesthetika, 2023). The study revolves around the communication style that online game players use towards each other. The study found that there was effective communication between the players. They used chat, symbols, and voice notes to communicate with each other. Later, the researcher emphasised how players managed to build solid connections and positive interactions in virtual environments.

Psychotherapy Distinction.

This research focuses on the use of chat in delivering psychotherapy rather than other psychological interventions such as guidance, coaching, consultation, or counselling. This section is dedicated to differentiating these five types of intervention and providing a rationale for why psychotherapy is chosen as the focus of the research.

Guidance. Solehuudin et al. (2022) define guidance as “providing assistance, information, or assistance to people with difficulty” (p. 3). Guidance in psychology is often tied to a vocational or academic setting (Jan & Mattoo, 2018). It involves showing the way, regulating, giving advice, and even giving instruction (Winkel & Hastuti, 2004). In guidance, individuals receive continuous support from someone who has a better understanding of the subject and is there to help them improve their abilities in the subject and develop confidence, independence, and self-esteem (Miller, 1961; Surya, 1988).

Coaching. Knowles (2021) defines coaching as “partnering with clients in a thought-provoking and creative process that inspires them to maximise their personal and professional potential” (p. 46). The basic idea of coaching is to facilitate someone to learn (Whitmore, 2002). Coaches do not necessarily need to be knowledgeable in the subject as their speciality is the process of learning (Hall & Duval, 2004). Coaches ask questions aimed at prompting clients towards self-directed learning and growth (Grant, 2001). Finally, people who seek coaching are often wanting to improve their performance in something they are already doing well (Page, 2005; Williams, 2004).

Consultation. Punwar and Peloquin (2000) define consultation as “giving advice, assistance or an opinion based on professional knowledge, skill or judgement” (p. 190). A consultant is a knowledgeable person with experience in a particular field who gives professional advice or opinions to people seeking specialist expertise (Falender & Shafranske, 2020). Through consultation, problems can be solved and conflicts resolved to prevent similar issues in the future and make further consultation unnecessary (Sweeney, 2019). In psychology, a consultation might revolve around a third person (Caplan, 1970), for example, a junior psychologist who is having difficulty with a client could consult with a senior psychologist about the case.

Counselling. Kaplan, Tarvydas, & Gladding (2014) define counselling as a “professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals” (p. 368). Counselling deals with the client's private logic, emotions, and behaviour (Sweeney, 2019). It refers to a therapeutic process that aims to empower clients so that they can meet and cope with regular developmental challenges (Nystul, 2015). Counselling focuses on short-term goals and preventive action for potential issues that might occur in the future (Nystul, 2015).

Psychotherapy. American Psychological Association (2023) defines psychotherapy as “any psychological service provided by a trained professional that primarily uses forms of communication and interaction to assess, diagnose, and treat dysfunctional emotional reactions, ways of thinking, and behavior patterns” (APA Dictionary). Compared to counselling, psychotherapy is remediative rather than preventive and people who receive psychotherapy have more complex issues that may be classified as mental disorders (Nystul, 2015). Sommers-Flanagan and Sommers-Flanagan (2018) have mentioned that although counselling and psychotherapy work in similar ways, psychotherapy tends to be less directive than counselling, to go a little deeper, and the work lasts longer. Jone-Smith (2019) has suggested that psychotherapy is a more reconstructive process for people with serious issues in coping.

Based on the discussion above, psychotherapy differs from guidance as the former did not stop providing information alone like the latter but instead tried to understand the issues that may cause the malfunctioning behaviour (Dreese, 1957; Tarrier & Shapell, 1973). Psychotherapy differs from coaching, which focuses heavily on the positive aspect of personal growth and not the disturbance aspect that hinders growth (Spinell, 2008).

Psychotherapy also focuses on the strength of the client, but it also has a retrospective aspect; therapists are equipped with the ability to do assessments and diagnoses. (Hart, Balttner, & Leipsic, 2001, Jordan & Livingstone, 2013). In comparison to consultation, the consultant is seen as an expert on a topic who shows the client on how to get things done; it focuses less on the client's feelings and personal background than psychotherapy does (Meyers, 1982). McGehearty (1969) suggested that the consultant might have a big impact in influencing the decision-making and even the behaviour of the client in dealing with the issue, while counselling aims to help the client to understand themselves and make their own decision. Finally, being the most similar to psychotherapy, counselling focuses more on normal clients who are under stress or having adjustment issues, while psychotherapy has the ability to treat a more severe or higher pathological degree of mental issues (Crago, 2000).

In reality, these interventions are closely tied to each other. As a starter, the term "guidance and counselling" is often found in the academic setting (Nasution & Abdillah, 2019; Sukatin et al., 2022; Syarqawi, 2018). The purpose of a guidance counsellor in the educational setting is primarily to prepare the students for the future by equipping them with knowledge about themselves and the environment they are in, as well as helping them with possible adjustment issues and vocational inquiries (Sukatin et al., 2022). A clinical psychologist could also become a consultant (Sheridan, 1995). Furthermore, having psychotherapy experience could help psychology practitioners become professional consultants as they will have the ability to identify transference and countertransference that might occur in the consultation process (Berlin, 1966). The philosophy of "Positive Psychotherapy" holds a similar method to coaching, which focuses on clients' strengths, resources and successes (Biwas-Diener, 2009). Finally, Zhang et al. (2022) mentioned that supportive counselling skills like empathy and active listening are crucial in Psychotherapy.

The discussion above shows that regardless of the differences between the interventions, some of the interventions' techniques are shared with one another. The choice of giving one of the mentioned interventions appears to depend on the setting, the goal of the intervention and the type of the issues. However, one thing that stood out about Psychotherapy is its ability to treat clients with higher mental pathological problems (Crago, 2000); while guidance, coaching, consultancy and counselling would focus more on the normal functioning people or normal people under stress (Crago, 2000; Meyers, 1982,

Spinelli, 2008).

This then becomes the main reason why this research chose Psychotherapy. Firstly, the focus of the treatment in this research was minor depression. A mental issue that is classified as a disorder in the Diagnostic and Statistical Manual of Mental Disorders and the International Classification of Diseases. Despite the term, minor depression is not a minor disease, as the sufferers may experience a poorer quality of life (Naber & Bullinger, 2022). Moreover, minor depression is a vital risk factor for major depression (Kessler et al., 1997; Fogel, Eaton, & Ford, 2006). A serious response with adequate and long-term treatment is needed (Kessler et al., 1997 & Naber & Bullinger, 2022). Secondly, the treatment for depression should include proper assessment and diagnosis along with a rather intensive and comprehensive intervention (Cuijpers et al., 2013; Gautam et al. 2017; Target & Fonagy, 1994). All of these findings suggest that psychotherapy would be more suitable to treat minor depression compared to other types of mental health interventions previously mentioned.

Brief History of Text-Based Distance Therapeutic Relationships.

As previously mentioned, letters and telephones were first used as a medium to deliver therapeutic relationships over distance in the 1920s-1950s (Benjamin Jr & Dixon, 1996; Mohr et al., 2008). However, the first "synchronous-like" text-based therapeutic relationships developed in the 1960s using computer programs. Green (2006) covers the history of text-based online therapeutic relationships, as shown in the following table.

Table 1

History Key Events of Distance Therapeutic Relationships Based on Green (2006).

Year	Key Events
1966	Computer scientists from Stanford University and Massachusetts Institute of Technology developed two computer programs that could conduct psychotherapy dialogue The MIT program, named Eliza, could play a role as a Rogerian psychotherapist. People using the programs would type their message and the program would respond, creating the first experience of a synchronous text-based therapeutic relationship.
1960s-1980s	The first wave of internet-assisted online support groups used a system called "usenet"—an early version of the Internet, which used newsgroups, or online mailing lists with threads that could be continuously updated. One newsgroup created as a support group was "alt.support.depression."
1979	A more personalised form of distance therapy using usenet was established. Psychotherapists at Cornell University offered free advice to students via their personal computers. This type of free advice-giving therapeutic relationship increased in the 1980s.

Year	Key Events
1988	Internet relay chat was released to the public allowing two or more people to correspond with each other in real-time via text messaging (or chat as it was known then).
1990s	In 1995, a graduate student in psychology launched his own website, Psychcentral, which focused on giving mental health support by providing free weekly chats. Besides this, the 1990s was filled with the development of other forms of online distance therapeutic relationships. These included emails, online self-help groups and self-help programmes. In 1994, online therapy became professional when Dr. David Sommers started charging clients for responses to their queries through emails, chat, and video conferencing. The interactions were brief and his service did not continue for long. In August 1995, Ed Needham became the first therapist to conduct chat room therapeutic relationships.

Strengths and Weaknesses of Chat Telepsychotherapy

This section lists a number of strengths and weaknesses for CT including accessibility; verbal and non-verbal cues; anonymity and invisibility; writing; suitability; ethical and legal matters; and strengths and weaknesses.

Accessibility. A major strength of CT that has been consistently mentioned is the ability for clients to easily access treatment (Bolton, 2017; Fang et al., 2018; Garde et al., 2017; Paterson et al., 2019). This benefits people from rural or isolated communities (Lee et al., 2017). CT removes the need to travel and cuts down the wait times that clients often experience with face-to-face therapy (Schwartzman & Boswell, 2020). Clients may also prefer a particular type of CP in terms of language, religion, gender, etc. (Green, 2006). Clients who are afraid of stigmatisation may also prefer CT as they do not need to physically come to the CPs' office (Bathje et al., 2014; Boccanfuso et al., 2021). Finally, accessibility can also mean flexibility. Time-zone differences between CPs and clients could also be a benefit. Clients could come home from work in the evening and chat with CPs in their afternoon (Gassova, 2016). On the CPs' side, it has been reported that accessibility in terms of time flexibility leads to practitioners getting far fewer cancellations and no-shows (Wiederhold, 2020). CT also allows CPs to maintain the therapeutic relationship if clients relocate (Kocsis & Yellowlees, 2018). One limitation of CT regarding accessibility is the exclusion of people with limited access to the relevant technologies (Blanchard et al., 2013).

Verbal and Nonverbal Cues. Since the therapy is conducted via chat messages, CT lacks verbal and nonverbal cues such as voice tone, expressions, and gestures (Bastemur & Bastemur, 2015; Huang et al., 2020). This situation can lead to misunderstandings and misjudgements by the CPs (Huang et al., 2020). The lack of verbal and nonverbal cues can

also affect the establishment of a therapeutic alliance. Geller (2021) mentioned that CT reduced the capability of the CPs to use verbal and non-verbal cues such as voice tone and physical mirroring to help clients build a sense of safety and trust. However, some researchers have challenged these ideas. Hanley (2012) mentioned that creating a working alliance in CT is possible for practitioners with the right skill set for online communication. Dowling (2015) mentioned that the difficulty of establishing therapeutic alliances in CT is primarily due to clients being unwilling to self-disclose. Suller (2011) has suggested that in the realm of CT, CPs might use virtual body language by paying attention to attributes of the clients' messages such as the length and organisation of the messages, the content, and the use of visual representations such as emojis.

Anonymity and Invisibility. Invisibility refers to a concept where neither the CPs nor the clients can see or hear each other (Suler, 2011), while anonymity refers to the concept where the identity of a person is unknown (lane, 2011). Invisibility can have a positive effect on the therapy. Clients may feel uncomfortable opening up if the CPs reacts physically in ways that indicate disapproval or boredom. (Suller, 2011). Another advantage of invisibility that favours the clients but might become a disadvantage for the CPs is a greater sense of control of the amount of information they want to share and the ability to end the session easily if they do not trust the CPs (Fletcher-Tomenius & Vossler, 2009).

Similarly, anonymity can also have a positive impact in the CT setting as clients may have the courage to act differently than normal, without worrying about being identified. This then affects the way the CT progresses as the risk of shame is reduced, meaning clients might feel more comfortable sharing sensitive information earlier than they might in face-to-face therapy (Suller, 2011).

Invisibility has disadvantages as there are no opportunities for the CP to observe the clients' gestures and eye movements directly, as in face-to-face therapy. This restriction determines elements of therapy such as how the CP formulates questions and how they react to clients' stories (Adeola, 2012).

Regarding the disadvantages of anonymity, both CPs and the clients can be sure whether they are talking to the person they claim to be (Goss, 2016). Client can never really be sure that the CP is indeed a licensed CP rather than somebody who is posing as one. This can also happen in reverse, where CP can never really be sure who is behind the chat messages.

Writing. Chat is a short informal way of writing. Writing can be defined as the activity of using signs or symbols to convey a framework created in one's thoughts (Lunsford, 2006; Takayoshi, 2015). Smith (2003) proposed the term synchronous computer-mediated communication (CMC) for chat, which refers to a real-time interaction between people sending written messages between each other.

In the CT setting, writing chat messages has been found to be beneficial in itself. Fang et al, (2018) and Leigh (2022) has found that writing down feelings is cathartic, allowing the release of internalised distress through acts of externalisation and exertion. Furthermore, unlike formal writing, which needs to follow grammatical rules and be mindful of specific patterns, there are no specific rules in chat. Chat communication is unique in that it follows neither written nor oral language conventions, but uses a mixture of both, with oral communication conventions becoming its central characteristic (Jibson, 2014). Thus, the burden of writing a correctly composed written message is reduced. Clients can simply write what they feel (Stephen et al., 2014). Another advantage of writing in the CT setting is the ability to control the content of the message by reviewing the content of the message before sending it (Baker & Ray, 2011).

Writing also has its limitations. Clients and CPs often need more time to compose the messages, which means the other party needs to wait. This delay in communication could slow the therapeutic progress in every session (Bambling et al., 2008), resulting in the need to have several CT sessions to achieve the same level as one face-to-face therapy session. In relation to that, considering that CT is often cheaper than face-to-face therapy, CT could lead to financial loss for the CPs as several one-hour sessions of CT could be worth the same as one-hour session of face-to-face therapy (Hollingshurst et al., 2010).

Suitability. As an emerging and novel type of psychotherapy, CT might not be suitable for every type of mental illness. Finn and Barak (2010) conducted a descriptive study of online counselling and therapy services. Of the counsellors and therapist surveyed, 93% stated that online counselling and therapy was only suitable for interpersonal and social issues. Fewer than 50% of participants agreed that online counselling and therapy are suitable for more severe cases such as substance abuse, child and domestic abuse, and rape or sexual assault. A high number of participants also thought that online or chat therapy is not suitable for suicidal clients.

Concerning this, while suicidal clients are often involved in crisis, text-based online

crisis is an existing and increasingly popular practice that aims to help the younger population who are in crisis (Cox et al., 2021). Practitioners who handle crises need to be equipped with crisis intervention skillsets (Wang & Gupta, 2023). Practitioners who have not been trained for the crisis would need to have the knowledge and relation with other professionals and services that can do so (Green, 2006). This shows that, under some circumstances, text-based online therapeutic relationships can handle crises. Some studies even have found CT to be effective in serious mental illnesses such as depression and alcohol-related issues (Blankers et al., 2011; Kessler et al., 2009; Kramer et al., 2014).

Age and technological literacy also affect suitability. CT might be more suitable for younger rather than older people. It has been found that 90% of young adults tend to communicate with each other through text messages while preferring in-person communication with close relatives (Lenhart, 2015; Madell & Muncer, 2007). They are also familiar with using written messages in chat rooms, blogs and on social media (Goss, 2016). Madell and Muncer (2007) found that younger people prefer text-based communication for the higher level of control over the content and timing of messages.

Older adults tend to prefer in-person communication over text messages along with voice calls (Yuan et al., 2015) due to the lack of access to technology and familiarity (Hunsaker & Hargittai, 2018). However, this could still depend on other social factors such as the location and availability of social ties, and access to technology and education (Hunsaker & Hargittai, 2018; Yuan et al., 2015). A better distinction is that CT might not be suitable for people with low digital literacy (Green, 2006).

CT may not also be suitable for people with literacy issues or deficits. A study by Brèthes (2022) and Simoës-Perlant et al. (2012) found that people with Dyslexia prefer to not communicate via text messages as they struggle to read and spell words. Thus, they will need more time and effort compared to those without such a disorder. Finally, as the basic requirement of CT is to have an internet signal, those who live in areas that do not receive cellular signal would not be able to have CT. Fikyansah (2023) suggested that 2,881 villages in Indonesia do not have internet access.

Ethical and Legal Matters. Kraus, Stricker, and Speyer (2011) mentioned that the ethical matters revolving around CT are rooted in apprehension around whether online therapies are as effective as face-to-face sessions. As previously discussed, the lack of verbal and nonverbal cues limits CPs' understanding of clients. The other major ethical issues

associated with online therapies are privacy and confidentiality. Unlike face-to-face therapies, CT requires the use of chat applications that are vulnerable to technical failures (i.e., related to technology and engineering), which may result in privacy breaches (Palomares & Miller, 2018). Confidentiality can be compromised even in a straightforward situation such as someone sitting next to a client and seeing the chat messages (Ranney et al., 2018).

However, Saks (2016) posited that confidentiality in a psychological setting has never been absolute and not many people are too concerned by this. CPs can breach confidentiality in a number of circumstances (Duncan et al., 2013). In a CT setting, clients must be aware of all such possibilities before proceeding to continue with therapy (Nelson & Bui, 2010). In terms of legality, it may be unclear which jurisdiction is responsible for professional licensing and professional guidelines (Mattison, 2012). CPs who conduct CT need to be familiar with the law in their clients' locations (Maheu et al., 2018).

Other Strengths and Weaknesses of CT. From a technical perspective, chat is everywhere. Almost every social media application on smartphones comes embedded with a chat feature. Thus, every person who has a smartphone can use these apps to communicate. (Lenhart, 2015). Chat is considered quick and easy to use, requiring no particular skill (Grinter, 2001). This means that people who want to undertake CT can quickly access it. CT is often more affordable than face-to-face or telepsychotherapy using voice or video calls (de Bitencourt Machado, 2016; Teh et al., 2016). However, CT mandates the use of computers or smartphones, software applications, and internet connections. These are sometimes unreliable and technical errors or loss of signal may hinder communication in CT (Wootton et al., 2020).

Finally, another strength of CT that is worth mentioning is that CT often acts as a gateway for clients who may feel hesitant or want to know more about psychotherapy before deciding to undertake further treatment (Williams et al., 2014). In the Indonesian setting, CPs who join telepsychology companies also list their physical practices. This means that the clients can continue their treatment with in-person meetings if that is possible and preferable.

The Effectiveness of CT

Several researchers have studied the effectiveness of chat or text-based therapeutic relationships. Kramer et al. (2014) conducted a study to determine the effectiveness of chat-based solution-focused brief treatment (SFBT) for 263 depressed adolescents and young

adults aged 12 to 22 using a randomised controlled trial (RCT). Participants were randomly assigned to either the chat treatment or a waiting list. The chat treatment consisted of five chat sessions focused on problem resolution, future goals, strengths, and resiliencies. The results showed that the experimental group ($n = 131$) experienced improvement compared to the waiting list group, with a small between-group effect size at nine weeks ($d = 0.18$, 95%) and a large effect size at 4.5 months ($d = 0.79$, 95%). At 7.5 months, the SFBT group showed even more significant improvement. This study indicates that SFBT chat therapy can be clinically effective and is associated with prolonged positive changes in mental state.

Blankers et al. (2011) conducted a RCT study investigating the effectiveness of chat therapy compared to online self-help programs with no therapist contact and no other intervention for people with alcohol problems. The chat therapy and the online self-help were based on cognitive behavioural therapy (CBT) and motivational interviewing. The 205 participants, with an average age of 42, were drinking an average of 450 gm of alcohol every day and were thus considered as having significant alcohol problems. The study showed that chat therapy was more effective than online self-help without therapist contact. A six-month follow-up showed that the chat therapy group had further decreased their alcohol consumption while the online self-help group remained at similar levels. This indicates that the chat therapy was superior in its immediate and extended effects over the online self-help and no-treatment conditions.

Kessler et al. (2009) conducted a randomised control trial to investigate the effectiveness of chat therapy in addition to face-to-face treatment compared to usual treatment alone for clients with depression. The 297 participants scored more than 14 on the Beck Depression Inventory (BDI-II) and had received a confirmed diagnosis of depression before being randomly assigned to either chat therapy in addition to usual treatment ($n = 149$) or the usual treatment alone while on an 8-month waiting list for chat therapy ($n = 148$). The chat therapy was based on CBT and given in 5 to 10 sessions with a duration of 55 minutes each over 16 weeks. The results showed that 38% of participants from the chat therapy groups decreased their BDI score (< 10) and were considered recovered. In comparison, only 23% of the control group participants reached the same level. This benefit was retained at follow up after eight months. This study showed that chat therapy was indeed effective and had a prolonged effect on mental health.

Chat therapy is also suitable to be paired with other treatments. Stubbings, Rees and

Roberts (2015) conducted a single case qualitative study to explore the engagement with therapy for obsessive-compulsive disorder (OCD) that combined video conferencing and chat therapy. The participant was a 22-year-old male diagnosed with severe OCD which then received 40 sessions of CBT-based therapy using a mix of video conferencing and chat. The result showed evidence of positive progress. The participant managed to reduce some of his compulsions and avoidance. Furthermore, by the 39th session, the participant was showing a new self-schema. It was found that the chat therapy had reduced his anxiety and encouraged self-disclosure.

Goldin et al. (2019) conducted a longitudinal observational study investigating the feasibility of a cellphone-delivered online intervention for depression. A group of 117 adults with depressive symptoms was treated in a programme of daily CBT, meditation, anonymous group chat with others, and direct chat with a licensed therapist was provided via cellphone. Symptoms were measured weekly using BDI and Patient Health Questionnaire 9 (PHQ-9), and by the fourth week, drops of 27% using BDI and 19% using PHQ-9 were observed. This study confirmed an association between reduced depression symptoms and the programme.

Indonesia

As this research is focused on Indonesians, it is essential to understand the characteristics of Indonesia both as a country and as a population. This section discusses an overview of the country and the latest findings on the characteristics of its population.

Overview of The Country

Indonesia is the biggest archipelago in the world. The country is spread over 5,270 km between the Asian mainland and Australia (Hannigan, 2015) and is currently the fourth most populous country in the world. Indonesia comprises more than 13,466 islands and is home to more than 260 million people of more than 1,340 ethnicities (Indonesia.go.id., n.d.a), speaking 719 different languages (Pisani, 2014).

Indonesia uses a unitary state governmental system, which means the central government is supreme, led by a president as the head of state assisted by a vice president and 34 ministers. The People's Consultative Assembly inaugurates the president and vice president, and the House of Representatives oversees state duties. Currently, Indonesia has 34 provinces, each led by a governor, and a second level of administrative subdivision consisting of 415 regencies led by regents and 93 cities led by mayors (Indonesia.go.id., n.d.a)

Indonesia is a democratic state, every eligible citizen has a right to participate in Indonesia's government. Every five years, the Indonesians vote for the president and vice president. Indonesians also vote for their governors, regents and mayors every four years. However, one province is led by a king who is also the governor and holds the position for a lifetime (Indonesia.go.id., n.d.a)

Indonesia has six official religions. Historically, the dominant religions have been Hinduism and Buddhism, but it is currently the most populous Muslim country in the world, with 87,2 % of its citizens following Islam, while Christianity, Hinduism, Buddhism and Confucianism make up the remainder (Indonesia.go.id., n.d.a).

Indonesia has a system of civil law based on the 1945 Constitution (Simamora, 2018). The 1945 Constitution was modelled on the Roman-Dutch Constitution, which was already established during the Dutch colonisation that ended on Independence Day on 17th August, 1945. The 1945 Constitution has sixteen chapters with forty-two articles.

In terms of its economy, Indonesia is the largest economy in South-East Asia, with a GDP per capita of USD 3,932 in 2018. Indonesia noted a 5.2% economic growth in 2019. However, approximately 9.96% of its people live below the poverty line, and approximately 20.19% are vulnerable to falling into poverty (World Bank, n.d.)

In terms of education, a 2022 survey showed that 96.35% of Indonesians aged 15 years and up can read and write (*Badan Pusat Statistik Indonesia* [BPS Indonesia, Statistics Bureau of Indonesia], n.d.a). Furthermore, the same survey also indicated that 99.10% of children up to the age of 12 are enrolled in primary school. 95.92% of teenagers aged 13–15 are enrolled in junior high school, and 73.15% of teenagers aged 16–18 are enrolled in senior high school. In 2018 around 25.99% of teenagers aged 19–23 years old were enrolled in higher education.

Nearly 60% of Indonesians aged 15–24 are IT literate, with the highest percentage in the capital city, Jakarta. The Papua Province had the lowest rate at 23.09%. A similar distribution pattern with lower overall percentages applies in the older age group.

The Characteristics of Indonesians

As previously discussed, Indonesia is a multicultural country. Matsumoto and Juang define culture as "a unique meaning and information system, shared by a group and transmitted across generations, that allows the group to meet basic needs of survival, pursue happiness and well-being, and derive meaning from life" (2017, p. 7). Culture can also be divided into two types: the macro-cultures, or of large complex social systems in countries or

regions, and the micro-cultures of small groups such as religious and ethnic groups, or even family groups (Nofiawaty, 2010; Zhuravlova, 2016). This understanding support the notion of multiculturalism in Indonesia, with 1,340 ethnicities currently existing in Indonesia.

With many ethnicities currently existing in Indonesia, it would be difficult to describe Indonesians as a homogenous population. However, in this section, I will try to give an idea about the characteristics of the Indonesians using several discussions: 1) The history of current society; 2) SARA, a sensitive topic; 3) The concept of Indigeneity in Indonesia; 4) The 1945 constitution; 5) Hofstede individualism scale; 6) The effect of colonisation on Indonesians; 7) The mental well-being for Indonesians. A conclusion can be found at the end of this section.

As a remainder, the characteristics discussions are provided as general guides to expected behaviours from the Indonesians. In mental health setting, any practitioners should avoid generalising clients as it can lead to misunderstanding and pathologising (Aten & Hernandez, 2004; Land, 2018; McNichols et al., 2016). Appreciation of each client's uniqueness leads to a better understanding of the client and improves the therapeutic relationship (Levitt & Piazza-Bonin, 2017; Norcross & Karpiak, 2023).

The History of Current Society. One way to understand multiculturalism in Indonesia is to look at the history of the current society and how it has formed. The first modern humans to settle in Indonesia were Homo sapiens—Melanesian who came to Indonesia approximately 60,000 years ago (Abdullah & PaEni, 2015) and can still be found in the eastern part of Indonesia (Tampubolon, 2015). The Austronesians who currently occupy most of Indonesia first came to Indonesia around 4,000 years ago (Simanjuntak, 2015). Subsequently, other groups of settlers and migrants became minority groups in Indonesia, including Arabs who first arrived in the seventh century (Mujib 2021), Sino-Tibetan (Chinese) who came in the 15th century (Groeneveldt, Triwira, & Kwa, 2009) and Dravida (Indian) in the 19th century (Putri, 2020). The native cultures brought by these migrants, along with their interactions with the local cultures in different parts of Indonesia have contributed to the multiculturalism of present-day Indonesia (Abidin, 2016; Indonesia.go.id., n.d.b).

SARA is a Sensitive Topic. There are advantages and disadvantages related to the multiculturalism of Indonesia. Antara and Yogantari (2018) noted that multiculturalism has led to feelings of nationalism and tolerance. Multiculturalism can also increase people's awareness (Drobot, 2022), and knowledge sharing between different cultures can lead to

positive outcomes (Dube & Ngulube, 2012). Multiculturalism offers significant opportunities in tourism and creative industries such as music, film, fashion, visual communication, handcrafts, and IT, which provide channels for Indonesian creativepreneurs (i.e., people doing business in creative industries; Ariestiningsih & Ningrum. 2021)

Nevertheless, multiculturalism can create conflict in the community. Harahap (2018) has postulated that conflict is normal because humans are social beings interacting with each other and these interactions can lead to conflict. With good management which leads to resolution and transformation through conciliation and mediation (Nieke, 2011), conflict can result in a better situation overall. Asserting hidden aspirations, better-establishing boundaries, and establishing communal goals can help to create peace and establish solidarity between groups. However, conflict can also result in tensions between groups which may lead to threats, hostilities, riots, the destruction of natural resources and public property, societal disorder, and even deaths (Harahap, 2018).

Indonesia has suffered many intercultural conflicts since its independence in 1945. SARA [*Suku, Agama, Ras dan Antargolongan* or Ethnicity, Religion, Race and Intergroups] is often used to explain the roots of conflict in Indonesia. Rahayu and Sodiq (2016) noted that Indonesia suffered nine conflicts fuelled by SARA between 1995 and 2001. One example of this conflict is the situation in Situbondo in 1995, where differences of opinion between junior and senior *kyais* (Islamic scholars) led to accusations of religious blasphemy and the burning of Christian churches because the mob convinced that the church was hiding the junior *kyais*. Another three conflicts were also mentioned by Yunus (2014), with one conflict continuing on and off for nine years. Lestari (2018) noted that SARA issues often arise during elections, with candidates using SARA issues to attack their rivals. Indonesian voters tend to base their votes solely on SARA characteristics rather than capabilities, and choose politicians with the same SARA characteristics as themselves.

These conflicts have made SARA a sensitive topic in Indonesia. Taqwa et al. (2019) mentioned that SARA can divide the nation. One good example would be the case of Basuki Tjahaya Purnama, a politician who ran for the position of governor for the city of Jakarta. Charges of religious blasphemy were brought against him causing large demonstrations in Jakarta and other parts of Indonesia (Kurniawan, 2018). SARA debates are often found in the virtual world Prabowo (2020), creating unrest between Indonesians. Yoedtadi and Savitri (2020) have mentioned that Indonesian media need to be careful when reporting news

related to SARA and consider the impacts before publication. The study noted the importance of gatekeeping, a process of filtering news, and using appropriate language to ensure community sensitivities are respected.

Reacting to such events, the Indonesian government has legislated on this issue. B.J. Habibie (the third President of Indonesia) issued a specific act, *Keputusan Presiden No. 26 Tahun 1999* (Presidential Instruction Number 26/1999), to stop the use of the terms *pribumi* and *non-pribumi* [indigenous and non-indigenous] (Putra, 2022). The act aimed to increase equality and unity in Indonesia by saying that all Indonesians are equally indigenous (Hadiprayitno, 2017). The act obligates the heads of Indonesian governmental bodies territories to: 1) cease the public use of such terms; 2) treat everyone equally regardless of ethnicity; 3) review and amend policies issued before this act; 4) communicate the contents of this act to their subordinates; and 5) coordinate the implementation of this act.

The Concept of Indigeneity in Indonesia. The concept of indigeneity in Indonesia is somewhat unsettled. As discussed earlier the word “indigenous” translates to *pribumi*, in Indonesian language, which can no longer be used. However, there is another Indonesian term that is similar to the concept of indigenous; that is *masyarakat adat*, or “traditional society.” In 2007, the Constitutional Court of Indonesia defined a *masyarakat adat* as a unitary group with 1) shared feelings due to the continuous existence of shared values; 2) traditional customary institutions; 3) traditional property; 4) traditional values that they still abide by; and 5) specific traditional territory (Rahman et al, 2011). This definition of traditional society is somewhat similar to the definition of indigenous people by the World Health Organization (WHO):

Communities that live within, or are attached to, geographically distinct traditional habitats or ancestral territories and who identify as part of a distinct cultural group descended from groups present in the area before modern states were created and current borders were defined. They generally maintain cultural and social identities and social, economic, cultural and political institutions separate from the mainstream or dominant society or culture. (WHO, 2015, para. 1)

Currently, the organisation *Aliansi Masyarakat Adat Nusantara* (AMAN [Alliance of Traditional Society of Indonesia]) includes 2,359 traditional societies (AMAN, n.d.).

The term “indigenous people” in Indonesia holds complex meanings. Every community that aligns with the 2007 Constitutional Court of Indonesia’s definitions can be a self-proclaimed traditional society, a term that is used interchangeably with the term indigenous

people (Embas, 2017). People from the same ethnicity can differ in their traditional social status. For example, the traditional society of Baduy is a Sundanese ethnic community lives traditionally in its territory, without electricity. However, people from the same Sundanese ethnicity could also be living modern lives in the big cities of Indonesia. These modern Sundanese people are not able to claim to be part of a traditional society.

The 1945 Indonesian Constitution. Multiculturalism was a concern in Indonesia even during the birth of Indonesia as a country. After its independence on 17 August 1945, the first Indonesian government announced the first official constitution of Indonesia on 18 August 1945 (Saputra, 2018). This constitution was written by *Badan Penyelidik Usaha Persiapan Kemerdekaan Indonesia* [Investigating Committee for Preparatory Work for Indonesian Independence] which was chaired by Ir. Soekarno, the founding father of Indonesia, along with 20 other members from different parts of Indonesia (Saputra, 2018). Within this constitution, some articles describe aspects of Indonesian nationality. Articles 35 to 36B states that the national coat of arms emblem is the *Garuda Pancasila* bird with the motto "*Bhinneka Tunggal Ika*" [Unity in Diversity]. The state philosophy of Indonesia is *Pancasila*, a word that consists of two Sanskrit words: *panca* (five) and *sila* (principle). The principles of *pancasila* are 1) belief in the One and Only God; 2) just and civilised society; 3) the unity of Indonesia; 4) democracy inspired by the wisdom in the consensus arising out of deliberations amongst representatives; and 5) social justice for all Indonesians (*Dewan Perwakilan Rakyat Republik Indonesia* [DPR-RI, The House of Representatives of the Republic of Indonesia], n.d.). As mentioned, this constitution is still used as the base of civil law in Indonesia.

It can be seen from the description that Indonesia emphasises both horizontal and vertical relationships. From the horizontal point of view, the motto of Indonesia, "*Bhinneka Tunggal Ika*" and the third principle of *Pancasila*, shows that Indonesians upholds mutual respect between people. From the vertical point of view, the first principles of *Pancasila*, "belief in the One and Only God" shows that Indonesians are expected to believe in God (Huda & Dimiyati, 2018; Mulyono, 2016).

Hofstede Individualism Scale. The emphasis on relationships in the Constitution of Indonesia is supported by research focused on Indonesian culture. A Dutch social psychologist named Hofstede postulated the concepts of individualism and collectivism, defined as the extent to which people are motivated to act autonomously as individuals or

collectively as members of a community or group (Minkov et al., 2010). Western countries such as Australia and the United States are often seen as countries with high levels of individualism. Asian countries, on the other hand, are often seen as collectivist countries that prioritise interrelatedness.

According to Hofstede Insights (n.d.a), Indonesia's score for individualism is 14, which is interpreted as a low level of individualism. This says that Indonesian people tend to conform to the ideals of their groups. Being said, Perdhana (2014) mentioned that Hofstede Insights only uses the primary ethnicity in Indonesia, Javanese, which might not be reliable since Indonesia is a multiethnic country. Suharnomo and Syahruramdhan (2018) have stated that research into Indonesian culture needs to consider the cultural variations in Indonesia. Later on, Suharnomo and Syahruramdhan (2018) surveyed a sample of 699 individuals with representative ethnic variation. Table 2 lists the individualism scores by ethnicity.

Table 2

Individualism Scores by Ethnicity

No	Ethnicities	Respondents %	Individualism Scores
1	Javanese	28.6	28
2	Sundanese	21.3	29
3	Batak	14.3	28
4	Minangkabau	14.3	52
5	Chinese Indonesian	21.5	38
Totals		100	<u>x</u> 34

Hofstede uses a rule of thumb score threshold of fifty to determine whether a country is categorised as collectivistic (< 50) or individualistic (> 50). However, Hofstede has also mentioned that scores obtained on the scale are relative. Two countries with scores below 50 are considered collectivist. However, a country that scores ten will be far more collectivistic than another country that scores forty. The data above shows that although one Indonesian ethnicity is considered higher in individualism according to Hofstede, the other four are more collectivist. Even so, the score of fifty-two for the Minangkabau ethnicity is still far lower than the scores for Australia (90) and New Zealand (79), which are also located in the Asia-Pacific region. The average score for the Indonesian as a whole was thirty-four, which was also low. It can safely be assumed that Indonesians tend to be more collectivist than individualistic.

For all that, some studies have found the opposite. A study by Mangundjaya (2013)

that also used Hofstede's scale with a sample of 2,000 people from various Indonesian ethnicities found an average individualism score of 62. Another study suggests that Indonesia's divorce rate is rising (Soebijoto, 2018), which is associated with high levels of individualism (Harper, 2010). Cai, Kwan and Sedikides (2012) found that narcissistic activities associated with individualism such as taking selfies or being a social media influencer on YouTube or Instagram, common among Indonesia's younger generations.

The Effect of Colonization on Indonesians. Historically, Indonesia has been colonised by six countries: Portugal, Spain, Great Britain, France, the Netherlands and Japan (Zed, 2017), beginning in the 16th century and ending in 1945 when Indonesia declared independence from the Japanese as the latest coloniser (Harkantiningasih, 2014; Limah et al., 2018). Ikbar and Andalas (2019) noted that the most significant impact of colonisation is on the mentality and morale of the colonised people. The effects of colonisation on the Indonesian people were discussed even during the period of colonisation. Hans Pols (2018) cited van Loon, an instructor in psychiatry and neurology, describing how he viewed the neurological disturbances he found in Malay and Javanese "native" people at the 1924 meeting of the Indies Society in The Hague:

He advocated a psychological colonial policy before elaborating on the slowness, indolence, lack of initiative, underdeveloped reasoning capacity, and inability to plan commonly observed among the Malay. They were overly emotional and impulsive, lacked concern for others, and were often cruel. They were highly suggestible and therefore vulnerable to political agitators. They were sensual, superstitious, and gullible... Melancholia was rare, while strongly emotional psychoses and acute confusional states were common. (p. 123)

This statement received immediate criticism even in the same meeting. Alinoeddin Enda Boemi, a student in the audience, argued that the statement used flawed generalisations. She continued by saying that there were more than seventy ethnic groups, and to understand the characteristics of each group, one must be familiar with the local language and customs and engage in a more extended period of research by living with each group.

Critics continued after the meeting was over. One criticism worth mentioning came from the "Indies (Indonesian) Physicians" that although the symptoms identified by van Loon were correct, the diagnosis that came along with the symptoms was wrong.

[The] lack of intellectual development observed in some Indonesians, they argued,

was readily explained by the absence of educational opportunities, a state of affairs which had persisted through more than three centuries of Dutch colonial rule. The slowness and lack of initiative van Loon had observed could be the effect of malaria and other tropical diseases, which were still common in the Indies despite the presence of the colonial medical service—or it might be explained by the strictures of colonial society, which allowed them only subordinate roles and failed to reward achievement. (p.129)

Mohammad Hatta, who later became the first vice president of Indonesia, seconded these criticisms, saying those symptoms were indeed the effects of colonialism that broke the Indonesian spirit. For Hatta, such failings were instead proof of the destructive work of colonialism.

The spiritual structure of the nation has been changed [and its] personality is temporarily broken.' The masses were kept in ignorance by limiting educational opportunities, repressing political activity, and censoring the vernacular press. Medical theories of white superiority drawing upon the authority of science helped bolster Dutch hegemony. 'Day in and day out, it has been emphasised that the Indonesians do not possess the capacities for leadership and that they are not capable of initiative', said Hatta, 'so that really they are predestined from the day of their birth to work under European leadership. (p. 130)

Finally, this view of Indonesian mentality seems to have persisted into the current modern era in Indonesia. Yuniarti (2016 as mentioned in Syalabi, 2016) asserted that the hundreds of years of colonisation experienced by Indonesia had created a predisposition in Indonesians to view themselves as inferior and be less confident and less likely to take initiative, instead waiting for others to act. She continued that the political conditions induced by the colonists, using policies such as *divide et impera* (divide and conquer) could cause Indonesians to fight each other over minor differences.

The Mental Well-being for Indonesians. The concept of mental well-being is one way to understand the characteristics of a person. This is because the concept of mental well-being is different between cultures. Currently, one could distinguish between two primary ways of defining mental well-being, one from an individualistic culture, and the other from a collectivist culture. From individualistic culture, mental well-being has two versions: the hedonic concept of happiness, where happiness relates to pleasure attainment and pain avoidance (Kahneman et al., 1999 in Di Fabio & Palazzeschi, 2015). The other is the eudaimonic concept of happiness, which relates to living a life that is rich with purpose and meaning (Ryff and Singer, 2008). A collectivist version of happiness has been described by Hitokoto and Uchida (2015) as interdependent happiness. Unlike the individualistic version of

happiness, which focuses more on individual achievement, interdependent happiness focuses more on relationships and finding balance between positive and negative effects (Uchida et al., 2004; Uchida & Ogihara, 2012).

Institut Public de Sondage d'Opinion Secteur (2013) conducted a study in which they asked 1,046 Indonesian respondents aged 15 to 64 to name the factors that contribute the most to their feelings of happiness. The participants named religion and spirituality (66%), good physical health (62%), having children (57%), close relations with a partner or spouse (54%), living conditions (41%), feeling that life is worth living (41%), having a meaningful job (40%), money (39%), and personal safety and security (39%). These findings imply that happiness for Indonesians might be partially interdependent. Several indicators align with interdependence, but money, a meaningful job and personal safety align with a eudaimonic concept of happiness. Religion and spirituality, as the factor with the highest percentage, can be seen as both individualistic and collectivistic; on the one hand, one can focus on the traditions and community-based practice of religion as a manifestation of collectivistic culture; on the other hand, one can focus on personal faith and a relationship with a higher being as a manifestation of individualistic culture (Cohen, 2016).

The Indonesian government completed a study about well-being in Indonesia (BPS Indonesia, 2017). The conceptualisation and measurement in this study followed the 2013 Organisation for Economic Co-operation and Development's (OECD) Guidelines on Measuring Subjective Well-Being—a concept of happiness that focuses on pleasure attainment and pain avoidance. The Indonesian government realised that this measure of subjective well-being might only be partially suitable for the Indonesian population. Therefore, the government added another dimension called "social life satisfaction". The final results of the study are listed in Table 3 below.

Table 3

Factors of Indonesian Well-Being According to the Indonesian Government

Satisfaction with Life	
Personal Satisfaction with Life	Social Life Satisfaction
- Skills and Education	- Household Harmony
- Occupation	- Leisure Time
- Household Income	- Physical Environmental Situation
- Health	- Social Relationships
- Household Conditions and Facilities	- Safety
Positive Affect	Meaning of Life

- Freedom from Anxiety	- Self-Development
- Feeling Happy	- Life Purpose
- Feeling Free of Stress	- Independence
	- Control of Environment
	- Self-Acceptance
	- Positive Relationships with Others

Maulana et al. (2018) conducted a similar study using a thematic qualitative approach to explore how Indonesian people perceive and experience well-being. The participants were 30 Indonesian adults aged 19 – 54 from Jakarta. This study concluded that three high-order and seven low-order themes must be fulfilled for Indonesians to experience well-being (see Table 4 below).

Table 4

Summary of Indonesian Perspectives of Well-Being

High-Order Theme	Low-Order Theme
Basic Needs Basic needs of the family are met	• Life's necessities Food, shelter, clothing, and financial independence • Material Needs Vehicle, house
Social Needs Maintaining relationships is essential for well-being.	• Family/Parents • Others
Positive Worldview Constructed conceptual framework which people use to understand the world created through organising, evaluating, and acting upon social reality: in this case, the framework that helps them to live well (Kagee & Dixon, 2000 as cited in Maulana et al., 2018)	• Gratitude Gratitude for what you have • Self-Acceptance Acceptance of your place in life • Spirituality Living a spiritual life is an essential element

Characteristics of Indonesians: Conclusions

To conclude, the enormous number of ethnicities and the historical events in Indonesia make it challenging to pinpoint the exact characteristics of Indonesians. Regardless, the discussion above provides some insight into the general characteristics of Indonesians. Indonesians are generally collectivist and consider themselves as part of a larger community. Indonesia's national coat of arms also emphasises the need for respect to ensure unity in the

diversity that exists in Indonesia. The ways Indonesians view well-being reflect a mixture of individualism and collectivism. While Indonesians strive for individual achievement, individual well-being includes the well-being of others and social interactions and relationships are vital for individual well-being.

Indonesians may still be affected by past colonialism. Years of oppression and the lack of opportunities might have damaged Indonesians' mentalities and morale, leading to less confidence and failure to take initiatives. The communal conflict between Indonesians over SARA issues and the ways that SARA issues emerge during elections, showing how the conflict might be rooted in politicisation of the issues, and also indicates that Indonesia is susceptible to influence. This also makes Indonesians cautious about SARA issues. Finally, more individualistic characteristics could also be seen in the younger generation of Indonesians, who can become assertive and opinionated in particular environments.

Indonesians and Mental Health

This section provides four discussion topics to overview the relationship between Indonesians and mental health. The discussion starts with how the Indonesian constitution conceptualises a mentally healthy person. It then describes a constitutional-level attempt from the Indonesian government to promote mental health. The third topic will discuss how Indonesians view mental health disorders. The fourth topic will discuss how mental health, in general, is treated in Indonesia. This discussion ends with a summary of the section.

Firstly, the Indonesian constitution conceptualises mental health. According to *Undang-Undang Republik Indonesia (UURI, Indonesian constitution) Tentang Kesehatan Jiwa Tahun 2014* [Indonesian Mental Health Act 2014], mental health is defined as a condition in which a person can develop physically, mentally, spiritually and socially to the extent that the person can realise their potential, be resilient and productive and contribute to their community.

The second topic concerns a constitutional-level attempt from the Indonesian government to promote mental health. The *constitution UURI Tentang Kesehatan Jiwa Tahun 2014* [Indonesian Mental Health Act 2014], was created with the aim to improve mental health in Indonesia. It involves several types of actions: 1) promotive; 2) preventive; 3) curative; and 4) rehabilitative. The table below provides a summary of each action:

Table 5*Summary of UURI Tentang Kesehatan Jiwa Tahun 2014: Achieving a Mentally Healthy Society*

Actions	Summary	Examples of Actions
Promotive	Activities that promote, sustain and improve mental health, diminish stigma, and improve knowledge and acceptance of people with mental health issues	Broadcasting information regarding mental health using mass media
Preventive	Activities that prevent mental health issues arising, prevent relapse reduce risk to society, and prevent psychosocial disturbance experienced by the sufferer	Developing healthy parenting styles that promote mental health using family psychoeducation
Curative	Provision of mental health services, includes diagnoses and interventions to cure, reduce, and control mental health issues and symptoms	Providing mental health services and treatment such as general doctors, psychologists, psychiatrists and psychiatric hospital care
Rehabilitative	Activities established by mental health services to prevent and control mental health issues, restore social functioning, restore occupational functioning, and prepare sufferers for independence in society	Providing psychiatric and psychosocial rehabilitation

Since the constitution was put in place, some research has been conducted that suggests that improvement in the mental health sector in Indonesia is in place. Eka Viora (as stated in Wijaya, 2019), stated that Indonesian's understanding of mental illness had increased and Indonesian people felt they could talk openly about mental health. Idham et al. (2019) surveyed university students in Indonesia and found that among 501 students from across Indonesia, 271 (54.1%) had high levels of mental health literacy. Furthermore, young adults could actively seek mental health interventions if needed and online media are the primary sources of mental health information and treatment advice.

That said, some researchers have claimed the act has been ineffective. Mawarpury et al. (2017) found that mental health programmes were not part of primary care but supported programmes in public health centres. The same research reflected that mental health issues are increasing. Agustina et al. (2019) also reported that issues of stigma still persist in Indonesia.

Should one still experience mental health disorders, stigmatisation is still intense in Indonesian society. Choresyo et al. (2015) indicated that people with mental health disorders are still ascribed a negative image and label. A person experiencing mental illness is still

considered an embarrassment to their family. Mental illness may be ascribed to supernatural causes, leading to inhumane treatment. Novianty (2018) investigated the knowledge in Indonesian society regarding schizophrenia and depression and explored perceptions and understandings of these two mental health disorders. It was found that Indonesians still have low levels of knowledge about schizophrenia and depression. Indonesians generally fail to recognise people as having such disorders. referred to them as being “in a difficult situation” for depression and simply having “mental illness” for schizophrenia.

In regards to treating mental health, Indonesia as a country has different levels of health care providers. According to *Peraturan Menteri Kesehatan Republik Indonesia 1992 tentang Persyaratan Kesehatan Lingkungan Rumah Sakit* [Ministry of Health Regulation of Indonesian Republic 1992 concerning Health Environment Requirement for Indonesian Hospital] suggest that Indonesian Hospital could be divided into five classes based on its ability to treat patients. For example, hospital class A would be considered a top referral hospital. It can provide specialist and subspecialist care for the patients. Hospital class D would be the first-line hospital with general practitioners and dentistry. Hospital class E is considered a specialist hospital focusing on one illness (e.g., psychiatric hospital). Indonesian hospitals could also be divided and categorised based on whether they are privately owned or government-owned (*Undang-Undang Indonesia nomor 44 Tahun 2009* [Indonesian Constitution No. 44 Year 2009]). The same class category applies to both government and private hospitals. Being said, the first line of health care in Indonesia is not a hospital but an institution called “*Pusat Kesehatan Masyarakat*” [Puskesmas, Public Health Center], which historically intended to focus on promotion and prevention (Putri et al., 2017). However, each mental health care provider class could move up the class. Puskesmas could become Hospital Class D if they meet the requirements (Aziza, 2014). This is why each hospital class could provide more than their essential requirement. For example, Ulfah (2020) mentioned that fourteen puskesmas in Jakarta can provide Psychological Treatments.

Another concept in Indonesian health care that needs to be mentioned is a policy called *Badan Penyelenggara Jaminan Sosial* [BPJS, Social Health Insurance Administration Body]. A government legal entity that was specifically established by the Indonesian government through *UU RI nomor 40 Tahun 2004* [Indonesian Constitution No. 40 Year 2004] to create a national social security system (Siahaan & Pardede, 2022). Each Indonesian are obligated to make monthly to yearly payments to support such a policy (Anggraeni, 2024)

and psychological treatment is also offered by this policy (Winurini, 2023).

While an ideal healthcare service seems available for Indonesians, it is still not at the level that caters to Indonesia's large population and area. As previously mentioned in the introduction, CPs are still primarily located on Java Island in Indonesia (IPK Indonesia, 2023). There are still insufficient mental health workers (Agustina et al., 2019; Mawarpury et al., 2017). Not all Puskesmas in Indonesia offer psychological treatments (Ardhi, 2021; Tarmizi, 2022). Should Indonesians decide to treat their mental health and use the BPJS system to meet mental health practitioners, they could be hindered by long queues and rejection from the hospital (Susanto, 2021). This then becomes one possible reason why many Indonesians might prefer to use distance treatment for their physical and mental health problem, as they could connect to an expert without the need to travel and wait (Schwartzman & Boswell, 2020).

Currently, Indonesia has a mental health phone helpline called "*Sejiwa*" (One Soul), in which Indonesians who have mental health issues such as anxiety, stress or family problems can call (Nurchayani, 2020). However, this service is limited as it only focuses on psychological first aid (PFA), which aims to provide temporary relief, connecting and referring clients for further treatment (Adni, Asrari & Pratiwi, 2020; Kreasih, 2020). Salim (2021) mentioned that one year after *Sejiwa* launched, it received 170,247 calls from Indonesians. Moving to chatting, Alodokter, an online medical company that provides healthcare via chat messages that is not limited to psychological treatment, claims to have helped 30 million Indonesians monthly (Alodokter.com, n.d.a). Riliv, an online psychological company that offers chat telepsychotherapy, claimed to have helped more than 900,000 Indonesians since its launch (Riliv.co., n.d.). These findings further support the idea of how CT is used and sought by Indonesians.

Indonesian Millennials and Gen Z

Millennials were born between 1981 and 1996 (*Kementerian Pemberdayaan Perempuan dan Perlindungan Anak Republik Indonesia* [KP3A-RI, The Ministry of Woman Empowerment and Child Protection of Republic of Indonesia] & BPS Indonesia, 2018), and Gen Z from 1997 to 2012 (Rakhmah, 2020). This section discusses the broad findings in relation to these two generations, starting with demographic information followed by the general characteristics.

Demographics.

According to the Indonesian census (BPS Indonesia, n.d.b), Generation Z was the

largest group in Indonesia, with 27.94% of the total population and millennials the second, with 25.87% of the total population. With a total population of 270.2 million people, the estimated number of millennials and Generation Z combined was 145.39 million people in Indonesia. However, this number may be unevenly spread across Indonesia. While there are no official demographic data regarding the distributions of these two generations, BPS Indonesia provided the overall distribution of the total population, which likely correlated to the distribution of the two generations. According to the report, 56.1% of the Indonesian population were located on the island of Java with the remainder on Sumatra (21.68 %); Celebes (7.36%); Borneo (6.15%); Papua (3.17%); and other smaller islands (5.54%). This uneven distribution has been caused by many factors, with one dominant economic factor. Java Island has been the centre of development since independence in 1945. As a result, non-Javanese people often migrated to Java Island (Ali & Purwandi, 2017).

Generational Characteristics.

As the main subjects of this study, it is essential to understand some of the fundamental characteristics of these two generations, as clients' characteristics can affect the process of psychotherapy (Lorenzo-Luaces et al., 2014; Lynch, 2012; Moors & Zech, 2017) and each generation has unique characteristics (Gursoy et al., 2013). It needs to be reminded again that this section provides information about the general characteristics of millennials and Gen Z, based on the literature. It is essential not to generalise about individuals from these descriptions but use them as guidelines for expected behaviours.

The Millennials. Ali and Purwandi (2017), noted three main characteristics of what they called urban middle-class millennials. Those characteristics are connected, creative and confident. These characteristics are based on the author's field observations, observational interviews, and other data. The following table briefly describes each characteristic and how the literature supports it.

Table 6

Millennial Characteristics

Characteristics and Description	Supporting Literature
Connected	
Millennials are connected throughout the globe. There is no need for face-to-face meetings as they can have virtual meetings over the internet using computers or	A study by Fenich et al. (2014) of 1,500 millennials worldwide found that the lowest score for liking online communication was 3.74 out of 5 (1 = not at all, five = very much). The

Characteristics and Description	Supporting Literature
smartphone software.	highest score was 4.56, suggesting that millennials from this study were at least neutral and tended to like online communication.
Connectedness is not only about social relationships; millennials are up to date on news and trends globally.	A study by Associated Press-NORC Center for Public Affairs Research and American Press Institute in 2015 that include 1,045 millennials found that 85% of the participants suggested that keeping up with the news is at least somewhat important to them.
Millennials have close connections to devices such as smartphones which help them to connect with others and the latest news.	According to <i>Kementerian Komunikasi dan Informatika Republik Indonesia</i> [Kominfo-RI, Ministry of Information and Technology of Republic of Indonesia] (2017), 66.3% of Indonesians have smartphones. Even though there are no specific data on how many millennials are included in the data, the survey suggested that 55.4% of the smartphone users were aged 20-49, making them millennials at the time of the research (Kominfo-RI, 2017).
Creative	
Being exposed to so much information, Millennials are generally creative people who can think outside the square.	No studies have been found comparing the creativity of millennials and older generations. Some evidence of millennials' creativity can be found in a study by Lester (2011), suggesting millennials are highly tolerant and appreciative of new ideas. The key difference between millennials and the previous generations is the position of mobile technology at the core of their lives (Eastman et al., 2014), helping with quicker problem-solving (Shafiq et al., 2016; Susarno et al., 2022)
Confident	
Millennials are more confident in themselves than previous generations. They trust their abilities, cope with rejection, have good self-control, and have clear life goals. However, they often break the rules.	Pew Research Centre (2010) studied 2,020 adults, including millennials, Gen X, Baby Boomers and the Silent Generation, examining their political and social values; lifestyles and life priorities; digital technology and social media habits; and economic and educational aspirations. They also compared and contrasted those generations. One finding that aligned with the notion of confidence was how millennials were found to have a high level of self-expression; this manifests in different ways, such as having social media profiles networks, uploading videos online, and having tattoos and

Characteristics and Description	Supporting Literature
	piercings. Furthermore, despite a recession during the research, they believed they would meet their long-term financial goals.

Gen Z. Rakhmah and Azizah (2020) completed a literature review based on studies conducted by Francis and Hoefel (2018) as well as Stillman and Stillman (2017). This section describes the original research and its findings.

Francis & Hoefel were associated with McKinsey & Company, a management consulting firm which collaborated with Box1824 to conduct an extensive survey involving baby boomers, Gen X, millennials and Gen Z in Brazil. Researchers, psychologists and social scientists were involved in the study that aimed to observe how Gen Z communicate, what they believe in, and understand their choices. The study used technographic techniques, including interviews, focus groups and online surveys with over 2,500 participants aged from 14 to 64. This study resulted in four characteristics, summarised in Table 7.

Table 7

Gen Z Characteristics According to Francis & Hoefel (2018)

Characteristic	Description
1. Fluid identities	Gen Z identities change and develop over time. They prefer not to identify themselves in a particular way but rather experiment with other identities as well. For example, the studies suggested that 76% of Gen Z are religious but open to other ideas that may not fit with their declared religion, such as decriminalising illegal drugs.
2. Communaholic	Gen Z is inclusive in terms of their social lives. They do not differentiate between online friends and friends from the physical world. They value online socialisation as it is based more on interests than the socioeconomic status. It was reported that 66% of the participants believed that communities form around similar interests rather than economic backgrounds or educational levels.
3. Dialogue	Gen Z value dialogue with their families and the institution they are affiliated with, even if they have different personal values. They can still comfortably have relationships with them while maintaining their personal values. They prefer dialogue to confrontation. For example, 52% of the participants overall, including baby boomers, Gen X and millennials, but only 39% of Gen Z, expected companies to answer customer complaints on the same day, suggesting that they are calmer in dealing with potential confrontations.
4. Realistic	Gen Z has a more realistic view towards life. The vast volumes of information they regularly receive make them more careful in deciding their next moves. For example, they prefer stability over high incentives in

Characteristic	Description
	terms of work. The study found that 42% of Gen Z participants already had a steady part-time, full-time, or freelance job which was considered high for their age.

Stillman and Stillman (2017) conducted a national survey involving 600 people conducted in the US in collaboration with the Institute for Corporate Productivity and the VANTAGE programme at Minnetonka High School, Minnesota. The study focused on Gen Z workplace attitudes and resulted in seven key traits summarised below:

Table 8

Gen Z Characteristics According to Stillman and Stillman (2017)

Characteristic	Description
1. Phigital	Gen Z lives in a world where the physical aspect has its digital equivalent. The digital world is considered part of their daily lives. For example, 91% of the participants suggested that technological sophistication would affect their choice of workplace.
2. Hyper-custom	Gen Z prefers surrounding that are customisable to their desires. For example, 56% of the participants preferred to write their own job descriptions rather than be given one by their employer.
3. Realistic	As Gen Z grew up during a recession, with violence and uncertainty. Gen Z is pragmatic in its planning. They favour plans that offer certainty in life. For example, 84% of the participants mentioned that they already have the necessary skills to be successful in the professional world after college.
4. Fear of Missing Out (FOMO)	Gen Z likes to have the latest information about everything, so much so that they develop anxiety about missing the latest trends. For example, of the participants, 75% preferred to work in multiple positions in a company so that they keep up to date with the latest information in their jobs.
5. Weconomist	Gen Z prefers to take a shared approach to create convenient and cost-effective solutions to existing societal problems. For example, 93% of the participants would consider a company's impact on society when considering employment.
6. Do It Yourself	Related to the previous finding, shared solutions are considered paramount. Gen Z believe that they can do everything themselves based on the information received from others. For example, 71% of the participants agreed with the statement, "If you want it done right, then do it yourself!"
7. Driven	Gen X raised Gen Z with an emphasis not only on participation but also on results. This then makes Gen Z a competitive generation. For example, 72% of the participants said they are competitive with others in the same job.

Millennials, Gen Z, and Mental Health.

Despite all the positive characteristics listed above, these two generations are still vulnerable to mental illness. According to the 2018 basic health survey by the Indonesian Ministry of Health of Indonesia, approximately 5.4% or 2.3 million Indonesian millennials suffer from depression, and approximately 8.5% or 3.6 million suffer from anxiety. The Indonesia National Adolescent Mental Health Survey in 2022 suggested that 3.7% of Gen Z aged 10-17 years old suffer from anxiety, and 1% suffer from depression (Center for Reproductive Health et al. 2022).

In 2022, Deloitte, a British accounting company focused on audit and assurance, consulting, financial and risk advisory services, tax, and related services, surveyed 8,412 millennials and Gen Z from 46 countries worldwide. The survey aimed to understand the views of these two generations about work and the world around them. One of the findings from the survey was about stress and anxiety, with 46% of Gen Z participants and 48% of millennials found to be either stressed or anxious most of the time. Five main reasons were found to be the cause: day-to-day finances, long-term financial prospects, family and personal relationships; the health and welfare of the family, and concern about their own mental health.

A similar study was done only in Indonesia by Kaligis et al. (2021) involving 393 millennials and Gen Z aged 16-24 from three zones (eastern, central and western) in Indonesia. The results suggested that the participants had a number of mental health problems including stress, learning difficulties, loneliness, addictions, self-harm, depression, anxiety, and eating disorders. Several factors were found to cause such conditions: time management; finances; academic-related stressors; family, social, and romantic relationships; and bullying.

The effects of this mental distress could be varied. Kaligis et al. (2021) noted that, at a person level, mental distress could affect further academic performance and relationships and create further mental illness. It could also have much more significant effects, such as hindering national productivity, considering that the younger generations are the main contributors to a country's future (Nababan, 2023).

Chat Telepsychotherapy in the Indonesian Setting

This section discusses the status of CT in the Indonesian setting. The section starts with how CT arrived in Indonesia, followed by discussion of the different names Indonesians use

for CT and the effectiveness of CT in the Indonesian setting.

History of CT in Indonesia.

There is no clear evidence in the literature on when exactly CT entered Indonesia. The first evidence of its use to conduct a therapeutic relationship might be a 2009 paper that was presented in an international seminar hosted by the Indonesian Association of Guidance and Counselling (Ifdil, 2009; Ifdil & Ardi, 2013; Siradjuddin; 2017). In the paper, Ifdil (2009) introduced the term *pelayanan e-konseling* (e-counselling services), to describe the use of internet technology to establish guidance and counselling services for students in a school setting. The service included a student database, counselling management apps, and psychological instrument management. Pasmawati (2016) stated that the rise of cyber-counselling happened at the same time as social media applications such as Facebook, Twitter, Line, BBM, myspace, email, and Google Talk became popular in Indonesia. No particular year was mentioned in the paper; however, most social media came to Indonesia in the early 2000s (Cahyono, 2016).

The Popularity of Chat Telepsychotherapy in Indonesia.

Nowadays, over 78% of the population of 275 million are recorded as active internet users who primarily use the internet to connect with others using social media and chat applications (APJII, 2023). Furthermore, the users with the highest age range are those aged 13 to 34. Another research project by Statista regarding Indonesia's internet behaviour stated that Indonesia ranked 3rd in terms of Facebook users worldwide (Gullen & Plungis, 2013; Rohlwing, 2018; Swoger, 2015). Indonesia also ranked 4th in the world regarding the number of Instagram users. Indonesians are thus active internet and social media users. These findings further support the reasoning made in the "Rationale" section (p. 1) about why CT is sought after type of treatment.

One of the latest significant developments of CT in Indonesia happened during the COVID-19 pandemic (Khan et al., 2020). Indonesia is an affected country with 6,812,127 cases and 161,879 deaths as of 5 July 2023 (World Health Organization, 2023). At the early peak of the virus spread on July 2021, the Indonesian government imposed emergency restrictions on public movement and community activities (Miharja, 2021). For the psychology community to still contribute to society, *Himpunan Psikologi Indonesia* [HIMPSI, Indonesian Psychological Association] created an online platform for a mental health intervention with registered psychologists. Hundreds of Indonesian psychologists contributed, with most of

them preferring to use chat rather than voice to conduct telepsychotherapy (Kawal COVID-19, n.d.).

Different Terms for Online Therapeutic Relationships.

Harahap (2021) listed ten companies or organisations in Indonesia that focused on providing distance therapy. Most offered three service delivery methods: chat, voice call, and video call. Companies used different terms for their service: "online counselling," "online consultation," and "online therapy," which are often used interchangeably in Indonesian psychology and practice. Discussion by experts to determine the differences between these three terms was ongoing in Indonesia at the time of writing.

Ulfiah (2020) claimed that some experts still think that counselling and psychotherapy are the same. Stating that the differences between these terms need to be understood to avoid misunderstandings and create more definition of the professions related to these terms. Rahuyu (2022) noted that the similarities and differences between counselling and psychotherapy had become the centre of an active debate.

Ulfiah (2020) described the differences between counselling and psychotherapy in the Indonesian setting. Firstly, counsellors tend to work with functioning people with minor problems, and the goals of counselling are more preventive and short-term. On the other hand, psychotherapists work with people diagnosed with a disorder, and psychotherapy's purpose is long-term remediation. Secondly, counselling is often associated with an educational setting, while psychotherapy is more often associated with a clinical setting. The law in Indonesia says that psychotherapy can only be provided by registered CPs or psychiatrists (*Perhimpunan Dokter Spesialis Kedokteran Jiwa Indonesia* [Indonesian Psychiatric Association], 2009; *Permen 2017 tentang Izin dan Penyelenggaraan Praktik Psikolog Klinis* [Ministerial Regulation concerning Licensing and Organizing the Practice of Clinical Psychologists 2017]). Both CPs and guidance counsellors can perform counselling (*Permen Kesehatan 2017 tentang Izin dan Penyelenggaraan Praktik Psikolog Klinis* [Minister of Health Regulation concerning Licensing and Organizing the Practice of Clinical Psychologists 2017]; *Permen Pendidikan dan Budaya tahun 2014 tentang Bimbingan dan Konseling Pada Pendidikan Dasar Dan Pendidikan Menengah* [Minister of Education and Culture Regulation concerning Guidance and Counseling in Basic and Secondary Education 2014]). Furthermore, guidance counsellors and CPs have different educational backgrounds. While CPs must have a Bachelor's degree in psychology and a Master's degree in clinical psychology, guidance

counsellors must have a Bachelor's degree in guidance and counselling.

In the Indonesian literature the terms consultation and counselling are sometimes used interchangeably as well (Jannah & Marjo, 2022; Wijayanti et al., 2018), while other literature makes clear distinctions between the term consultation, counselling and psychotherapy (Anjar, 2011; Raden, 2015; Rahmad, 2019; Supratiknya, 2011). The main difference is whether consultation involves a direct relationship with the client. Some argue that consultancy is a triadic model where the consultants who perform consultations advise and problem solve with a third party responsible for the client (Anjar, 2011; Raden, 2015; Rahmad, 2019). On the other hand, Supratiknya (2011) has argued that consultancy can be done without a third party as long as the consultants do not have direct control over the client's situation and only provide advice and assist with problem-solving.

Most telepsychology companies in Indonesia promote counselling sessions involving direct communication with licensed CPs. Only two companies offer counselling sessions with psychiatrists or counsellors with either a Bachelor's degree in psychology or a Master's degree in guidance and counselling. Regarding the topics, these companies listed mild issues, such as relationships, family, parenting, personal development, and education, through to what could be considered severe issues including depression, trauma, ADHD, phobias, sexual and physical abuse, and suicidal ideation.

It can be seen from the discussion above that incongruence exists between the terms, the services offered and the type of issues. Following Ulfiah (2020), counselling is unsuitable for severe issues such as depression, phobia, or schizophrenia. However, serious issues were listed on the companies' websites under the service term counselling. Even though these companies provide access to CPs and psychiatrists who can legally deal with these serious issues, the service for these issues should not be described as counselling but as psychotherapy. The term consultation can be used for these serious issues, but the service would be different as it may require a third party. If the companies want to provide one-on-one consultation for clients with serious issues, they need to ensure that consultation is suitable for clients with serious issues rather than more comprehensive service such as psychotherapy. If these companies use the term counselling on their websites, then mention of serious issues should be avoided. This incongruence in the field and the literature in Indonesia is also the reason why I finally used a new term, i.e., Chat telepsychotherapy, in this study.

Effectiveness of CT in Indonesia.

There is limited evidence in the Indonesian literature regarding the efficacy of chat messaging in distance therapeutic relationships. The existing literature discusses the efficacy of other methods used in distance therapeutic relationships such as video calls (Handika & Herdi, 2021), voice calls (Freska et al., 2021), guided internet-based interventions (Arjadi et al., 2018c) and mixed approaches where the therapeutic relationship is delivered using a combination of methods such as online modules or psychoeducation and asynchronous textual communication via email (Hernawati et al., 2018; Suranata et al., 2020).

The only study that has focused on the effectiveness of chat-based therapeutic relationships was conducted by Junita, Dewi and Adyani (2019), who investigated whether online counselling through the chat application WhatsApp could effectively reduce university students' anxiety during the COVID-19 pandemic. Nine students had sessions with a counsellor via WhatsApp. The counselling process included: a) building up rapport; b) problem identification and assessment; c) facilitating change by building up clients' resources; and d) evaluation and termination. Clients were then given an evaluation form where the clients were asked about the effectiveness of the counselling process. The researchers used the qualitative method and then used the clients' feedback to determine the efficacy of this counselling process. This research showed that the clients improved after they had undergone the counselling process. Before the counselling sessions, clients were anxious, afraid and confused. Later after the counselling sessions, clients reported having positive thoughts and feeling able to cope with the pandemic. Despite such research, this study cannot be considered as comprehensive evidence of effectiveness due to the small number of samples and the qualitative nature of the study.

In another Indonesian study of chat counselling Darmawani and Suryahadikusumah (2020) investigated the communication process in text-based therapeutic relationships. In a mixed-method study to analyse the communications between 25 students, including students from a vocational high school, and their counsellors during chat counselling. A survey of participants was used for the quantitative part of the study, while open-ended questions were used for the qualitative aspect. Both the quantitative and the qualitative parts focused on the reasons for seeking counselling and the strengths and weaknesses of chat counselling. They found that the chat counselling effectively created feelings of comfort and openness for the clients but failed to develop an empathetic aspect of the communication.

The participants reported that the confidentiality and written aspects of chat counselling helped them to feel comfortable which promoted self-disclosure. However, the participants also reported not feeling that the counsellor fully empathised with their situation. Participants reported that when they accessed chat counselling, they probably needed a quick remedy for a problem which the counsellor had yet to meet this need. Counsellors were also expected to provide more empathetic messages using emojis and less formal language.

Minor Depression Disorder

This section provides information on this particular disorder, starting with a general discussion about definition followed by causes, effects, and treatment in the Indonesian setting.

Overview

It is now commonly agreed that depression has two main characteristics which are depressed mood and loss of interest and pleasure (Paykel, 2022). This study focuses on one of many manifestations of depression: minor depression disorder. The guidelines used to identify this disorder are the Indonesian Version of Structured Clinical Interview for DSM IV-1 (SCID IV-1) which is a semistructured interview guideline to help Indonesian CPs to make clinical diagnoses based on the DSM IV criteria. The criteria for minor depression disorder are: 1) The experience of at least two, but less than five (while five or more symptoms would qualify for major depression disorder), of the following symptoms: a) depressed mood most of the day, nearly every day; b) diminished interest or pleasure in all or almost all activities most of the day, nearly every day; c) significant weight change; d) insomnia or hypersomnia; e) psychomotor agitation; f) fatigue; g) feelings of worthlessness or inappropriate guilt; g) diminished ability to think or concentrate; i) recurrent thoughts of deaths. To be diagnosed with minor depression disorder, symptoms a or b must present over the last two weeks.; 2) the symptoms suffered cause distress in daily functioning; 3) the symptoms are not a direct effect of substance abuse or a medical condition; 4) the symptoms are not the result of bereavement.

Further assessment must also be taken to check whether the client has suffered from previous major depressive, manic, mixed or hypomanic episodes, as experiencing those conditions will rule out minor depression. In addition, CPs need to be sure that the symptoms are not better explained by other mental disorders such as dysthymic and

cyclothymic disorders. Finally, the symptoms must not be present only during psychotic episodes.

Minor depression disorder is the less severe form of major depression disorder (Fils et al., 2010). However, as previously discussed in the “Psychotherapy Distinction” section (p. 5), minor depression is not a minor disease (Naber & Bullinger, 2022). It represents the same illness and risk as major depression disorder (Fils et al., 2010; Naber & Bullinger, 2022). A comprehensive study by Rapaport et al. (2002) found that people who suffer minor depression had impaired functioning in almost all aspects of their lives compared to normal people; this includes social, emotional, physical and vitality aspects. Another comprehensive study by Nierenberg et al. (2009) also found that people who suffer from minor depression experience a severe decrease in their psychological well-being and quality of life. Finally, minor depression is a vital risk factor for major depression (Kessler et al., 1997; Fogel, Eaton, & Ford, 2006), which leads them to an even more severe impairment. This understanding was the reason why this study chose minor depression as the object of treatment. As minor depression was found to be much more complex compared to its term, along with the fact that this study focused on creating a relatively new type of treatment, it would be best to concentrate on a less severe form of depression to see its efficacy before treating a rather severe type of depression (i.e., major depressive disorder).

Depression in the Indonesian Setting. Indonesian government through Kemenkes R.I. (2018) indicated that 6.1% of the population or approximately 16 million Indonesian people were depressed in 2018. Indonesian mental health experts based their depression symptom classification on a mental health classification system called *Pedoman Penggolongan dan Diagnosis Gangguan Jiwa di Indonesia III* [PPDGJ III or Manual of Classification and Diagnosis of Mental Disorder in Indonesia III], that is issued by *Departemen Kesehatan Republik Indonesia 1993* [Department of Health of the Republic of Indonesia]. PPDGJ III was based on two sources: The International Classification of Disease 10 (ICD 10; World Health Organization, 1993) and the Diagnostic and Statistical Manual of Mental Disorders-IV (DSM IV; American Psychiatric Association, 1994). The code and diagnostic criteria for each mental disorder in PPDGJ III were purely based on ICD. PPDGJ III also used multi-axial diagnosis based on DSM IV (Maramis & Maramis, 2009).

However, it is worth noting that both ICD and DSM diagnostic features and criteria were derived from a Western psychopathology approach, and may reflect European and

North American psychiatric agendas (Armesto et al., 2008). For example, according to Burns (2014) diagnoses might be made in the context of the national mental health system, the thresholds to access appropriate treatment or claim insurance, and even legal and professional responsibilities. These systems are different in different countries. Jacob (2013) has argued that imposing a Euro-American paradigm on non-Western cultures can become problematic. The standards of abnormality can be different between cultures, which can lead to misdiagnosis (Canino & Alegría, 2008).

Being said, there is growing evidence that the signs of depression vary, especially in Eastern societies. Chang et al. (2017) have argued that depression in Chinese people tend to be expressed in the form of somatic symptoms such as insomnia, poor appetite, and headaches, rather than psychological symptoms such as feeling sad or worthless. Saint Arnault and Kim (2008, as cited in Chentsova-Dutton et al., 2014) found that in Korean and Korean-American society, depression is associated with complaints of constipation, heartburn, loss of appetite, indigestion, abdominal cramps, numbness, weakness, dizziness, faintness, hot flashes, fatigue, tiredness, sore muscles, swollen ankles, stiff muscles, stiff joints, palpitations, racing heart, and chest pains.

As opposed to that, other studies do not support these findings. Lin (1989) that the Chinese do express their psychological symptoms if given the chance; despite initially presenting with somatic symptoms. Simon et al. (2019) claimed that somatic presentations vary little between countries. Yen (2000) found that Chinese students reported significantly lower somatic symptoms than American students.

No studies focused on somatic symptoms of depression in Indonesians have been found, and recent studies of depression in Indonesia used Western-based measurement tools such as the Beck Depression Inventory (BDI) and the Patient Health Questionnaire (Arjadi et al., 2018b; Ningrum & Kartinah, 2020; Ramdhani et al., 2020). While the current study also uses Western conceptions and measurements of depression, it also tries to start the discussion about somatic symptoms of depression among Indonesians as a secondary goal.

Causes of Depression

This study uses the biopsychosocial model to explain the causes of depression. The model was chosen due to its comprehensive conceptualisation of depression (Kusnanto et al., 2018; Németh et al., 2021). "Biopsychosocial" stands for the amalgam of biological,

psychological and social factors that often account for the presence of depression (Barlow et al., 2015). The model claims to integrate the two fundamental etiological perspectives on depression, the biomedical and the psychosocial; and provides their interconnection and interdependence (Garcia-Toro & Aguirre, 2006)

Biological Factors. Genetic factors are crucial in depression (Nevid et al., 2013). Like heart disease, some people are more prone to depression than others. An excellent way to explain this matter is through family studies. It is found that first-degree relatives of an individual with diagnosed depression are two to three times more likely to experience depression compared to a person with no diagnosed depression (Lau & Eley, 2010; Klein et al., 2002; Levinson, 2009 in Barlow et al., 2015).

Identical twins who share identical genes have twice the possibility of depression if the first twin has already been diagnosed with depression than fraternal twins, who share only 50% of their genes. Sex was also found to be one of the determinants of depression. Women are 36% to 44% more likely to inherit genes for depression, with 18% to 24% for men (Barlow et al., 2015).

The balance of neurotransmitters is more important than the levels of any single neurotransmitter as they interact with each other in complex ways. For example, a low level of serotonin—the hormone that determines our emotional reactions, is associated with the imbalance of other hormones, norepinephrine and dopamine. Later on, low levels of norepinephrine and dopamine lead to depressive-like behaviours (Barlow et al., 2015).

The endocrine system is also found to be linked with depression. High levels of cortisol—the stress hormone—are often found in depressed clients. Furthermore, high levels of cortisol are associated with lower serotonin, leading to depressive-like behaviours (Dinan, 1994).

Psychological Factors. Several theories could link psychological factors and depression. In stressful event-related theories, psychological factors can be related to biological factors. The diathesis-stress model suggests that stressful life events could or could not lead to depression depending on whether a person has vulnerabilities or predispositions, i.e., genetic risk factors, for depression (Arnau-Soler, 2019). Furthermore, Barlow and Durand (2015) mentioned that an adverse event could be perceived differently depending on a person's context and value. For example, losing a family member might be stressful for one person but not for another, and a person without depressive tendencies

might not become depressed while facing stressful events. That being said, any events that are perceived to be stressful can lead to depression. Major stressful life events are strong predictors of depressive symptoms for people who have never experienced the symptoms before (Lewinsohn et al., 1999 in Barlow et al., 2015)

Learned helplessness theory complements the stressful life events theory. Seligman and Maier (1967 in Teodorescu & Erev, 2014) explained learned helplessness as exposure to uncontrollable events impairing future exploration and learning. A person who experiences repeated stressful events in their life might develop a belief that they are helpless and unable to control or stop stressful life events. In addition, a person with learned helplessness develops a depressive attributional style with self-blame for every adverse event.

Psychodynamics offers a self-focusing model of depression. This model argues that the experience of adverse life events such as the death of a loved one or a personal failure or significant disappointment would make a person fall into a self-regulatory cycle that focuses more on the negative outcomes rather than the positive ones. This cycle then leads to a negative self-image that furthers the disappointment and ends up in depression (Pyszczynski & Greenberg, 1987).

Aligned with psychodynamics, the humanistic theory emphasises that adverse events cause a person to lose self-esteem and self-worth, leading to the inability to achieve self-fulfilment (Nevid et al., 2013). Operant conditioning learning theories postulate that the loss of positive reinforcement causes depression. Furthermore, losing positive reinforcement makes life unrewarding, making a person unmotivated and depressed (Nevid et al., 2013).

Social and Cultural Dimensions. The most prominent social and cultural aspects identified which contribute to depression are marital relationships, gender, and social support (Barlow et al., 2015). An unsatisfactory marital relationship is a strong predictor of depression as it affects mood stability, possibly resulting in depression. Men who have split up from their spouses are reported to be susceptible to severe depression, even without any previous history of depression (Nevid et al., 2013). Similar findings from an Indonesian study by Giena et al, (2020) found that more females who have split from their partner suffer from depression compared to the ones who were still together or had not married. Marital conflict seems to affect men and women differently. A study by Fincham, Beach, Harold, and Osborne (1997) found that men tended to withdraw from the relationship or damage it because of feeling depressed, while women became depressed because of the conflict in the

relationship. This study concludes that both men's and women's states of depression are associated with marital conflict; however, the causal directions are opposite

Gender can also be a factor in depression. Women are more likely to develop depression over their lifetimes compared to men (Kuehner, 2017). Cultural roles have possibly been found to be responsible for this difference. Although changes are happening, females are generally expected to be passive and sensitive and rely on males to complete specific tasks (Nevid et al., 2013). This role expectation can increase feelings of helplessness. Females also tend to experience more daily obstacles and ordeals than men, with more discrimination, sexual harassment and abuse (Otterbach et al., 2021) and less respect and power (Barlow et al., 2015). An Indonesian study by Nazneen (2019) also found a similar pattern in which females have more tendency to be depressed than men due to different coping styles towards stress in which females tend to focus more on negative emotions than their male counterparts.

Social support is also crucial in the presence of depression. People who live alone are more likely to have depressive symptoms, and having no close relationships is also detrimental to mental health. It has been found that 10% of women experience depressive symptoms if they have the support of a close relationship compared to 37% of women that have no close emotional support (Brown and Harris, 1978 in Barlow et al., 2015). An Indonesian study by Putriana and Gunatirin (2021) found that the opportunity to interact and receive emotional support helps Indonesians regulate their emotions and avoid depression during the pandemic. On the other hand, social support also helps the recovery of depressed people. Hallgren et al. (2017) found that supportive social networks play an important role in recovery from depression.

Causes of Depression for Indonesian Millennials and Gen Z. Other than the causes mentioned above, the Indonesian literature suggests that there seem to be two significant factors associated with depression among Indonesian millennials and Gen Z: the quarter-life crisis and social media.

Quarter-life Crisis. Several Indonesian studies have cited quarter-life crises as the one factor that accounts for Indonesian millennials falling into depression (Ameliya, 2020; Karpika & Segel, 2021; Maulana & Hidayat, 2019; Putra, 2021; Sari & Prastiti, 2021; Wibowo, 2017). A quarter-life crisis can be defined as anxiety related to uncertainty about the future that occurs in young adults in their twenties and is often centred around romantic relations,

careers, and social lives (Fischer, 2008). In Indonesia, the reasons for such anxiety vary. A study conducted by Yahya and Bahri (2016) explored the problems experienced by 300 university students in and found they lack of confidence about their futures. The students were unsure about who they would become and what kind of jobs they would get, and worried about economic circumstances once they finished their degree and whether the major they had chosen suited them.

The economy and careers seem to be causal factors in quarter-life crises, with concerns about securing jobs that provide sufficient financial security to support their families. Having a promising career does not always make the feelings of anxiety disappear. Wibowo (2017) described a study case of an Indonesian woman who secured a highly sought-after job as a consultant in an American company. Despite her large salary, she ended up not liking her job due to the excessive workload. She learned that more than just financial security she wanted flexibility and time for more social life. Additionally, Misra and Srivastava (2021) mentioned that highly successful people are still prone to suicide due to 1) the pressures of perfectionism; 2) feeling lonely or having only superficial relationships; 3) an inability to handle failure; 4) feelings of insecurity; 5) having domestic issues such as marital conflict; 6) the recession during COVID-19; 7) mental illness; 8) inability to maintain a work-life balance; and 9) pressure to maintain a public image.

Family is also a theme that emerged in research by Sari and Prastiti (2021). In their research, five participants experiencing quarter-life crises were interviewed in an attempt to map the causes. All five participants described that the causes of their quarter-life crises were family-related. Participants mentioned that they were anxious about not being able to support their family economically once they graduate from their university; fear of disappointing their parents was the main reason for their crisis; and anxious about their ability to find a partner and have a family on their own. One participant who already had a partner at the time was unable to maintain their relationship and ended up separating.

Social Media. Even though social media can be at the forefront in spreading awareness and hope around mental distress (Amalia & Anggraeni, 2022), social media has also been cited as one of the causal factors for depression among Indonesian millennials and Gen Z (Al Aziz, 2021; *Universitas Gadjah Mada* [UGM, Gadjah Mada University], 2018; Kurnia, 2019; Pranoto, 2020; Rezkisari, 2020; Sudrajat, 2020). There are several reasons why social media can induce depression. Pranoto (2020) mentioned that Gen Z often compare

themselves with others on social media. Given the pressure to achieve academically, seeing others achieve more can lead to anxiety and depression.

Hamidah (in Kurnia, 2019) postulated that millennials are too reliant on their social media to communicate with others, so much so that they do not develop actual social skills. If these millennials do have to have direct social interactions without the help of social media, any negative feedback or unpleasant experience will be magnified, which can lead to depression. Kartasasmite (in Al Aziz, 2021) mentioned that Gen Z who are addicted to social media, can experience low self-confidence and loneliness and develop a fear of missing out, leading to depression.

Witopo (in UGM, 2018) mentioned a combination of false body image and the inability to filter information on social media as one of the main reasons social media use can lead to depression, as teenagers often look to social media for body image standards. These standards can make viewers feel pressured to meet them. Failure to meet the standard may lead to a lack of self-confidence, potentially leading to depression. Basanti and Susanto (2020) has mentioned that the tendency of Indonesian teenagers to create second social media accounts could indicate splits in their personalities that could lead to depression.

Finally, Sudrajat (2020) conducted a study that investigated the effects of social media on mental health and well-being. Sudrajat used a qualitative approach and interviewed 52 participants aged 11-18. From the study, Sudrajat found that all participants agreed that social media is terrible for mental health and well-being. The participants reported that social media induces depression, stress, and even suicidal thoughts. One of the participants reported feeling intimidated by images on social media which portrayed unrealistic body images. Participants also reported that they had often wanted to imitate the self-harm behaviours that they saw on social media. Finally, the participants reported that they often experienced bullying and intimidation through social media, which led to depression.

Psychological Framework Formulation of Depression

In the clinical psychology and psychiatry setting, practitioners often impose psychological framework formulation methods to understand depression or any other mental health disorder (Johnstone, 2018; Thrower et al., 2023). This particular method has come to the surface, as a result of criticism towards a psychiatric diagnosis that is often criticised for lack of social context and brings stigma towards the service user (Bental, 2009). Psychological framework formulation came as an alternative approach to understanding

mental disorders, with the unique of being more contextualised in relationships, social circumstances, life events, and the sense behind their situation (Johnstone, 2018). Unlike psychiatric diagnoses that rely on the expert's judgement, psychological framework formulation focuses on the strength of the clients. It brings the philosophy of that condition to happen for a reason (Johnstone, 2018).

In alignment with the previous discussion, the biopsychosocial model influences the formulation of the psychological framework. However, instead of making it categorical and focusing on the sole cause of depression, psychological framework formulation brings biological, psychological and social context to create a comprehensive formulation that explains and makes sense of the client's case (Johnstone, 2018; Weerasekera, 1993). Finally, one particular model of psychological framework formulation called the "4Ps Model" can be used to create such a formulation (Bolton, 2014; Weerasekera, 1993)

In a nutshell, the 4Ps model comprises four aspects which are: 1) predisposing/preconditions, which refer to vulnerable conditions that lead a person to suffer from such a mental problem; 2) precipitating, which triggers such a mental problem; 3) perpetuating, what maintains the mental problem, 4) protective, what factors that prevent the person's mental problem become worse (Bolton, 2014; Weerasekera, 1993). Each biopsychosocial aspect can be either predisposing/preconditions, perpetuating, precipitating, or perpetuating factors. The following table provides an example of the biopsychosocial 4Ps model.

Table 9

The 4Ps model using biopsychosocial model.

	Biological	Psychological	Social
Predisposing	Genetic vulnerability Age Gender Race	Adverse childhood events	Socioeconomic status Culture
Precipitating	Substance misuse Onset of medical condition	Negative/maladaptive thoughts	Life events such as: Accidents Loss of a significant person
Perpetuating	Underlying chronic illness	Self-destructive coping mechanism	Social Stigma Unemployment
Protective	Above average intelligence	Adaptive coping mechanism	Social support from communities

Note: From Workplace Assessment Scale: Pilot Validation Study by Huang et al. (2022) under Creative Commons Attribution 4.0 International with some modification based on Handerson and Martin (2014) and Wright et al. (2019)

An example of a Psychological Framework Formulation using the 4Ps model is as below:

X paid an online CT company with a presenting problem of feeling down for the past two weeks. X does not feel like leaving the room and can stay in bed all day, except when taking water and food. While the most likely diagnosis for X would be Depression, instead, the clinical psychologist managed to write a formulation based on one CT session as below:

There are several key points in your life that led you to your current mental state. You informed me that you come from a lower-middle-class family, and even though your parents had always been able to provide the basic necessities for the family, a surplus of needs had never been achieved. Instead, all family members live under constant pressure to be wise and reasonable in every material aspect of their lives. While holidays were present, you never had a holiday that you thought was special enough, such as going interlocal, let alone international. You never have the luxury of owning fancy clothing or gadgets you can be proud of. Whenever you and your family browse the local mall, you are never allowed to buy decent attire. You mentioned that throughout your life, you have managed to accept the situation, that is, until three weeks ago when your group of friends invited you to join a trip to a nearby amusement park that had just opened. The ticket was on promotion, but the price was still too much for you, making you decline the invitation. Your friends ended up having the best time of their lives while you stayed at home. Since that happened, you have been feeling this sad emotion and prefer to stay in your room rather than go out. When I probed you about your feelings, you mentioned that going out would lead to another similar scenario, which could hurt you even more. Your parents realised such a condition; however, you never told them the real reason

every time they asked about it. We then managed to uncover your thoughts about the situation in our first session. You think your life is somewhat confusing; on the one hand, you realise that your parents work hard and provide all the necessary things. However, the fact that they have not given you enough to enjoy what you want makes you sad. You also had conflicting thoughts, where you thought that having such a thought made you believe you were an ungrateful child. With all the confusion, you admit that you need a mental health expert and, thus, come here to have CT sessions.

From the formulation above, it can be seen that it summarises all the important key points in X's life that led to such a mental state. The CP managed to ask the necessary questions and combined them into one chronological formulation to help X understand the situation. This formulation could then become the basis for planning a treatment for X (Weerasekera, 1993)

Effects of Depression

Depressive symptoms offer a glimpse of what might be happening when people are depressed. The symptoms include disturbed eating and sleeping patterns, cognitive dysfunction, and reduced daily productivity (SCID IV-1—Indonesian Version, 2000). However, there are more long-term and short-term effects of depression.

In the medical context, depression is a predictor for repeated hospitalisation with heart failure (Johnson et al., 2012) and early death for patients with heart failure (Ramos et al., 2016). Depression is also a predictor of the development of diabetic foot ulcers (Gonzales et al., 2010). Decreased body immunity is also associated with depression (Reiche, Nunes & Morimoto, 2004).

In the cognitive area, depression can lead to paranoia (Salokangas et al., 2016). Deficits in cognitive domains such as attention, memory and executive functions have been linked to depression (Dillon & Pizzagalli, 2018; Keller et al, 2019; Kraft et al, 2023)

In the social context, depression leads to impairment in social functioning in the workplace, at school and with family (Lépine & Briley, 2011)—increasing the burden of depression. Depression is associated with problematic social interactions and close relationships. It can also lead to lost workdays and family instability.

Perhaps the most crucial impact of depression is an increased rate of self-harm. Recurrent thoughts of suicide are one symptom of depression, and this symptom does not resolve quickly. A study about death by suicide found that the rate of death by suicide for people who have previously attempted suicide was 8.6%. The rate of death by suicide for

people who were currently hospitalized due to an affective disorder was 4%, while the rate for outpatients was 2.2% (Bostwick & Pankratz, 2000 in Lépine & Briley, 2011).

Treating Depression

The following sections describe how depression is treated based on international and Indonesian literature. This section also discusses how CT could treat depression. Finally, a consideration of culture is also discussed to add more Indonesian context to the treatment.

Firstly, it needs to be emphasised that the literature suggests insignificant differences in treating different types of depression; instead, depression disorder should be treated as a continuum of severity. (Rapaport et al., 2002). It has now been established that minor depression disorder is a less severe form of major depression disorder (Fils et al., 2010); but with risks that need to be addressed as soon as possible (Fils et al., 2010; Naber & Bullinger, 2022; Nierenberg et al., 2009; Rapaport et al., 2002). It is important to respond to the disorder with adequate and long-term treatment (Kessler et al., 1997; Naber & Bullinger, 2022) and not perform watchful-waiting; where no treatment is given with the expectation that the sufferer will improve on their own (Naber & Bullinger, 2022).

International literature suggests there are several treatment options for people with depression. The "Handbook of Evidence-Based Practice in Clinical Psychology" edited by Sturmey and Herson (2012) contains extensive references to evidence-based psychotherapies to help people with various mental health complaints. In regard to treating depression, this book lists a number of psychotherapies that have been proven to be effective: a) CBT; b) behavioural activation; c) self-control therapy; d) problem-solving; e) social skills training; f) interpersonal therapy; g) nondirective supportive therapy; h) short-term psychodynamic psychotherapy; i) reminiscence and life review therapy; and j) couple therapy. As additional information, another psychotherapeutic paradigm, mindfulness-based interventions, and medical approach towards treating depression will be explained as well.

The first of best-studied psychotherapy (Cuijpers et al., 2023) for depression is CBT. The basic idea in CBT is that thoughts, emotions and behaviours interact with each other to determine the state of mental health (McLeod et al., 2020). CBT focuses on the dysfunctional (unhelpful or inaccurate) beliefs and thought patterns that often lead to negative emotions which might then become the reasons for negative behaviours (Beck, 2020). Evidence suggests that dysfunctional thoughts might form because of stressful life events (Miranda, 1992). CBT aims to change or modify these dysfunctional thoughts into more neutral and

objective beliefs (Beck, 2011).

Another form of effective treatment for depression is behavioural activation therapy which encourages engagement in pleasurable and meaningful activities to create positive interactions and experiences for the client in their environment (Malik et al., 2021)

Self-control therapy (Kanfer, 1971) is based on the assumptions that mental health issues might be caused by deficits in the three processes of self-control: self-monitoring, self-evaluation, and self-reinforcement. Initially, the therapist asks clients with depression to broaden their attention and focus on the adverse events that have occurred as a result of their behaviours. Secondly, clients are asked to set more realistic goals and standards for themselves, and lastly, to plan ways of achieving those realistic goals using self-rewards rather than self-punishments (Rehm, 1985).

Problem-solving therapy aims to equip people with suitable problem-solving skills and attitudes to cope more effectively with stressful situations in life (Bell & D’Zurilla. 2009). Sessions in problem-solving therapy revolve around generating options for solutions, selecting and actively evaluating the outcome of each, and deciding whether or not the problems have been solved (Nezu et al., 2013).

Social skills training (SST) is based on the assumptions that humans are social beings and that young people with depression often have interpersonal difficulties (Krumholz, 2014). It trains people with depression to interact appropriately with each other (Ndegwa, 2021). Goldstein (1981, in Reed, 1994) states that appropriate social skills involve the ability to organise and assess one’s thoughts and behaviours and direct them towards culturally acceptable goals.

Interpersonal psychotherapy (IPT) focuses more on the immediate problematic interpersonal relationships the client is currently involved in (de Mello, 2005). In IPT sessions, the therapist investigates the client's experiences of loss of attachment, social support, communication patterns, and problem-solving skills (Sburlati et al., 2012). The client's problems are then said to fall into one or more of these categories 1) grief; 2) interpersonal role disputes; 3) role transitions; and 4) interpersonal role deficits (Mufson et al., 2004). Once the problem is identified, the therapy proceeds with a tailored plan specific to the problematic area.

Nondirective supportive therapy is defined as any unstructured therapy that uses only the psychological techniques common to all approaches, such as listening and showing

empathy (Cuijpers et al., 2012). This is the kind of therapy used in counselling and in support groups. It does not aim to teach clients how to solve problems or new coping skills but rather to give them an appropriate time and place to vent and talk about their problems and emotions (Cuijpers et al., 2012).

Short-term psychodynamic psychotherapy (STPP) is a psychotherapy rooted in psychoanalytical theories that analyse the roots of clients' problematic behaviours in elements in their internal world such as drive, ego, object relations, and attachments (Driessen et al., 2015). However, unlike conventional psychodynamic theories, STPP is conducted over a shorter period of time, with up to 16 sessions (Ho & Adcock, 2012)

Reminiscence and life review therapy is specifically recommended for older adults (Westerhof & Slatman, 2019). This therapy considers how one's life experiences have provided the subjective contexts that may have resulted in certain emotions. Thus, the leading framework for this therapy is for the clients to organise and evaluate their memories (Gonçalves et al., 2009)

Couples therapy considers relationship disharmony which could lead both partners into depression (Dekel et al., 2014). It supports both partners in changing the negative patterns in their relationship into more supportive patterns that positively impact the relationship (Barbato et al., 2018).

Mindfulness-based interventions (MBI) are another paradigm to consider when treating depression. This concept became popular in Western literature in the 1990s (Academic Mindfulness Interest Group, 2006). Kabat-Zinn (2003) defined mindfulness as "the awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience moment to moment" (p. 145). In terms of treating depression, Hofmann & Gómez (2017) listed the two most common MBIs: Mindfulness-Based Stress Reduction (MBSR) and Mindfulness-Based Cognitive Therapy (MBCT). During MBSR therapy, clients are asked to practice meditation and body scanning to learn to objectively observe their feelings (Tao et al., 2022). Doing this is believed help clients develop better coping mechanisms for stress, pain, and emotions, and feel better physically and emotionally (Carmody et al., 2009). MBCT is a therapy specially designed for people with a history of depression to prevent future relapse (Crane et al., 2017). It is a combination between MBSR and CBT aimed at helping client to become more aware of the present moment and physical sensations, thoughts and emotions, which can facilitate a decentred

relationship to their own thoughts (Crane et al., 2017).

The practitioner should also consider a medical approach to treating depression. In fact, psychotherapy and antidepressants are often seen as the first-line treatments for depression (Cuijpers, Stringaris, & Wolpert, 2020). Meadows and Martin (2007) also suggest that there could be a collaboration between GP, Psychiatrist and Psychologist when treating people with mental health issues if deemed necessary. At the time of this study, the most influential theoretical approach by the medical profession towards depression is the serotonin theory, which said that depression is caused by a deficit in brain serotonin (Albert, Benkelfat, & Descarries, 2012; Moncrieff et al., 2023). This is then corrected using a selective serotonin reuptake inhibitor, which works by blocking the reabsorption of serotonin into neurons, thereby increasing serotonin activity (Albert, Benkelfat, & Descarries, 2012; Chu & Wadhwa, 2023).

Having said that, newer findings in the medical community have suggested that abnormalities in brain chemicals cause Depression to become unconvincing (Moncrieff et al., 2023). While the medical profession still favours antidepressants that target the chemical imbalance (Moncrieff et al., 2023), other medically based treatments have shown to be promising. Bhatt et al. (2022) find that medicative treatment that targets the inflammatory aspect, specifically inflammatory signalling pathways and their mediators, could be an additional medication approach to accompany other benchmark antidepressant drugs. Musazadeh et al. (2022) suggested that at least eight weeks with a probiotic dosage of $>10 \times 10^9$ CFU could also relieve depression symptoms.

Treatments for Depression in Indonesia.

To explore the situation in Indonesia over the previous 10 years regarding treatments for young adults with depression, a literature review was conducted using Google Scholar and the electronic database of the Indonesian National Library, which was using the EBSCO products at the time. Any academic work with the words "therapy", "depression" and "Indonesia" in the title published between 2012 and 2022 were included. Works with the words "children" or "old age" in the title were excluded.

Searching Google Scholar using the criteria above, a total of 197 academic works were retrieved which included journal articles, conference proceedings, and theses. The therapies discussed in the 197 works were: a) spiritual therapies (16.2%), b) music therapy (12.1%), c) group therapy (9.1%) d) CBT (8.6%) e) psychopharmaceutical treatments (7.6%), f)

cognitive therapy (5%), g) emotion-focused therapy (5%), and h) other therapies (36.4%).

Searching the Electronic Database of the Indonesian National Library using the criteria above retrieved 45 academic works which were mainly journal articles. The therapies discussed in the 45 works were: a) CBT (22.2%), b) spiritual therapies (15.5%), c) group therapies (11.1%), d) music therapy (8.8%); e) Other Therapies (42.4%).

To add to the understanding of the treatment of depression in Indonesia, official publications produced by governmental and professional organisations in Indonesia were examined. Firstly, *Keputusan Menteri Kesehatan Tentang Pedoman Nasional Pelayanan Kedokteran Jiwa* [Minister of Health Decree Concerning the National Guidelines for Psychiatric Services] (2015) provides guidelines on how to treat depressed people by using medication (i.e., antidepressants), followed by psychosocial therapies recommended by the ministry including: 1) cognitive therapy; 2) interpersonal therapy; 3) behaviour therapy; 4) psychodynamic therapy; and 5) family therapy.

IPK Indonesia (2021) has produced *Pedoman Nasional Pelayanan Psikologi Klinis* [National Guidelines of Clinical Psychology Services] to support Indonesian CPs in their daily clinical psychology practices. The primary contents of this book are the guidelines for best practices for treating people with psychological disorders. According to this book, the therapies that are suitable to be used for depression based on the evidence are a) CBT; b) acceptance-based and mindfulness-based CBT (ACT, MBCT); c) cognitive behavioural analysis system of psychotherapy (CBASP); d) interpersonal therapy; e) behavioural activation; f) behavioural couple therapy (BCT); and g) psychodynamic theory. The guidelines also suggest a collaboration with the medical profession if deemed necessary. There are two main scenarios in which CPs are recommended to collaborate with the medical profession. Firstly, CPs are recommended to collaborate with a psychiatrist when the depressed client is diagnosed to be at a severe level to the point of being suicidal or having psychotic episodes. Another collaboration is deemed necessary if the depressed client seems to have a medical illness or condition that needs to be addressed by the specialist.

Comparing and contrasting these findings from multiple sources, there are similarities and differences between the treatments recommended in the literature, by the Indonesian government, and by the official professional body of Indonesian CPs. Firstly, therapies based on cognition and behaviours are present in all sources. These types of therapy manifest under different terms, including CBT, cognitive therapy and behavioural therapy. As

suggested previously, this finding was expected given that there is the most evidence for the efficacy of this type of therapy (Cuijpers et al., 2023).

There are two main differences that stand out in the findings above: firstly, the appearance of psychopharmaceuticals in Indonesian government policy and secondly, that the search in Google Scholar retrieved works from disciplines other than psychology. This could be justified because mental health professionals collaborate with each other to treat depression (Setiadi et al., 2017). One cannot prefer one discipline over another, and the focus must be on the client. According to Turnip (2020) from the IPK Indonesia, there are four levels of mental health intervention, with the fourth level requiring a specialist mental health professional, who is described as either a psychiatrist or a CP.

Another difference between the findings is that the official (IPK Indonesian and Kemenkes) recommendations tended to favour already well-established therapies, while the literature survey tends to have more diverse therapies. The survey shows that the Indonesian community is also interested in other types of therapy, such as spiritual and music therapies, which emerged between 2012 and 2022.

Spiritual therapies are comprised of many subtypes. Two of the subtypes being used are *dzikir* and *murottal* therapies which are based on Islamic religious principles. *Dzikir* therapy, according to Hidayat and Mulyadi (2020), induces passivity or resignation using repeated words, resulting in composure and calm. A person practicing *dzikir* therapy must enunciate phrases aligned with teachings in Al-Quran. In English, "*dzikir*" can be translated as a remembrance, and the basic idea of this therapy is to remember God (Niko, 2018). As well as producing calm as a psychological effect, *dzikir* therapy can also act as a cathartic outlet, increase optimism and belief that God will help the person to get through difficult moments and, lastly, as a means of surrendering to God's will (Haq, 2011; Niko, 2018).

Murottal therapy, a music therapy, was also found to be one of the most researched therapies in Indonesia. In music therapy, a person will listen to certain kinds of music to induce physical and mental states (Ocktaviani & Mariayati, 2022). Music therapy aims to increase levels of serotonin and endorphins to induce relaxation. The types of music used are varied; it could be classical, popular, traditional, or, in the case of *murottal* therapy, religious music (Astuti, 2018; Hairiah & Harianto, 2017; Harisa et al., 2020; Rusanto et al., 2012).

Finally, survey also found that group therapy has also been commonly used by the Indonesian practitioners. In self-help group therapy, people with the same issues meet to

support each other (Seekles, 2011). During the sessions, group members talk about their issues and treatments and offer cautionary advice, and receive encouragement and advice in return from other members (Ririnisahawaitun, 2010).

Chat Telepsychotherapy in Treating Depression.

Several treatment options from the perspective of international and Indonesian literature have been mentioned in the previous two sections. Looking at the literature, several therapeutic approaches seem to be favoured by text-based distance therapy to treat depression. Kessler et al. (2009) use CBT as their theoretical approach in their chat-based intervention to treat depression. The client and therapist communicate in real-time synchronous chat. The sessions last for 55 minutes and last for 16 weeks.

Kramer et al. (2014) used chat-based treatment with the solution-focused brief as the theoretical approach to dealing with depression. Similar to the previous discussion, the communication is conducted via real-time synchronous chat. Through these chat messages, the therapist delivers miracle questions, a philosophy in solution-focused treatment where the clients describe how the future will be different when the problem is gone. The therapeutic chat session also practices other solution-focused unique techniques such as setting goals, being aware of their strengths, and formulating solutions, along with other solution-focused methods. All of this was conveyed or discussed using chat messages.

Goldin et al. (2019) use CBT as their theoretical approach in their chat-based intervention to treat depression. The content of the chat intervention not only relies on chatting communications but uses other features of the mobile app application that can deliver video, audio, and graphics. Lindqvist et al. (2020) used internet-based psychodynamic psychotherapy (IPDT) as a theoretical approach to dealing with depression. The intervention consists of real-time synchronous chat communication with the therapist for eight weeks. It also has other components: modules that consist of text, videos, and exercises.

To summarise, a multiple theoretical approach can be used in CT treatment. This discussion also emphasised that the chatting application used for the therapy would need to have extra features, such as the ability to send pictures and videos, which could help the process.

Targetting The Perpetuating Factors

Looking back at the Psychological Framework Formulation, the literature suggests treatment for depression or any other mental health illness should target perpetuating

factors and not only focus on symptoms (Potsch & Rief, 2024). To start with, Borsboom (2017) introduce a network theory of mental disorders that postulates that there is a network in the mental disorder in which symptoms of a mental disorder are causally related to each other through myriads of biological, psychological and societal mechanisms. This means targeting a particular symptom that may be activated because of other untreated symptoms may not be effective. For example, loss of energy and insomnia, two symptoms of depression, are biologically correlated with each other, as lack of sleep will result in the loss of energy. If we look further, the insomnia behaviour may be an effect of another cause; thus, giving treatment such as a sleeping pill might give more sleep. However, without treating other symptoms that cause insomnia in the first place, it will not be as effective. In a nutshell, Borsboom (2017) suggest that symptoms that are highly correlated with each other could lead to a cluster of psychopathology symptoms that becomes self-sustaining; there would be specific symptoms that maintain the disorders.

Regarding depression, the literature suggests that therapy should even go deeper than finding specific symptoms that maintain the disorder. Therapy should go into the perpetuating factors that cause the symptoms to be sustained. Mancini and Gangemi (2015) postulated that two perpetuating factors in depression should be addressed: cognitive and interpersonal processes. Regarding the cognitive process, Kaney (1997) suggested that people with depression tend to overestimate the negative sides of events, leading to them feeling fewer positive events occurring to themselves and more positive events happening to others. For interpersonal processes, Hames et al. (2013) suggest that depressed people tend to show deficits or negatively evaluate their social skills. Behaviour such as responding less to the conversation and disclosing negative information would make depressed people unable to pursue or maintain relationships. This then leads to the absence of relationships that could increase the severity of depression. Finally, the literature suggests that two theoretical approaches towards psychological treatment that seem to be effective and aligned with this Psychological Framework Formulation are CBT and IPT, which have been discussed in the previous sections.

Culture and Psychotherapy.

Culture not only affects the symptoms of mental disorders; it also affects psychotherapeutic interventions. According to Bernstein et al. (2018), psychotherapy originated in Western culture, which can be considered as individualistic rather than

collectivist. As discussed, the terms individualism and collectivism describe the extent to which people are motivated to act as individuals or members of a community or group. Western countries such as Australia and the United States are often seen as countries with high levels of individualism, where an individual's autonomy is prioritised. Asian countries, on the other hand, are often seen as collectivist countries that prioritise interrelatedness (Hofstede et al., 2010). The different cultural views affect how psychotherapy is given. Applying psychotherapy that has originated in one culture to clients from another culture may be irrelevant or even oppressive (Moleiro et al., 2018). One of the reasons is that psychotherapy requires clients to reflect on themselves. This self-reflection can differ due to cultural variations. Some clients might perceive themselves as separate from others, while others might perceive themselves as a part of a more extensive system (Bernstein et al., 2018). Another reason is that psychotherapy aims to optimise clients' functioning within society, which may differ due to differing cultural values (Bernstein et al., 2018).

It has previously been discussed that Indonesia, as a country, tends to have a high level of collectivism. This leads to a concern regarding the suitability of Psychotherapy in the Indonesian setting. In response to this, existing literature might offer some answers. Firstly, it has been mentioned in "The Characteristics of Indonesians" section (p. 22) that newer research found that Indonesians may not be all collectivist. The study from Suharnomo and Syahruramdhan (2018) found that one ethnicity in Indonesia, Minangkabau, is relatively high on the individualism scale. A similar finding also comes from Mangundjaya (2013), with a sample of over 2000, found that Indonesian people score relatively high in individualism. Forty-two per cent of the sample comes from Javanese ethnicities. Furthermore, the rising rate of divorce, along with the narcissistic behaviour often portrayed by the younger Indonesians, are also associated with a high level of individualism. Secondly, the literature also suggests that Psychotherapy could be tailored towards the client's culture. For example, the newer version of CBT, a theoretical approach in psychotherapy based on the Western individualistic worldview (Guo and Hanley, 2015), has more room for the client's values and culture (Beck, 2021). CBT could be culturally responsive by assessing the client's and family's needs, emphasising culturally respectful behaviour, identifying culturally related strengths and supports, and validating clients' experiences of oppression (Beck, 2021).

In Indonesian literature, Zaumseil (2003) mentioned that different processes and

techniques can make psychotherapy work in the Indonesian population. For example, Indonesians value the certainty of the outcome; they also have a somewhat hierarchical relationship with the therapist as opposed to a relatively equal position as Western psychotherapy (Zaumseil, 2003). In regard to treatment planning, therapists should be aware that Indonesians value their belonging to subgroups (such as religion) and family as important (Zaumseil, 2003). This discussion suggests that there is an indication that Psychotherapy could be appropriate for Indonesians. Being individualistic in nature, conventional Western psychotherapy might be suitable for certain ethnicities and age groups in Indonesia. Adjustments or tailor-fitting might need to be made to be suitable for the rest of Indonesians, which has a high level of collectivism.

The importance of culturally sensitive psychotherapy has been established to be beneficial for this study. To act on that, the current research used a framework from Bernal et al. (1995), which consists of nine dimensions as a guideline to make a culturally sensitive Psychotherapy. The framework is based on a scoping review of twenty years of clinical studies, with the final review analysis focused on cultural sensitivity and ecologically valid interventions. This framework outlined in Table 10 results from a review of the relevant clinical literature published in years dating back to when Bernal's study was published

Table 10

Aspects of Culturally Sensitive Psychotherapy by Bernal et al., (1995)

Aspect	Explanation
Language	Language is the vehicle for emotional expressions, mannerisms, and verbal style. Failure to understand these matters could lead to misinterpretation of such expressions that could lead to ineffective treatment
Persons	Ethnicity plays a significant role in client-therapist relationship during the intervention. Different behaviours are accepted, expected or rejected in different cultures. Failure to act accordingly could result in ineffective treatment.
Metaphors	Every culture uses distinct metaphors, symbols and concepts that members of the same culture all understand. The psychotherapist who understands their clients' metaphors can help them feel more comfortable.
Content	Psychotherapists should be aware of their client's unique values, customs and traditions when conducting assessments and planning treatments.
Concepts	It is essential to communicate the theoretical models underpinning diagnoses and treatments to the clients using concepts that are appropriate to the client's culture.
Goals	It is essential to ensure that goals are sensitive to the clients' values, customs and traditions.

Methods	Every treatment given to clients to support them to achieve the treatment goals should align with their culture.
Context	Consideration for clients' broader social, economic, and political contexts as well as their developmental stages, social supports, acculturative stress and migration phases is important.

The Therapeutic Relationship as The Common Factor of Psychotherapy.

It has been mentioned previously that culture affects psychotherapy wholly or partially, with different frameworks for psychotherapy lead to different types of problems with conceptualisation and treatment. However, Rosenzweig (1936) argued that all psychotherapies share common factors. Cuijpers et al. (2019) stated that the therapeutic relationship has been proposed as the most important common factor. The current study investigates the therapeutic relationship as the common factor by exploring the aspects that contribute to the relationship.

Norcross and Lambert (2018) explored which factors in the therapeutic relationship are most influential. The results of the study yielded six factors that are evidently effective in individual psychotherapy and calculated the effect size of each factor. Factors with significant effects are (a) Collaboration ($d = 0.61$); (b) Empathy ($d = 0.58$); and (c) Alliance ($d = 0.57$). Goal Consensus, with a medium effect size, and Positive Regard and Affirmation, with a small effect size, did not show significant effects but were still found to be important. The last factor, Giving and Receiving Significant Client Feedback, had a varying effect size ($d = 0.14$ – 0.49) depending on the comparison group and feedback method.

Evidence-Based Manual

The current study aims to create the first-ever evidence-based guidelines (i.e., the manual) to conduct psychotherapy using synchronous text-based (i.e., chatting) communication for Indonesian people with minor depression. The term evidence-based used in this research refers to Evidence-Based Psychological Practice (EBPP) postulated by American Psychological Association Task Force on Evidence-Based Practice (2006). The scope of this study is establishing the CT manual only and not to the point where the manual being tested for its effectiveness. All in all, evidence-based psychology practice refers to any psychological practice that considers three important aspects in their decision-making: 1) best available research evidence, which suggests that every psychological treatment decision-making should be based on previous studies that have claimed that such

practice/treatment is safe and effective; 2) Clinical expertise, which refers to the fact that CP is trained as both practitioner and scientist; CP should be able to integrate clients characteristic and best available evidence to design a treatment that has the highest probability to achieve the goals of the therapy; and 3) Client characteristic, culture and preference, refers to the notion that treatment would be effective if clients unique values (characteristic, culture and preference) are taken into account when designing the treatment.

This philosophy of EBPP also guides the production of the manual, which examines all data from the participant and compares it with the available research. The manual also considers the client's values and how they should be embedded in the treatment suggested in the manual.

Summary of literature review

As the main focus of the study, the use of the term chat telepsychotherapy (CT) might only be first utilised in this study. The literature uses a number of terms, such as online counselling, online therapy, chat psychotherapy/counselling, e-counselling, and text-based therapy/counselling, to describe a concept and build a comprehensive understanding of a therapeutic relationship in which the practitioner provides an intervention to ease clients' mental illness via chat messages. However, a completely new term (i.e., Chat Telepsychotherapy) is used in this study to distinguish the concept from previous ones.

The literature suggests that the concept of text-based therapeutic relationships is common and has existed since the 1920s. However, the current form of text-based therapeutic relationship was established in the 1960s. The evidence from Indonesian literature suggests that the concept arrived in Indonesia in the 2000s. The possible combination several of factors, which are: 1) technological advances; 2) the rise of online social media; 3) the shift in communication style from in-person communication towards chatting for the younger generations; 4) the ability of chatting communication to also provide support and relief; 5) the low numbers of Indonesian CPs or mental health professionals in general compared to the widely dispersed population of Indonesian; 6) the centralised location of the practitioners; 7) the stigma faced by person with mental illness and lastly, 8) the effects of the COVID-19 pandemic have made CT popular in Indonesia, especially with younger generations.

The literature study has shown that CT may have advantages and disadvantages, which can be grouped under accessibility, verbal and non-verbal cues, anonymity and invisibility,

writing, the types of mental illnesses suitable for CT, ethical and legal matters, and client suitability. Despite these, the potential for CT to become an effective mental health intervention may be high. Several pieces of evidence from international and local Indonesian literature have shown that CT can be effective and make lasting changes to mental health.

This study has focused on designing a manual to help Indonesian CPs treat Indonesian people, particularly Indonesian millennials and Gen Z, who suffer from minor depression, using CT as the primary intervention. There are several reasons as to why this particular choice has been made. Firstly, it has been mentioned that CT has become popular among Indonesia's younger generations; Millennials and Gen Z are the dominant generations in the Indonesian population, making up about 53.81% of the population. Secondly, depression is a common mental illness in Indonesia, with approximately 6.1% or 16 million people affected by it. While there is no specific data on how many of the younger generation suffer from depression, Indonesian surveys have suggested that, on average, 5.7% of Indonesian people between 15 and 44 years old suffer from depression. Thirdly, mental health treatment in Indonesia is still in the early stages. Despite an active programme to improve mental health, Indonesian sufferers experience stigma, mental health programmes are only supporting rather than primary programmes in public health centres, and finally, the numbers experiencing mental illness and distress are increasing. This then leads to the increased need to strengthen the seemingly seek-upon intervention (i.e., CT) by the sufferers. Finally, despite the urgency, there have been no Indonesian studies that focused on providing comprehensive guidance that could help Indonesian CPs conduct CT in general, let alone treat depression as a mental disorder with high prevalence in the Indonesian population. The discussion shows the worth of this study and that creating a CT manual to provide guidance on delivering a mental health intervention popular with the younger generations can have a significant impact on Indonesian society.

The decision to use the term psychotherapy in CT is deemed to be suitable as psychotherapy in mental health treatment that is characterised by its ability to treat a rather complex mental health disorder; it is more structured and aims to facilitate long-term change. Despite the term, minor depression is not a minor disease as it represents the same illness and risk as major depression disorder. This is the reason why the specific minor depression, and not major depression, is chosen to be the target of intervention in its study. Even in its degree of severity, minor depression needs a serious response with adequate and

long-term treatment.

This study also acknowledges the importance of culture in the process of psychotherapy. Essentially, psychotherapy is an individualistic intervention that is based on Western culture. A tailor-fitting is needed to ensure it is appropriate for Indonesia's collectivist culture. The literature also suggests the manifestations of depression might be different in Indonesian settings. Based on several studies found in the literature, depression may have physical manifestations that Indonesian psychologists should be aware of. To cater for these possible differences, this study uses the philosophy of evidence-based psychological practice to ensure that the manual's content would consider the best available research evidence, clinical expertise, and the client's values. Two main theories were also used as a reference for the data gathering. Bernal (1995) listed eight factors that can be utilised to design culturally sensitive psychotherapy. Therapeutic relationships as a common factor in psychotherapies are also explored to understand how the therapeutic relationship should be addressed in the study setting. Finally, physical symptoms of depression are also investigated to create a better understanding of the manifestation of depression in an Indonesian setting.

Research Questions

The primary goal of this study is to establish the first-ever CT manual that would contain fully comprehensive and practical guidance that could potentially provide guidelines for Indonesian CPs to treat Indonesian millennials and members of Gen Z who suffer from minor depression. This study also has a secondary goal, which is to start a discussion about the somatic symptoms being experienced by Indonesians who suffer from minor depression. The data-gathering process would include a small portion of the discussion dedicated to the secondary goal. For the primary goal, the following research questions would guide the data-gathering process.

Regarding the concepts and processes of CT:

- How is CT conceptualised and defined in Indonesia?
- How do Indonesians experience text-based therapeutic relationships currently?
- What are the advantages and disadvantages of CT, and what might improve the current state of text-based therapeutic relationships?
- How can CT be best delivered to meet clients' needs?
- What are the features needed in order for the CT to be effective?
- How can a therapeutic relationship be created through chat?

Regarding depression and therapeutic aspects of the manual,

- How can clients with minor depression be best supported over chat?
- Are there any differences in terms of the manifestations of depression in Indonesia compared with other countries?
- What types of psychotherapy are suitable to be delivered using CT?
- How should the stages in CT be laid out?
- How should the sessions be arranged and structured?
- What are the goals for each session?
- How can confidentiality be addressed in CT?

To optimise the cultural aspects of CT,

- How might culture affect the process of CT with Indonesians?
- What values need to be upheld during CT with Indonesians?
- What are the characteristics of Indonesian millennials and Gen Z, and how do they affect the CT process?
- How can we best address the diversity of Indonesian people, knowing that CT is a national service?
- How are the Aspects of Culturally Sensitive Psychotherapy by Bernal et al. (1995) conceptualised in Indonesian CT?
- How is the therapeutic relationship, which is the common factor of psychotherapy, being conceptualised in Indonesian CT?

Chapter 3 – Research Design

Introduction

This chapter describes the research design for this study, including: 1) the research paradigm; 2) recruitment of participants; 3) methodology; 4) measurement tools; 5) data collection; 6) ethics permissions and funding; 7) data analysis. A protocol article containing the rationale until the research design has been published¹ and can be found in Appendix L (p. 484).

Research Paradigm

One reason for research is to come closer to reality by acquiring knowledge about it (Pajo, 2022). In practice, the researcher's understanding of reality, or the research paradigm needs to be considered (Rehman & Alhartini, 2016). Three questions provided by Guba and Lincoln (1994) are a commonly used method (Barrow, 2018) to help researchers to explore their research paradigm.

1. *What is the nature of reality, and what can be known about it? What do we believe about the nature of reality?*

This ontological question explores the researcher's assumptions about reality, which can range from an assumption that there is one single reality driven by immutable natural laws and mechanisms to the assumption that there are multiple realities depending on the time and context (Chilisa, 2012; Guba & Lincoln 1994)

2. *What is the nature of the relationship between the known, the inquirer and what can be known? How do we know what we know?*

This epistemological question explores the researcher's process to arrive at their assumptions about reality, which range from objective means where the investigated concept is seen as completely separate from the researcher to a subjective process, where the findings are seen to be the result of the interactions between the researchers and the investigated concept (Guba & Lincoln, 1994)

3. *How can the inquirer discover what they believe can be known? How should we design the study?*

Answers to this methodological question depend on the answers to the previous two questions. Potential methodologies include hypothesis testing in quantitative studies, which sits with objective process, to direct interactions with the phenomena in qualitative studies, which sit with a subjective process (Guba & Lincoln, 1994)

¹ Endro, W. T. W., Shepherd, M., Kempton, H., & van Ommen, C. (2021). The Co-Design of a Chat Telepsychotherapy Manual for Indonesians with Minor Depression-A Research Protocol. *Journal of Innovation in Psychology, Education and Didactics*, 25(2), 115-130.

Each research paradigm relates to different ontologies, epistemologies and methodologies. A positivist researcher would stand on the view that there is only a single reality, and the researcher could objectively find the true nature of the phenomenon using methods such as questionnaires to prove hypotheses related to the investigation. Post-positivist researchers hold a similar value to positivist researchers regarding epistemology and methodology. However, they do not believe that studies would find the true nature of the phenomenon, but rather a possible explanation towards the phenomenon. On the opposite side, a constructivist researcher would assume that there are multiple realities depending on the context and locality. Explanation could be approached subjectively with interviews and observation (Guba & Lincoln, 1994).

Current Research

One of the factors that influence a researcher's choice of paradigm is their research experience (Barrow, 2018). Reflecting on my own research which were all in the discipline of psychology, I believe that psychology as a discipline cannot assume a single objective reality. For example, the concepts of happiness are dependent on culture. Western definitions of happiness are generally different from Eastern definitions. During the literature review, I also realised that even mental disorders can manifest differently in different cultures. Using standard Western standard diagnostics with Eastern people might result in misdiagnoses and maltreatment. Throughout this journey, I have become increasingly enlightened on how different societies and contexts shape the knowledge that works effectively in the specific society and not elsewhere.

That said, I am also aware that some assumptions of a single reality could best explain some situations. For example, I conducted research to see whether there were differences in the levels of religiosity of two religious groups. Starting with a hypothesis and using statistical analysis to determine whether the two groups showed significant differences in their scores. Scores in some of the dimensions were significantly different, and some were not. This experience taught me that a single objective reality is either significantly or not significantly different. The findings of the analysis were driven by objectivist values that was based on the scores from the questionnaires. From these experiences, along with my discoveries during this PhD, I have learnt that any determination about reality depends on the aims of the research and the research questions.

The primary goal of this research is to create a manual that could potentially help Indonesian CPs conduct CT with Indonesian millennials and Gen Z who are suffering from minor depression. My literature review suggested that the best way to create such a manual was by collaborating with the stakeholders, i.e., those whom the manual will directly impact. These are the Indonesian CPs who deliver the therapy along with the Indonesian millennials and Gen Z who receive it. I hoped that combining the data and information from the participants' experiences and expertise along with the support from the existing research would create the best basis for the manual. There is also a need to consider that I was also an active practitioner of such treatment for almost three years before stopping my practice to focus on my PhD study. This means I also have the experience, skills, and knowledge about CT.

In consideration of the points above, I chose pragmatism as the particular research paradigm for this research. Pragmatism was described by the 1870s by American philosophers Charles Sanders Peirce and William James (Boersema, 2002; Forney, 2001) in response to the then prominent issue of "dualism". Kuhn (1962) mentioned that previously scientists from opposing paradigms of positivism and interpretivism could not even talk to each other due to their opposite views of reality and methodology. Pragmatism became a solution to the issue as it encompasses the belief that it is impossible to hold to one single paradigm and that multiple paradigms are necessary to fully understand phenomena (Johnson, 2008). Pragmatists base their choices of methods on what works and what solves the problem (Johnson & Onwuegbuzi, 2004).

Pragmatism was chosen as the best paradigm to use in the design of the research because the research includes many perspectives and a range of evidence to be considered in decisions about the final product, and the design of the research may need to allow both deductive and inductive reasoning in the process of solving the problem (O'Brien et al., 2016). Moreover, as the goal of the current research was a product (i.e., the manual), the conduct of the research required myself as the researcher to be creative and curious about the real-life experiences of the stakeholders to form the best understanding; this in itself required different epistemologies such as hypothesis testing and the evaluation of experiences during the process (Simonsen and Robertson, 2013).

The pragmatist paradigm suited the current research as the knowledge generated by this research was contextually specific and might only apply to the specific subjects, i.e.,

Indonesian millennials and Gen Z who suffer from minor depression. While the concepts of depression and psychotherapy might be universal, the manifestations and suitable psychotherapeutic techniques might not be the same for other populations outside of this context. However, the process for recruiting the participants, which was best done utilising an established depression measure and structured interviews with high psychometric value, along with the analysis of the data from the participants, which need to be compared with findings from the existing research, suggested that this research also needed to accept the paradigm of a single reality. This research therefore needed to hold two paradigms simultaneously.

Recruitment of Participants

This section starts with a discussion about the number of participants, the inclusion and exclusion criteria for both participant groups, followed by a summary of the recruitment processes for both groups. This section also provides demographic data of the participants.

The Number of Participants

There were two groups of participants. The first group consisted of CPs, and the second group consisted of clients (i.e., Indonesians millennials and Gen Z who suffer from minor depression). Several factors were considered to determine the number of participants in each group. Firstly, Morgan and Lobe (2011) suggested that online synchronous focus groups should consist of only of three to five participants. However, Kite (2017) conducted an online focus group with six participants, and the research received comments on having a very small sample by a referee. Looking at offline focus group discussions, Krueger and Casey (2014) mentioned that offline group discussions of five to eight would be suitable as more may hinder active participation.

As these findings were acknowledged, I decided to use eight participants for each group. Having three to five participants, as suggested by Morgan and Lobe (2011), would be too small for the study. The possibility of not all clients attending all the sessions and even losing clients throughout the research journey was high. The article itself was a relatively older reference. In 2011, the advancement of technology and features in online focus group discussions were probably less advanced than at the time of this study. With extra findings from Kite (2017) suggesting that six participants were still too small and Casey (2014) suggesting that eight participants could result in active participation, I was confident to decide to have eight participants for each group.

Inclusion and Exclusion Criteria

Inclusion Criteria. Clinical Psychologist working in Indonesia were recruited for the Psychologists Group (PG), while Indonesian millennials and Gen Z who experience minor depression were recruited for the clients group (CG). The criteria for each group are listed below:

A. Psychologists Group.

- Identify themselves as people who belong to the Indonesian culture
- Identify themselves as people who grew up with Indonesian customs and lifestyles (e.g., eating Indonesian dishes, having an Indonesian lifestyle in their upbringing, and surrounding themselves with other Indonesian people)
- Able to speak Bahasa Indonesia
- Registered Clinical Psychologist
- Technologically literate (e.g., having smartphone/s with access to emails, having chatting application/s installed, understanding the concept of downloading, uploading, and storing data in a cloud system)
- At least six months experience in CT
- Have experience in CT with a minimum of 10 clients

B. Clients Group.

- Identify themselves as people who belong to the Indonesian culture
- Identify themselves as people who grew up with Indonesian customs and lifestyles (e.g., eating Indonesian dishes, having an Indonesian lifestyle in their upbringing, and surrounding themselves with other Indonesian people)
- Able to speak Bahasa Indonesia
- Aged between 19-40
- Technologically literate (e.g., having smartphone/s with access to emails, having chatting application/s installed, understanding the concept of downloading, uploading, and storing data in a cloud system)
- Have at least one experience been a client of CT.
- Currently suffers from minor depression (based on The Inventory of Depressive Symptomatology–Self Report [IDS-SR] - Indonesian Version and Structured Clinical Interview for DSM IV–1 [SCID-IV-1] – Indonesian Version)

Exclusion Criteria. The exclusion criteria for CG participants are CG were based on SCID-IV—1—Indonesian Version. Any participant who met any of the criteria below was not eligible to contribute to this study:

- Substance abuse
- Illness or disease caused by neurological, cerebrovascular, metabolic, endocrine, virus, infection, or cancer
- Current or previous psychotic disorder
- Current or previous manic or hypomanic disorder

Other exclusion criteria include: 1) having suicidal behaviour for the last seven days; 2) currently on menstrual period as literature suggests It might be related to symptoms of depression (Jan et al., 2016; Sumarni et al., 2022; Yonkers et al., 2008; Yuliani & Izzati, 2017).

The Recruitment Process.

Clients Group Participants. To recruit the clients group participants, a recruitment poster (Appendix H, p. 452) with a link to the online questionnaires was posted on two social media platforms: Facebook and Instagram. The questionnaires used for the first stage of screening were IDS-SR - Indonesian Version (Appendix I, p. 453), depression symptomatic questions (Appendix N, p. 505), and demographic questions (Appendix N, p. 505). A possibility of emotional distress was informed before completing the questionnaire, and an emergency helpline was also listed for clients who might need it during the recruitment process. Paid promotions were used to enhance the poster's reach. The poster was first posted on 5 May 2021. I closed the recruitment on 19 May 2021 with 181 interested people who completed the online questionnaires. Of those people, 152 were unsuitable for participants for several reasons, as summarised in the table below.

Table 11

Reasons for Exclusion from Clients Group Participation Following IDS-SR, Symptomatic and Demographic Questionnaire.

No	Reasons	Number	Percentages
1	No experience with a chat-based therapeutic relationship	60	39.47%
2	Having suicidal thoughts in the past seven days.	47	30.92%
3	Not depressed or too depressed (Based on IDS-SR)	27	17.75%
4	Depressed but menstruating at the time	3	1.97%
5	Neurological or cerebrovascular illness or disease	3	1.97%
6	Depression related to bereavement	8	5.26%
7	Unresponsive to the communications made by the researcher for future interview	3	1.97%
8	Conflicts of Interest	1	0.69%
Totals		152	100.00%

The next part of the recruitment process was the interview using SCID-IV-1 – Indonesian Version (Appendix K, p. 471), for which 29 people were eligible. Twenty-five interviews were scheduled from 8 May 2021 to 16 May 2021; the remaining four people were

not scheduled for an interview due to the participant quota being filled. One person scheduled for an interview was also told that the interview was cancelled due to the participant quota being filled. These potentially eligible participants were sent apology messages stating that future contact might occur if needed. Three people did not attend the interviews. Finally, out of 21 who were interviewed, eight people were eligible to become the participant in this study. The remaining 13 people were ineligible for the reasons listed in Table 12. Table 13 outlines the profiles of the participants.

Table 12

Reasons for Exclusion from Clients Group Participation Following Interviews

No	Reason	Number	Percentage
1	No experience with a chat-based therapeutic relationship	2	15.30
2	Not depressed or too depressed (Based on SCID-IV—1)	10	76.92
3	Depression related to bereavement	1	7.78
Totals		13	100.00

Table 13

Clients Group Characteristics

No	Gender	Age	Domicile	Generation	Occupation	Education	CT Sessions Experience
1	Male	24	Jambi Sumatra Island	Gen Z	No occupation	Bachelor of Public Administration	6
2	Male	24	Surabaya Java Island	Gen Z	Casual rice seller	Bachelor of Biology	<i>missing participant</i>
3	Male	26	Sumbawa Island	Millennial	Field agent in agricultural company	Bachelor of Agriculture	5
4	Male	27	Bandung Java Island	Millennial	Casual master of ceremony	3-year diploma in textiles. Currently studying for Bachelor of Public Relations	2
5	Male	20	Bengkulu Sumatra Island	Gen Z	Air conditioning technician	Vocational high school communication networks major	8
6	Female	26	Lampung	Millennial	Casual food	Bachelor of	7

No	Gender	Age	Domicile	Generation	Occupation	Education	CT Sessions Experience
			Sumatra Island		seller	Management	
7	Female	30	Jakarta Java Island	Millennial	Teacher	Bachelor of Education	2
8	Female	30	Jakarta Java Island	Millennial	Lecturer	Master of Guidance and Counselling	4
Mean Age		26.14	Mean CT Experience				4.85
Age SD		3.84	CT Experience SD				2.34
			CT Experience Range				6

Psychologists Group Participants. The recruitment process for the PG was assisted with the help of IPK Indonesia. First contact was made on 3 June 2020 and IPK Indonesia posted the research poster (Appendix G, p. 450) on their social media on 22 May 2021. Between those dates, I was required to send a letter of request and make a presentation on the proposed research.

Following the social media post, a number of CPs immediately contacted me and showed interest in the research project. I closed the recruitment just one day after the posting due to high interest. In total, 23 CPs showed interest in the research. Fourteen interviews were held between 23 May 2021 and 3 June 2021 for eligible participants. Eight of the interested psychologists did not qualify because: 1) their license needed renewal, 2) they needed more experience in CT, or 3) they did not respond to my communications. One psychologist was not interviewed because the participant quota was filled. Out of the 14 interviewed, eight psychologists were deemed suitable for the research, while the other six were not suitable because 1) their licenses needed renewal, 2) they needed more experience in CT, or 3) they could not commit to attending the OFGDs. Table 14 below summarises the PG members' characteristics.

Table 14

Psychologists Group Characteristics

No	Gender	Age	Ethnicity	Place of Practice	CT Experience (Months)
1	Female	39	Javanese	Yogyakarta	9

No	Gender	Age	Ethnicity	Place of Practice	CT Experience (Months)
Java Island					
2	Female	36	Sundanese	Bekasi Java Island	19
3	Female	27	Malay	Jambi Sumatra Island	7
4	Female	34	Bugis	Bekasi Java Island	29
5	Female	28	Malay	Kuala Tungkal Sumatra Island	16
6	Male	31	Javanese	Sragen Java Island	7
7	Female	38	Malay	Banyuasin Sumatra Island	21
8	Female	31	Javanese, Sundanese	Sleman Java Island	14
Mean Age		33	Mean Experience		15.25
Age SD		4.47	Experience SD		7.68
			Experience Range		22.00

Methodology

In line with the research questions and chosen research paradigm, the study used mainly qualitative methods to obtain and analyse the data. As the main idea of the study was to understand how to best conduct CT, based on the experiences of direct stakeholders in such an intervention. A qualitative approach allowed me to have the flexibility to explore and understand the phenomenon and obtain rich data from the participants (Queirós et al., 2017). Furthermore, the qualitative method was chosen because the method was suited to the phenomenon, which was novel and previously unresearched (Bauer & Gaskell, 2000; Morse, 1991; Murshed & Zhang, 2016). There was no previous CT manual in the Indonesian literature to base this research on. The naturalistic inquiry paradigm was adopted to guide me in forming the research questions and the questions posed to the participants. Naturalistic inquiry allows me to not only to formulate holistic questions to explore a phenomenon but also to have interactive discussions with participants rather than just one-way questioning (Guba & Lincoln, 1982)

Collaborative design, commonly known as codesign, incorporates qualitative

methodology and the naturalistic paradigm. CoDesign involves a process of collective creativity between stakeholders in the entire design process (Thabrew et al., 2018). The end user (i.e., the consumer of the product) acts as an “expert of their experiences,” actively collaborating with the researcher, product experts, designer, and developers to design a product that meets their needs and expectations. The codesign process consists of several stages. This study used the stages proposed by Bowen et al. (2013): 1) understanding and sharing experiences; 2) exploring blue-sky ideas; 3) selecting and developing blue-sky concepts; 4) converging on practical proposals; and 5) prototyping and evaluating. The implementation of this framework in this study can be seen in the data collection section.

This study also used a small portion of the quantitative method to discuss how the data-gathering process has no harmful effects on the participants. More discussion about this can be found on “Focus Groups as Support Groups” section (p. 75).

Online Focus Group Discussion as Data Collection Technique

To execute the CoDesign, this study used online focus group discussions (OFGD), in which the participants and I held video conference sessions to gather data. As mentioned by Stewart and Shamdasani (2017), OFGD can be used to reach physically distant consumers. Tuttas (2015) mentioned that web conferences can create real-time communication between participants in various geographical locations. A web conference provides a service whereby participants and moderators can see each other in real time and listen to what each other is saying. Thus, a similar environment to real-time focus group discussions can be provided.

However, OFGD also has limitations. Firstly, given regional time differences, gathering a geographically dispersed group of people to meet online can be challenging. Other possible barriers, including financial and technological requirements, can also surface. It is also essential to ensure that all participants are familiar with the platform used for online group discussions. Other possible issues include unable to hear other participants and the quality of the connections between the participants and the researcher, can also affect the effectiveness of OFGD discussions (Tuttas, 2015),

Reflecting on the data gathering, some positive and negative aspects of online focus group discussions were occasionally experienced. From the perspective of data generation, this study managed to generate an abundance of data that consisted of hundreds of excerpts. However, the quality of the data might be less than perfect. Not all the participants attended the scheduled sessions and not all participants were willing to show their faces on

camera. Even if the participants were willing to do so, technical errors with the signal, laptop cameras, and lighting prevented some participants from doing so. The voice quality was mostly clear but could have been better at times. All of these obstructions affected the quality of the OFGD as discussions were not purely about the research but also about how to deal with these technical issues.

Focus Groups as Support Groups

As mentioned, this study gathered together Indonesian millennials and Gen Z who suffer from minor depression as CG participants in the OFGD. I had to be careful in conducting the research, considering that some participants were in fragile states of mental health. As an emergency plan, CG participants were informed that if ever they experience an emergency, they could call the Indonesian Mental Health Emergency Helpline 119 extension 8 for psychological assistance if they felt strong negative emotions (Siregar & Siregar, 2022).

However, it could also be argued that the focus groups may potentially be beneficial for the participants. Peek and Fothergill (2009) conducted studies with sensitive participants: second-generation Muslim Americans interviewed following the 9/11 attacks and children affected by Hurricane Katrina and found that during the focus groups, these participants were able to show vulnerability in the groups. The focus groups also became places to find people who listened and empathised with them. Thus, the focus group discussions could have therapeutic effects for these CG participants.

Reflecting on the data gathering, the OFGD with the CG succeeded. In terms of attendance, even though one of the eight enlisted client participants was absent from the beginning and throughout the study, the rest attended the sessions. No session had fewer than seven CG members. Furthermore, they were responsive and willing to engage in the discussion during the sessions. The same applied with the written feedback on the manual. Some contradictory answers were given during the sessions but never in a way that other participants felt offended. Lastly, CG members were also willing to provide answers to questions that could be considered sensitive. An example of this was when I asked about self-harm towards the CG members. There was no occasion when any CG member experienced a crisis (which was listed as one of the risks of this study) and needed to call the emergency helpline.

For additional data to check that no harm was done during the data collection process, I gathered data on CG members' mental health status using two questionnaires (IDS-SR and

The World Health Organization Quality of Life BREF Version [WHOQoL-BREF]—Indonesian Version as discussed in the next section) before the start of the data gathering and after the end of Stage 4 (when the routine weekly OFGD data collection ended—see Table 15 on page 81) and found that there were no differences statistically in their mental health levels. Even though the sample is small, the OFGD did not indicate to cause harm to, nor had beneficial effects for the participants. The fact the OFGD was not intentionally designed to benefit the participants is probably the main reason for such a finding. The details of the statistical analysis can be found in Appendix Y (p. 546).

Measurement tools

Two measurement tools and two interview guidelines were used throughout the research. The IDS-SR - Indonesian Version was used to screen the levels of depression in potential clients group participants. Based on the result of the IDS-SR, eligible participants were then interviewed using the SCID IV-1 - Indonesian Version. Based on the interview results, eligible participants were then accepted to be a part of the study. Participants were also given the WHOQoL-BREF before and after the data-gathering process. Finally, a set of questions were used as guidelines to initiate the discussion during data gathering in the FGD. The FGD questions are discussed in a later section.

The Inventory of Depressive Symptomatology Self Report (IDS-SR)—Indonesian Version. The IDS-SR is a freely available depression self-report assessment with good psychometric properties (Rush et al., 1996). The Indonesian version of IDS-SR was developed by Arjadi et al. (2017) using confirmatory factor analysis with a sample of 1622 Indonesians aged 16 years and older. The three-factor model indicated that the Indonesian version of IDS-SR meets all fit indices' rule of thumb criteria. The reliability of Indonesian IDS-SR was $\alpha = .92$, and the cut-off score between healthy and depressed people was found to be 14.

Structured Clinical Interview for DSM IV – 1 (SCID-IV—1)—Indonesian Version. SCID is a widely used set of semi-structured interview questions to determine whether an individual meets the criteria for any DSM disorder (Glasofer et al., 2017). SCID-IV is based on DSM-IV The Indonesia version of SCID-IV—1 was created and validated by the Psychiatry Department at the University of Indonesia in 2000 (Primasari & Hidayat, 2016).

The World Health Organization Quality of Life BREF Version (WHOQoL-BREF)—Indonesian Version. The WHOQoL-BREF is a 26-item questionnaire developed by the World Health Organization which measures four domains of life: a) physical health; b)

psychological health; c) social relationships; and d) environment (World Health Organization, 1996). This study used the Indonesian version of WHOQoL BREF. WHO has defined quality of life as an individual's perceptions of their position in life in the context of the culture and value systems in which they live and their goals, expectations, standards and concerns. This measurement tool was used in this study because of its ability to detect multidimensional aspect of one's life. Depression itself has been shown to correlate with poorer quality of life (Cho et al., 2019)

Data Collection

Codesign Approach

I used the method of codesign proposed by Bowen et al. (2013) for this study which consists of five main stages. I also added an iterative process to allow discussion between the two groups and a revision stage at the end to check results before creating the final product. Figure 1 and the description for each stage below outlines the codesign process.

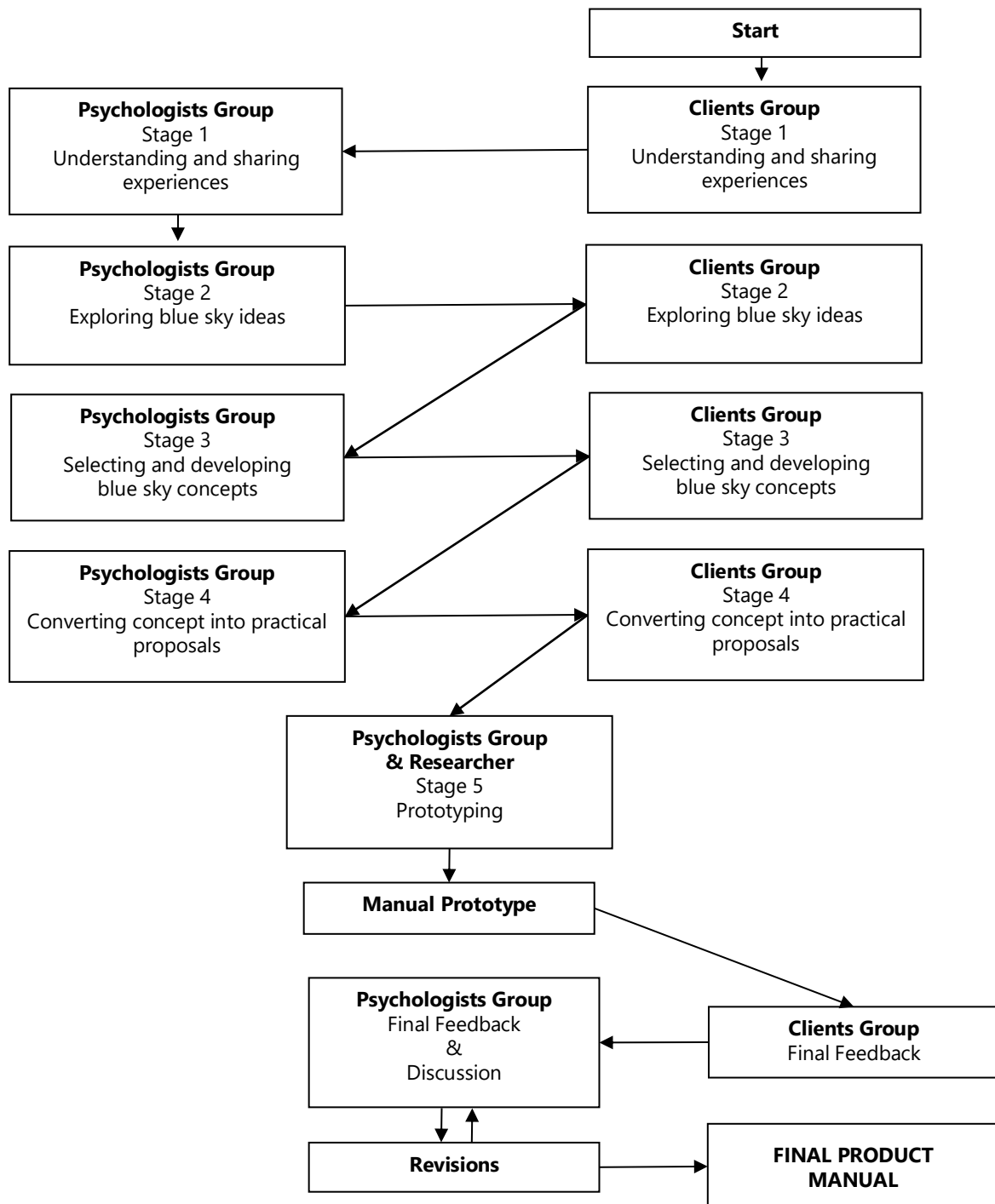
Stage 1—Understanding and Sharing Experiences. The CG discussion was conducted first because the first discussion focused on the experiences and needs of CT clients. The output from the first discussion with the CG was used to enrich for the first discussion session with the PG, which explored the experiences and needs of the PG members regarding CT,

Stage 2—Exploring Blue-Sky Ideas. The output from Stage 1 was used to guide the discussion Stage 2. Unlike the previous stage, the PG discussion was conducted first. This sequence was chosen to allow the PG members to explore blue-sky ideas based on the needs of themselves and the CG. Blue sky ideas are the outputs of blue sky thinking, a term used to describe imaginative thought beyond the boundaries of existing realities (Cowley, 2013). This was needed as no manual had been created before.

The PG discussed the broad concepts of treatment plans, culture, and therapeutic relationships and approaches. In a second group discussion with the CG, I encouraged participants to contribute their ideas about ways to best support them in CT and also discussed the ideas from the PG and asked about their perceptions.

Figure 1

Codesign Process



Stage 3—Selecting and Developing Blue Sky Concepts. The PG used the blue sky ideas from both participant groups, to start developing initial blue-sky concepts. This stage was more practical as it involved the design of the sessions, goals, and activities and materials to be used in each session. Blue-sky concepts from the PG members were then brought to the CG for their comments and thoughts.

Stage 4—Converting Concepts into Practical Proposals. After re-evaluating the blue-sky concepts from both groups in the previous stage, both PG and CG started to compile concrete proposals for the manual. These concrete proposals included detail as topics such as where to store materials, how each session would start, technical concerns such as session durations, intervals between sessions, and resulted in a detailed manual describing each session.

Stage 5—Prototyping and Evaluating. In this stage, I started to write the manual based on all the data compiled. Once the manual was finished, I shared it with the participants for their comments and evaluation. Three drafts and six more OFGD were involved in this stage before the final version was confirmed.

The iterative process of the codesign, which involved passing the data back and forth between the CG and PG, as shown in Figure 1 above, was designed to ensure that both participant groups were involved in every step of the data-gathering process. Being said, the CG members were not involved at the beginning of Stage 5 Prototyping, as this stage focused on myself creating the manual based on data compiled from all the sessions in Stages 1 to 4. The PG members were involved in this stage, as I needed to consult the PG members during the making of the manual. The CG members were involved again once the second draft of the manual had been completed and given opportunities to comment on the draft used to create the third draft. Finally, the third draft was again given to the PG for final comment before proceeding to the final version of the manual.

Online Focus Group Discussion Guidelines

Sets of questions based on the literature research and my experience of practice in the CT setting were used as the FGD guidelines for each session with each group from Stages 1 to 4. The questions were designed to elicit answers to the research questions and agreed upon by the supervisory panel and proposal confirmation committee, who had considered the whole proposal.

The questions were tailored to each group's characteristics, with the questions given to the CG focused on the CG members' experiences of CT. It also focused on their suggestions for how CT should be carried out from the client's perspective. The questions given to the PG looked at their experiences and best practice in CT from the providers' perspectives, and in relation to psychological theory.

The question guidelines were treated flexibly as I was open to any new topics and

insights found in discussions with both participant groups. A list of the questions can be found in Appendix U (p. 540).

The Sessions

The data gathering (codesign) began on 14 July 2021 and ended on 8 September 2023. A total of six sessions were conducted with the CG and 15 with the PG with various number of participants attended. In the CG, one participant never attended the sessions despite multiple attempted contacts made by myself. In the PG, only three sessions were attended by all participants. Between one and three participants did not attend the sessions for the other twelve. Table 15 below summarises the attendance

There was an unequal number of sessions with the CG and the PG. Based on my observations and recollections of the data-gathering process, this was due to the difference in the depth of discussion and the different characteristics and behaviours by the PG and CG members during the data-gathering process. The CG members tended to offer relatively concise responses in the discussions, while the PG members tended to provide much more comprehensive answers. I also needed more discussion with the PG members as for guidance and confirmation during the prototyping stage.

Table 15

List of Sessions

Stage	Participants Involved	Dates of Sessions	Nos Attended
Stage 1 Understanding and Sharing Experience	CG	15/6/21	7/8
	PG	19/6/21	7/8
		21/6/21	5/8
Stage 2 Exploring blue sky ideas	PG	26/6/21	7/8
		28/6/21	7/8
	CG	29/6/21	7/8
Stage 3 Selecting and developing a blue sky concept	PG	2/8/21	8/8
		4/8/21	7/8
	CG	5/8/21	7/8
Stage 4 Converting into practical proposals	PG	9/8/21	7/8
		11/8/21	8/8
		16/8/21	7/8
		25/8/21	8/8
	CG	12/8/21	7/8
Stage 5 Prototyping and Evaluating	Researcher	26/8/21	7/8
		27/8/21	N/A
		-	
Making of First Draft		25/11/21	

First Draft Reading	PG	26/10/21	8/8
		– 2/11/21	
First Draft Discussion	PG	1/11/21	7/8
		23/11/21	6/8
		29/11/21	7/8
Making of Second Draft	Researcher	30/11/21	N/A
		– 10/1/22	
Second Draft Reading	PG & CG	10/1/22 –	8/8
		2/2/22	7/8
Second Draft Discussion	PG	21/2/22 -	6/8
		23/2/22	6/8
	CG	24/2/22	7/8
Making of Third Draft	Researcher	24/2/22 – 3/07/23	N/A
Third Draft Reading	PG	16/8/23	7/8
		- 8/9/23	
Finalising Manual	Researcher	8/9/23	N/A
		- 27/9/23	

Ethics, Permissions and Funding

This project was reviewed and approved by the Massey University Human Ethics Committee: Northern, Application NOR 20/53. Permission to use all research instruments was obtained from the authors or the publishing organisations. To use IDS-SR—Indonesian Version, I contacted the author and was informed that IDS-SR-Indonesian Version is free to use with acknowledgment. To use SCID IV-1—Indonesian Version, I received training and a permission letter numbered UM.01.05/VII.1/0234/2020 from Dr Cipto Mangunkusomo at the Ministry of Health of Indonesia, Directorate General of Health Services, Central General Hospital. Permission to use the WHOQoL-BREF—Indonesian Version was given by the World Health Organization with request number 364228. Finally, the IPK Indonesia granted a permit to recruit Indonesian CPs as participants in this research in letter 125/EKT/PP-IPK-Indonesia/III/2021. This research was funded through the general funding support for PhD students from the School of Psychology, Massey University in Auckland, New Zealand.

Data Analysis

Most of the data from this study was qualitative data obtained from the FGD sessions. However, a portion of the data was quantitative data from two questionnaires, IDS-SR and WHOQoL-BREF. The following segment explains how these two types of data were analysed.

Quantitative Data

Fundamental descriptive data analysis was used to analyse the quantitative data. A Wilcoxon signed-rank test was conducted to see whether there was a significant difference between the quality of life and depression measures before and after FGDs.

Qualitative Data

Codesign is a collaborative approach to designing products involving all groups who will use the product. The two main user groups were represented in this research by the CG and the PG. Each participant was encouraged to acknowledge, appreciate, and comment on each other opinions regarding the product. This then affected how the data analysis of the data was performed.

To stay true to the codesign principles, data analysis needed to be done as soon as the sessions had finished. Every relevant finding from each data analysis needed to be submitted to the other group prior to their next scheduled session; for future discussion. By doing this, all parties could learn about the findings from the previous sessions, comment on them and contribute new insights into the topics discussed.

Similar codesign strategies can be found in the literature. Krueger (2014) has asserted that it is possible to do continuous data analysis for multiple FGDs because where data collection and data entry stop and data analysis begins is unclear. For FGDs, the first analysis can begin after the first session and data analysis is concurrent with data collection. By using this approach, researchers can be alert to more questions that need to be followed up and further discussed in the next session (Krueger, 2014). Krueger (2014) has argued that this approach to data analysis can result in better data collection than waiting until all FGD sessions are finished.

Proceeding with the strategy, I performed data analysis after every session, beginning with transcription using the denaturalised method. Denaturalised transcription, according to Oliver et al. (2005), is a method that removes the idiosyncratic elements of speech, such as stutters, pauses, and nonverbal and involuntary vocalisations. This method differs from naturalised transcription, in which every utterance is transcribed in as much detail as possible. Widodo (2014) has suggested that the choice between the naturalised and denaturalised methods depends on the degree of reflexivity required, the nature of the research (e.g., the research design), the data analysis focus, sensitivity to participants, and the nature of their involvement in the research.

Denaturalised transcription was perceived as more suitable for this research for several reasons. From the research design perspective, the data-gathering was conducted using an online platform, and due to technological issues, some participants only showed themselves on camera sometimes. Some participants utilised the chat function rather than speaking to convey their answers. This resulted in a lack of nonverbal data, such as expressions and gestures. Some participants sometimes lost connection, resulting in pauses and dropping out from the session. Much of the conversation in the FGD sessions was also about technological issues and attempts to fix problems. Given this study used ongoing data analysis during the data collection and the periods between sessions could be as short as one day, a quick transcription method was needed. Since denaturalised transcription does not require focus on every utterance in the conversation, the process is much faster than naturalised transcription. After Stage 4, the qualitative data did not always come from sessions. Written feedback from the participants on the drafts, which did not contain nonverbal information, was also considered as qualitative data. I was mostly focused on the content of the conversation, for which denaturalised transcription is suitable (Widodo, 2014). Denaturalised transcription focuses more on the substance of the interview, that is, the meanings and perceptions created and shared during a conversation (Cameron 1996, cited in Oliver, Serovich and Mason, 2005)

For the transcription, I re-watched the video recordings of the sessions and listened carefully to what the participants were saying before writing down quotations. The data was organised into tables. An example of such a table is given in Appendix V (p. 543). Written feedback on the drafts was compiled in one file according to versions of the protocol draft. Each transcription was completed in the original language. All excerpts that are presented in this study were subsequently translated into English. They are not word-by-word translations from the original language and some excerpts are shorter or longer than the originals. During the translation, I focused more on what the participants were trying to say, thus, big chunks of the words might have been lost during the translation process. This kind of treatment was justified as I used thematic analysis rather than quantitative content or discourse/communication analysis. Furthermore, because participants gave feedback on the manual, they would notice any misinterpretation that I possibly made on the translation. The excerpts were still considered as clean but inaccurate transcriptions (Illien, 2022). Once the transcription was finished, a unique application of thematic analysis as described by Braun

and Clarke (2006) was utilised to analyse the data. This unique application is explained in the next section. However, the basic step-by-step process described by Braun and Clarke (2006) was still followed, including: 1) familiarisation with the data, 2) generation of initial codes, 3) searching for themes, 4) reviewing themes, 5) defining and naming themes, and, 6) producing a report.

1. Familiarisation with The Data. As suggested by Riessman (1993, as cited by Braun and Clarke, 2006), familiarisation with the data started during transcription. Re-watching the recordings of the sessions while transcribing and rereading the transcriptions were the two strategies I used to become familiar with the data. During this stage, I tried to find any meanings, patterns, and significant aspects the answers in relation to my analytical interest and prior knowledge (Braun and Clarke, 2006). As stated, the data gathering was a continuous process with each session producing new data for myself to become familiar with. In Stage 5, data was produced not only in sessions but also in written feedback about the manual. After compilation of all the data (i.e., excerpts and written feedback), I also familiarised myself with this data.

2. Generating Initial Codes. In this step, I generated initial codes based on the data. An example of this can be seen in Appendix V (p. 543). The initial codes were derived from the previous stage of data familiarisation. Following the suggestions from Braun and Clarke (2006), the coding process was both data- and theory-driven. On the one hand, I initiated the discussions by putting theory-driven questions to the participants. On the other hand, the answers that came up during discussions were sometimes unpredictable and thus, created data that was not theory driven. As the manual is the first of its kind, it was expected that the discussion would be wide ranging. Braun and Clarke (2006) have also recommended that I include as many codes as possible and use single data coding where possible. As the data analysis process started before the data gathering finished, any striking and unique answers were coded and the codes used in the subsequent data gathering, even though they originated in statements by one participant. It is possible that a single code has enough depth and detail to tell its own story (Neale, 2020). Such a single data coding could create new discussions and even change the direction of the manual.

3. Searching for Themes. Once the data had been coded, I searched for the broader themes, as described by Braun and Clarke (2006). This was done by analysing how different codes aligned with each other and whether they could be combined to create a theme. A

sample of this process can be found in Appendix W (p. 544). Braun and Clarke (2006) have suggested that this step can only be done when all the data has been gathered. However, as described at the beginning of the data analysis section, this process was started by myself even before the data gathering had finished. Every session, especially in Stages 1 to 4, created valuable data that needed urgent analysis as the codes and themes that emerged from one session could be used for the next session. In Stage 5, I analysed data from the participants' written feedback and used the findings in the following sessions. This treatment of data was applied throughout the study until the last sessions for both participant groups in Stage 5 (finalising the manual). The difference was that the specific documents that served as summaries of sessions were only made up to Stage 4. These summaries were then passed between the groups for comment and became the source of insights for further discussion. An example of a session summary can be found in Appendix X (p. 545). In Stage 5, no summaries were created as I had already written the manual to be given to each group.

4. Reviewing Themes, Defining and Naming Themes, Producing the Report.

Reviewing themes involves a process in which I refined the already collected themes, with some themes might turned into codes, collapsed with other themes, or organised into sub-themes. Researchers might also create new codes that could lead to new themes or ignore some codes as they are deemed irrelevant to the whole dataset. Endless coding should be avoided when reviewing themes. Defining and naming the themes involves a process in which I defined the essence of each theme that has already been decided. I should have enough excerpts from the data that are organised, coherent, and consistent enough to build the themes and sub-themes and make sure that those themes and sub-themes are different. At the end of the process, each theme and sub-theme required a name. The final step in the process involves a final description of the themes. The final report should be a concise, coherent, logical, non-repetitive and compelling account of the story the data tell (Braun and Clarke, 2006). Finally, the final report must be discussed analytically and supported by the relevant evidence.

In this study, the last three stages described by Braun and Clarke (2006) were performed differently. Firstly, the reviewing, defining and naming of the themes was done not only by myself but also by the participants. For example, themes that were determined and listed in the summaries of sessions from CG could be amended, added to, corrected or removed by the PG in the following sessions, and vice versa. In Stage 5, participants were

given a chance to read the draft of the manual and provide comments on the content. Participants could amend, add to, correct, or remove content. As can be seen in the list of session in Table 15, I produced three drafts of the manual and held another six sessions with the participants to refine the drafts. These iterative processes helped to make the themes more solid and distinct.

On the surface, this study resulted in two types of reports. The thesis document contains the results of the data collection and analysis. The manual, which is the study's product, applies the results of the data collection and analysis to the practice of CT. However, a report of a qualitative study is distinctly characterised by Braun and Clarke (2006) as needing to contain excerpts from the data that serve as evidence for the themes. This means the manual does not count as a report, and hence the excerpts of the data are reported in chapter 4. Furthermore, the report laid out in the thesis document also contains a discussion of the themes found. I used reasoning to compare the result of the data gathering with the existing literature. This final process also functioned as a final step in the analysis of the data that contributed to the content of the manual. I then included literature in the manual that strengthened it, where deemed relevant.

The Rigour of the Study

Even though the nature of a qualitative study is a process of exploration and discovery that tends to resist rigid boundaries, it is still essential to put forward the scientific approach to the study. Earlier in this chapter, it was mentioned that subjectivity was an apparent factor in this current research, which often associated with bias (Galdas, 2016, Lisi, 2016). Bias then could lead to distorted results and wrong conclusions of any kind of research (Šimundić, 2013). Thus, a concept of rigour is important to minimise the risk of bias and maximise the accuracy and credibility of research results (Johnson et al., 2020; Thoma & Magilvy, 2011). The concept of rigour has many definitions. Fereday and Muir-Cochrane (2006) have defined rigour in a study as demonstrating integrity and competence. Brennan et al. (2014) have defined rigour as dependent on whether the methods used to generate the study data are credible and trustworthy. Attending to the rigour discussion, this research used reflexivity and trustworthiness which will be discussed in the following sections.

Reflexivity. One of the way to cater to subjectivity in any research is to be conscious and acknowledge that there is such subjectivity before, during and after the research process; doing so, the researcher will constantly reconstruct their understanding of the

research and ensure that the study is insightful and not guided by subjectivity and bias (Jamieson, Govaart, & Pownall, 2023).

A concept of reflexivity captures this idea. Reflexivity is “an awareness of how the researcher as an individual with a particular social identity and background has an impact on the research process” (Robson, 2002, p. 22). Reflexivity is one method that adds rigour to the qualitative research process as it encourages researchers to be actively and constantly engaged in critical reflection throughout the research to define the rationales for their methodological decisions and interpretations of their findings (Jamie & Rathbone, 2022; Jootun et al., 2009; Lazard & McAvoy, 2020; May & Perry, 2017; Rettke et al., 2018; Tuval-Mashiach, 2017).

The concept of reflexivity is particularly important in this study. Firstly, I came from the same cultural background as the subjects of the research. The current research aims to make a contribution to Indonesian society by supporting Indonesian CPs to conduct CT with Indonesian millennials and Gen Z suffering from minor depression. I myself is an Indonesian mental health professional who was a practitioner of text-based therapeutic relationship for over three years. This means that my cultural and professional background could highly influence the base knowledge, perceptions and assumptions in the formulation of research rationale, research questions, methods, data gathering and analysis.

I managed the reflexivity by involving both the supervisory team (Lincoln & Guba, 1985) and the study participants. While writing the research proposal, I had routine supervision with supervisory teams of three. During the process, I discussed the issues and received feedback on ways to reduce researcher subjectivity (Hoover & Morrow, 2015). During the data collection and analysis, PG and CG members were encouraged to evaluate the product (i.e., the manual) to ensure that I had not overly influenced the manual.

Trustworthiness. Another concept tightly connected to rigour but often used interchangeably in the research (Connelly, 2016; Morrow, 2005; Thomson & Crowther, 2022). According to Guba (1981), trustworthiness involves four aspects of a study: 1) truth value, which focuses on whether the study can confidently claim the findings as true; 2) applicability, which focuses on whether the findings might be applicable in other contexts or with other respondents; 3) consistency, which focuses on whether the findings of the study are consistent if the same or a similar study is repeated; 4) neutrality, which focuses on whether the findings of the study are truly based on the subjects (respondents) and free

from biases. These four aspects are labelled differently in quantitative and qualitative research. In quantitative research, truth value is termed as internal validity, applicability external validity, consistency as reliability, and neutrality as objectivity. These four aspects are assessed using methods that are applicable to quantitative methods, such as statistical analyses.

For qualitative studies, Guba (1981) proposed different terms and methods to assess the four aspects of trustworthiness accepted by many qualitative researchers (Shenton, 2004). The following section discusses these aspects in detail.

Credibility. Refers to the aspect of truth value, as it focuses on ensuring whether the research findings have congruency with reality (Merriam, 1998). I tested this aspect in the current research using several methods. Firstly, I conducted a debrief discussion with the supervisory team to discuss any emerging ideas and approaches to addressing the research questions. Debriefing also allows myself to find and address any flaws and biases that might arise during the research process. Secondly, I also performed a member check. As codesign is participatory, members of the current research (i.e., the participants) could check any findings from the study. This activity allowed the research members to verify the research findings and provide feedback if necessary. Thirdly, I performed iterative questioning, often returning to the discussed topic more than once to ensure the data was correct and robust. Any flaws in the participants' answers could be found and revised during this process. Finally, I examined previous studies and compared with the findings in the current study to ensure they are truthful and supported.

Transferability. Refers to the aspect of applicability. It focuses on whether the study can be applied in other situations. To fulfil this aspect, I have made a “thick” description of both the data and the context of the study to ensure other researchers who have an interest in replicating or emulating this study can understand the phenomena behind the research, the method used in the research, the participants involved in the study, the findings, and the analysis of the findings.

Dependability. Refers to consistency; it focuses on whether the same data will be found if the study is repeated in the same context, with the same method, and similar participants. In order to fulfil this aspect, I performed a study audit in which the supervisory team read the draft of the reports (i.e., thesis and manual) and provided comments on the documents. The same intervention was also completed with the help of the participants. The

participants had the opportunity to read the manual and provide feedback. These interventions were similar to those taken in regard of the first aspect, credibility, as both are closely tied to each other (Lincoln & Guba, 1985), however the difference is, for dependability, I must provide a detailed description of the study to ensure other researchers could replicate the study. The thesis long-document report comprises five chapters that report the phenomenon, method, and result study.

Confirmability. Refers to consistency and neutrality; it focuses on the assurance that the findings result from participants' ideas and experience, rather than the researcher's (Shenton, 2004). To fulfil this aspect, I performed a confirmability audit with the supervisory team, where the team read the data report that includes of the excerpts from the data collection. The supervisory team then had the opportunity to examine whether the interpretations of the excerpts were suitable, correct, and consistent. Another intervention to ensure confirmability is for myself to admit my predisposition towards the research. This intervention is called "practising reflexivity" which has also been done and is described in the previous section (p. 86).

Chapter 4—Results and Discussion

This chapter includes two major parts of the research: the results of the data gathering and the discussion of the results. This is presented in seven sections arranged by topic. The process of writing the manual involved comprehensive, reiterative, and repeated data gathering which produced a great number of topics for discussion. Thus, the goal of combining the results and discussion is to immerse the reader in the evidence from the literature at the same time as the results are presented, avoiding the impracticality of going back and forth between results and discussion.

This chapter begins with a table that contains information about the topics discussed at each stage to show the original data gathering process. The table shows that some topics were discussed repeatedly to ensure that the best answers were developed to include in the manual. The next part contains a flow chart of the data gathering process to show how different topics emerged at different stages and how some topics developed into other topics. All of these topics discussed then form the full CT manual.

In the next part, seven main sections are presented based on the similarities between the elements within each topic: 1) the format of the manual; 2) CT in general discussion; 3) depression in the Indonesian setting; 4) millennials and Gen Z; 5) the therapeutic aspect; 6) the cultural aspect; 7) CT for Indonesians with minor depression. In each section, the results are presented alongside the supporting data.

The last part of the chapter includes a discussion on how the data resulting from the data gathering could be explained according to the two main theories used in the research: the eight cultural elements of culturally sensitive psychotherapy, and the therapeutic relationship as the common factor of psychotherapy.

Topics Discussed in Each Stage

This section describes the discussions in each session with the PG and the CG. Table 16 summarises the information. The dates and the numbers of participants who attended each session, please refer to Table 15 in Chapter 3.

Table 16

Topic Discussed in Each Stage

Stage	Parties Involved	Topics Discussed
Stage 1 Understanding and Sharing Experiences	CG	• Advantages, disadvantages of CT and suggestions • Culture and CT • Physical symptoms
	PG	• Advantages, disadvantages and suggestions • Culture and CT • Definition of CT • Physical symptoms • The characteristics of Gen Z and millennials • The characteristics of Indonesians with depression • Therapeutic approach
Stage 2 Exploring Blue Sky Ideas	PG	• Confidentiality • Culture and goal setting • Fees • General values • Starting and promoting the service • Therapeutic relationship • Treatment stages
	CG	• Chat style • Clients' expectations • Confidentiality • Fees • General values • Homework • Therapeutic relationship • Treatment stages
Stage 3 Selecting and Developing Blue Sky Concepts	PG	• Culture, goal setting, solutions and giving advice • Final session • Homework compliance • Intervention techniques • Language • Limits to informality in behaviours • Session duration and contact between sessions • Showing empathy • Structure of regular sessions
	CG	• Culture, goal setting, solutions and giving advice • Homework compliance • Language • Provision of solutions • Relationships after therapy • Structure of regular sessions

Stage	Parties Involved	Topics Discussed
Stage 4 Converting Concepts into Practical Proposals	PG	• Advantages, disadvantages and suggestions • Chat style • Culture, goal setting, solutions and giving advice • Dealing with different clients • Definition • Fees • Format of the manual • General values • Homework compliance • Language • Manipulative clients • Multiple interpretations of emojis • Personal & professional phone numbers • Self-harm • The characteristics of Indonesians with depression • Treatment stages • Warranties and refunds
	CG	• Advantages, disadvantages and suggestions • Culture and CT • Dealing with different clients • Manipulative clients • Physical symptoms • Self-harm • Therapeutic approach • Warranties and refunds
Stage 5 Prototyping and Evaluating	Researcher	N/A
<i>Writing First Draft</i>		
Stage 5 Prototyping and Evaluating	PG	• Advantages, disadvantages and suggestions • Chat style • Clients' expectations • Collaboration • Confidentiality • Culture and CT • Culture, goal setting, solutions and giving advice • Dealing with different clients • Definition • Format of the manual • General values • Intervention techniques • Manipulative clients • Self-harm • Showing empathy • Starting and promoting the service • Structure of regular sessions • The characteristics of Gen Z and millennials • The characteristics of Indonesians with depression • Therapeutic relationship
<i>Reading the First Draft</i>		

Stage	Parties Involved	Topics Discussed
Stage 5 Prototyping and Evaluating <i>Discussion of First Draft</i>	PG	•Treatment stages •Warranties and Refunds
		•Appropriate uses of emojis and voice notes •Confidentiality •Culture, goal setting, solutions and giving advice •Dealing with different clients •Fees •Format of the manual •Forming the treatment plan •Intervention techniques •Limits to informality of behaviour •Manipulative clients •Self-harm •Self-harm protocols •Therapeutic approach •Treatment stages •Underage clients •Warranties and refunds
Stage 5 Prototyping and Evaluating <i>Writing of Second Draft</i>	Researcher	N/A
Stage 5 Prototyping and Evaluating <i>Reading of Second Draft</i>	PG & CG	PG: •Advantages, disadvantages and suggestions •Appropriate uses of emojis and voice notes •Confidentiality •Culture and CT •Definition •Intervention techniques •Self-harm •Self-harm protocol •The characteristics of Gen Z and millennials •Treatment stages •Underage clients
		CG: •Advantages, disadvantages and suggestions •Clients' expectations •Collaboration •Culture and CT •Dealing with different clients •Format of the manual •Physical symptoms •Showing empathy •Starting and promoting the service •Therapeutic relationship •Treatment stages

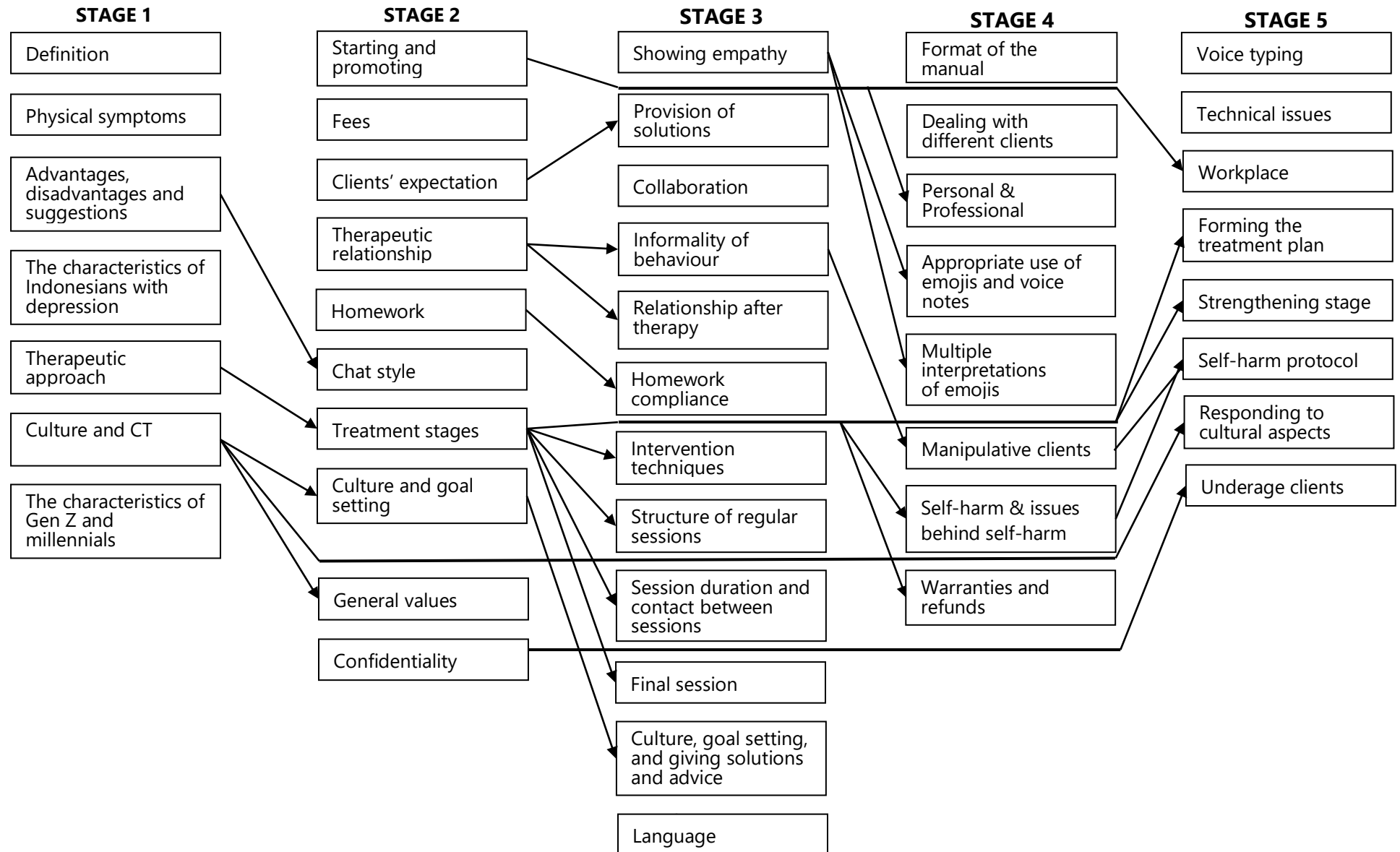
Stage	Parties Involved	Topics Discussed
Stage 5 Prototyping and Evaluating <i>Discussion of Second Draft</i>	PG	•Appropriate use of emojis and voice notes •Confidentiality •Culture and CT •Fees •Format of the manual •General values •Self-harm •Starting and promoting the service •Technical issues •The characteristics of Indonesians with depression •Therapeutic relationship •Treatment stages •Voice typing •Workplace
	CG	•Culture and CT •Showing empathy •Starting and promoting the service •Technical Issues •Treatment Stages
Stage 5 Prototyping and Evaluating <i>Writing Third Draft</i>	Researcher	•N/A
Stage 5 Prototyping and Evaluating <i>Reading of Third Draft</i>	PG	•Culture and CT Starting and promoting the service •Culture, goal setting, solutions and giving advice •Dealing with different clients •Fees •Intervention techniques •Self-harm •Treatment Stages •Voice typing •Warranties and refunds •Workplace
Stage 5 Prototyping and Evaluating <i>Writing Final Product</i>	Researcher	N/A

Codesign Flow

The following chart shows the flow of discussion in the codesign process.

Figure 2

Codesign Flow Chart



The Format of the Manual

This section discusses how the manual would be presented to the CP community in Indonesia. A discussion was specifically held on this topic and six members of the PG joined the discussion and described their expectations for the format of the contents of the manual. The following table shows the result of the discussion.

Table 17

Format of the Manual

Sections	Description and Quotation
Theoretical (P5, P7)	The manual is expected to include information about the theoretical basis of CT. <i>In my mind, there is going to be some explanation about the use of CT in suitable situations...since the term is specific, i.e., therapy not counselling, and the situation is minor depression. So, I imagine when I am reading this, [I]will find guidance...about the differences of CT compared to other types of therapy, especially [face-to-face]. (P7)</i>
General guidance (P1, P4)	The manual is expected to include general guidance on how to conduct CT. Some examples would be the dos and don'ts in CT. <i>The general guidelines will contain information on how to conduct CT. (P1)</i>
Specific guidance (P4, P6)	The manual is expected to include more specific practical guidance in relation to CT. Some examples would be dealing with difficult clients, harassment by clients, and preserving online connections during CT. <i>Also, the manual will contain information such as how to deal with difficult clients, or any other problems we discussed in the early sessions. (P6).</i>
Specific Guidance about Depression (P1, P5, P6, P7)	The manual is expected to include practical guidance on how to conduct CT specifically for clients with minor depression. It is expected to provide information about the appropriate stages in treating clients with minor depression using CT. The stages may not need to be rigid as different clients would require different sequences of treatment stages. <i>And since it already refers to minor depression, I expect to find some modules that relate to treating minor depression. What kind of therapy will be used? CT is the medium, but within it there is going to be therapy as well. It does not need to be detailed but there would be like "First Stage – What to handle first, is it the emotion or the behaviour?", and then the second stage, etc, even though in practice, the stages might be changed according to need. At least we would have some guidelines, some stages might be skipped, but there is some clarity within the stages, some sort of SOPs (P7)</i>
Visual elements (P8)	The manual is expected to include some visual representation to allow the CPs to visualise what CT would be like in a real-life setting. <i>I am a rather visual psychologist. I imagine that examples are not just written as lengthy sentences but rather in the form of chat balloons in the chat format as it would be seen in a phone screenshot. (P8)</i>

The sections in the manual as proposed by the members of the CP align with other psychotherapy manuals found in the literature. The "Positive Psychotherapy for Psychosis Manual" by Slade et al. (2016) and "Psychodynamic Psychotherapy Manual" by Cabaniss et al. (2016) both include theoretical discussion about their therapy orientation. The structure of the CT manual is also in line with the primary textbook on CBT by Beck (2020), which includes an introductory section about CBT itself before further discussing the sessions. The PG member's expectation of a theoretical section is understandable as no evidence-based manual that specifically discusses CT has been produced to date.

The members of the PG also expected some specific guidance on how to conduct CT for the subjects of this research who are Indonesian millennials and Gen Zs suffering minor depression. This is also aligned with the manual by Slade, et al. (2016), who created a manual specifically for people with psychosis, and another manual by Hassiotis et al. (2012), whose main subjects were people with learning disabilities. Lecroy (2008) edited a compilation of manuals aimed at treating children and adolescence. Further examination shows that all manuals include sections discussing the targeted disorders and populations. All manuals also describe the specific techniques that are intended to be used to treat the targeted disorders and populations. P8's comment about the use of visuals aligns with the manual by Roselló and Bernal (2007) that includes graphical features that can help the therapist's understanding and worksheets that can be used with clients.

The members of the PG expect guidance on how to handle some problems that might occur during the course of the treatment. Problems could manifest as technical issues, such as internet connection, or related to the client, such as harassment. Discussion of technical problems can be found in a manual titled "Clinician's Guide to Low Intensity Psychological Interventions (LIPs) for Anxiety and Depression" by McEvoy et al. (2021). As this guide focuses on interventions that are often delivered via distance therapy, the discussion of technical problems focuses on technological failures. Issues that are related to the client can be found in the manual by Cabaniss et al. (2016), which discusses issues such as resistance, transference, and boundaries.

To conclude, all the expectations expressed by PG members are justifiable for a CT manual.

CT in General Discussion

This section discusses general topics in regard to the manual as follows: definition of CT; advantages, disadvantages, and suggestions; and how to get started in CT.

A Definition of Chat Telepsychotherapy

The concept of a remote therapeutic relationship using text messages has been called many names. The current study introduces a new term—*chat telepsychotherapy*—as it is deemed more suited to the concept. While the semantic aspects of the term have already been discussed chapter 2 (p. 3), further discussion was made with the PG to define the term.

The discussion with the PG resulted in two main concepts the PG members thought needed to be found in the definition. Half of the group (P1, P2, P5, & P8) suggested that “providing help” would be one of those concepts. CT is about providing useful help for people in need and those experiencing mental health issues or wanting to improve their life or increase their self-knowledge. CT should be curative in nature and aims to help clients feel better about their situations. The help could be manifested as giving solutions or inducing insights into the clients’ difficulties. Another concept that emerged as important was the concept of “chat” itself. As the main medium of CT delivery, the chat could include emojis and stickers.

[CT is] a process of psychological intervention that is curative in nature and delivered by chat. (P8)

I would define it as a therapeutic relationship that aims to help anyone with mental [health] issues and uses text as a medium of delivery. Furthermore, since texting has become varied...the texting will not always use words but could...[also] use emojis and stickers. (P2)

It is also about understanding the condition and [acquiring] self-knowledge. Sometimes clients seek professional help via CT because they don't understand their conditions or have low levels of self-knowledge. So, the clients want to receive some psychoeducation or expert opinion on their condition [and] about themselves. (P6)

Based on both the semantic research done by myself and the data from the PG members, a definition of CT was created. The agreed definition of CT is as follows:

Chat telepsychotherapy is a therapeutic online synchronous text-based communication (chatting) relationship that is curative in nature with the aim of providing help for clients who suffer from mental health problems or are in need of guidance to improve their lives.

The definition resulted from the participants is aligned with the semantic discussion included in the literature review section. The phrase “therapeutic online synchronous text-based communication (chatting) relationship” ensures that the definition covers the most distinct parts of the concept, which are “chat” and “tele”. These terms show that CT is being delivered through real-time communication that is carried out via an internet network (Derrig-Palumbo, 2016). The terms also implicitly suggest that the psychotherapy is being conducted in two places at a distance (Etymologeek, n.d.; etymonline, n.d; Wiktionary, n.d.). The phrase “with the aim of providing help for clients who suffer from mental health problems or are in need of guidance to improve their lives” is also aligned with the spirit of psychotherapy, as discussed in the literature review section. Breath, life, soul, and healing are parts of the semantic meanings of psychotherapy (dictionary, n.d.; etymonline, n.d.b.). The phrases also align with the concept of psychotherapy suggested by Nystul (2015) and Jones-Smith (2019) which also emphasise the concept of positive changes in clients’ behaviours.

The concept of therapeutic communication found in the definition could also refer to a particular pattern of interaction between psychologist and client that creates a therapeutic relationship (Sharma & Gupta, 2021). The term “curative” in the definition might be questioned by some native English speakers as curative is usually defined as “able to cure disease” (Oxford English Dictionary, n.d.; Merriam-Webster, n.d.b). Including the term “curative” in the agreed definition of CT, might imply that CT views mental distress as disease. However, this is not the case. As Indonesian CPs created the definition, the understanding of the term “curative” also comes from the Indonesian perspective. According to Kamus Besar Bahasa Indonesia (The Great Dictionary of Indonesian Language, n.d.), the word “*kuratif*” which translates as “curative” is defined as “the ability to help or cure disease and other problems”. This then explains the possible misunderstanding of the word “curative” in the agreed definition.

Advantages, Disadvantages, and Suggestions

There are two major themes emerging from the data which cover all three concepts as listed above. These are the therapeutic aspect and the technical aspect. Considering the novelty of CT in Indonesia, understanding the advantages and disadvantages, and how CT could be improved from its current state, would be beneficial.

Advantages. Starting with the discussion, this section discusses the therapeutic advantages of CT, which are as a source of support and its suitability for use with clients with

certain mental difficulties. It also discusses the technical advantages, which are accessibility, affordability, anonymity, instant documentation, and practicability.

Source of Support and Relief. Similarly, to previous studies (Fang et al., 2018; Gibson & Cartwright, 2014), three CG members (C4, C6, & C8) mentioned that CT could provide a sense of relief. Having someone that could pay attention, provide a summary (Fernando, 2011), and possibly a solution (Amos, Bedu-Addo, & Antwi., 2020) for their difficulties, made the clients feel understood and motivated.

I feel relieved and calm. I had a problem, I shared it, they gave me a solution and then I felt motivated. (C4)

I felt relieved when the psychologist performed a comprehensive interview and later provided a summary of the issue. It means the psychologist was actually listening and paying attention. I have someone that listens to me. (C8)

Suitability with Certain Mental Difficulties. Two PG members (P6 & P8) suggested that some people may not have anyone to listen to them and some people with social anxiety lack the confidence to go out and meet CP face-to-face (Stott et al., 2013). Some people might not have the energy to engage in verbal communication. These types of clients prefer to use chat media instead, to seek psychological help.

[CT is] suitable for people who want help or to get an opinion but lack friends who could listen to them. (P6)

[CT is an] affordable service for people with social anxiety issues, those who are not comfortable with eye contact. [It is] also suitable for clients with low energy, ones who do not have the energy to talk. (P8)

There is also a similarity between the two answers where people with mental health issues do not have someone to talk to. Hence, they turn to CT to have someone to communicate with and give them the attention they need. Indonesian literature suggests that loneliness could possibly explain this finding. Loneliness is a subjective feeling that appears when someone lacks an intimate relationship or social relationships with other people (Yaswi, 2019). This feeling can emerge in anybody in many situations. Teenagers might be experiencing obstacles to establishing themselves as people with autonomy (Dafnaz & Effendy, 2020). Adults with low levels of resilience might also feel lonely (Sari & Listiyandini, 2015).

In the context of depression, one possible explanation for this finding is the unique degenerative cycle of depression and loneliness. The stigma that still affecting people with

mental illness in Indonesia has been discussed previously (Celina & Arjadi, 2021; Danukusumah et al., 2022; Sarfika et al., 2021). This, by itself, makes people with depression hesitant to express their feelings to others due to the fear for being judged. It has also been found that people with depression give social cues such as expressions suggesting that they are not willing to engage in relationships with other people (Achterbergh et al., 2020; Girard, et al., 2014). However, such cues result in people with depression then feeling lonely and separated from others (Farmer, 2002)

Accessibility. As an online-based therapeutic relationship, CT can be accessed anywhere. Three members of the PG (P6, P7, P8) suggested that CT allows clients to be heard at any time when they feel they need to be. Clients do not have to travel to talk to a CP. This finding aligns with finding in previous studies that accessibility is a consistent advantage for CT (Bolton, 2017; Fang et al., 2018; Garde et al., 2017; Paterson et al., 2019).

In my opinion, since CT is online, we don't have to leave our houses and go to the CP's office. We can do it from home through text. (C1)

Affordability. CT being more affordable compared to face-to-face therapies was mentioned by six of the participants (P2, P4, P6, P8, C6, & C8). P2 also pointed out that CT is also more affordable compared to other types of telepsychotherapy. In term of internet usage, the literature suggests that one single chat message sent by a chat application can be as small as 5 KB, while voice calls can use 30 KB per second and video calls 107 KB per second (Budiman, 2020; Patel et al., 2018; Prasanthi, 2022). This suggests that people who use CT pay smaller amounts of internet credit than other telepsychotherapy interventions. While this aspect is true, it is not always the same from the service fee aspect. Some companies do charge much less than for face-to-face therapy, however, some companies charge more than they do for face-to-face therapy. For example, in Jakarta, the capital city of Indonesia, a public health centre can provide a one-hour individual session for as little as IDR 30,000 (NZD 3.20). On the other hand, an online psychology company might charge a client between IDR 110,000 and IDR, 498,000 (NZD 11.66–NZD 52.70) per hour, depending on how senior the psychologist is (Az Zahra, 2020; Harahap, 2021).

CT is more affordable because it does not require a large amount of data. Not all clients have enough data. (P2)

Anonymity. Three CG members (C6, C7, & C8) mentioned anonymity as one advantage of CT. Anonymity refers to the concept where the identity of a person sending the

messages is unknown (lane, 2011). Anonymity could help clients express themselves which they might not do if their identity was known (Suler, 2004).

I can be anonymous; I can give myself any name. (C6)

Instant Documentation. C6 mentioned that CT allows clients to reread messages they exchange with the CP. Fang et al. (2018) mentioned that the ability to reread chat messages in CT enables clients to reflect on the discussions with the CP.

I like CT because I can reread the process. On several occasions, I have rewritten the suggestions from the psychologists. (C6)

Practicality. Two PG members (P3 & P8) mentioned two different forms of practicality in CT. P3 emphasised the ease of preparation for CT compared to face-to-face sessions in terms of attire and make-up. This answer can be explained by study done by King (2016) which found that therapist's appearance does affect clients' thoughts and behaviour towards the therapist. In the early stages of the therapy, clients might also make assumptions about the therapist's professionalism based on their looks. Thus, looking professional is essential in Psychologist profession.

A different manifestation of practicality mentioned by P8 suggested that doing CT allows the psychologist to search for information on any unfamiliar topic related to the client, while the session is in progress. In P8's case the unfamiliarity was related to unique vocabulary, known as slang. Zein and Wagiaty (2018) found that the use of slang is a form of linguistic creativity that is often found in younger generations. Slang is often characterised by its efficient reuse of formal language that results in new variants that are much simpler and shorter compared to the original words. It is also found to create disconnection between the younger and older generations in terms of communication.

CT is more practical from both clients and psychologists' sides. We don't have to prepare, put on make-up, etc. The client is also more relaxed in telling their stories. (P3)

If I am conducting CT with "cool" teenagers and I do not understand their slang, I can google it on the spot. (P8)

Disadvantages. This section discusses the therapeutic disadvantages which include: difficulties in composing chat messages, the lack of nonverbal communication, the quality of therapy, lack of control, the likelihood of on-referral, and technical difficulties.

Difficulty in Composing Chat Messages. This perspective comes from both CG and PG members. Two members of the CG (C1, C3) suggested that in a state of depression with no energy and motivation, composing chat messages is a burden. The forced effort led to chat messages that were short and did not represent the client's situation. P1 suggested that converting verbal speech into a written message was the main difficulty. The final message often differed to the original intention. Even well written messages serve no guarantee that the client would understand the message in the same way as the CP who wrote it. Possible misunderstandings that might be caused would also be more difficult to handle in CT compared to face-to-face settings.

We don't have any energy, but we need to type. The length of the text could not equal the length of our words. It is always shorter compared to our spoken words. So not all messages are being conveyed. (C1)

Sometimes when we finish writing the message and we read it again, the message has a different meaning than our original intention. Therefore, we need to retype it. When talking directly we could just simply clarify, while with CT we again need to use chat to clarify it and we are facing the same problem. Even if we managed to send the chat, we never know whether the client truly understood what we are trying to say. (P4)

A similar topic has been reported in the previous research as well. Fang et al. (2018) examined the experience of undergraduate students regarding text-based online counselling. Participants found that writing messages was considered as significant work, need a special effort, and cannot be done quickly. Gibson and Cartwright (2014) also explored young people's experiences of mobile phone text counselling and found a minority of the participants considered that texting was not an effective form of communication.

As previously discussed, chatting communication is unique. It is neither a written communication nor an oral communication; it is a mixture of both, with oral communication style becoming the main feature of it (Jibson, 2014). Compiling chat messages could be challenging because it is mainly based on oral communication but missing the verbal and non-verbal aspects to help effectively deliver the messages the senders want to be conveyed (Plumb, 2013).

Nonverbal Communication. Related to the previous subtheme, seven participants (C1, C3, C4, C5, C6, P1, & P2) mentioned that CT lacks the nonverbal communication which often helps in face-to-face interactions. From the perspective of CP, the lack of nonverbal communication meant that CT service is not on the same level as face-to-face sessions as

there are not many therapeutic interventions that could be done in CT. The risk of misunderstanding between clients and CP is also apparent.

There were several occasions where the psychologist misunderstood me. The psychologist thought I was happy while I was not. I guess that is because of the lack of intonation. (C6)

For me personally, when I am doing CT, I feel that I need to put in more effort. When we do face-to-face, we can use facial expressions, our communication is verbal and nonverbal, our gestures speak something, or when I am explaining something, I will use the white board. In CT, everything is limited. So when I do CT, I feel that I cannot provide my usual standard of service. (P1)

The lack of nonverbal cues has been consistently found to be a disadvantage in a number of text-based therapeutic relationship studies (Gibson & Cartwright, 2014; Hardiansyah et al, 2021; Harris & Birnbaum, 2014; Thompson, 2016). To understand the impact of this, Venter (2019) has emphasised that online chat communication jeopardises the meaningful aspects of communication. Face-to-face communication allows for all sorts of communication techniques, such as active, passive, verbal and non-verbal cues, that create a good quality of communication. Chat communication uses mainly questions from one party and self-disclosure from the other party. No one can really predict the reactions that might arise in the conversation.

The Quality of Therapy. A number of testimonies from the CG members (C1, C6, C7, & C8) suggested that CT did not really meet their expectations. Clients often received a very slow reply from the CP, resulting in a sense of abandonment. CPs either asked too many questions and gave nothing in return, or did not listen to their story and jumped to conclusions, which made clients feel they were being judged. Summaries, feedback and solutions given by the CP could be general, in that clients could figure them out by themselves. Finally, the lack of explanations for assignments made clients feel unmotivated.

I had one session where the psychologist just asked questions and gave nothing in return, and it made me feel disappointed. (C6)

I was telling the psychologist a story, but she did not listen until the end but gave suggestions instead. I felt disheartened by that. They judged me. (C8)

It did not affect me significantly. Suggestions were rather general, which I knew already. If we are restless or depressed, we usually search the internet for ways to solve our problems. We know the answers already from listening to YouTube. (C3)

When I brought this data to the PG, some members offered some explanations regarding the clients' answers. It was found that an online telepsychology companies often

ask CPs to help several clients at the same time. Some companies also allow a very short time to conduct the session. This results in a difference in depth in terms of the therapeutic relationship.

In my company, when we are online, we need to serve a number of clients. One time, I needed to serve eight clients at the same time. Imagine that I need to divide my focus into the different issues experienced by these clients. If the issues are too deep, I would rather refer them for face-to-face sessions as I don't feel I have enough energy to go deeper. (P4)

There are companies that only give 30 minutes' sessions. In that time, we cannot give everything that we want to give. (P3)

Furthermore, clients often only shared minimal information in regard to their difficulties. This meant that the CP could not find the root of their difficulties. On the one hand, with the difficulties of compiling chat messages, CPs need more time to go deeper into their problems. But on the other hand, not many clients were willing to commit that far.

During CT, the issues that clients convey to us often peripheral, such as "I cannot sleep, I am overthinking." When I ask more detailed questions about the issues, I might have a hunch that the client has a more complex problem. However, because of time and the fact is CT, we need to make more effort to unveil that main problem. To do that, we need to be careful as CT does not allow us to give a more directive question. This is the barrier in CT, the difficulty of unveiling the main problem. I rarely had any clients that had such intense contact with me, that we finally found the main problem. The maximum number of sessions is only four. (P1)

Finally, the slow responses mentioned by the clients were also mentioned by the PG members. Three PG members (P4, P6, & P8) mentioned that they also had experiences when clients responded to them very slowly. While this might be because clients were having difficulty compiling messages, it could also be because the clients were not attentive. Slow responses from the clients also mean that the CP needs to make an extra effort to make sure the clients are doing all right on the other side, which is often difficult.

I had a client who gave a very slow response. After a while, the client messaged me and said, "I am sorry, I am feeding my child as well, at the moment." (P4)

Slow responses mean the psychologist must reconfirm whether the client is still on the other side, whether they are experiencing technical difficulties, and whether they are safe or not. (P8)

From the results presented above, it can be seen that the CG members found that the quality of the therapeutic process using CT might be compromised. Following the answers from PG members, the difficulty in providing a standard quality therapy session occurred

because of the lack of opportunity to provide one. The duration, the number of clients served, the level of engagement, and the commitment to the therapy were all lacking. For example, CBT sessions are usually 45 minutes per session, per individual, in face-to-face setting (Brujniks, 2015). Based on the data, a session in CT was 30 minutes to one hour, in which the CP has to divide their focus between multiple clients. Finally, even though the CP wants to make up for the time lost by having a number of sessions, commitment from the clients seems to be lacking. This again would hinder the progress of therapy as commitment is crucial for positive outcomes in psychotherapy (Bachelor, 2013).

Slow responses have also been consistently found in previous studies. Gibson and Cartwright (2014) found that the slow responses made in text-based online counselling potentially decreased the sense of connection between the counsellor and the clients. In the same study, it was also found that slow responses from the counsellor could be very difficult for some clients, especially when the service is off during the night as there were reports that symptoms of mental illness are often worst during those long hours of the night. Slow responses could create ambiguity in the therapeutic process and even trigger the departure of the clients from the therapeutic process (Amos, Bedu-Addo, & Antwi., 2020; Xu et al., 2021).

Lack of control. A similar yet more focused subtheme concerns the difficulties that appear due to the CPs and the clients not being in the same premises. Two PG members (P1 & P4) mentioned that not being in the same room with the clients limit or hinders the CPs from offering or effectively providing a certain kind of psychotherapeutic intervention..

The psychologist would have difficulty ensuring the client completes the homework or assignment according to the instructions. For example, in relaxation, when the client is instructed to inhale deeply, we could never know if the client actually did it. (P1)

I had a client who holds grudges against their family for whom I believe the empty chair method would be suitable. When I informed the client about the method, I was afraid that the client would lose control. if we provide therapy [in the same room] and they cry, or worse faint, we can help them and give them comfort. (P4)

The lack of control over the course of therapy is something that tends to be negative. Tsalavouta (2013) found that the lack of physical proximity means the therapist is more anxious about the levels of stress and safety. A psychiatric study mentioned the inability to exert control over the patient and provide emergency care if needed are seen as risk factors (Gilmore & Ward-Ciesielski, 2019). Tsalavouta (2013) again mentioned that the lack of

physical proximity also hinders the client's ability to control the environment of the therapy. Many forms of distraction, such as people walking into the client's room or a phone ringing, could lead to a loss of engagement in the therapy.

From the clients' perspective, however, there have been findings that suggest a lack of physical proximity could actually increase the clients' control over the therapeutic process. Gibson and Cartwright (2014) found the clients might actually have a positive view of the lack of physical proximity. Clients could actually control the pace of the interaction by replying to the CPs' messages in their own time. Clients could also end the conversation when they felt they have had enough. This might be an additional explanation for the phenomenon of slow responses experienced by the PG as previously discussed.

Likelihood of On-Referral. C6 stated that CPs often stop the CT and refer clients to more advanced types of telepsychotherapy (i.e., via video-call), or even refer clients for face-to-face therapy.

There were several occasions where the psychologist asked me to have video-call therapy or face-to-face instead. So, CT seems not to be able to handle more serious issues. (C6)

This was then repeated by the three PG members (P1, P2, & P4) who said that they refer clients to more advanced telepsychotherapy or face-to-face therapy when they feel the issues are too complex for CT. P1 marked a threshold of complexity beyond which CT may be detrimental to the client's quality of life. P2 also answered that the referrals might be made due to the existence of suicidal ideation.

If the complaints have somehow impaired the client's quality of life, it is better to refer them for face-to-face intervention. (P1)

Usually, during CT sessions, if a client appears to be depressed, I also check whether they have suicidal ideation. If so, it is an emergency signal. In that case, I suggest they go to the nearest hospital. (P2)

The answer from the CP implies that CT might not be suitable for more serious mental illness. While some studies have also suggested that CT might only be suitable for mild disorders such as interpersonal issues. As discussed in chapter 2, Some studies have found CT to be effective in serious mental illnesses such as depression and alcohol-related issues (Blankers et al., 2011; Kessler et al., 2009; Kramer et al., 2014). The answer from P2 about suicidal ideation will be thoroughly discussed in the "Self-Harm in the CT Setting" section (p. 168)

Technical Difficulties. Finally, technical difficulties may also be disadvantages in CT due to CT being a technology-based therapeutic relationship. Problems can arise from the devices both clients and psychologists are using, the signal, or the server for the chat application that is being used. Slightly different answers came from P6 and P4. They mentioned that they often misremember the clients' names as they are helping multiple clients at the same time. The same issue also meant the CPs needed to remind themselves about each client's case by reading the previous chat messages.

The [chat application] server could suddenly go down, so the long messages that we had already typed and were still typing just vanished, just like that. That panicked me, and I then had to redo the messages and remember what I was saying. (P4)

Sometimes I have to help three to four people at a time with different problems. I often mistake their names because there are too many of them. Also, I often need clarification about their progress and need to re-read again their previous chat. (P6)

The technological issues are aligned with the previous discussion in chapter 2, where issues such as technical errors or loss of signal may hinder perfect communication in CT (Wootton et al., 2020). The issue with misremembering clients' names could also be explained by the technical arrangement set up by online psychotherapy companies. As previously discussed, the lack of time and the excessive number of clients who need to be helped at the same time result in the inability of CP to provide standard therapeutic sessions. Given this situation, misremembering clients' names would not be an uncommon mistake.

Suggestions. As the final part of the discussion, both the PG and the CG were asked about their suggestions to improve CT based on its current state. The same two themes emerged: the therapeutic and technical aspects. The therapeutic aspect includes the subthemes of remedies for the disadvantages, voice notes, informed consent, and one size does not fit all. The technical aspect has no subthemes.

Remedies for the Disadvantages. Most of the suggestions from the CG members did not deviate from their opinions on the disadvantages. Four CG members (C1, C6, C7, & C8) suggested that CPs in CT should be friendly and focus on the clients first of all, and not work on something else while helping clients. CPs also need to assess the client's issues thoroughly and not ask superficial questions. While doing so, it is also preferable that the CPs pay full attention, listen to the whole story, and create a responsive chat that eliminates long waits from the clients' side. As the output of CT, clients also suggested that the CPs give something in return. A summary of the client's story, suggestions that the client could apply

in their situation, and encouragement are expected. Clients also expected that the homeworks need to be discussed and given feedback.

Psychologists should focus on helping the clients and not doing something else simultaneously. I would also like the psychologist to listen to all of my story till the end, probe the story, summarise it, and later give some motivational intervention. If there is homework, the psychologist should give feedback on it. (C8)

The psychologist needs to be friendly in their selection of words. When I did [CT], I experienced slow replies. Psychologists should take notice of this. (C7)

Voice Notes. A completely new subtheme arose from suggestions by three CG members (C2, C4, & C5) to use voice notes, which would serve as a specific remedy for disadvantages of nonverbal communication mentioned earlier.

As I said earlier, I don't feel like composing chat messages. For me the solution is to use the voice notes feature, which I think all chat applications currently have. (C3)

Voice note is a feature in many chat applications where users can record their voices to send to the other party. As voice notes are a recording of one's voice, they will contain at least the verbal cues and provide more clarity in the messages without requiring a lot of time to craft chat messages. Using voice notes in therapeutic relationships is not new in Indonesia. Triyanto et al. (2022) studied found that guidance counsellor in an Indonesian high school used voice notes in their guidance counselling sessions. Wideasari et al. (2022) looked into how online psychological first aid was being given during the COVID-19 pandemic and found that voice notes are better for communicating the emotions of clients because of the ability to deliver the tone of the communication.

Voice Typing. Another feature that also came up during data gathering and was conveyed by P8. Voice typing is described as a speech interaction model where users' utterances are transcribed. The discussion between P8 and I along with extra contribution by P6 indicated some of the advantages and disadvantages of using voice typing.

Advantages

- Potentially faster than manual typing
- Psychologists can double-check the written message before sending it to the client
- During this study, voice typing is sophisticated enough to catch some phrases that are not meant to be written in letters. For example, if the psychologist wants to state a specific time, the voice typing feature can capture it and write it in numeric time format.
- This feature can also capture multilingual words and is not restricted to a specific language. This is required because Indonesian speakers often use English words.

Disadvantages

- To use the function, the user must connect to a stable internet. If such a requirement is not met (i.e., unstable internet), it could make typing longer than manual typing.
- The most well-known brand of voice typing during this study is Gboard. Installing such an app might be more challenging than compared to other apps users usually download from the app store. Rather than simply downloading and installing in a matter of few clicks, it involves three steps that require the user to make changes in the phone setting and input method which not all CPs might be familiar with. Even then, trial and error might still occur.
- Concerning its advantages, this feature might sometimes need to recognize certain words and the wanted format (e.g., the hour format). This makes the psychologist need more time to double-check the messages.
- The way this feature works as per this study is that CP must say "Dot" to end a sentence. However, sometimes the system might write the word "Dot" instead of putting the sign "." to end a sentence. This, again could demand more time from the psychologist to double-check messages

Voice recognition technology has been used in psychology for a while. Richards (1983) developed a voice recognition system to help administer the Minnesota Multiphasic Personality Inventory for disabled patients with limited hand function. Xiang et al. (2021) mentioned that voice typing was used in developing an iCBT program for older adults with depression who are receiving home care. Voice typing was used to help the clients enter the text into the iCBT program, as the program contained a workbook with assignments for the clients to work on. This suggests that the use of voice typing in CT is justifiable.

Informed Consent. Four participants (C6, P1, P4, & P5) mentioned how informed consent should be upheld in CT. It functions as a document that puts clients and CPs "in the same boat" regarding the process of CT. Clients might already have certain expectations towards CT that may not be consistent with the actual CT practice. Informed consent should contain basic information, such as risks and benefits, to give the client a better understanding of CT and avoid possible future disappointment. Finally, informed consent should also include technical matters such as scheduling and the policy about late session attendance.

Reading clients' opinions about the positive and negative things of CT, I am thinking about the importance of informed consent. When we conduct CT, what are the risks? It could also include the benefits. So then the client could decide, if CT is suitable for them. This is to avoid any disappointment since clients might already have expectations for the CT. (P1)

A similar discussion was raised by Barnett and Kolmes (2016), in which the main idea of informed consent in online therapeutic relationships is to provide information about the

online nature of the therapy and let the clients decide whether they will continue with it. Informed consent for an online therapeutic relationship should include the strength and weaknesses, appropriateness, fees, scheduling, insurance, and emergency contact.

One Size Does Not Fit All. P2 suggested that CPs may not be able to use a “one size fits all” therapeutic template even for clients with the same issue. The CT process must be able to accommodate each client’s uniqueness and be responsive to it.

I don't think using one template is possible, even for the same diagnosis. It goes back to the uniqueness of each client. (P2)

Gutierrez et al. (2018) examined how experienced counsellors planned their treatments. Six factors influenced mental health treatment: 1) client readiness to receive the therapy, 2) client preferences for what they want in their therapy, 3) client coping systems that might be needed during the therapy, 4) how family dynamics might contribute to the client’s problem and the course of the therapy, 5) a collaboratively developed treatment goal to ensure positive change, 6) safeguards as to a client’s potential to harm themselves or others.

Technical Suggestions. Four participants (C4, C6, P3, & P6) provided some technical suggestions that include the availability of emoji, reply, template message, typing, last-seen online and read functions, and the ability of the chat application to connect or be linked to a computer. While emojis have been discussed, the chat application's read feature refers to information provided by the application that tells the chat message sender that the other party has read the messages. The reply feature allows users to reply to specific messages. The template message is the ability of the app to send a pre-arrange message. The typing feature comes as a notification that shows the person on the other end is in the process of typing the messages. Last-seen online tells the user when the person at the other end is last connected to the chat room.

The read function, so we know they have read our messages. (C4)

Once I used application X and didn't see any emojis, I could not find any emojis to express myself when needed. C6)

If I compare chatting by phone and computer, it is more flexible to compose messages on the computer. So choose a chat application that can be linked to the computer. (P3)

It is convenient if the application has a template feature. Just to send some greetings to the clients so they feel responded. A “reply” feature. For example, sometimes clients send multiple chat messages, and I only want to reply to the second message. This sometimes cannot be done. Also, typing and last seen status (P6)

How to Get Started in CT.

The main idea of this section is to discuss the best practice for CPs to enter the world of CT. It is aimed at CPs interested in offering CT as one of their services. The section includes two main themes: starting and promoting CT services and fees.

Starting and Promoting CT. The section discusses different pathways CP can use to enter the world of CT. It also discusses the advantages and disadvantages of each pathway; one of which is promoting the service. Nine participants (All PG members & C3) joined the discussion, which then resulted in three main subthemes: joining telepsychology companies, private CT practice, and collaborating with information technology companies. Other subthemes also found in this theme including workplace recommendations and using personal and professional phone numbers.

Joining Telepsychology Companies. CPs can join existing psychology companies that provide CT services for Indonesians. However, as there are multiple telepsychology companies in Indonesia, the CP needs to be considerate in regards to the technical and therapeutic aspects along with career improvement that these companies might offer, before joining one of them.

When I graduated, it was during the pandemic. So whether I like it or not, I had to join several online [telepsychology companies]. (P6)

I joined this company because they often publish information and articles that I find interesting. They often hold webinars that are exclusively for us, the payment is smooth and transparent, and also, it is easy for me to contact them when I need to. (P4)

Also, consider the duration of therapy given by the company. Companies that apply time limits facilitate time efficiency during therapy, while companies that do not would make the client feel they could convey different issues simultaneously, leading to ineffective time management (P6)

Looking at the literature and evidence from the field, Harahap (2021) listed ten companies in Indonesia that provided online counselling. Personal research through their website found that all of those companies have either a website or social media page where they promote their services. In general, their websites and social media pages will include information such as types of service, online articles, and terms and conditions. They also display promotional content such as testimonies, podcasts and YouTube videos. Some provide online tests and even online interventions such as medication and breathing exercises for the consumer to try out. They also provide information about their company,

such as address, contact details, and the history of the company. These findings indicate that telepsychotherapy companies are alive and running. Consideration in choosing which company to collaborate with aligns with Novotney (2017) who mentioned that practitioners who work at online telepsychology companies would not only provide therapy but could also given supervisory, training roles as well as full-time research positions. Discussion about session duration will be discussed more comprehensively on page 218.

Collaborating with Information Technology Companies. P2 mentioned that while they were working as a CP (tied to a health institution), an information technology company approached the institution and offered to create a CT application for the institution to use to conduct CT.

Our clinic received a collaboration offer from a company. During the pandemic, our clinic started offering telemedicine due to patients' anxieties about coming to the clinic. It all started with Zoom sessions, but after six months, a company came to us and proposed a collaboration. (P2)

A quick survey was done to investigate whether or not Indonesian hospitals provide CT as one of their services. Twenty-five of the top Indonesian hospitals based on Webometric Hospital rankings (2022) were investigated for the purpose of this research. The top Indonesian hospital listed was Rumah Sakit Mitra Keluarga Group (Mitra Keluarga Group Hospital) which ranked 3848th in the world; the 25th ranked Indonesian hospital was listed as Prima Medika Hospital which ranked 11875th in the world. The survey showed that all 25 hospitals have websites where they promote themselves and provide information such as an address, names of doctors, and types of services, among other details. Out of those 25, 13 were found to be offering telemedicine as a part of their service, in which patients could consult with doctors about their condition remotely. Another ten hospitals were found to use information technology for registering purposes only. The remaining two did not indicate on their website that clients could access hospital services remotely.

In terms of telemedicine, there were several methods being used by the hospitals to provide this service. Some of them were using a common chat application that is widely used by Indonesians. Some of them have created their own applications in which patients could not only chat with the doctors but also complete some administrative matters such as setting up appointments with the doctors. Some of them were collaborating with third-party online telehealth companies and listed their

doctors in the apps made by the companies. Only four of these hospitals gave clear indications that patients could book a mental health consultation with either a psychologist or psychiatrist. Other hospitals were not so clear as some hospitals did not list psychology as one of their departments or the application could not be downloaded due to regional restrictions. This finding aligns with P2's answer that institutions or in this case hospitals, could provide online psychological consultations. Some of the hospitals clearly have their own application that patients just simply download to their smartphones.

Private CT Practice. CPs can easily open an independent practice by downloading a chat application that is used by Indonesians. While this pathway gives more flexibility compared to joining existing companies, CPs need to consider how to market and promote their services. P5 mentioned that there are several ways to promote the service. CPs could use social media, word-of-mouth, or even the clients themselves. P5 also suggested that CPs should give promotional prices or even free services in the beginning to attract customers. Aligned with P5, P3, who also owns a private practice, emphasises the importance of having creative teams in the practice to make promotional posters to be posted on social media. P3 also suggests that CPs could use paid promotional advertisements that social media often offer to gain more coverage.

There were so many apps already, but I didn't feel comfortable with the scheduling. Then I thought, why don't I use my private apps such as WhatsApp, Instagram and Facebook? I then removed myself from the specialist apps and focused on my personal apps instead. Then I promoted my service. Of course, we need to use marketing methods. Initially, I charged no fee, then gave discounts before I started charging normally. As I thought, it has been more flexible in terms of scheduling. I also noticed that social media really works. Another way would be peer promotion. Later when the clients contacted me, I had to gain their trust so that they would promote me to others as well. (P5)

The data was brought to the CG and commented on by C3, who suggested that CPs should choose chat applications that are already familiar to the clients. Choosing a relatively unfamiliar chat application will require the clients to install a new chat application and spend time to become familiar with it. This comment was then passed on to the PG group. Two members (P5 and P8) suggested that the CP and client would usually come to an agreement on which chat application they would use for the therapy, based on the preferences of both parties. However, P8 suggested that some psychology companies might require the client to choose a particular chat application.

In one of the companies that I work for, they require clients to use Google Meet because it integrates with Google Mail, Google Calendar, etc. However, there is a company that does not have such a requirement and lets both the CP and the clients choose the application. Even though I still usually use Google Chat, I would offer something else if the clients are not familiar with the application. We could use other apps such as WhatsApp or something else. (P8)

I usually use WhatsApp because the process starts from there. However, I would also ask the clients whether they are comfortable with it. In my experience, there are some clients who are... suspicious about the online security status of the WhatsApp chat application. So the clients then asked to change the chat application to Telegram. So now, I often use that application. (P5)

I also investigated individual CPs who have their own personal CT practice to get a sense of how individual CPs present themselves to promote their service. According to my knowledge and personal experience, CPs might use Instagram as a channel to promote such a service. Hashtags are often used to direct a person to a certain kind of content. If the CPs provide hashtags followed by wording to promote their service, anyone can simply search on the hashtags to see what is offered rather than trying to find the psychologist. I searched for *#konselingonline* (*#onlinecounseling*) to see what posts came up in the Instagram feed and then examined the Instagram accounts of three Indonesian CPs who offer online counselling as one of their services. I noticed several things from their Instagram pages: 1) all CPs listed their title as CP on their page; 2) two CPs listed their private practice clinics, which have different names and are listed under the category of "mental health service" in Instagram; 3) one CP listed their expertise in areas such as trauma, anxiety, depression, and stress; 4) all CPs frequently put up Instagram posts that revolve around psychology topics relevant to their areas of expertise: some written and some in the form of videos; 5) the posts are usually attractively designed with clear titles; 6) some of the video posts had more than 100,000 views. These findings seem to support the answers from P3 and P5, who both have private CT practices. From the three psychologists' accounts, it was observed that these psychologists clearly promote their services in attractive ways to inform Indonesians that such services are offered. Editing was evident in the pictures and videos posted for which comprehensive editing skills are needed. This aligns with the answer from P3 that suggested creative teams are needed for psychologists who have their own CT practices.

The feedback from C3 about using apps familiar to the clients aligned with a study by Ball and Rivas (2021), where it was found that unfamiliarity with the apps and technology in general hinders the effectiveness of online-based therapy. In Indonesian setting, a 2022 survey from APJII Indonesia (APJII, 2022) reported that WhatsApp and Facebook Messenger were the top two chat applications used in Indonesia. A 2019-2020 survey by the same company listed Line, Telegram, and WeChat as other popular chat applications that are often used by Indonesians. Nurlita (2023) listed some of the strengths of the WhatsApp chat application that might explain its popularity: 1) WhatsApp contacts are synchronised automatically, and there is no need to add a special ID as the IDs are the phone numbers; 2) features are easy to use; 3) the interface is highly customisable and users can easily change elements such as the background of the chat room; 4) backing up the chat is easy; 5) it uses internet data instead of phone credit.

Work Place Recommendations. A workplace or workstation might still be needed even though CT is a remote psychology service. A common subtheme from the participants was that the CP should find a location that allows the CP to be mindful and attentive to the clients. Some CPs are likely to get distracted while others are not. P6 mentioned that the CP should have a well-lighted room and maintain a sitting position to avoid falling asleep during the session.

My house is noisy as I have a lot of nephews and nieces. If I don't have a private room, I will get distracted as they will ask me to play with them. (P7)

If possible, maintain a sitting position and have a well-lighted room to avoid both CP and clients falling asleep during the session (P6)

Distraction in CT has been discussed previously with more focus on the client. The answers from the PG members suggested that distraction could also happen to the CP. Békés et al. (2021) conducted a study of how therapists perceive the practice of online therapy. The study found that distraction was consistently mentioned by the participants. One assumption made in the study was that the lack of a physically separate therapeutic place from normal life might induce distraction. The therapist might be triggered by other domestic work such as household chores. A study by Shklarski et al. (2021) made a similar finding that a therapist who works from home to help clients is often distracted by family members. All this evidence suggests that finding a special place in the home setting, as mentioned, seems to be one way

to resolve the issue. The comment from P6 about the well-lighted room and sitting position are aligned with Suni and Singh (2023) and Fry and DeBanto (2023) that suggest lying down helps with sleeping and exposure to light will block the production of melatonin that prevents sleep.

Personal and Professional Phone Numbers. A discussion about whether a CP should use a personal number for CT was also brought into the session. Two PG members (P3 & P4) joined the discussion and produced different answers. P4, who collaborates in a telepsychology company, had never shared their personal phone numbers and asked clients to contact them through the company. On the other hand, P3, who owns a private CT practice, asserted that they would share personal numbers with the clients. However, this does not mean clients could contact them all the time.

For CT, I do not share my phone numbers. My situation is this, I have 2 hours for every session and the reality is some clients comment that the time is too short, and some clients do not even show up until the last minute. Sometimes the clients tell stories that are not even related to the initial issue and become multiple issues. This confuses and affects me as I have other plans. There are times that I try to continue and it lasts a much longer time. So it would be a great idea to tell the clients how long the session is and this be conveyed at the beginning of the session. So when I close a chat room, I always add that you can contact me when I am online or you can contact my coworkers at that time. (P4)

In my office, the initial listing shows the number of my admin person. If the clients decide to have a CT session, the admin will, for now, give my personal phone number to the clients. The clients need to sort out administrative things with my admin before they can contact me. So far, I haven't had any bad experiences through doing this. Former clients will still contact my admin if they ever want another session, unless they just want to follow up or clarify the suggestions that I've been giving to them. Sometimes, when a former client contacts me, I will ask them whether they want to have another session because of a new issue or whether it is related to the last one. If it is still related to the last one, I will limit my answer and they might need to wait for my response. If the clients want to consult me on something new and need a fast response, I will refer them to my admin. (P3)

Literature suggests a firm position on this topic. Ideally, therapists should not share their personal numbers with clients and should have dedicated lines for communication with their clients. Goldschmidt et al. (2021) have stated the importance of boundaries and how they relate to personal numbers. According to the research, clients who have a therapist's number have more opportunity to make excessive after-hours' contact. Sousa et al. (2020) postulated that the major issue with sharing personal numbers is the possible intertwining between professional and personal chat communications. The only consideration that needs

to be made with separating the numbers is that having a dedicated professional number might require extra effort and overheads (Sousa et al., 2020).

Fees. A crucial matter in CT as CT may be one of the sources of income for the CP. A discussion was held with the PG members to understand some of the important points that need to be considered on the topic of fees. Three subthemes then emerged from the discussion: determining the fee for CT; fee and sessions arrangements; and when the fee is to be paid.

Determining Fees for CT. The first discussion was about how to best determine the fee for CT service. P1 and P8 contributed to the discussion and suggested that CPs need to consider operational costs and how CPs assess their worth in terms of being a professional providing a professional service.

The operational cost of such a service needs to be considered. For CT, this could be how much electricity we are using, how much internet data we are using and also how we assess our price as professionals, not to forget, our own living costs. Considering all of those factors, we can determine our hourly fees. (P1)

The answer from P1 aligns with an article from Stout and Grand (2004) who suggested a number of considerations in determining practice fees. In brief, the fees for psychological services should reflect the start-up and ongoing costs of a psychological practice. Start-up costs could include computers, software, internet service, and a website, among other things. Ongoing costs could include marketing costs, billing, networking and utilities, among other things. While thoughts about higher practice fees for higher levels of experience were also found in the literature (Master, 2019; Scott et al., 2015), McWilliams (2004) suggested that it is not always the case in psychotherapy. A junior-level therapist might charge more than a more experienced therapist because more experienced therapists understand that higher fees produce higher expectations in the clients, which is not healthy for the therapeutic relationship (Kerberg, as cited in McWilliams, 2004).

Fees and Session Arrangements. Another thing that needs to be considered in terms of the fees is how fees are related to the number of sessions accessed by the clients. Three PG members (P2, P3, & P5) thought that fees could be set for single sessions and for bundled sessions. P2 suggested that bundled-session payment will increase the client's commitment and be a form of economic benefit for the client. P5 preferred single-session payments as bundle sessions payment are at risk of cancellation due to unforeseen work trips.

In our clinic, even before the age of telemedicine, we always used payment plans

[because], we have a module that consists of five sessions. We hope that with payment plan, the clients will be more committed to coming to therapy. Our clinic had an experience where we removed the payment plans, and it resulted in a high number of absent clients. Now, when we offer telemedicine, the same reasoning and policy was used. Client also get a discount with the payment plan. If the module has five sessions at IDR 250,000 each, they only need to pay IDR 1,000,000 for five sessions instead of IDR. 1,250,000. (P2)

I don't use payment plans as I am worried that I might have to go interstate for work at a time when I already have appointments with clients. I don't want to disappoint them. (P5)

Regardless of whether payment is for single sessions or on a payment plan, as suggested by P2, the notion of payment of fees for therapy has been around for quite a while, with some mixed findings. At one hand, Forrest (as cited by Herell, 1993), Freud (1913) and Menninger (1961) all suggested that low fees or even pro-bono therapy will result in clients perceiving the therapy has little value, leading to a superficial analysis and a low commitment towards the therapy. On the other hand, Sammons (2019) found that clients who paid fees for their sessions were more likely to attend the sessions. Being said, Clark and Kimberly (2014) conducted a study of 1,125 records and found that fee payment did not predict therapy attendance and outcomes.

Yoken and Berman (1984) ran an experiment with 76 undergraduate students interested in attending counselling and then randomly assigned them to different groups. Members of one group made mandatory payments, while members of the other group did not need to pay for the treatment. It is found that the group that did not need to pay for the treatment had a better outcome. The explanation offered in this research was that therapists who offered free treatment were perceived by the clients as warmer and more welcoming, which provided an environment more conducive to change. Another explanation is that clients who paid for their treatment expected more from the treatment, which led them to underestimate their own progress.

All of these findings indicate that there is no conclusive statement on the payment of fees and therapy outcomes. Different factors should be considered for the practitioner to determine the fee that needs be charged to the client. The balance between clients' and practitioners' interests should be thoroughly assessed, on a case-by-case basis.

Another consideration associated with P2's answer is the financial benefit in the favour of the clients. While such payment plans have not been mentioned in the literature,

Chamberlin (2009) offer six options for therapists to provide some financing for the clients: 1) propose flexible scheduling where clients can meet the therapist fortnightly instead of weekly; 2) suggest a payment plan in which the therapist accepts payment of an amount that corresponds to the client's current financial situation, and if that improves, the amount increases; 3) offer a sliding fee scale, where the amount of fee correspondence to the client situation at the start, without any possibility of increase; 4) accept whatever amount the client says they can afford when the therapist asks directly; 5) see them pro bono; 6) refer them to community mental health services. P6 then contributed to the discussion promoting the pro-bono service Indonesian CPs could give during community service events held by different community organisations. This event provides mutual advantages for both clients and CPs.

In some occasions, community organisations often hold community service events which provide pro-bono psychology service which could help CPs to gather points for licensing matters (P6).

When to pay the fees. One last discussion about fees is related to when the client has to make payment. Two PG members (P7 & P8) joined the discussion and a consensus was reached that the fee should be discussed and decided upfront, before the CT. This is to help the clients determine whether they can afford such a service. The CP, however, might need to know about more affordable psychological services, in case the CT fee is too high for potential clients.

In my practice, the fee is always discussed upfront, so the client can decide whether they can afford the session or not. If they don't, the admin can recommend more affordable services such as a local hospital. Also, ethical codes tell us to let the client know about the fees upfront. I am also involved in a CT platform that is free, so whenever a client needs some free therapy, I refer them to the free platform (P8)

With regard to upfront information about fees and payments, HIMPSI and IPK Indonesia ethics policies only mandate that the psychologist should inform the client upfront about the fees involved in the therapy. There is no mandatory requirement to pay the fee upfront *per se*. However, most online psychology companies do ask for upfront payments.

Depression in the Indonesian Setting

Being the chosen disorder for the manual, a comprehensive understanding of depression in Indonesia is required to deliver a practical, evidenced-based CT manual. This section discusses: the physical symptoms of depression; the characteristics of Indonesians with depression; and the therapeutic approach towards Indonesians with depression.

Physical Symptoms of Depression

A discussion of physical symptoms of depression in an Indonesian setting is a secondary goal of this study. Based on my knowledge, the physical symptoms of depression have rarely been discussed in the Indonesian literature. As previously described in chapter 2, cultural factors might affect the manifestations of depressive symptoms. Asians might present with more physical complaints than their Caucasian counterparts (Saint Arnault & Kim, 2008). As Asians themselves, Indonesians might exhibit similar depression manifestation as discussed.

In the study, ten participants (C1, C3, C4, C5, C7, C8, P1, P2, P3, & P8) contributed to the discussion which resulted in findings worthy of discussion in future research. In total, combinations of 26 physical symptoms were mentioned by both the PG and the CG. Table 18 shows a summary of the findings and whether those physical symptoms mentioned in previous studies.

Table 18

Physical Symptoms of Depression

Physical Symptoms	Mentioned by	Supporting Evidence
Headaches	C1, C3, C5, C7, C8, P1	Powers et al. (2006) Saint Arnault & Kim (2008)
Dizziness	C3, C5, C7, C8, P1	Karlińska (2017) Saint Arnault & Kim (2008)
Weakness	C8, P1, P3, P8	Ofonedu et al. (2013) Saint Arnault & Kim (2008)
Ulcers	C4, C5, P1	Shin et al. (2008) Vereecke et al. (2022)
Chest Tightness	C3, P3, P8	Indayani (2016) Leander et al. (2014)
Irregular breathing patterns/shortness of breath	C8, P3	Leander et al. (2014) Crockett et al. (2016)
Nausea	C4, P3	Haug et al. (2002)
Painless bruises	C4, P3	<i>Not Found</i>
Sore muscles	C4, C8	Saint Arnault & Kim (2008)
Vertigo	C6, P3	Bigelow et al. (2015) Karlińska. (2017)
Abdominal cramps	C8	Saint Arnault & Kim (2008)
Abdominal pain	P3	Walter et al. (2013) Youssef et al. (2008)
Constipation	C7	Haug et al. (2002)
Diarrhoea	P3	Haug et al. (2002)
Eczema	C8	Schonmann et al. (2020)

Physical Symptoms	Mentioned by	Supporting Evidence
Eye-Bags	P2	Akram & Irvine (2020)
Faintness	C8	Saint Arnault & Kim (2008)
Hair Loss	C8	Schmitt et al. (2012)
Muscle cramps	C1	<i>Not Found</i>
Nosebleeds	P3	Polacsek et al. (2019)
Pale appearance	P8	Lever-van Milligen et al. (2014)
Palpitation	C8	Saint Arnault & Kim (2008)
Joint Pains	C4	Trivedi (2004) Stahl (2002)
Stiff neck	C8	Asai et al. (2006)
Stiff shoulders	C8	Asai et al. (2006)
Tactile numbness	C8	Saint Arnault & Kim (2008)
Vomiting	C4	Muraoka, et al. (1990)

Quotation examples:

I experienced a lack of sleep, headaches, abdominal cramping, physical numbness, dizziness, fainting, sore and stiff muscles, and heart palpitations. (C8)

Their breathing patterns are irregular. And yes, they experience dizziness, nausea, and stomach aches. Some experience diarrhoea. (P3)

It can be seen from the table above that most of the physical symptoms reported by the participants have been previously in previous studies. Nine of the physical symptoms were identical to those found in the study by Saint Arnault and Kim (2008) who explored culturally specific experiences of the manifestations of depressive symptoms. The sample included 111 Japanese and Korean female students. A total of 19 physical symptoms were found in the sample.

Returning to the current research, some of the symptoms are better understood than others. Dizziness and vertigo, which were mentioned by seven participants, might be explained by the increase in blood flow to the brain caused by strong emotion (Narożny & Pierchała, 2010; Prusiński, 2001 as mentioned in Karlińska, 2017). As an aside, the relationship between headaches and depression is still not yet fully understood as there are still inconsistencies in the research. Regardless, the evidence of an increased risk of headaches in depressed people has been persistent (Powers et al., 2006). Finally, some physical symptoms might not directly link to depression but to its more familiar symptoms. Akram and Irvine (2020) explained how bags under the eyes are most likely caused by sleeplessness, which is a symptom of depression.

Reporting Physical Symptoms. An interesting finding was also conveyed by three of the participants (C8, P1 and P3), suggesting that Indonesians tend to discuss their physical symptoms and not their emotional symptoms when they visit health professionals.

In general, Indonesians tend to complain more about their physical symptoms. Probably physical complaints tend to be more accepted. (P1)

Of the clients with depressive symptoms that I have worked with so far, some of were referrals from GPs. They had done Xrays and MRIs, etc. The reasons for their headaches could not be detected or seen in the tests. (P3)

I thought I had a heart condition. I then went to a neurologist only to find there was nothing wrong with my nervous system. I was then referred to a psychologist. (C8)

Supporting evidence for such findings also aligns with findings in the field. *Poliklinik Psikosomatis-Rumah Sakit Cipto Mangunkusumo* [Polyclinic of Psychosomatic-Cipto Mangunkusumo Hospital] (2017) a government-run hospital in Central Jakarta, even lists on its website that 30% of clients who complain about physical symptoms suffer from mental illness. This phenomenon can be explained by mental illness causing bodily symptoms, without the accompaniment of a general medical condition (Kallivayalil & Punnoose, 2010).

The excerpt above implies that the preference for reporting on physical symptoms might be a pattern in Indonesia's mental health settings. This topic opens opportunities for further research as no Indonesian literature supports this statement at the moment, despite similar patterns being found elsewhere. Grover and Ghosh (2014) mentioned that Asian people tend to emphasise physical discomfort rather than psychological discomfort due to the attached stigma and the lack of acceptance by others. Subu et al. (2017) investigated how Indonesian adults understand mental illness and stigma found that people with mental disorders might experience stigma from family members, members of the community, mental health professionals and staff, and also from governmental institutions and the media. Similar findings from recent Indonesian literature (Celina & Arjadi, 2021; Danukusumah et al., 2022; Sarfika, et al., 2021) have suggested that the phenomenon of stigmatising people with mental disorders persists.

Another possible reason may be explained by Lin and Cheung (1999) which suggested that the ways Asian people see their bodies and emotions as unitary rather than dualistic might cause Asian people to overstate their physical symptoms.

Responding to physical symptoms. Discussion also made with the PG members The on how they should respond to the physical symptoms that the clients may mention. Four PG

members (P1, P2, P6, & P8) postulated that further examinations should be done of clients with physical symptoms, as it is important to diagnose any illness correctly. It is best to eliminate all physical causes of the symptoms that clients present with, as clients with physical symptoms might also have other illnesses that are physical in nature. This can be done by referring the clients to a GP or specialist.

When the client describes their complaint and it is found to contain physical symptoms, we must try to eliminate any physical cause for these symptoms, so we can focus on the psychological problems. (P1)

From my experience with clients who complain about physical symptoms, if their physical symptoms become too intense, I will also ask them to undergo a medical check-up with a GP or specialist. Clients who complain about headaches may have epilepsy and hearts palpitations related to arrhythmia. (P8)

The answers from the PG emphasised the importance of one aspect of a clinical psychological assessment, which is the differential diagnosis. Cook and Décary (2019) have defined differential diagnosis as “a systematic process to identify the proper diagnosis from a set of possible competing diagnoses” (p. 1). Differential diagnosis is important because it will become the basis of clinical decision-making as clients might need more definitive care (McGuinness et al., 2012). At worst, inaccurate diagnoses could lead to incorrect treatment (Moreira, 2019).

Possible Comorbidity. Three PG members (P1, P2, P5) also asserted that several physical symptoms mentioned in the discussion are associated with other mental illnesses, such as anxiety. Hence, the members also discussed the importance of possible comorbidities between depression and anxiety disorders. This notion was brought back to the CG, and three members (C4, C6, & C8) supported it.

Symptoms such as dizziness and gastric reflux might be caused by an anxiety disorder. The distinctive physical symptoms of depression are lack of motivation, feeling weak, and excessive sleep. When a client presents with these kinds of physical symptoms [referring to the data from the CG] we need to check further whether the clients might have a condition that needs to be treated by a medical professional. It also could be questioned whether these are caused by pure depression or whether they also have some sort of relation to anxiety. (P1)

I have had anxiety for a long time, and depression, I think it's more like a secondary complaint (C6)

The prevalence of comorbidities with mental illness has been well documented throughout the literature (Anker et al., 2018; Baranyi et al., 2022; Veisani et al., 2017). Steffen et al. (2020) found that nearly all mental health disorders were at least twice as prevalent in

persons with depression, with the most common comorbidities being neurotic stress disorder, substance abuse disorder, and personality disorder. A study conducted by Thaipisuttikul et al. (2014) in Thailand found that patients with MDD also suffered from dysthymia and anxiety disorders including panic disorder, agoraphobia, social phobia, obsessive–compulsive disorder, generalised anxiety disorder, posttraumatic stress disorder, alcohol dependence, psychotic disorder, and antisocial personality disorder.

Looking back at the physical symptoms data, it can be seen that muscle cramps and painless bruises were the two physical symptoms of depression that were not supported by the literature. This might be because muscle cramps/spasms have been linked with anxiety disorders (Blackman et al., 2019), and skin inflammation can be linked to psychological stress (Chen & Lyga, 2014). Gardner-Diamond syndrome is a condition characterised by the emergence of unexplained bruises on the arms, legs or faces of people with mental illnesses or experiencing emotional stress (Karakaş et al., 2014)

The Characteristics of Indonesians with Depression

PG members were asked about the unique characteristics of Indonesians who suffer from depression (ISD) that they often observe in their practice. Five members of the PG (P1, P2, P3, P6, & P8) joined the discussion. The data showed two major subthemes, which included characteristics that are listed in the PPDGJ III and some that are not listed.

Listed in PPDGJ III. Four PG members (P1, P2, P6, & P8) mentioned that change in appetite is the most commonly seen symptom in ISD. They could experience either significant weight gains or loss and either lack of sleep or excessive sleep. Finally, ISD could experience a lack of energy and negative cognition.

A symptom that I often find is excessive sleeping, so clients always feel sleepy. In terms of food consumption, they can be under- or over- eating. And then there has always been diminished energy. They feel that they don't have the energy to conduct activities. (P1)

Their negative cognition is the unique thing about depression. (P2)

All of these characteristics can be found in the list of official depressive symptoms in PPDGJ III which is based on two sources: the ICD-10 (WHO, 1993) and the DSM-IV (APA, 1988).

Not Listed in PPDGJ III. Four PG members (P2, P3, P6, & P8) mentioned that social withdrawal is often seen in ISD. It manifests in behaviour such as isolating oneself in a room

or being alone, being reluctant to go outside the house and preferring to lie down, and spending a large amount of time in front of devices. They also often have an unhealthy diet, eating fast food and drinking a lot of caffeinated drinks and not enough water. In terms of communication, ISD can say very little during therapy or being very talkative. Finally, P6 mentioned that ISD often have rather jumbled ideas when they communicate.

Clients often spend their time in their rooms. (P1)

What I often find is an unhealthy lifestyle. Often, they consume junk food, thus, they have a lack of nutrition. Some of them only eat one or two meals a day. And then, regarding water consumption, I find that the majority consume less than 2 litres of water per day and drink tea or coffee instead. (P8)

During communication, they talk less; we are the ones who need to be active. (P5)

Unlike P5 who said they talk less, in my case, they talk excessively. Maybe it is cathartic. (P3)

If they want to tell stories, the ideas of the story are often jumbled. (P6)

It has been mentioned in chapter 2 that depressed people tend to withdraw from social encounters as they are hesitant to convey their feelings or afraid of being judged (Achterbergh, et al., 2020). The literature shows that there is a connection between processed food and depression. A study by Ljungberg et al. (2020) concluded with strong evidence that processed foods such as sausages, juices, soft drinks, and sweets can result in an increase in depression symptoms. Furthermore, a causal relationship between a healthy diet and decreased symptoms of depression has also been found. In a study by Jacka, et al. (2017), a dietary intervention was added to Motivational Interview treatment for people with MDD. Twelve key food groups that included whole grains, vegetables, fruit, legumes, low-fat and unsweetened dairy foods, raw unsalted nuts, fish, lean red meats, chicken, eggs, and olive oil were part of a dietary programme for the participants. At the same time, the participants were also required to reduce their intakes of sweets, refined cereals, fried food, fast food, processed meats, and sugary drinks. The result suggested that the group with the dietary intervention experienced a significantly greater improvement compared to the control group. Some studies have found that caffeine actually decreased the symptoms of depression as it prompts the release of the serotonin hormone (Ferré, 2007; Grosso, et al., 2016; Lucas, et al., 2012). However, Rusconi, et al., (2014) have argued that it is not one size fits all. Symptoms of depression can worsen with the use of caffeine, especially in postpartum depression.

Furthermore, even though it is a rare occurrence, caffeine has been linked with suicidal behaviour, which is one of the symptoms of depression (Silva, et al., 2014).

A study by Mundt (2007) found that the speech patterns of depressed and nondepressed persons were different. In the early stage of depression, speech can become slower and more monotonal and laboured, with frequent stops and starts and pauses. As the depression becomes more severe, speech becomes gravelly and hoarse and less fluent. This could explain the participant's comments on how their depressed clients often talk less. The answer from P6 about jumping between ideas might refer to the concept of a "flight of ideas," where a person rapidly shifts between thoughts (Gaag, 2013). Maj (2015) provided some information about a rather unique type of depression known as "mixed depression" that was first raised by Weygandt, Kraepelin, and Hecker at the end of the 19th century. This type of depression has different symptoms that can be clustered as agitated or excited. Symptoms that can be found in mixed depression are as follows: psychomotor agitation, talkativeness, flights of ideas, and irritability. This could also explain P5's answer.

The Therapeutic Approach towards Indonesians with Depression

The PG members were asked about their therapeutic approach to working with ISD. Five members of the PG (P1, P3, P5, P6, & P8) contributed to the discussion which resulted in two subthemes: psychotherapy type and common stages of treatment.

Psychotherapy type. The data from the PG suggests that CBT is the most favoured psychotherapy for use with ISD. It has been found that CBT best suits Indonesians, who generally need insight into their therapy. Aside from CBT, the PG also favoured problem-solving therapy (PST) as Indonesian clients often request quick solutions to their problems. Humanistic therapy (HT) was also mentioned as Indonesians who suffer from depression often need emotional validation to improve.

From my experience, CBT is the most suitable for Indonesian clients. There are clients who often need to be heard and understood; for that, humanistic [therapy] would be suitable. (P1)

Some clients come for only one session and want a quick solution, so I often use problem-solving therapy with CBT as a supplementary method. (P3)

It can be seen from the data that PG tended to choose CBT as the main intervention for ISD. Among other therapies, CBT has been described as one of the best psychotherapies for depression for more than a decade (Parker & Fletcher, 2007; Markowitz, 2008) and it is still

considered as the gold standard for depression treatment (David, Cristea, & Hofmann, 2018). IPK Indonesia (2021) also lists CBT as the first option for treating depression. Furthermore, CBT has also been incorporated into a number of internet-based and computerised psychological interventions (Komariah, et al., 2022; Patterson et al., 2022; Schröder et al., 2022; Wickhershaw et al., 2022). PST is efficacious, especially for children and adolescents (Zhou, et al., 2015), and also for adults (Kleiboer et al., 2015). HT has also been found to be efficacious for depression. Lambert et al. (2016) mentioned that HT are efficacious for treating depression as they are superior to no treatment and have equivalence with CBT in treating depression.

Common Stages of Treatment. The PG members then were asked about the common step-by-step/procedures they use most often in psychotherapy for ISD. P1 gave a very comprehensive answer which other participants agreed with. Ideally, the CP would first address the clients' most dominant (urgent) symptoms and let them vent their emotions. Once this process has been completed and the clients have improved their quality of life, the CP can address the clients' emotions. According to P1, Indonesians often have difficulty identifying emotions such as sadness, disappointment, anger, etc. Thus, CPs need to help clients to identify those emotions. This step is important because emotions are the windows to access thoughts. Finally, as negative automatic thoughts are highly characteristic of depression, once the clients are stable, CPs need to be able to identify those negative thoughts and reconstruct them. P3 and P8 responded by stressing the importance of focusing on the unhealthy lifestyles of depressed Indonesians.

P5 also contributed to the discussion by stating that Indonesian clients often lack focus regarding therapy. Thus, CP could use the here-and-now specifically "Grounding" method deal it. Finally, P6 contributed to the discussion by stating the importance of social support to help the clients commit to therapy.

Firstly, I will identify which symptoms or complaints are dominant. For example, we will first focus on lack of sleep. Other examples would be if the client needs to vent first, then we will first do that. Later, when the condition has improved we then try to help them to identify the most dominant emotion that they have. Sometimes, Indonesians have difficulties in differentiating sadness, disappointment, and anger. This activity is then related to our next effort to explore their thoughts. Since depression is correlated with negative thoughts, we then try to identify the client's negative automatic thoughts. (P1).

I often give them psychoeducation on why lifestyle affects their psychological condition. I will explain how lifestyle affects brain function because psychological

function comes from the brain. (P8)

"Grounding" is very important, so their mind does not wander everywhere. Grounding in itself is a part of PFA [Psychological First Aid] that includes interventions such as looking and listening, among other things. This can be done using simple techniques such as simply asking them to name five items near them. This is to bring them into the "here and now," to help them focus and be ready for the next intervention. (P5)

Social support is important, as some clients need to take medicine regularly. These ones need social support. We need to find out who the client is close to. (P6)

The step-by-step procedures in treating depression discussed by the PG seem to be aligned with the guidelines from IPK Indonesia (2021). The guideline suggests that, as the first response to depression, CPs should assess the mental and interpersonal functioning of the clients; provide social supports, that could be in the form of emotional support (Sarafino, 2014); educate clients about the disorder; continuously evaluate their mental status; and provide referrals if needed. Going to the second step, the guidelines suggest that CPs check on clients' physical health and educate them, about sleeping patterns especially, along with providing suggestions about eating, maintaining a healthy environment, and physical exercise. In the final step, depending on the severity level of the depression, CPs can choose the best treatment plan for the clients. The options for treatment can include 1) self-help computerised and group CBT, physical group activity, counselling, psychoeducation, brief psychodynamic therapy, and medical treatments for mild-to-moderate depression; 2) medical, CBT, interpersonal psychotherapy (IPT), and behavioural activation for moderate-to-severe depression; and 3) medical treatment only for complex and severe depression that involves psychosis and self-harm.

Dissecting P1's answers about CP must deal with clients' emotions after the most urgent symptoms have improved, and before going on to analyse the thoughts that the clients might be having, is aligned with the step-by-step method of CBT; which recommended by IPK Indonesia's guideline. According to the primary reference for CBT by Beck (2020), every session should start with a mood check. Aligned with P1's answers, mood checks allow the CP to further analyse the automatic thoughts behind the moods.

However, as suggested by P1, Indonesians might not have awareness of their own emotions or the emotional literacy to describe their mood. This argument is backed up by a study by Kurniawan and Dewi (2016) who investigated the level of school engagement (how

students see their relationship with their school) in high school students. It was found that there was a positive correlation between low levels of school engagement and inability to understand one's feelings. It was argued that problematic behaviour often manifested from students with the inability to monitor and differentiate one's own and others' emotions.

One possible tool to help the situation is that CPs could consider using the emotion list provided by Makmun (2014) during the course of therapy. The list consists of eight primary human emotions: shyness, irritation, surprise, love, enjoyment, fear, sadness, and anger. Each emotion contains a more specific form of such emotion that might represent the client's emotion better. For example, shyness could also be represented by crushed, disgraced, humiliated, upset, ashamed, guilty, and regretful. A more complete list can be found in the page 104 of the manual (Appendix A, p. 307).

The inability to focus or concentrate is one of the symptoms of depression (American Psychiatric Association, 1994; Keller et al., 2019). Grounding, as described by P5, to help clients with such an issue is a mindfulness practice in which the clients are asked to focus on attention to sensory input, which may be an image or object (Zerubavel & Messman-Moore, 2013). This method has been recommended for use in CT settings by both clients and the therapist themselves, for preparation (Burgoyne & Cohn, 2020; Robinson, 2021; Ronen-Setter & Cohen, 2020).

Millennials and Gen-Z

While chapter 2 has provided the literature review of Millennials and Gen Z in general or in the Indonesian context, a discussion was still made with the study participants to gain extra knowledge. This section starts by discussing the characteristics of different generations, followed by their expectations of CT.

Characteristics of Millennials and Gen-Z

As the main subject of the study, I wanted to understand the different characteristics of millennials and Gen-Z regarding therapeutic relationships. This topic is argued to be essential as the results of the discussion could inform future CPs who have clients from these generations. The discussion was not specialised to CT but rather therapeutic relationships in general. Five PG members (P1, P3, P5, P6 & P8) contributed to the discussion that resulted in six subthemes: 1) technological literacy and being up to date; 2) mental health literacy; 3) self-diagnosis; 4) attitudes towards therapy; 5) types of issues; and 6) expected psychologist characteristics. The group also offered suggestions on how to work with each generation.

Technological Literacy and Being Up to Date. P1 and P8 indicated that both generations are familiar with technology and keep up with the latest trends. This meant the CPs needed to stay up to date with new trends to be able to create and maintain therapeutic relationships with clients.

They are technologically literate; they know what applications to use on a daily basis. They are very up to date in terms of new stuff. This made me realise that we must also be up to date ourselves. (P1)

We need to be more up to date in regard to currently trending topics. It could be soap operas, games, music, K-Pop, even. Because I have found that if we understand their interests, it is easier to build rapport. (P8)

This particular finding aligned with the discussion in chapter 2. Millennials and Gen Z are said to be connected online and up to date (Ali & Purwandi, 2017; Stillman and Stillman, 2017). Additionally, Kim et al. (2022) have argued that because millennials and Gen Z have grown up in a digital world, they tend to be very curious about new technology, leading to them continuously developing new skills.

Mental Health Literacy and Awareness. P1, P5 and P6 found that these generations demonstrate good mental health literacy. For example, they can use their smartphone applications to monitor their mood. For P5, Gen Z demonstrated more literacy than the millennials. Similar to the previous subthemes, this characteristic motivates the CPs to stay up to date with new findings and theories related to mental health.

What I can conclude from Generation Z and millennials is that they know what trending applications to use to track their moods. They have told me about apps that can monitor their moods. Some of my clients have a high literacy in mental health and they have told me about new syndromes. (P1)

For Generation Z, their mental health awareness is high and quite comprehensive. If they are feeling out of the ordinary, they might say, "I think there is something wrong with me." So they have a good awareness compared to the millennials. (P5)

We also need to learn about new stuff (referring to mental health) such as new love languages, new diagnoses, new symptoms. That's why we need to keep up to date ourselves and not only rely on DSM or ICD 10 (P6)

The observations above could be explained by the current state of mental health awareness in Indonesia. As previously discussed, Idham et al. (2019) concluded that not only Gen Z, but also millennials have high mental health literacy. However, this might not positively correlate with emotional awareness as Kurniawan and Dewi (2016) found that the levels of emotional awareness amongst Indonesian Gen Zs was low.

Self-Diagnosis. P3 found that teenagers (Gen Z) often self-diagnose based on superficial information they obtained from third parties online.

Some teenagers, when they contacted the psychologist, already knew what disorder they had. They do self-diagnosis. If they have up-and-down moods, they think they have bipolar, but they only see one symptom and are not looking for other symptoms as well. So when I met them, they often ask, "Am I really suffering from bipolar?" (P3)

In a study involving 160 participants aged 17–21 in the Indonesian context, Nugroho et al. (2022), found that the participants often self-diagnosed using the abundant information accessible online. A qualitative study with four participants aged 20–21 years by Maskanah (2019), found several reasons for self-diagnosis: curiosity regarding their symptoms, feeling confused and pressured, and feeling unable to handle negative emotions.

Attitude Towards Therapy. Both P6 and P8 stated that these generations tend to seek instant solutions for their issues, not appreciating the necessary therapeutic process. This included wanting to know intervention details and diagnosis. Regarding the latter, P8 had developed a particular response to these requests, informing the client that there would be no diagnosis in CT as this requires a face-to-face session with a CP. He also informs them that psychotherapy takes time. P5 suggested that these characteristics were more applicable to Gen Z, and P5 found millennials were more trusting of the psychologist and the treatment route. Gen Z, however, are more impulsive and likely to suddenly withdraw from the treatment.

I feel the majority of the millennials are only focusing on the output. If I ask them to go slowly and experience the process step by step, they usually go, "How many sessions do I need? Will I be cured? What is my diagnosis?" They don't focus on the process, what can be done at this moment, but rather on the result. "What do I gain from all of this?" However, due to limitations, we don't do diagnosis in online therapy. If they want a diagnosis, they need to see me face-to-face. I also told them psychological recovery needs time, and is not instant, because your experience in the past went on for years, to recovery will also take time. It can't be done in one day. If we explain the treatment plan in detail, like "we need eight sessions, with a period between them of one or two weeks, and this is what we are going to do in the first session, and this is the purpose of such a treatment," then they understand that and they tend to be more committed. I have also said to them, "For us to reach the 8th session, I need you to cooperate with me." (P8)

Compared to the millennials, it is not that they don't ask, but they feel confident with the professionalism of the psychologist. When Gen Z do not feel comfortable with the psychologist, even after just one session, they can quickly withdraw and change psychologist. Millennials, on the other hand, are more willing to try to adjust to the psychologist. (P5)

A need for instant or immediate gratification has been linked to both millennials and Gen Z. The APA (n.d.b) define instant gratification as the meeting or satisfying of one's needs or wishes without delay. Turner (2015) has argued that the ease, immediacy and free access to results in Gen Z could lead to them being impatience, rebelliousness, and craving instant results. Jones and Kang (2019) also found instant gratification characteristics in millennials. Riedy (2018) have suggested counselling strategies that align with such tendencies, such as offering technology-based interventions, and offering quick information and quick homework assignments. Ng and James (2013) suggest Chinese people prefer therapy that is pragmatic in nature. They prefer the therapist to provide active advice rather than spending time to deal with mental distress. While Indonesian and Chinese cultures are different, both might have shared characteristics as Eastern cultures. Furthermore, the need for quick solutions might apply not only to younger generations but Indonesians in general.

Expected Characteristics of the CP. P5 and P8 suggested that the CP should be close in terms of age and also have a warm and friendly attitude.

What I think is "cool" with Gen Z is that when we talk with them, it is not that formal, like how friends converse with each other. (P5)

What I feel when I work with the millennial generation is that they need psychologists who are warm and friendly who could be a "friend" who listens to them, so the age gap should not be that great, so they are comfortable to share their stories. (P8)

In a systematic literature review on how health professionals can improve their interpersonal communications with adolescents and young adults, Kim and White (2017), identified several preferred characteristics: sincere caring, being empathetic and respectful, not objectifying, being honest, making clients feel worthy of time and effort, and being open and friendly.

Types of Issues. P5 stated that there is a difference in terms of the types of issues that these two generations exhibit, suggesting that millennials' issues are more severe but that these issues are more familiar to the CPs. Gen Z's issues, on the other hand, require the CPs to be more familiar with recent social media trends.

Because, at their age they are more adult than teenagers, we can predict their issues, and the issues tend to be similar, like marital issues etc. For teenagers, however, we need to keep up to date on social media issues. (P5)

The answer aligned with the earlier discussion in chapter 2, where it was discussed how

social media was one of the two main contributors towards Indonesian Gen Z's level of depression. Witopo (in UGM, 2018) mentioned that Gen Z often experiences the fear of missing out on the latest trends. This explains P5's answer in which CPs need to be updated on the latest trend in social media. Regarding the millennials, the previous discussion suggests that social media is also an apparent contributor to their level of depression (Hamidah in Kurnia, 2019). However, data from KP3A-RI and BPS (2018) has emphasised how Indonesian millennials' stress could be related to the need to compete in many aspects of their life, such as education, the job market, the economy and social relations. As suggested by P5, some of these aspects, such as the job market and economy may be more related to millennials, given their stage of life.

Clients' Expectations of CT.

It would be beneficial for CPs to know what clients expect from the CT service before they enter the service. When I asked the CG about this, several themes emerged, including: a) solutions; b) venting opportunities; c) information; d) different perspectives; and e) length of intervention.

Solutions. Five CG members (C1, C3, C6, C7 & C8) asserted that they expected to receive solutions to their issues. Some clients already know why they are feeling down and are only looking for solutions to ease the stress they are experiencing at that moment (C1).

Venting Opportunities. Three CG members (C1, C3, & C8) mentioned that they were looking for someone who could listen (figuratively) to their story. C1 then qualified their answer by stating that they were looking for someone who could listen to them without judgement or confrontation in return.

Information. Two CG members (C4 & C6) postulated that sometimes clients do not know what is happening for them. C4 and C6 then asserted that providing information about their condition would benefit the therapeutic relationship.

Different Perspectives. C8 mentioned that the client sometimes wanted to compare the psychologist's way of thinking about the problem with their own, to see if it was any different.

Length of Intervention. Three CG members (C3, C7, & C8) said that they were seeking a relatively short or quick intervention in which they would be given solutions to their problems. However, two CG members (C3 & C8) did not mind if the intervention needed to take a longer route, especially when a longer route would result in a more comprehensive

result such as new behaviour or new personality.

I am looking for solutions. I want to be given tips on what I should do to return to that calm and comfortable state. Also, I am looking for someone who listens to my venting about my situation. We know why we are like this, with our problems, so we need solutions. What do we need to do to lessen this depression? I want these solutions as soon as possible, probably after one session, although if the psychologist says that I need two or three sessions, I don't mind. (C3)

I want to find answers about what is going on with me. I am also looking for peace of mind. (C4)

I am looking for another point of view on my problem, from someone who knows how my perspective on the problem needs to be corrected. (C8)

For me personally, in the short term, I would like to feel calmer as soon as possible, but in the long term, I don't mind having further sessions to create new behaviours and [change my] personality. (C8)

Having read these answers, the PG then provided their responses. P1 emphasised how important it is to understand clients' expectations right at the beginning of the therapy. CPs must have therapeutic communication skills to help identify clients' needs and expectations without making the clients uncomfortable with direct questions. P1 suggested that by being sensitive towards clients' chat messages could identify their expectations towards the therapy. Another member of the PG (P5) contributed to the discussion by stating that clients' expectations and prior experience with CT are essential information to collect at the beginning of the sessions as CP could learn about clients' previous experience with CT. A somewhat different opinion came from P2 and P6, about clients expecting to receive solutions from their psychologist. They mentioned that psychologists should not provide solutions in therapeutic settings as the solutions should come from the clients themselves; doing otherwise could lead to therapeutic ineffectiveness.

I see individual differences in terms of their expectations when they see us. Some need a solution, some need an opinion, and some need an equal response. We need art in therapeutic communication to determine whether the clients just need to be listened to, are wanting solutions, or something else. We have to deliver the questions so that the client doesn't feel "Why am I being asked these questions?" Often when I am doing CT Sessions, I know more or less what the clients want. If a client sends lengthy messages, they might want to be listened to. If they start to ask questions, I know they want a solution. (P1)

It is important to know whether the clients have done CT before so that we know about the clients' experience regarding that. For example, if the client asserts that "the previous psychologist's solution tended to be more like this, I don't feel comfortable with that," we can understand the client's likes and dislikes based on their previous CT sessions. (P5)

In therapy, the solutions should come from the clients themselves. So I am considering whether this point should be discussed early in therapy. The psychologist is there to facilitate the client in finding those solutions. I feel bad when clients come to us for a solution, but our mindset is the opposite. (P2)

Direct solutions could make clients less responsible for themselves; they could blame and demean the CPs if the solutions are ineffective. (P6)

The data suggested that clients' expectations towards CT echo the discussion of the advantages. The solution subtheme appeared to be dominant across the data collected. The CG members also mentioned quick solutions as an advantageous aspect of CT. P3 also acknowledged that some clients expect quick answers as an output of CT and that problem-solving therapy was their preferred choice for the type of psychotherapy when conducting CT. Thus, the subtheme of solutions is not discussed here but can be found in the "Providing Solutions" section (p. 138).

Venting, as another expectation from clients, is also not uncommon in psychotherapy. One type of therapy where venting often happens is emotion focused therapy (Greenberg, 2015). Venting is essential and effective only if a moderate amount of time in a session is dedicated to dealing with emotion. Too much or too little feeling in a session hinders the therapy (Carrier & Greenberg, 2010). However, it is found that venting alone might not be therapeutic and should be accompanied by problem-solving (Bushman, Baumeister, & Stack, 1999; Tavis, 1989). Clients who perform negative venting (of negative emotions) can become more aggressive (Scarpa & Haden, 2006). On the other hand, the concept of positive venting is a way to debrief on stressful encounters to elicit peer support while reinforcing compassion (Gerhart et al., 2017). In positive venting, clients try to relate the frustration to the contextual aspect of a person or situation that caused the stress. The following sentence would be an example; "I am frustrated by his behaviour, but I know he is on a deadline now." By doing this, the emotion is released, but at the same time, the clients also increase their compassion towards the situation.

The clients also expect information and different perspectives are more aligned with a consultation rather than psychotherapy. In a psychotherapy setting, an intervention called psychoeducation allows information to be given to the clients. Psychoeducation is an educative intervention that primarily aims to provide knowledge about various facets of illness, including signs, symptoms, likely course, outcome and prognosis, and dispelling misconceptions (Bhattacharjee et al., 2011). The need to receive a different perspective from

the CP may not be catered to in psychotherapy as psychotherapy tends not to provide advice or solutions for the client. A dedicated discussion about this topic can be found in page 138. Alternatively, clients could choose to have a consultation. As previously mentioned, consultation allows anyone with more knowledge and expertise to give professional advice, suggestions, or opinions to someone seeking them (Falender & Shafranske, 2020)

The short period of therapy which the clients expect is aligned with the characteristics of millennials and Gen Z, which has been discussed earlier. Their attitude towards therapy tends to expect quick and even instant results. However, as mentioned by C3 and C8, millennial and Gen Z clients might be open to more comprehensive therapy as long as the treatment makes a big difference for them. These two generations have mental health literacy and awareness (Idham et al., 2019) and the fact that online therapeutic relationships have become popular with these two generations shows that clients from these two generations are concerned about their mental health and want to be well. It is the job of the CPs to use clients' interest in mental health to appeal for the clients to make changes to improve their mental health (Kim & White, 2018).

The Therapeutic Aspect

This section focuses on the discussion of the therapeutic aspect of CT. It includes chat style, creating therapeutic relationships, providing solutions, homework, confidentiality, and self-harm.

Chat Style

It has been previously discussed how the use of chat or texting as the primary communication medium in CT is challenging. I have also realised from my experience that chat styles can differ between people. Some people prefer to use relatively long chat messages, while others prefer them to be short. Other people might prefer to break down long messages into several short messages. These preferences might be related to gender (Thurlow & Poff, 2011), the recipient of the chat messages (Ignacio & De Jesus, 2021), and personality (Roffo et al, 2014). I brought this topic to the CG and six members (C1, C4, C5, C6, C7, & C8) participated in the discussion to understand how different chat styles affect the relationship between the CPs and the clients. To give a better visual representation of the discussion, readers could go to the page 37 of the manual (Appendix A, p. 307), attached to this thesis.

To begin with, C5 members preferred if the CPs send rather long messages. Sending

long messages broken down into several short messages creates a risk of a change of topic midway through the unfinished messages. This is because clients respond to the short messages, before the whole message is completed. In contrast, C1 preferred to read short, concise messages. C1 then argued that the risk of a change of topic can be avoided with good timing and knowing when to respond. C4 suggested that CPs could use both styles as a middle ground, depending on the circumstances.

I like long ones. Long messages are complete and easier to read than the shorter ones. I feel the topic might change if I reply to one of the psychologist's messages. (C5)

I like short messages; the main point doesn't need to be lengthy. I don't feel like reading long messages. "This is what happens to you," "This is what you need to do"—these are easy for me to read. I think the apprehensiveness about changing topics, as C5 said, is about timing. Has the psychologist finished sending messages or not? (C1)

It depends on the need. There are parts of the therapy when we prefer short messages; in some parts, long informative messages are preferred. Short messages are suitable for topics that are not too serious as chat sessions might include jokes. Long messages are for serious topics such as offering solutions. (C4)

At the beginning of the therapy, when we tell our stories, some psychologists send short messages such as "I see..." even after only a small portion of the stories. I feel listened to when psychologists do that. There are also sentences like, "It is gonna be difficult, but it is doable." The sentences are short, but they are motivating. (C6)

A study by Sindahl and Dolan (2020) investigated how the average number of characters per message used by the counsellor in text-based counselling sessions impacts the clients. The study found that more characters per message but fewer messages positively influenced the clients. The assumption made from this finding is that a session with a low number of important messages is seen to have better overall content than a brief session with a high number of short messages. This research finding aligns with the answer from P5, who prefers to send longer CT messages.

Providing Solutions

The discussions outlined previously produced different opinions regarding whether solutions should come from the clients or the CPs. One of the expectations by clients for CT was to receive solutions regarding their issues—which P2 and P6 were not prepared to meet. The CG members were asked who should provide the solutions. A total of six members (C3, C4, C5, C6, C7, C8) gave their opinions on the issue. The discussions resulted in four major themes.

Solution Should Come from the Clients. Some clients suggested that they preferred the solutions to come from the clients. They believed each client's case is uniquely different, and clients are the only ones who truly understand their situations. Solutions from the CP might not be applicable as they might need to understand more about the context of the issues raised by the clients. Professional guidance might be more suitable than producing solutions for clients.

I would prefer if I am the one who produces the solution. This is because the person knows their own situation best. I cannot be given a solution; I would be like, "What do you know about my problem?" (C3)

Solutions Should be Discussed Between Both Parties. C4 responded that solutions should result from discussions between CPs and the clients. CPs and clients could brainstorm rough solutions to be refined between them until final agreement on a solution is achieved. Giving the production of solutions to the clients entirely might result in more extended, unproductive sessions.

If the psychologist offers their solution, I will also provide my solution. We could then negotiate a solution. By doing this, I would feel better about myself. If my opinion is valued, I feel proud of myself. I don't mind if the psychologist brainstorms with me to find a solution. It is just that it may take longer since the capacity to do that is different from person to person. (C4)

Solutions Should Come from the CPs. Some clients want to be more knowledgeable about their issues. In these cases, clients would expect the CPs to provide expert solutions. Clients who lack insight might be disappointed with the sessions if the CPs spend their time in the sessions trying to make the clients produce solutions on their own.

Sometimes, clients feel like they don't want to think, even when they initially preferred to discuss the solution. So in cases like this, when the client overtly asks for a solution, the client likes to discuss the solution early on and then be given the solution (C8)

Discuss expectations early. Responding to different opinions about the solution, some members of the CG emphasised the importance of clients making their expectations clear at the beginning on whether they want immediate solutions or a discussion partner.

Since there are differences in preferences between people, we could discuss them in the first interview. (C8)

The data from the participants did not show consensus on who should initiate the provisions of solutions. Nevertheless, it does provide some guidelines on how CPs could approach providing solutions. The literature suggests that providing solutions is not

uncommon in psychotherapy. For example, one type of psychotherapy that P3 mentioned is problem-solving therapy, and another type of therapy is solution-focused therapy, which both deal with solving the client's issue (Priest & Gass, 2015). Even though the focus of the therapy is different, with the former focusing on eliminating the problem while the latter focuses on implementing a solution to the problem, both therapies have a stage which requires the clients to brainstorm with the CP to find the solution (Nezu et al. 2013; Priest & Gass, 2015). Thus, it needs to be realised that directives and solutions would generally not be given to the clients by the CP. Fiske (2017) has emphasised continuing to ask open questions, even with desperate clients.

As probable middle ground, Indonesian CPs might practice a suggestion from Anderson and Handelsman (2009) who have discussed how there are two types of advice-giving psychotherapy: substantive and process. Substantive advice is defined as "suggestions for specific solutions to the problems, or for how to live". In contrast, process advice is defined as "suggestions for *how* to solve problems, or how to make the most of therapy". Substantive advice may be counterproductive since it may contain the therapist's values and does not help the client to be independent and capable of making future decisions. As a concrete example, providing clients with some critical thinking skills would be better than providing quick opinions.

Creating Therapeutic Relationships

One of the aims of this study is to explore how therapeutic relationships are being created in the CT setting. As discussed in the literature review, the therapeutic relationship has been found to be one of the common factors that is applicable in every type of psychotherapy (Cuijpers et al., 2019). In the discussion with the PG and the CG, eight participants (P1, P3, P4, P6, C1, C4, C6, & C7) contributed. Table 19 outlines the results and the discussions in the data collection.

Table 19

Creating Therapeutic Relationships

Subthemes from Participants	Result and Discussion
Developing Trust by Creating Good Rapport P1	While CT is electronic, the human touch is still needed to create a therapeutic relationship. A therapeutic relationship will be established if the clients have trust in their psychologist. Furthermore, clients will develop trust if the CP creates a proper rapport. CPs need to treat clients with kindness, sensitivity, and warmth during the conversations, and introduce themselves properly and engage in

Subthemes from Participants	Result and Discussion
	small talk with the client (Gallardo, 2013). <i>Therapy requires the client to put trust in us. So it is necessary to build rapport at the beginning of the therapy, like we discussed in the previous sessions about greetings. Probably the right way is to emphasise the human aspects of the client in the texts. The way I do it usually is by greeting them, introducing myself, and saying things like, "Nice meeting you." All those personal touches. (P1)</i>
Use of Correct Titles and Pronunciation P3, P5, P6	As a multicultural country, Indonesia has different titles that reflect its culture. P3 mentioned that psychologists could openly ask the clients what title they would like to be called by as this might increase the likelihood of a therapeutic relationship between therapist and clients (Akhtar, 2020, as mentioned in Eppel, 2023) <i>We might ask them what they want to be called. If it's a male, they might want to be called "Mas" or "Bapak" (Mas = a younger version of Sir; Bapak = Sir). Most of my clients do not want to be called by their name but rather by these titles. (P3)</i>
Emotional Validation P1, P2, P4, P5, P6	Most members of the PG agreed that the psychologist must provide emotional validation as this can provide comfort for the clients. P3 suggested that the CP could do that by attending to and focusing on the client's story and empathising with the client. With depression, the levels of empathy in the early stages of psychotherapy predicted the reported levels of alliance between client and CPs and found to be an important agent of change with self-destructive behaviours and self-harm (Malin & Pos, 2014; Watson et al., 2014). <i>It is important to understand the client's condition first. How do they think and feel about their daily lives? We need to understand the feelings they convey; we need to validate those emotions. Doing that will make them feel comfortable.</i>
Providing Summaries P3, P6, P8, C6, C8	Participants mentioned that the CP could summarise the clients' stories when the clients have finished telling the stories. According to Fernando (2011), summarising is one of the counselling skills, as well as active listening and paraphrasing, that can help to establish a therapeutic relationship. <i>We could ask about their physical and emotional condition. If we already have a lot of information, we could summarise or classify the cause of the problem and later ask the client, "If I am to summarise this, is this what you think about it?" so we make sure our perception is the same. (P6)</i>
Fast Responses C3, C6, C7	Responding promptly to clients' messages can induce a feeling of comfort. Fast responses in a live chat environment are the key to rapport building (Ikoro et al., 2017). A fast response can help a person feel connected to the other person they are communicating with, while a slow response could make them quit. (Dollman et al., 2007; McMillan & Hwang, (2002). <i>Fast responses. I have had a CT where I needed to wait half an hour, or even an hour, just for the psychologist to respond. (C6).</i>

Subthemes from Participants	Result and Discussion
Being Informal and Humorous C3, C6, C7	CPs need to know when they can be slightly informal and not be too formal all the time. However, P1 responded to this answer, defining appropriate humour as being informal and not in the sense of being comical towards or with the clients. This description is aligned with a study by Hussong and Micucci (2021), where they found that humour can strengthen the therapeutic alliance and lessen the client's defensiveness. The same study also emphasised the risks of including humour in sessions. For example, introducing humour at an inappropriate time could negatively affect a therapy session. <i>[I like] the way they communicate with us. Knowing when to be formal or informal. I like it like that. The words seem to be embracing us. (C7)</i> <i>[I like] the ones who can motivate us. Humour is also fine; I don't think I could do it with a psychologist who is too serious. (C3)</i> <i>[I like] humours as in the psychologist not being too formal. All psychologists could do that. However, humorous, as in a comical sense, like delivering jokes, would be inappropriate. (P1)</i> <i>With clients who are millennials or Generation Z, I often see strange abbreviations which are their signatures. I allow them to do that, to communicate like that, so they can be more expressive. However, I will always respond formally, because we have to go back to ethics, and we need to maintain the prestige of our profession. (P8)</i>
Being patient C6 and C4	Extracting information in the CT assessment session sometimes requires more time and effort from the CPs. This kind of behaviour might show that the client is resistant. Clients who are resistant are often unwilling to cooperate with the therapist, and this manifests in behaviour such as opposing, diverting, and blocking the course of the therapy (Beutler et al., 2002; Westra et al., 2009). In the CT setting resistance poses an additional challenge as the therapist cannot see the person and interpret the resistance accurately (Fréchette, 2021). Being patient, reflective, and sensitive towards the client's resistance is one way to deal with it correctly (Fréchette, 2021). Patience is also about the fact that CP will encounter many emotions in clients, which sometimes unpleasant. Responding to a client's negative affect is a crucial skill that a psychotherapist needs to have (Markowitz & Milrod, 2011). Aligning with the answer from P4, tolerating expressions of such emotions is recommended as it can give the psychologist a chance to understand them and create a resolution for them. (Markowitz & Milrod, 2011) <i>Be patient because I am the type who is slow to warm up in telling stories. I usually give a general answer in the beginning instead. Sometimes clients might also be pessimistic; they might ask..."Is it doable?"...If the psychologist responds with "It is going to be all right, we can get through this together," that would be wonderful. (C6).</i> <i>Some clients are assertive in expressing their anger. They even use curse words at me. Dealing with this kind of client, I tend to let them be and allow them to express their anger. I might disagree with their behaviour, but I prefer to hear their heart first and have a discussion in the later part of the session. (P4)</i>

Limiting Informal Behaviours. Previous discussion showed that clients might expect the CP to be relatively informal and humorous during the session. I reflected on this theme and sought further clarification. The main questions were about how informal is too informal, the limits to being informal with the client, and when CPs should be assertive in their position as the CP in the relationship. A discussion was held, and four PG members (P3, P4, P7, P8) participated. The following subthemes were found:

Anger and Harsh Language. P3 and P4 mentioned that from their experience, clients who are angry or use harsh language, whether it is directed at the CP or in their choice of language during the session, would receive psychoeducation from the CP.

I had a client who used inappropriate words towards me. These words were not suitable for a professional relationship. I thought the client's personality was just like that, not being able to differentiate between ways of talking to different people, such as parents or teachers. In response, I had a session discussing the values of respecting each other. This is because the client was young, and this relationship skill might not have been taught by the client's parents or modelled in their environment. (P3)

The use of profanity in therapy by clients may be due to several reasons. Some clients could be angry towards the therapist (Muntigl, 2019), while some clients are seeking attention from the therapist (Kramer, 2021), or, as in P3's case, the client is just being a teenager who uses profanity in their language during therapy (Hanna and Hunt, 1999). The way P3 handled the client is aligned with the general rule of thumb for dealing with clients who are angry or use profanity during therapy.

Losing the Purpose of the Therapy. P7 and P8 mentioned that sometimes, the clients were too comfortable with the CP, so much so that discussion in the session has no focus but is about the client just venting. In this situation, CPs could discuss refocusing the sessions towards the goal.

Sometimes the clients enjoy the session too much, so their story becomes unfocused. In that situation, I often bring them back to the goal of the therapy. (P8)

Clients use different amounts of speech during therapy. Some warm up slower than others, and some might be talkative even from the beginning (Nelson-Jones, 2015). At some point, CPs must control and even interrupt them (Stratford, 1998).

Overdependence. Some clients become so dependent that they frequently contact the CP outside the agreed hours for guidance. CPs that experience this could again provide some psychoeducation and reassert the agreed informed consent about the goals and schedule.

I also notice that the client becomes too dependent when they contact me frequently. I will tell them I am a psychologist who wants to help you to be self-sufficient. I hope that by this session, you can achieve that. By saying that, I hope the client remembers the therapy's goal again. (P8)

Drum and Littleton (2014) suggested that CPs should not forbid clients to make contact outside hours; instead, how the CP responds to the contact is what matters. CPs are advised to only make therapeutic communication within the scheduled hour. By doing this, clients would be reminded that therapy is a professional relationship and not an everyday interaction. Prasko et al. (2010) mentioned that CPs should not advise an overly dependent client and try as best to strengthen the client's independence by discussing the advantages and disadvantages of dependent behaviour with the client. CP could also provide homework that may also encourage clients' independence.

Impulsiveness. Like overly dependent clients, impulsive clients often contact the CP outside working hours. However, impulsive clients are not depending on the CP but cannot control their impulse to contact the CP. Dealing with this, the CP could acknowledge their message and, at the same time, inform them that messages will not be replied to outside the scheduled hours.

Some clients are impulsive. Even though I have told them their chats will only be responded to in the agreed schedule after they have finished with administration, some clients don't observe the schedule and chat with me whenever they want. The way I usually respond to them is to say something like, "Thank you for your time and stories, but unfortunately, I can only respond according to our policy. (P8)

CPs should acknowledge that clients sometimes have questions they want to ask without expecting an immediate answer. The clients just want to ask the questions before they forget what they are.

However, some clients have questions after the sessions end, even though they didn't have questions during the session. Knowing that, I usually say to the clients at the end of our session something like, "If you have questions after the sessions and you are afraid that you will forget those questions, it is all right; just chat with me here, and I will read it, but I might only answer it during our scheduled sessions." (P8)

Another intervention that CPs could make with impulsive clients is to be open and welcome their messages, as it is a cathartic mechanism for the clients. CP could reply once, stating that they won't reply to their messages, but the client can feel free to send those messages.

The funny thing about these impulsive clients is that when I think they need intervention and schedule them in urgently, they don't complete their booking immediately but rather in weeks or months. Once I have gotten a hold of them, they will say something like, "After I contact you, I feel calmer even if you didn't reply. It

helped me to know that I was being impulsive. I needed a cathartic output, so even though I have sent you messages, and you did not reply and said I needed to make a booking instead, I was thinking...I am all right.” (P8)

Impulsive after-hours contacts by the clients, as described by P8, are discussed in the literature (Ben-Porath, 2004; Chalker, et al., 2015). In the CT setting, a more in depth understanding of contact outside hours is required. Such behaviour could be an issue, as mentioned by Emran, Smith and Iqbal (2022), when therapists feel that after-hours contact is a breach of professional boundaries but, at the same time, a source of guilt if the therapist does not respond to them. After all, after-hours communication is the strength of CT. Tirel et al. (2019) suggest that the availability of contact with the therapist after hours is the reason why people seek internet psychological intervention. Gatti, Brivio, and Calciano (2016) mention that clients believed that online therapy services are always open and available whenever needed. In dealing with this, Jones and Stokes (2008) mention that online therapists should still provide a formal contract that discusses the hours of service and how therapists will respond to after-hours contact. Similarly, Skewes, van Vreeswijk and Merens (2019) suggest that therapists make agreements with the clients about after-hours communication; an understanding that the response might be delayed outside of scheduled hours.

Transference. Clients might develop inappropriate emotions towards the CP which then manifest as inappropriate behaviours directed towards the CP. This could damage the established therapeutic relationships. CPs who experience this should politely address the issues and provide some intervention to deal with the issue.

I had a client who did not have enough support, and the pandemic exacerbated that situation. These lead to the client's inability to have their usual meeting with friends. However, since she could still come to my therapy, the client often invited me to join her for a meal. This happened several times. I knew it could not be like that as that is unhealthy. So I gave the client an assignment where they were asked to contact their friends and people outside their usual circle and do that every day. In that way, the client's social skills were exercised, and the client could make new friends. (P7)

Prasko et al. (2010) have defined transference as the unconscious redirection of feelings from one person to another. The basic idea is that clients might have an emotional memory triggered by something in the present that causes them to react in the same way they did in the past. Should a therapist become a figure that evokes positive feelings from the past, this will be reflected in the response behaviour portrayed by the clients. Prasko et al.

(2010) described eleven possibilities for transference manifestations that could occur during the therapeutic relationship process, ranging from positive transference manifesting as emotions such as euphoria, to negative transference, manifesting as fear and anger. Regardless of the manifestation, transference can interfere with therapeutic collaboration and should be addressed. The answer from P7 illustrates a phenomenon described by Barth (2022), where the client wished to befriend the therapist. From the therapeutic perspective, this move could be detrimental as the client could be longing for independence but have fears of being isolated and alone.

Dealing with Different Types of Clients. The discussion then developed into another topic in which I wanted to learn about other uncooperative behaviour clients might show during therapy. A discussion was held with both groups and nine participants (P1, P2, P3, P4, P7, P8, C4, C5, and C6) contributed to the discussion. Three subthemes were produced: 1) silent client; 2) no-show; and 3) problematic interpersonal style.

Silent Client. There are times during CT sessions when clients do not reply to CPs' chat messages. A good understanding needs to be established of why this happens and how to handle it best. Firstly, the discussion with the PG suggested that the CP label nonresponsiveness as silence in two conditions: after between 10 and 30 minutes without a response or when the response is taking longer than the clients' usual response time. Secondly, there are several reasons why clients stop responding. The data from both PG and CG suggested that a client might be thinking about the best response to the CP's messages, or they might be feeling some discomfort with the session and they need more time to process their feelings. Another possible reason is that the client is not focusing on the session.

Regarding responses to this situation, similar suggestions were made by all contributing participants, that is, to make friendly contact with the client asking why they have not yet responded. CPs could include some comforting words to the clients when making contact. The CP could also remind the client about the remaining time in the session when making contact. It is also considered to have a no response policy and mention this at the beginning of therapy.

We need to observe; I will note the response time when we chat. If the client takes longer than usual, there must be something going on. When the client suddenly becomes nonresponsive, there are several possible reasons. Clients may be thinking or feeling something related to the things that are being discussed. They may be still

thinking about the best response to our questions, are still trying to make a decision, or needing time to pause for reflection. They may also be feeling bothered or discomforted by the things we were talking about. Finally, they may be trying to regulate the emotions arising from the session. When this happens, we need to stay calm and don't talk (chat) too much. We can also reflect on why this client has become silent by saying, "You are being quiet; what are you currently thinking?" or "It seems you are having difficulty continuing the session." Finally, the psychologist could just wait until the client chats again. (P1)

I would say to the clients initially, "If there is no response for 30 minutes, the session will be ended." This is like I said earlier. Some clients are doing something else during the session. Furthermore, if we are not strict like this, they could return to us whenever they want. So there should be some limitations. (P4)

I did that once, only because I was crying. Probably after 10 minutes, I managed to calm myself and continue. The psychologist chatted with me several times. She said, "Hi, I want to know more about your issue. Would you mind sharing further?" So the way the psychologist invited me back was also friendly. (C6)

When I am missing from the chat, it's probably because I am stuck and don't know what to say anymore or what to do. So I need to refresh and let go of the stress first. (C4)

In a face-to-face setting, Levitt (2001) conducted a study that tried to categorise different types of client pauses. A qualitative analysis of the self-reported experiences of seven participants was carried out, and 20 types of pauses were found that could be categorised into three major themes. The answers from all the members of the PG and CG are listed in the category. Thinking about the answer and feeling some emotion (positive or negative) would be categorised as productive silence, given these silences are related to having insights and are helpful to the therapy. Not focusing on the session would be considered obstructive silence, as such silences are detrimental to the therapy. The other theme is neutral silence, where the silences are related more to remembering events. Levitt's (2001) suggestion aligns with the responses from the PG members, which was to directly ask the clients after awkward pauses to explore what the clients were thinking. Another suggestion is for the CPs to observe whether the silence is repetitive and patterned. For example, if the client always pauses in a specific task, that would be a sign for the CP to explore.

No Show Clients. Unlike silent clients, no show clients would be defined as those who do not attend their scheduled session. The data from PG members shows that CPs could contact the clients if they missed their appointment, or, on the contrary, CPs could try their best to induce commitment during therapy but leave the result up to the client. It is the

client's free choice to attend or not to attend the session. If the clients are absent and then decide to return, the CP needs to be neutral and not dwell on why the client was absent from the previous sessions. Instead, the CP needs to focus on the present and be open in their communication and also ask the client about their progress.

I am the type of psychologist who will contact the clients if they are not contacting me at the scheduled time. For me, two weeks without any contact is too long. I might say something like, "It's been over one month since our last contact; how have you been progressing since our last meeting? Has there been a new experience has that affected you?" (P8)

I have had experiences when missing clients decided to come back and contact me again. If this happens, I will ask how they were rather than ask them about our last session. Did the client do what I asked them to do? I rarely ask clients about their reason as to why they missed their session. This could make the clients feel uncomfortable. (P4)

Chat Telepsychotherapy might be positively impacting psychological therapy, as the literature suggests that no-shows are decreasing since online psychological services have become more popular (Berger, 2022; Muppavarapu et al., 2022). Regardless, many online psychology companies still put a policy in place in case the clients decide not to show up to their appointment (konseling.ub.ac.id, n.d.; itherapy.com, n.d.; coloradocounselingcenter.com, n.d.; willowtreecounseling.ca., n.d.). The policy might cover how clients should let the centre know before the agreed time and how cancellations affect the refund of money already paid. Smyth, Lakey and Higginbotham (2018) studied why clients decide not to attend the scheduled sessions. The study resulted in five major themes, which were: 1) the therapeutic relationship—where the challenge of creating the therapeutic relationship decreases clients' motivations to come back to the therapy; 2) the emotional effects of talking—where the clients feel fearful that talking to the therapist could lead to the experience of more distress; 3) facing the outside world—where the clients feel anxiety about the journey to get to therapy; 4) importance of hope—where the clients feel there is little hope therapy can help them; and 5) competing demands—where the clients need to fulfil other demands and are not able to come to the therapy. Swift and Greenberg (2015) provided some strategies to help reduce early terminations, such as a) providing role inductions; b) incorporating preferences into the treatment decision-making process; c) assisting in planning for appropriate termination; d) providing education about patterns of change in psychotherapy; e) strengthening hope; f) Enhancing motivation for treatment; g) fostering the therapeutic

alliance; and h) assessing and discussing treatment progress with clients. Binnie and Boden (2016) have also provided some suggestions to reduce non-show behaviour by clients. These are: a) convenient scheduling; b) reminders; c) attendance by the psychologist at the scheduled time; d) social influence theory—where clients are asked to write down the time of their next appointment to increase involvement in the booking activity; and e) providing an end date for the therapy.

The answer from P8 is aligned with findings from DeFife, Smith, and Conklin (2013). CPs could address the no-show behaviour of the participants in the therapy or CPs could ask no-show clients on the same day whether everything is alright. Interestingly, in the same article, DeFife, Smith, and Conklin (2013) also offer another option aligned with P4's answer, where the CP does not need to make a call but lets the clients choose whether or not to attend. The article argues that it is better to focus on creating excellent therapeutic experiences that leads to low no-shows by the clients. Should the no-shows happen frequently, CPs could end the therapy but keep the door open for future sessions.

Problematic Interpersonal Style. Other difficult behaviours might occur during CT when the client has a problematic relationship with the CP. The discussion raised four types of difficult behaviour: a) aggressive and hostile; b) threatening; c) harassing; and d) stalking. As an opening, clients could become aggressive and hostile, and even threaten the CP. They might use curse words, or even interfere in the CP's personal life. In response, the CP could stop the therapy by providing a formal and professional explanation to the clients about the reason for the termination. On the other hand, P2 suggested that the CP could wait a while and observe the situation. If the clients are being hostile but still answering questions, the CP could work on the therapeutic relationship. Termination might be necessary for aggressive clients who refuse to answer questions asked by the CP.

I had an experience when a client threatened me. The client was a referral from another CP and according to that CP, this client had also threatened them. The client even came to the city where the CP lived, contacted the CP's friends and even followed the CP on social media. This is stalking. When the client was referred to me, they threatened me that they would report me to the police. I then decided not to continue the therapy. I told the client, "You are not ready for consultation, and this behaviour has breached the ethical code. I don't feel secure that I could maintain my professionalism towards you. Please find another psychologist." (P8)

I had an experience where a client was already hostile from the beginning. The client was not friendly and directed their aggressiveness towards me; for me, if it is only swearing, I will continue the session, but if the client does not answer my questions at

all, I will terminate the session. (P2)

Harassment can also happen in a CT setting. Clients can become flirtatious towards the CP. P4 shared that some clients tried to send them inappropriate sexual videos and even tried to include them in their sexual fantasies. P6 shared how clients could take screenshots of the conversation to be later shared on their social media along with negative remarks. A similar approach to that described to the previous discussion could be applied in dealing with such behaviour. Simple flirting could be handled by giving a neutral, flat, and professional response that ignores the flirtatious messages. If the clients do something more than that, the CP could terminate the session by sending a professional termination message. However, CPs also need to examine the situation before deciding to terminate the sessions, as some clients do have sexual problems that they want to work on.

I had clients who flirted while saying thanks, such things such as "Thank you, beautiful." To this, I would reply rather flatly, saying something such as "Thank you," without any emoji. If they do this repeatedly, and I continue to respond rather flatly, it stops. (P2)

I had a client who discussed a rather sexual matter; they asked me questions such as, "Am I abnormal if I do this? Do you want to see me having sexual intercourse with my partner? Or see my partner doing that?" Initially, I said it was not harassment; I would first analyse whether the behaviour was abnormal. But later, the client put me in a corner, and it seems the client wants me to watch and enjoy. In the psychological company I collaborate with, there is this spam button (in the application) where we can report the client to the appropriate team. The client will know when we press the spam button. Later on, we need to tell the client that the issue is too sensitive and if the client is bothered by it, I encourage them to have a face-to-face session instead. (P4)

They take screenshots of the sessions and shared in their social media with the purpose of humiliating the CPs (P6)

The literature supports all the answers provided by members of the PG. Clay (2017) mentions that clients could sometimes become hostile and rude and comment negatively on the CP. This tends to happen with clients who come to the therapy involuntarily, and such clients can make the therapists question their ability (Clay, 2017). Purcell et al. (2005) suggest that clients can also harass and stalk the therapist during the process of therapy. Harassment and stalking are defined as the client engaging in any two of the following behaviours over a minimum of two weeks: following the psychologist, putting the psychologist under surveillance, loitering around the psychologist, making unwanted approaches, making unsolicited telephone calls, sending unwanted correspondence, sending offensive materials,

interfering with the psychologist's property, making vexatious complaints, and spreading malicious gossip (Purcell et al., 2005). In the online setting, physical stalking might be irrelevant, but clients can still conduct cyberstalking. According to Pereira and Matos (2015), "Cyberstalking is a set of repeated and planned stalking behaviours in which a person imposes inappropriate and unwanted forms of communication, contact or an intention to approach in a virtual space" (p. 5). Cyberstalking can eventually lead to physical stalking (Shambhavee, 2019), which Galeazzi, Elkins and Curci (2005) suggest can go as far as threats, violation, and damage to personal property. For the CPs, this behaviour can induce fear and anxiety, leading to reduced work output and even the intention to leave the profession (Gentile et al., 2002).

A few measures can be taken by the CPs to hinder or handle this behaviour. The first thing that CPs can do is prevent it happening. Gentile et al. (2002) found that CPs with a negative experience would delist their home address and phone number, screen every new client before treatment, and even carry a pepper spray for dealing with physical stalking. A similar approach can prevent cyber-stalking by limiting personal information on social media or websites (Keswani, 2017). Cornish et al. (2019) suggested that it is best to address the limitations to confidentiality for clients engaging in harassing, threatening, to harmful behaviour. Should the prevention be done if such behaviour persists, then CPs must be able to handle it in a way that, as much as it could, does not breach any ethical codes of conduct.

The answer from P2 about dealing with this kind of behaviour initially by staying professional and continuing to give flat, neutral answers is aligned with Clay (2017) who suggested that CPs should remain calm and probably ask for time from the client to calm down if the harassment or aggression is too apparent or harsh to the point it is affecting the CP. Clay (2017) also suggested that CPs empathise with the client to learn the real reason behind such behaviour and to understand the client better. A similar suggestion about sexual demands by clients has also been offered by Gutheil and Brodsky (2008), who suggested that CPs explore such demands but also remind the clients that such behaviour is unethical and crosses boundaries. Termination, as suggested by P8, is also suggested by Gutheil and Brodsky (2008) as acceptable if the clients persist with such behaviours despite being reminded about it. However, as suggested by P8, CPs still have a duty to make an appropriate referral to another therapist. Gutheil and Brodsky (2008) have suggested that the CP might write in the referral letter the reason for such a referral without giving too much

detail. An example of a referral statement in the manual states, "I'm referring this patient to you because of the patient's behaviour. I don't have permission to tell you what that behaviour was, but the patient knows this is the reason for termination" (p. 157). Finally, physical stalking behaviour might be best handled by including third-party help, such as seeking assistance from a security or legal team (Gutheil & Brodsky, 2008).

Showing Empathy. Empathy is an essential aspect of psychotherapy. It was discussed in the previous discussion that emotion validation is a way to create a therapeutic relationship. Norcross and Lambert (2018) also mention that empathy is a significant aspect of creating a therapeutic relationship. This topic was then brought to the PG to explore how the CPs could communicate empathy using chat messages. Four PG members (P2, P4, P5, & P6) joined the discussion, and four subthemes emerged.

Table 20

Showing Empathy

Subthemes and Participants	Result and Discussion
Emojis P2 & P4	PG members' answers suggested that emojis can be used to respond to any messages or information showing strong emotion, which opens an opportunity for the CP to do empathetic listening. Emojis could also be used when the CP's questions invoke strong feelings for the clients. However, care should be taken to use emojis appropriately. A study investigating the correlation between emojis and empathy was carried out by Qiu et al. (2016). One finding related to this study is how emojis increase the recipients' perceptions of empathy in the messages. Recipients who noticed emojis in the messages would understand the sender's feelings. Nusrat and Huang (2021), investigated how emojis affect clients' overall experience of text therapy. Three types of messages were shown to the participants of the study: long texts without emojis, long texts with emojis, concise texts with emojis, and concise texts without emojis. The finding suggested that concise texts with emojis create the most positive atmosphere in the chat room. Clients perceived the therapist to be more empathetic and were more likely to open up to the therapist. <i>I consistently use emojis; since I can't face the clients directly, I often use the "hug" emoji (🤗) to say, "I can understand your feelings." This is because I will often hold their hand in a face-to-face session. If they start crying, I stroke them—giving a "hug" emoji is the same. Usually, the clients say thanks for that. Interestingly, I have never used emojis if the clients were male. I am just being apprehensive that the client would experience transference. (P4)</i> <i>I use the "thank you" emoji (🙏) at the end of the session or when I am about to ask something that might be the core of the problem. (P2)</i>
Emotional validation and	Unlike offline therapy, where CPs can make eye contact and use expression and intonation to show empathy, words are the only way for CPs to show empathy in

Subthemes and Participants	Result and Discussion
empathic paraphrasing in texts P2, P4, P5, & P6	a CT setting. The CP can type chat messages to convey their emotional validation. This can be conveyed by sending messages of emotional validation such as, "I understand how you feel," or paraphrasing the client's story to ensure they are understood. Empathetic paraphrasing and emotional validation effectively show empathy towards the client in a therapeutic setting. Emotional validation assures clients that their emotion is real, essential, and acceptable (Stevens, 2022), while paraphrasing shows the clients that the psychologist understands their perspective (Seehausen et al., 2012). <i>We can use words to show them we are attending to them and empathising with their feelings. We can do validation by using paraphrasing. I don't use emojis except when saying thank you at the end of the session. If the situation has cooled off, I might use emojis, but I don't use it if it is serious. (P5)</i>
Ellipses P2	An original method was contributed by P2 who uses three dots (...) at the end of emotional validation statements to add to the effect. According to P2, these three dots indicate that clients should pause and feel their emotions. The three dots (...) that P2 uses are known as an ellipsis, which is a punctuation tool to show a pause or indicate silence (Siddique, 2017). Judging from P2's answer about giving "extra time for the clients to feel their emotion," it can be interpreted as an offer of time without interruption to the client to feel their emotions. This concept is similar to allowing a pause or silence in face-to-face therapy. This is aligned with a study by Hill, Thompson and Ladany (2003), which showed that several seconds of silence can be used to convey empathy towards clients. <i>Another thing that I often use to validate clients' emotions when the client feels sad, I often use extra dots at the end of the sentences. What I mean by that is giving the clients time to feel their emotions. That is, I use dots and also other general emojis. (P2)</i>
Fast responses P6	P6 suggested that showing empathy could be as simple as responding quickly to the clients. Sending a quick response is a sign that CPs understand that clients need to receive a response from the CPs. Understanding that need or expectation is empathetic in itself. Fast responses are essential in CT as they are the only way in CT for the psychologist to show presence and care towards their client (Sindahl & van Dolen, 2020). Furthermore, Weiner and Auster (2008) have suggested that caring is a behavioural manifestation of empathy. <i>Responding quickly is a way of showing empathy in CT. We sometimes do need to read lengthy messages from clients, but instead of reading them before giving a response that makes them wait too long, I will send a first message like, "I will read it first, okay?" (P6)</i>

Emojis and Voice Notes. It was found in the previous discussions that both CPs and clients can convey their emotions during CT using voice notes and emojis. Another finding suggested that these methods might only be appropriate in some situations. For example, P4 said that they would not use emojis if the clients were of a different gender. These findings prompted another discussion about these two methods of communicating emotions in CT. This section discusses the appropriate use of emojis and multiple interpretations for emojis.

Appropriate use of Voice Notes and Emojis. Understanding what are suitable times to use emojis and voice notes still needs to be explored. Two PG members (P8 & P3) contributed to the discussion, saying that a decision to use voice notes in CT depends on several things. Some CT companies may not allow CP to send voice notes given the client has chosen a CT service. However, in private practice, the decision to use voice notes is up to the CP. CPs could use voice notes if clients send them first and in contexts such as distress to show support for the clients.

It depends on the company you work with. In my company, there are options for chat and voice and video calls. If they choose to chat, we have to only respond by chat; if they ask to send or receive voice notes during the session, we will offer them a voice call instead in the next session. (P8)

It depends on the problem. Sometimes, clients send voice notes in a stuttered way, and I respond to them with voice notes as well; to show my understanding of those voice notes. Even then, I would reply again later using chat. (P3)

As mentioned in the previous voice notes discussion, CPs do not need to use emojis all the time. The use of emojis might not be suitable with some types of clients. CP might also get an idea about whether a client likes to use emojis if the client starts using them first.

I will use emojis when the client uses them first. In the beginning, I might only use general emojis such as smileys. (P8)

We cannot use emojis with every client. For example, if the client is over 30, they might feel the psychologist is too expressive and it might potentially make the client uncomfortable. (P3)

The discussion about the use of voice notes in CT to better communicate emotion that helps the outcome of therapy has been covered in the previous sections. This discussion concerns when the CPs know they need to use voice notes. The PG members seemed to have the same policy about when to start to use both emojis or voice notes—that is, when the clients use them first. There are several explanations for this. The main situation in which P3 uses voice notes is to show appreciation, which is very common in psychotherapy (Crumb et

al., 2019; Kira & Tummala-Narra, 2015; Thayne, 2014). Not showing appreciation for clients can indirectly impair the psychotherapy treatment (Vieten et al., 2013). P3 mentioned that responding to clients' stuttered voice notes with a voice note can calm them. Stuttered voices can indicate that clients are in distress, a calming, soothing and gentle voice from the CP can help clients control their emotions and become more productive (Bernholtz, 2013; Elliott et al., 2004; Stone, 1961).

Another concept that might explain this behaviour is the concept of synchrony between CPs and clients during CT sessions. The concept of a protherapeutic relationship involves people synchronising their neural, perceptual, affective, physiological, and behavioural responses in their interactions with others (Koole & Tschacher, 2016). A better therapeutic relationship will be established by using the same communication style as the clients use with the CPs.

The answer from P3 about the inappropriateness of using emoji for older people is supported by Gallud et al. (2018), where it was found that although older people experience more difficulties in interpreting emojis, they like to use them as much as younger people. CPs might need to decide case by case whether to use emojis in their sessions. Finally, the answer from P8 that the appropriateness of using voice notes depends on the company is also discussed in an article by Harahap (2021). In the article, there are descriptions of ten Indonesian psychology companies that provide online therapeutic support. Of those ten companies, only one explicitly says that voice notes can be used in the sessions.

Multiple Interpretations of Emojis. The wide variety of emojis might result in misinterpretations or a need to learn the meanings of the emojis. A review from Reelfs et al. (2022) also mentions that there are no universal meanings for emojis as they vary between cultures. Furthermore, since clients are from younger generations who are more familiar with the meanings of emojis, CPs are the ones who might need to make extra effort to become familiar with the meanings. In a discussion with the PG, three group members (P3, P4, and P6) contributed to the discussion.

Firstly, P3 and P4 acknowledged that misinterpretations and failures to recognise the meanings of emojis were indeed already happening. The younger generation is familiar with and uses a more diverse range of emojis than the older generation. They then qualified this by saying the older generation does recognise some emojis.

I sometimes need clarification on the meaning of an emoji used by a client.

Teenagers' emojis are varied and comprehensive, while my knowledge is basic. If that happens, I would rather be neutral and not follow in their footsteps. I only use general emojis to avoid multiple interpretations. (P4)

Emojis are often misinterpreted (Bai et al., 2019), and CPs must be familiar with the meanings of emojis to avoid conflict and misunderstanding (Prabawa, 2021). A study by Aldunate et al. (2018) showed that people with negative states of emotion often send ambiguous messages containing positive emojis with negative statements. This could confuse CPs in terms of the real emotions experienced by the clients. Sending the wrong emojis might also lead to embarrassment for the sender (Liu et al., 2020), which might affect the state of mind of the CP, who, at that moment, needs to be focused on helping the client rather than criticising themselves and being inattentive to client's need.

Participants P6 so contributed to the discussion stating that P6 were never in favour of emojis and rarely used them as using too many emojis in the CT might be seen as unprofessional by the clients.

I am not expressive like other psychologists here. Multiple interpretations are possible. The thank you emoji might be perceived as the high-five emoji by others. Using emojis might also expose the psychologist's personality. If we build trust with the clients and then the psychologist often uses emojis, the trust will go downhill. I rarely use emojis; I probably only use the thumbs-up emoji, to show support. (P6)

Byron and Baldrige (2007) found that recipients of written messages actively seek cues in the messages to judge the sender of the messages. Furthermore, this habit is also influenced by the receiver's personality and state of mind. Clients with a high level of extroversion may be more sensitive towards positive and negative cues (Byron and Baldrige, 2007). A testimony article by Chapin (2016) shows how clients could start questioning the therapist's professionalism when the therapist used too many emojis. This testimony was then validated by a study from Yoo (2007) that found people who use too many emoji can be perceived as careless, insincere, or as trying to hide their real feelings.

P3 also mentioned that misinterpretations can sometimes be related to the meaning of the emojis in the social context of the relationship. As an example, CPs might choose emoji carefully when they were working with the opposite gender to avoid misinterpretation by the clients.

If the client is opposite of my gender, there are limitations on what kind of emojis I will use. I tend to not use emojis for this situation. (P3)

A study by Butterworth et al. (2019) found the gender of the sender of emojis can

affect the interpretations of the emojis sent. It was found that people tend to make heteronormative assumptions about the emojis being used in communication. Even though it is seen as more appropriate for females to use affectionate emojis, the assumptions made regarding an emoji cannot be controlled. CPs who use emojis to appear kind could induce client transference (Prasko et al., 2022).

At the end of the discussion about multiple interpretations of emojis, I arranged a discussion with the clients group to explore the generality/specificness of emojis. I listed 26 emojis and brought the list to the CG. The CG members then decided which emojis are in general use and which are specific and not often used by people outside certain groups. The results can be found on the page 43 of the manual (Appendix A, p. 307).

Creating Collaboration in CT. Norcross and Lambert (2018) also mentioned that collaboration is a significant factor that can affect therapeutic relationships formed during therapy. This section discusses how collaboration could be encouraged in the CT setting. Three PG members (P1, P7 & P8) contributed to the discussion, and three subthemes were found.

Table 21

Creating Collaboration

Subthemes and Participants	Description and Discussion
Understanding the client's expectations (P7)	The CPs need to understand what the client wants from the therapy. Constantino et al. (2011) suggests that clients often make their own prognoses about how they will respond to the treatment they have engaged in. This concept is called the clients' output expectation (OE). A client's OE may be formed before the therapy starts (Constantino et al., 2011). Furthermore, a therapeutic alliance, which would be manifested in a collaborative relationship can be optimally created when the client and the CP share the same belief regarding the goals of the therapy (Ardito & Rabellino, 2011; Corrêa & Ribeiro, 2016)
<i>Ask the client about their expectations when they come to us. (P7)</i>	
Written contracts and informed consent (P7)	Collaboration can be strengthened with a written contract or informed consent. CPs might want to use conditions in the contract and consent as consequences if the clients choose not to collaborate. Sills (2006) mentions that a therapeutic contract may contain elements of collaboration between the therapist and the clients. Consequences that seem like coerced collaboration might be useful only with some clients (Sheehan and Burns, 2011). However, a study by Baourda and Lakioti (2020) suggested the therapeutic contract can describe how clients <i>must</i> work with the therapist towards a common goal. Other than that, informed consent is helpful to

Subthemes and Participants	Description and Discussion
	initiate collaboration through simply discussing about how being active in achieving the goals will lead to an optimal result from the therapy (Pomerantz, 2012) <i>Informed consent, in the beginning, is essential. There should be a clause in the informed consent saying that the client needs to do the work suggested by the psychologist, and if they choose not to do it, the therapy will be terminated. This approach is effective with clients who are stubborn or undisciplined. (P7)</i>
Encouragement and appraisal (P1, P8)	Collaboration can be established by providing motivation early in the process to encourage collaboration and give clients the expectation it should occur. Encouragement is a technique that CPs can use to build clients' self-esteem (Winston, Rosenthal, & Roberts, 2019), which fosters a therapeutic alliance that can be manifested as collaborative behaviour (Ardito & Rabellino, 2011). Encouragement does not need to be comprehensive as minimal encouragements such as "Hmm" , "Ah ha," or "ok" can also lead to collaborative behaviour (Ribeiro et al., 2012) Recommendations to give praise for any collaborative behaviour clients display can be found In the literature (Jungbluth & Shirk, 2013). However, CPs must be careful not to give evaluative compliments such as "Wow, you're great. All the work is done," but instead use processed, focused compliments such as, "I see you took your assignment seriously." This is because direct praise can be an external motivation. Ideally, CPs want the clients to be able to improve by being internally motivated and not by pursuing approval from external parties (Sweeney, 2009). <i>I use the phrase "Let's work on this together," in the hope the client will realise they are not alone in the work to heal themselves. (P1)</i> <i>I show appreciation at the end of the session, by saying something like, "Thank you for opening yourself to me for the last hour." (P8)</i>
Referrals (P8)	Both clients and CPs must be mindful and notice if collaboration is nonexistent and make a necessary termination for the clients' good. Essentially, non-collaborative behaviour can be considered as a manifestation of resistant behaviour (Aviram et al., 2016). CP are advised to be sensitive and aware of situations when collaboration has not really been established as it could potentially make the therapy ineffective. As discussed prior, CP should be patient about it and approach it with sensitivity (Fréchette, 2021). If the techniques to establish collaboration are still not working, the CP are advised to terminate therapy and refer on, or allow the clients to find another CP that may be more suitable for the client. <i>At the end of the session, I would say to the client, "If in the process today or in future processes, you do not feel comfortable with me, you are welcome to contact the admin and change to another psychologist to continue the process with you." (P8)</i>

Homework

Another common concept in psychotherapy is the provision of assignments or homework. I wanted to learn how clients perceive assignments as a part of CT therapy. In the discussion with the CG, six members (C1, C4, C5, C6, C7, & C8) had a favourable view towards assignments. In general, clients said that they were aware that assignments are given for the clients' benefit with the aim of creating positive change in their mental health. Some resistance might typically appear due to the difficulties and the usefulness of the homework. One interesting point from the discussion was that C6 mentioned that CPs could sometimes forget and leave the assignment undiscussed.

I am happy with my homework. I feel like somebody is guiding me to change. I once had a psychology journal to list the things I feel grateful about in my life—that homework made me feel more valued. (C8)

It is relative; sometimes I like it sometimes I don't. The last time I had difficulties with my sleeping schedule, I was told to eat less sugar, exercise, and relax to fall sleep earlier. I wouldn't say I liked the food part as I am a foodie, and when I see the Psychologist's social media, she also goes on culinarians. I was like...(sighing). Other homework, such as listing emotions, is all right...for a few days. I once had a psychologist who even forgot what homework they had given me. (C6)

If the assignment will solve my problem, I will try it for a day. If it does make a difference, I will keep doing it; if not, I will ignore it. (C1)

Homework in a therapeutic psychological relationship refers to any tasks the therapist gives to the client to be done between the sessions (Strong & Massfeller, 2010). It is often practical and aims to improve clients' mental health (Hanton, 2011; Strong & Massfeller, 2010). As stated by C8, it enhances the therapy outcome over a more extended period (Kazantzis et al., 2010; Kazantzis et al., 2016). However, as stated by C1 and C6, clients may not have the necessary levels of compliance to do the homework. Some clients do not have the commitment and motivation to do it because they do not understand the rationale, or because of the difficulty, or lack of perceived benefit (Dunn et al., 2022; Glenn et al., 2013). Failing to review previously assigned homework, as noted by C6, was also found in a study by Bryant et al. (1999). As a potential solution, Jensen et al. (2020) suggested that clients are more likely to complete the homework if the assignment was congruent with their latest session. This study then suggested that clinicians first ask the client what they took from the last session and use that as a basis for the next homework assignment.

Homework Compliance. To further entertain the mixed responses about homework

from the clients, a discussion was needed to understand the best way to give homework to clients and ensure that clients engage in the homework. Six participants from both the PG and the CG (P1, P6, P7, P7, C4, C6) contributed to the discussion, resulting in three subthemes.

Table 22

Homework compliance

Subthemes and Participants	Description and Discussion
Tailored, engaging homework (P7; C4)	Homework should be an exciting task and uniquely designed based on the client's issues and characteristics. Diguseppe et al. (2013) mentioned that practical, fun, and challenging between-session tasks could help in producing a positive therapeutic outcome. In Behavioural orientation psychotherapy, the goals of the between-session tasks are to challenge and restructure the cognitive dissonance (Diguseppe et al., 2013). Homework should be tailored to help clients find new perspectives, test hypotheses, or generalise behaviour changes outside the therapy session (Young & Beck, 1980). Tailoring homework can be based on culture, stage of development, and personality (Bunnel et al., 2021; Foo & Kazantzis, 2007, Scheel et al., 2004) <i>We would need to adjust the homework to the client. For example, I had this client who self-harmed. I know the client likes to draw and owns a cat. Therefore, I would ask the client to draw a cat on her wrist so that she would hurt the cat if she cut her wrist. This seems quite effective. (P7)</i> <i>Give clients some exciting assignments. The psychologist must understand their clients' personality. (C4)</i>
The rationale of the homework (P6, C6)	CPs should tell clients about the aim of the homework and inform them of the rationale behind giving them that particular homework. Tomkins (2002) has suggested that clients will have higher compliance towards homework if they understand the reasoning behind it. CPs should explain the rationale of the homework, including its importance and how to complete the homework (Scheel et al., 2004). <i>The psychologist could say, "I am giving you homework; let's collaborate so that you can get better. I hope this homework will have a positive effect for you." So the psychologist should inform the client about the aim of the assignment. (C6)</i>
Client involvement (P6)	Clients should be involved in the process of giving homework. Homework is not a one-directional intervention that the CP gives to the client. Client involvement can alter the type of homework that the CP originally planned to set. Hay and Kinnier (2011) have suggested that clients should be involved in determining the appropriateness of the homework and the homework's goals. <i>I usually involve them. For example, if they need to control their emotions, I would give them homework and an emotional thermometer tool. If their emotional regulation is not improving, we would again discuss what other interventions might work. (P6)</i>

The use of deadlines and feedback (P8)	Every piece of homework should have a deadline and feedback should be given. Paxling (2013) found that flexible deadlines in which the CPs are lenient about completing homework were associated with negative treatment outcomes and slow progress. Reviewing on homework can help CPs find out what else the client needs and possibly help them tailor the interventions (Nelson et al., 2007). Furthermore, feedback should not only be given after the homework is completed; asking for feedback from the clients during the assigning of the homework is also helpful to foresee potential obstacles that might arise when clients try to finish the homework and also to provide solutions for such potential obstacles (Jungbluth & Shirk, 2013). <i>I would usually ask them to email the homework at least a day before the next session for me to read and give feedback. (P8)</i>
No coercion (P1, P6)	There should be no coercion in therapy; clients' mental health is their own responsibility. The job of a CP is to facilitate their change and not decide their beliefs. In a study by Wolfe et al. (2013), coercion was found to be a nonsignificant aspect that did not contribute to the outcomes for clients with drug and alcohol problems. Theodoridou et al. (2012) found that perceived coercion led to higher symptom levels and lower global functioning on admission. <i>We don't force our treatment; the client is responsible for their psychological condition. It is more about touching the cognitive side of the client. For example, if we want to make the client go out in the sun more, we could, if the client likes science, give an explanation from a hormonal point of view. (P6)</i>

Confidentiality

The concept of confidentiality is crucial in mental health therapy. I realised how important it was to explore how both the PG and the CG conceived this concept in relation to CT. The discussion was made with both PG and CG and two subthemes was found: identity and therapeutic process data.

Five PG members (P2, P3, P4, P5, P6, P8) contributed to the discussion. Members compared how they perform CT in different private in-app practices. To start with, P3, P4, and P6 mentioned that different CT apps have different policies regarding how the "therapeutic process data" is handled. The term refers to the chat history and any documents, such as a soft copy of worksheets, that might be shared during sessions. Some applications delete such data. Some applications do not delete the data and it can still be accessed by both CPs and clients when they want to. Identity data refers to any information related to clients' personal information, such as names, ages, gender, etc. P3 and P4 mentioned that some apps allow the clients to conceal their identities and appear as anonymous to the CPs.

One thing about CT apps that needs to be realised is that the administrator can most

likely access both the therapeutic process data and the identity of the client. The apps need a server where all the data is stored. P4 suggested, from experience, that the transcripts of the sessions with the clients could be easily retrieved by the administrator. Furthermore, even though clients could give a false name during the session, they might still use their original email when downloading the app. According to P8, this fact might cause discomfort for the clients. P8 then gave an example of how clients sometimes feel uncomfortable when they need to complete an initial online form as they suspect that the administrator could read it.

P2, P3, and P5 mentioned they retain therapeutic process data and identity data in their private practices. P3 even asked the clients to send their national ID cards and next of kin's numbers for emergencies before they could begin the sessions. The clients' trust is earned by giving an informed consent form to the clients before the sessions, which states that all data will be kept secure. P2 contributed to the discussion by suggesting how to best store the therapeutic data, including all the digital assignments or homework that had been part of the sessions, in a digital folder. Keeping the data is necessary for evidence to show that a therapeutic session had occurred and in the event these data were needed in the future, if the same clients communicated with them again, and they needed to know about the clients' therapeutic history. P4 also contributed by saying that psychologists should be able to know who their clients are and to be able to store and review the therapeutic process data in the future.

The chat will always stay in one of the two applications I use for collaboration. It cannot be deleted. In another application, the chat will disappear after two days. In my practice, I don't delete the chat, but screenshot or screen record it. This is for my personal practice's patient records. In terms of confidentiality and privacy, I have told them during informed consent that all data produced during the consultation will be kept confidential. I usually also have their next of kin's number in case suicidal behaviours arise. These data could also prove that the clients have engaged in a professional psychological consultation in my practice. If this data is needed or the client relapses, I can look back to see what emotions came out during the consultation. Usually, the admin staff in my practice will ask for a copy of their identification. Hence, the data has their name, address, and next of kin's number. However, clients in the apps often appear as anonymous (P3)

For me, I am not sure whether the [clients'] data is kept confidential or not. They say it is, however, sometimes, I ask the admin or support team to check whether a particular client has already had previous contact with me or not. They will reply by asking me to screenshot the client's name and email so they can find that client's history (P4)

I don't delete the chat history. However, assignments or homework produced during the sessions will be downloaded and stored in an electronic computer folder in my

clinic after the session. The chat history will be kept in my device; if ever the client comes back, I could check the existing data. (P2)

The discussion above was then brought to the CG, where all attending members provided input. All CG members joined the discussion and provided their opinion. The answers from the CG members were somewhat mixed. As a starting point, clients were generally happy to provide their data for the CT as long as there was a guarantee that the data was kept safe and wouldn't be leaked. They even welcomed the use of their data for advertising purposes if their names were concealed or hidden. However, some resistance was also shown by the participants.

For example, C8 required a guarantee that the data would be destroyed after a period of time to prevent data leak that could lead to embarrassment. Following the same reason, C3 and C6 would rather be anonymous from the beginning. Even though they thought demographic data such as age and ethnicity might still be shared, they preferred not to give their names or else went by a different name. C1 and C3 placed more emphasis on how they did not trust the system because it included third and maybe fourth parties: the internet and the administrators. They were cautious that these other parties might be the ones who leaked their information.

I don't mind. If that is the standard procedure, then I don't mind. Even though a third party will have access to [the client information], that is inevitable since I am using their service. As long as they don't leak the data and use it for their own purposes. (C7)

I might just become anonymous, as what I am telling the psychologist is a complete disgrace. I am afraid that even though they say that confidentially is guaranteed, nowadays, there is no such thing as privacy, especially in the IT world. It is just being safe from the worst-case scenario; admins are also people. Who can guarantee it? (C3)

I do mind it a lot. One month is okay, but please delete it after that. I feel ashamed; maybe one day... I am just afraid my name will be tarnished. (C8)

The policy about confidentiality in the Indonesian CPs is well established. According to *Kode Etik Psikolog Klinis Indonesia* [KEPKI, Indonesian Clinical Psychology Code of Ethics] (IPK Indonesia, 2021), several aspects need to be adhered in regard to clients' confidentiality: 1) CPs must respect the client's privacy and confidentiality; 2) care must be taken of any data (identity and therapeutic process) that is produced during the course of the session. Taking care means making sure that all data is stored tidily in a highly secure place to maintain its

confidentiality; 3) protection of the privacy and the confidentiality of the client's data must be covered during initial discussions and also listed in the informed consent; 4) The confidentiality of the data may only be breached under special circumstances, namely if the client is a danger to themselves or other people, and also if legal authorities ask for the data; 5) The destruction of the data should be carried out in adherence to Indonesian Law. Indonesian constitution allows any medical professional to destroy any medical data after twenty-five years after the last visit (*Peraturan Menteri [Permen] Kesehatan Republik Indonesia Tahun 2022 Tentang Rekam Medis* [Ministry of Health of Indonesia Regulation concerning Medical Records 2022])

Looking at the data from this research, on a personal level, every PG Group member would prefer to keep the clients' data rather than not, which aligns with the ethical code discussed above. Five members of the PG opted to not only ask for clients' identity information but also to store the therapeutic data produced in the course of the therapy.

Data handling is a bit different in the CT companies, in that data can be destroyed as soon as 24 hours after the session. However, as P4 suggested, the data might have been removed from the psychologist's device but not from the company database. Hence it could still be accessed by the administrator. In relate to this discussion, Indonesian constitution says that every *penyelenggara sistem elektronik* (PSE, or electronic system provider) must prevent personal data being accessed, revealed, amended, misused, damaged, or erased by unauthorised parties (*UU Perlindungan Data Pribadi* [Personal Data Protection Act], 2022). Personal data can be categorised as general personal data (such as name, gender and age) and specific personal data (such medical history, financial information and political view). The act defined PSE as any person or business entity that provides, manages and/or operates electronic systems by themselves or together with the electronic system user in its own interests or those of another party's. The act also says that there should be a minimum of two people who are responsible for the processing of personal data. Finally, the act also says that personal data should be destroyed after the retention time is over, requested by the people whose personal data it is, or determined by other laws.

Based on the information above, I did research towards three online counselling practices in Indonesia (Riliv, HaloDoc and Alodokter) to find out whether they have a policy that aligns with the regulation mentioned. In the general privacy and confidentiality policies listed on their website, similar wording could be found: 1) all companies collect personal data

related to the client as a person, such as name, national ID number, etc. and also personal data that is attached to the device being used by the client such as the IMEI, phone number, etc; 2) all companies will do their best to secure those said data even though they cannot provide a 100% guarantee that the data will be secure due to the nature of the digital world; 3) following the regulations in Indonesia regarding digital data, clients have the right to contact the company and ask for their data to be removed. Only one company openly stated that data would be destroyed after five years or more-depending on the constitution; which is aligned with the regulation (*Permen Kesehatan Republik Indonesia Tahun 2022 Tentang Rekam Medis* [Ministry of Health of Indonesia Regulation concerning Medical Records 2022]; Alodokter, n.d.b, Halodoc, n.d.b, Riliv, n.d.b)

One possible effort that both CT provider and the clients could do is to find to apply the concept of encryption or choose applications that has encryption feature. According to Ayuningsih (2019), encryption is *"a method that can secure information by changing the information into a certain pattern so that it is not easy to read and understand. Encryption is part of securing data so that it is not misused by irresponsible parties"* (p. 23). In chatting applications, the end-to-end encryption system works by encrypting the message typed by the sender party before sending it to the server. The server then receives the encrypted message and sends it to the other party, who will then receive it, and then automatically open it so that the other party can open and read the message (Ali & Sagheer, 2017). End to end encryption increases security but does not guarantee total protection of the data (Graham, 2016).

In the end, the inability to completely secure the data is tied to the cautiousness of members of CG, particularly C3 and C8, who were concerned that their data might be leaked at some point. Concerns about privacy and confidentiality being fragile in online settings is common (Stoll et al., 2020). However, the Indonesian literature has moved forward to acknowledging it and urges practitioners to understand the importance of privacy and confidentiality and the limits of those concepts in the CT setting (Haryati, 2020; Syamilla & Marjo, 2022; Wibowo, 2016).

Anonymity. I noticed that the topic of anonymity had been mentioned several times by both PG and CG members, not only in the confidentiality discussion but also in earlier discussions, where clients favoured CT over face-to-face therapy because they could be anonymous. I then brought this topic to the PG as it does not align with the ongoing

discussion. Two PG members (P2 & P3) suggested that the CP should accept and respond to the first contact made by an anonymous client. This first contact could be utilised to give psychological first aid with the hope that it will build trust with the client, and eventually open up and reveal their true identity.

If a client insists on hiding their identity but wants to continue the therapeutic relationship, the CP might only give basic therapy such as psychoeducation. A further conclusion was that clients must be willing to open up and reveal their identity and sign an informed consent form if they want to go deeper in the CT: deeper in the sense that the CP will conduct an assessment and plan an intervention.

Some people want to be anonymous because they have some concerns. When clients feel comfortable with the therapy, they may open up about themselves. It is a shame if these anonymous clients need help, but they are stopped at an early stage. So for these anonymous clients, the therapy will maybe not go deep but be first aid only. For example, if the clients are anonymous and found to need comprehensive therapy, we could give information about health care that they could access. It is more about what we can do within the presented limitations. They are willing to seek help; we must appreciate that. (P2)

One advantage of the company where I work is that [clients] can be anonymous, so they usually use the first session to check whether they feel comfortable with the psychologist. If they feel comfortable, they will open up and reveal their identity. (P3)

A thorough discussion of the concept of anonymity can be found earlier in this thesis (p. 101). The practical solution proposed by P2 and P3 might be a middle-ground solution that allows as many people as possible to be helped while upholding the core ethical considerations of psychotherapy. Ideally, anonymity would not be possible in psychotherapy as clients might be engaged in risky behaviours that need to be monitored (van Spijker et al., 2010). Thus, the CPs must not proceed with the therapy. However, according to the answers from C3 and P2, some clients will not even want to contact CPs if revealing their identities becomes compulsory. Lester and Rogers (2012) have suggested that allowing anonymity in remote therapy reduces the fear of being ridiculed, abused, and losing social status as a result of revealing their identities. This aligns with the solution proposed by P2 and P3, who said that CPs should allow the anonymous client one session only, to provide initial help and relieve distress in the hope that clients will eventually reveal their identity to be able to continue to the next session.

This practical solution is rational and has a high possibility of being achieved.

Withholding identity can be seen as a manifestation of resistant behaviour. Beutler et al. (2002) have said that the concept of resistance as discussed in the psychology literature includes: a) dichotomous behaviour in which the concept exists or does not exist in the therapeutic relationship (in this context, providing or not providing identity); or b) a range of behaviours from overly compliant to completely oppositional. This resistant behaviour can be modified by creating trust in the therapy. One explanation for such an idea relates to attachment theory. Skourteli and Lennie (2011) argue that clients might experience a type of attachment towards their therapist, who, at the time of the therapy, acts as a caregiver who provides emotional availability, comfort and a sense of a secure base for the client. Later, resistant behaviour might occur if the client feels insecure in relation to their therapist (Yotsidi, et al., 2018). Aligned with that, Gold (2008) has suggested that clients will often perceive the therapist as an authority figure. Any negative experiences with previous authority figures will be a reference for the client to assess the ongoing relationship with the therapist, thus creating resistance.

Underage Clients. Discussion about underage clients was ongoing throughout the prototyping process. As underage clients now have greater access to smartphones, it is likely they will be aware of CT and make a contact with CPs. Bringing the topic to the PG, P1 and P3 commented on the topic. Both members suggested that the CP listen to them first before informing them that their parents need to be aware of the intervention. P1 justified their answer by mentioning the standard policy in hospitals where underage clients need to have the consent of a guardian to proceed with treatment. Furthermore, P1 suggested that for underage clients, CPs would be better to focus on listening to them rather than providing interventions; if the CP decided to provide an intervention, full knowledge by their parents is necessary.

I have several clients that are underage, probably under 13 years old. In my company, [underage clients] can pay for the [CT] service and talk to us. Once they contact me, I will confirm their age and then listen to their stories first. I will then ask whether their parents know about their issues. If we assess them to need psychological intervention, I will refer them and their parents to meet face-to-face with the CP. I will even ask them to show our conversation to their parents. Kids today, even under 12 years old, already have their own devices, so they can easily access everything. Those who often go on social media will know about CT and take the initiative to talk with a CP. (P3)

I still need to determine whether CT comes under the Ministry of Health. If it does, there is a policy where every client who comes to get intervention needs a guardian's

consent. This is to provide protection for everyone, so everybody knows what is going on. Underage clients, in particular, must have a guardian present. In my hospital, if an underage client is not accompanied by a person responsible for them, we cannot provide service. We don't want to be responsible for any treatment since the parent might query it. So in my opinion, underage clients might need to be accompanied by a person responsible for them, to avoid any possible complaints from the parents. So I agree with P3; we might ask the client about their parents and ask them to have their parents join the session. We need to play safe; we could still provide service. Avoid giving interventions without their parents knowing. Focus more on listening to them, as we don't know the whole story. (P1)

The answer from the participants suggests that CPs need to be very cautious in providing service to underage clients. This answer is understandable and supported by existing policies on psychological interventions with underage clients. *Kode Etik Himpunan Psikologi Indonesia* [KEHPI, Indonesian Psychological Association Code of Ethics] (HIMPSI, 2010) suggests that a CP must make sure that any intervention given to children or adults with no ability to consent is free from the risk of harm. There is no restriction on CPs providing service to underage clients without parental consent. Thus, the answers from P1 and P3 about providing service at the first contact is justified. However, the answers from both members also suggest that parents should be informed if there is ever a need for a more serious intervention. P1 mentioned hospital settings and how the Indonesian Ministry of Health sees its role in the matter. *Permen Kesehatan 2008 tentang Persetujuan Tindakan Kedokteran* [Ministry of Health Regulation concerning Approval of Medical Actions 2008] requires that any medical intervention has consent from a competent patient. Furthermore, according to the law, a competent patient would be described as an adult patient, not a child. Finally, UU Perlindungan Anak (Indonesian Child Protection Act, 2002) describes a child as someone under 18 years old.

Self-Harm in the CT Setting.

The notion of self-harm was first mentioned by P2 in "Likelihood of On-Referral" section where it was suggested that CPs would tend to refer on clients if it was found that the client had suicidal tendencies (p. 107). Further mentioned of self-harm behaviours happened in one of the discussions about limiting informal behaviour. P7 interjected into the middle of the discussion by P8, where impulsivity was mentioned as one of the behaviours that the CP should address (p. 144). P7 contributed to the discussion stating that there should be firm moves by the CP to handle these impulsive clients. Furthermore, P7 opened another topic by saying that sometimes clients could be manipulative and go the extra mile,

such as making self-harm threats, to get a session with the CP sooner.

I also want to comment on P8's answer about impulsive clients who chat with us often and could get angry if we don't reply to them. We need to be assertive and firm to limit our communication. We have to find a way not to be carried away by clients' demands. Some clients are manipulative. I have experience with a repeat client, who sometimes wants to fast forward the sessions. The client dramatises the situation and threatens self-harm; the client uses provocative words to get a response, with statements such as, "I cannot hold on anymore." This even when I had already given the clients some homework that I believed could help the clients to avoid these moments of desperation. So every time these clients chat with me, I delay my responses. I also give relatively short answers, not long like we are in a session. I would ask what the problem is and ask them to do the homework that I gave them.
(P7)

The literature suggests that impulsive behaviour often correlates with personality disorders such as borderline and histrionic personality disorders (French & Shrestha, 2020; Lawrence et al., 2010). People with mood disorders, such as depression, can also be impulsive (Dvorak et al., 2013; Jakubczyk, et al., 2012; Swann et al., 2008). Similarly, manipulateness is also linked to borderline and histrionic personality disorders (French & Shrestha, 2020; Mandal & Kocur, 2013). Therefore, clients who are being manipulative may have borderline or histrionic personality disorders. This leads to the notion of clients being manipulative, as suggested by P7.

Another explanation for such behaviour is a unique type of personality trait, namely Machiavellianism. People with this personality trait are characterised by cynical beliefs and pragmatic morality (Jones & Paulhus, 2009). In a study by Dahling, Whitaker, and Levy (2009), Machiavellianism is characterised by a tendency to distrust others, a willingness to engage in amoral manipulation, a desire to accumulate status for oneself, and a desire to maintain interpersonal control. Studies have found that Machiavellianism is associated with depression (Al Aïn et al., 2013; Bianchi & Mirkovic, 2020; Gómez-Leal et al., 2019). This might explain the second part of P7's answer, which is about self-harm threats made by clients to get what they want from the CPs. This kind of behaviour seems to be common for manipulative people (Cummings & Thompson, 2009; Dear et al., 2000; Wetter & Wetter, 2006)

The literature suggests ways to deal with these self-harm tendencies or threats outside of the scheduled hours. Coulter, Offutt, and Mascher (2003) wrote about how college-based counselling centres should have special management policies for after-hours crises. The article mentioned how a centre could have on-call staff to attend to these situations. In an online setting, Emran, Smith and Iqbal (2022) also found that online therapists would provide

a consent form that listed the proper communication channels to use if an emergency arose. In the Indonesian setting, this might direct clients with self-harm tendencies to the official helpline of the Indonesian Ministry of Health.

These discussions suggested that CP refer clients with self-harm tendencies both during and outside the scheduled hours. I then brought this information to the CG group to obtain their responses.

Three members of the CG (C1, C4, & C8) contributed to the discussion with two subthemes emerging. Firstly, C4 and C8 argued that clients with self-harm tendencies should not be referred on immediately. Clients might be in a crisis situation, and CPs should try to help them first to calm the situation and prevent clients from executing their plans. Some clients might also need help accessing face-to-face therapy.

I think that the psychologist would need to help a self-harm client. This is because self-harm is urgent. It is okay if the session is still online; at least calm them down first. If it is not succeeding, the psychologist could refer them for a face-to-face session. Don't refer on the client face-to-face straight away; I am afraid if the client does not want to and only wants to engage online, there might not be enough time to help the client. (C8)

Clients might have different capacities to manage it if the CP refers us on directly for face-to-face [counselling]. Some clients might be able to afford it, and others might not. So, if something can be done online, they should do it, at least so they don't get worse or proceed with their intention of harming themselves or others. (P4)

Another point of view came from C1 who stated that referring clients is not the main issue, rather it is not utilising a screening test optimally and not referring them from the beginning.

This is the function of early screening; self-harm tendencies could be detected at the beginning of the sessions. If the psychologist doesn't want to work with a client with self-harm tendencies, then they should say so. So the client is not wasting their money. accept them if they have already paid. (C1)

Bringing this data to the PG for comments, P4 entered into the discussion, suggesting the CP should not simply stop the therapy and refer the client as self-harm clients might only need minimal intervention to stabilise.

I recently had a client who sent me a picture of self-harm on their wrist. I did emotional regulation with the client as the client firmly asserted that they needed someone to talk to. I did consider that the harming happened before the session, and the client was not actively doing it. I do believe that we should not just stop and refer the client, as there are clients who need short-term relief and some psychoeducation. (P4)

No other PG members negated P4's response, implying that the members tend to agree with P4's thoughts. However, P1 added more opinions to complete their answer, suggesting there should be wording in the informed consent form that addresses this type of intervention.

As far as I know, CT, through the popular applications that we have at the moment, does not use informed consent in its practice. This differs from face-to-face practice, where they usually have some policy to use informed consent for clients who self-harm. Now, we have to understand that informed consent is needed for the safety of both the CP and the client. Thus, for me, the middle way is through wording in the informed consent somewhere, along the line of, "If during the CT, the CP learns about any kind of risky behaviour, the CP is obligated to perform emotion stabilisation. If the situation is considered an emergency, the CP might need to refer a client to the nearest health facility" (P1).

The data outlined above shows that the PG changed their opinion in regard to treating clients who self-harm. Listening to the disagreement from the CG about being referred on when they have self-harm tendencies made the CP member opt for informed consent as a middle ground that could allow CPs to treat self-harm clients more safely. Other findings show that people with suicidal ideation prefer online therapy rather than face-to-face therapy (Wilks et al. (2017). Frost, Casey and Rando (2016) listed seven reasons why people who self-harm prefer online counselling: information, guidance, reduced isolation, online culture, facilitation of help-seeking, ease of access, and privacy. This suggests that Indonesian CPs might need to rethink their approach of referring online clients who self-harm.

It is possible to use modified informed consent with vulnerable clients, as suggested by P1 (Sudore et al., 2006). Rudd et al. (2009) suggest that there should be extra information provided when it comes to seeking informed consent from suicidal clients; those are the risks and the protective factors of having psychotherapy, the goal of the treatment, the determination of the crisis response, and when the crisis response would be used.

Finally, Carr and McNulty (2016) have provided an immediate comprehensive assessment that would be useful to get an understanding of the client's self-harm behaviour. The authors created two sets of interview questions, one of which would be suitable for clients who have already harmed themselves (regardless of whether it was a failed attempted suicide or a manifestation of Nonsuicidal Self-Injury [will be discussed in page 172]), and the other which would be suitable for clients without any previous experience of harming themselves but with the idea to do so. This would be useful for the CP to assess the possibility of self-harm given the current mental status of clients. The following is an example of the interview questions.

- Clients with self-harm history
 - How did you decide to harm yourself and what alternatives did you consider?
 - To what extent did you act on impulse, without thinking, when you harmed yourself?
 - Had you a plan to harm yourself, and what preparations had you made?
 - How exactly did you harm yourself?
 - When did this happen?
 - Did you believe the method of self-harm was lethal and that nothing could be done to save you if you were discovered?
 - Did you tell others about your plan to harm yourself or were you secretive?
 - Did you write a letter to anyone explaining why you were harming yourself?
 - What happened afterwards and how did you survive?
 - Do you regret having survived?

- Clients with self-harm ideation but without self-harm history
 - How would harming yourself solve your problems, and can you see any alternatives right now?
 - If you harm yourself in future, are you likely to do this impulsively without thinking?
 - Which is stronger right now on a scale of 1 to 10: your will to live or your will to die?
 - Have you a plan to harm yourself?
 - What preparations have you made to harm yourself?
 - How exactly will you harm yourself?
 - When do you think this will happen?
 - Do you believe the method of self-harm is lethal and that there will be nothing anyone can do to save you if you are discovered?
 - Will you tell others about your plan to harm yourself or keep it a secret?
 - Will you write a letter to anyone explaining why you are harming yourself?
 - If you survive, will you regret this?

Manipulative Clients and Self-Harm Behaviour. A further discussion would need to be held about clients making self-harm threats, as mentioned by P7 (p. 169). The answer from P7 implied that in these cases CPs would often know that clients making self-harm threats were being manipulative and did not necessarily intend to commit such actions. In their answer, P7 also suggested that these threats do not necessarily need an immediate or lengthy response from the CP. This kind of response from the CP is also described in the literature. Wetter and Wetter (2006) mentioned that it is common for the therapist to dismiss self-harm threats as they are used to manipulation and, thus, could tell the difference.

However, Dear et al. (2000) convey an opposing view. Their study described a phenomenon in which prisoners often commit self-harm, but their actions are deemed manipulative by prison staff. Seventy-four prisoners with a history of self-harm were interviewed over the course of three days. They were also assessed using the Suicide Intent Scale (SIS). The results suggested that out of the 74 prisoners, only 18 had self-harmed with

manipulative intentions: intentions that are characterised by attention-seeking and attempts to change one's circumstances. However, out of those 18, twelve had a high suicidal intention. This means that even though the prisoners performed self-harm to get attention or change their circumstances, they could feel suicidal as well. For example, a prisoner might only make a small cut to his forearm to get attention but also score five on the SIS (suicidal intent scale). The article concluded that prison staff could not assume that a prisoner who seemed manipulative was not suicidal at the time of the incident.

Cummings and Thompson (2009) have suggested that it is not helpful to try to differentiate between people who are being manipulative and those who have genuine intentions of committing suicide. The article suggested that if a client engages in self-harm behaviour, the therapist should provide treatment and not dismiss it.

At this stage of the study, an approach aligned with Cummings and Thompson (2009) had already been established through discussion between the PG and the CG: that is, to still help such clients and not refer them on immediately at the time of contact. There is still an issue with how to best handle these self-harm clients. On one hand, it is not useful to differentiate between clients with honest intentions and those without. The CP can provide the best treatment once clients have reported such behaviour. On another hand, this so-called best treatment may include hospitalisation (Carr & McNulty, 2016) which is not applicable in CT. It has been said that on-referral is not favoured in CT and the CP needs to communicate with the client instead. However, CPs must also be ethical and cannot keep clients with serious self-harm behaviour in CT as it is not a sufficient treatment. Hence, it is helpful for the CP to differentiate clients with severe and non-serious self-harm behaviour in the CT setting. CP might be able to retain clients with non-serious self-harm behaviours and refer on those with serious behaviours.

In this section of the study, I brought the topic of clients who self-harm clients to the discussion and to explore how best to work with this type of client. I wanted to know how participants such as P7 can differentiate clients who manipulatively self-harm from genuine ones. The main idea of this section was to help CPs provide help services to clients who may potentially be self-harming and not simply refer them on or direct them to the nearest mental health facility every time the clients report self-harm behaviour.

A discussion was held with both the PG and the CG regarding identifying whether a client is being manipulative or has a real intention to harm themselves. The following

answers were given.

Table 23

Differentiating Manipulative or Clients with Real Intention of Self-Harm

Subthemes and Participants	Description and Discussion
History (P2; P3)	Clients who want to harm themselves during CT might already have a history of doing so. P3 even mentioned that they might have documentation about it. <i>Several clients I had had already harmed themselves, by means such as cutting, banging their heads on a wall, and sticking a fork into their feet. Usually, when this comes up, I want to determine whether their story is true or not. I would ask them if they were comfortable sharing pictures of the wounds. I would ask them, "How far have you gone with it? If you feel comfortable, you could send me a photo." They usually send pictures to me. (P3)</i>
Collaborative attitude towards CT (P1, P4)	Clients who want to harm themselves would respond positively to the help offered by the CP. Clients would still be willing to communicate and have a two-way conversation about the condition. On the other hand, clients who are manipulative might only look for attention and refuse to collaborate with the CP during the session. The clients would often ignore every therapeutic intervention attempted by the CP. <i>I can tell between clients who tend to be histrionic and clients who need help. Clients who are seeking help have the willingness to listen to us; they will not be defensive. Histrionic clients tend to make threats about self-harm and reject our words. Every word that I say to them will be bounced back. (P1)</i>
Disclosing intentions (C1, C4, C5, C6, C7, C8)	Manipulative clients might make repeated threats about how they want to harm themselves to get attention from the CP. The threats might stop when attention is given and be repeated when it isn't. On the other hand, clients who want to harm themselves might not directly tell anyone about it. They might show some nonverbal signs, or give some verbal indications, potentially leading to an event that might happen spontaneously. <i>From my experience, clients who want to perform self-harm do not talk much about it. However, probably sometime prior, these clients have already conveyed that they have done it, but do not say they would harm themselves; they just suddenly show that they have done it already. People who are only looking for attention will keep saying it over and over, and they do not do anything about their problem; they just want attention (C8)</i>

The concept that needs to be understood here is how to determine whether a client has a genuine intention to harm themselves or is just being manipulative when they report self-harm behaviours or suicidal thoughts or make threats. Robinson et al. (2022) found that suicide threats/gestures were not uniquely associated with suicide attempts but rather

communicated distress to others. That said, the ability to differentiate them would be helpful to better respond to such behaviours.

Looking at the themes raised by the participants, two of the themes are aligned with a discussion and guidelines by Carr and McNulty (2016), which discussed the differences between suicidal clients with genuine intent and another suicidal client who engage in behaviours that are often categorised as non-suicidal self-harm/injury (NSSH/I). Non-suicidal self-injury (NSSI) refers to deliberately inflicted damage to one's bodily tissue, and/or pain, without suicidal intent (Nock & Favazza, 2009). The literature suggests that Machiavellianism, suicidal thoughts, and suicidal threats are related to NSSI (Greitemeyer & Sagioglou, 2021; Ose et al., 2021; Woods, 2017) which have a low risk of death (Wilkinson, 2011). NSSI differs from suicide attempts. The former constitutes a maladaptive coping mechanism to regulate overwhelming emotion, while the latter is based on the intention to end one's life (Butler & Malone, 2013). NSSI however is still a strong predictor of suicide attempts (Wilkinson, 2011). Based on these discussions, CPs need to understand whether the clients who talk about suicidal ideation or make suicidal threats are at risk of suicidal attempts or, rather, NSSI. CPs would be better able to help clients with NSSI or potential NSSI since their risk is lower than a suicide attempt.

Returning to the themes, the two themes that are aligned with Carr and McNulty (2016) are the history of and disclosing of intention. Firstly, as mentioned by the participants, people who have a genuine intention to end their lives often do not seek help but may communicate their intention to the person they are closest to or to a complete third party, like a family doctor or health care professional; they may also write a suicide note as a "final act" before they commit the attempt. Secondly, previous self-harm indeed predicts future self-harm. As suggested by P3, it has been found that people who self-harm often take photos of the wounds (Brown et al., 2018). The literature also supports collaborative behaviour towards therapy, NSSI behaviours are correlated with higher therapy resistance (Hom et al., 2018; Whitlock & Selekman, 2014). A study by Wolk-Wasserman (1987) also found that repeated client threats could induce fear and anger in the therapist. Carr and McNulty's (2016) guidance on differentiating between NSSI and suicide attempts goes beyond help-seeking behaviour and history. The following table summarises all the factors to consider when assessing whether a client is likely to attempt suicide or, rather client with low risk.

Table 24

Differentiating Clients with NSSI and Clients with High Risk of Suicide.

Aspect	High Risk (Suicide)	Low Risk
<i>Please note that clients do not need to fulfil all criteria to be categorised as high risk. The presence of even one aspect should be enough for the psychologist to refer the client.</i>		
General characteristics	• Tends to have made detailed plans, including when, where, and using what method • Tends to design the plans in such a way that no one could find him/her • A final letter has been written	• No planning • Tends to plan in such a way that somebody will find him/her, especially a person he or she is looking for attention from
Implementation method	• Lethal, for example using a weapon, hanging, jumping from a height	• Non-lethal like cutting or using cigarettes to burn oneself
Triggers	• Significant stressful events that involve feelings of loss. For example, losing a job, family or a partner • Deep feelings of shame	• Romantic problems • Disputes with partners
Motivation	• To end a state of unbearable stress	• Trying to change personal circumstances that are not as expected • Related to a perfectionist personality
History	• Has a history of self-harm, bullying, abuse, harsh treatment in childhood, and loss	• None
Family Factors	• Has a history of self-harm, bullying, abuse, harsh treatment in childhood and loss	• None
Demographics	• Highest risk in males • Low socioeconomic status	• Highest risk in Females • Middle-to-upper socioeconomic status

Reasons Behind Self-harm. During the data gathering, the clients talked about why self-harm is done and an interesting theme emerged from answers by C1, C6, C7 and C8. The common theme was that self-harm induces a feeling of satisfaction by releasing the emotional turmoil that a person is experiencing at the time. P6 contributed to the discussion by emphasising that unmet physical needs could also lead to self-harm.

For me, people do self-harm as a form of protest. Like, "Where have you been all this time?" I told you stuff, and you don't listen. So this is me here, doing this (self-harm). There is a feeling of satisfaction in releasing the feeling of disappointment. (C8).

Sometimes I think, what would happen if I hit my head on the wall? Will it make the headache disappear? Will the pain of doing so solve my problem? (C7)

Having a mental illness is difficult. There is a feeling of pain that cannot be conveyed verbally. So when doing self-harm, the pain can somehow be touched and released.

There are stories that I have heard about self-harmers feeling satisfied, and it becomes like an addiction. They feel happy when they see the blood coming out. The heartache is somehow released. (C6)

Unmet physical needs such as sleeping disturbance and nutritional needs (P6)

Edmondson et al. (2016) reviewed 152 studies of self-harm and identified ten possible themes related to why someone decides to commit NSSI. Eight themes were frameworks initially derived from a combination of studies by Suyemoto (1998) and Klonsky (2007). The other two themes were created to cater for extra information that did not fit into the initial framework. The following is a summary of the findings. CPs are encouraged to read the original articles for a fuller description of the findings.

- Managing distress/affect regulation: to relieve the distress from strong emotions
- Exerting interpersonal influence: to get attention from someone else
- Punishment: punishing oneself or others for past actions
- Dissociation: to induce or terminate a dissociative state in oneself
- Sensation seeking: to generate a feeling of excitement
- Averting suicide: to stop oneself from carrying out an actual suicide
- Maintaining or exploring boundaries: to assert one's boundaries (autonomy)
- Expressing and coping with sexuality: to cope with sexual conflict or sexual feelings
- Creating a positive experience: to feel comfort or experience a new sensation
- To protect others from one's anger
- Defining the self: showing superiority to others by being able to feel the pain
- Ascertaining one's identity, and showing that one understands the pain: to feel in power or control of the situation

Table 25

Internal and External Factors Contributing to Suicidal Tendency

Internal Factors	
Biology	A person with a family history of suicide and mental disorders is more likely to commit suicide.
Mental health	A mental disorder such as depression or depressive episodes of bipolar disorder is a factor in 90% of suicide cases.
Personality	A study has suggested that being healthy, kind, open, responsible, and extroverted reduces the chance of committing suicide by 56.7%.
Cognitive aspects	Research shows that a person with a history of attempted suicide tends to have an inflexible cognitive style, such as being defensive and unable to change habits and attitudes.
Attitudes	Having an affirmative attitude towards suicidality increases the level of suicidal ideation
External Factors	
Negative life experiences	People with stressful lives have a higher risk of becoming suicidal

Family	People who have experienced family instability and certain parenting styles and people who have suffer child abuse and neglect have higher risks of being suicidal
Social and environment	Research shows that the internet and social media are possible agents that popularise suicide.
Culture	A harsh cultural environment could lead to suicidal ideation by affecting attitudes towards suicide.

Unmet physical needs suggested by P6 aligned with Bernert and Joiner (2007) and Kamdar et al. (2021), where it was found that sleep disturbance and food insecurity could increase suicidal risk. Finally, other considerations in understanding the concept of self-harm are dynamic and static risk factors. Bonta (2002) defined static risk factors as those that do not change or change only in one direction. Two examples of these are age and self-harm history. Static risk factors are rigid in the sense that once a client has fulfilled one category of static risk factors, the client is in the risk category (Welton, 2007). Dynamic risk factors are factors that can change throughout the life course. Examples could include unemployment and peer group influences (MacLeod, 2012). Unlike static risk factors, dynamic risk factors are modifiable; clients can dynamically move from high risk to low risk depending on the circumstances.

A Protocol for Clients with Self-harm. It has now been established that it is appropriate for CPs to help clients who self-harm via CT. It has been mentioned that the chances of CPs being contacted by clients who self-harm are high, considering that clients who self-harm prefer online psychological services over face-to-face services. Depression itself might create more possibilities for ongoing clients to conduct self-harm in the middle of the therapy. Thus, the CT needs to have a protocol for how to deal with clients with self-harm tendencies correctly. The discussion was brought to the PG, and the following protocol created.

Table 26

Protocol for Clients with Self-harm

Stages and Participants	Description
Calm the client and assess the client's safety P1, P5, P6, P7	Four PG members suggested that the response from the CP should be the same no matter when the self-harm behaviour comes up, whether in the first contact, at the beginning, or even in the middle of therapy. The first thing that CPs need to do is to calm the client using counselling skills such as

	attending, empathising, and validating. CPs could also use grounding techniques to help the client focus. P7 emphasised the importance of assessing the client's safety during the event, at this stage. To do this, the CP might ask whether the client is alone. If not, the CP can have better peace of mind, knowing that there is somebody with the client at the time who can help them in case of an emergency.
Obtaining emergency contact details P6, P7	The idea of this stage is to obtain the details for an emergency contact who can be contacted quickly in an emergency. For ongoing clients, the CP might already have such a contact. However, the CP might not have such emergency contact details if it is the first contact by the client. Therefore, the CP could wait until an appropriate time to ask for such information.
Assessing the emergency: contacting the emergency contact followed by referral or further consideration. P1, P5, P7	Based on the previous discussion about manipulative clients, CP should try to assess the situation to determine whether the situation is indeed an emergency. P1 suggested that if the clients seem unable to control their impulse to harm themselves, it is best to communicate with the emergency contact and refer them to the nearest medical or mental health emergency clinic. The CP must ensure that the client understands this referral and confirm that such an action will be taken. Finally, this scenario would be ended by the CP ensuring that all necessary precautions are taken and that the client and/or the emergency contact understands the next steps. Should all of this be achieved, CP can safely end the CT. On the other hand, if the CP assesses that there is no emergency, then the CP can thoroughly assess the situation and determine whether or not the clients are serious and determined about harming themselves.
Final decisions P5, P7	This final stage of the protocol only applies if there is no emergency for the client. If the CP finds that the client has calmed down as a result of Stage 1 of the protocol or the CP finds out that the client did not intend to harm themselves, the session can continue. However, if the CP finds that the client continues to have a strong tendency to harm themselves, they can make a referral as described in the previous stage of this protocol.
Harm to others / Criminal activity P5	In the case of potential harm to others or criminal activity, CP may report clients to the authorities only if CP is really confident that clients will commit such an act and not just be emotional. Calming the client down could still be tried to neutralise the situation. A detailed and concrete plan and supporting evidence could be good indicators to report the client. In doubt, CP may consult with a lawyer before making the decision.

Firstly, we need to stabilise the client's emotions. If the client cannot control their impulse, we will ask them to go to the nearest health facility for more appropriate treatment. In CT, we cannot ensure they go to the facility. If we have recommended that to the client and they understand it, we will take it as a commitment. We need to make sure that before we close the session. (P1)

We could do some grounding techniques to stabilise the client; after that, we could ask again how they are feeling and whether they can continue the session. If not, we advise them to have a face-to-face session with a psychologist or psychiatrist. (P5)

For potential harm others or criminal activity, we do not call authority directly; rather, we ask opinions from lawyers in my team. Sometimes, they are just

emotional; we will try to calm them and control the situation. However, if we observe that the words are convincing and they even prepared the tool already (such as: gun to commit the crime), that would be good evidence, and therefore, calling authority is justified. (P5)

If ever we encounter that situation, we could use counselling skills such as emotional validation, the opportunity to vent, and build rapport. We need to advise them about where to go, for example, to the nearest mental health facility or emergency clinic. We could also ask them to contact their next of kin or ask the client who would be able to provide them with any support. (P6)

I don't think it matters whether self-harm appears at the beginning or the middle of the therapy as the main focus is the self-harm behaviour. Clients should be asked questions at the beginning of the therapy about their tendencies to self-harm. We also need to know whether someone else is at home besides the client and the phone number of a person that could be contacted. So regardless of when this self-harm appears, and whether is based on looking for attention or not, we are prepared for it. In answer to P1, I think if we are sure that there is support available to them, such as from a family member who is with them, we could safely close the session after we have recommended a health facility. We don't always have to contact the emergency contact; if we know the self-harm is more about seeking attention, then we could continue the session. (P7)

The literature validates the pattern of intervention proposed by the PG members. CPs should not panic or invalidate the thoughts of suicide that the clients convey. Instead, they should take them seriously, attend to the client, validate, and emphasise the positive aspect of conveying those thoughts to the CP (Mills et al., 2012). A communicated thought of suicide is a sign of suicide risk; sometimes suicidal thoughts are implicit in expressions such as, "I cannot do this anymore," or "Nobody wants me here" (Reeves, 2020). In these cases, CPs are encouraged to be sensitive to those kinds of statements and to discuss those feelings, as such interventions can create a safe space for the client to express their thoughts and feelings about the concept of suicide itself (Reeves, 2020). The careful wording of questions can make clients open up and feel happy and relieved to be able to talk about those suicidal thoughts and feelings (Mills, 2012; Reeves, 2020). CPs could then use these opportunities to discuss clients' protective factors (Reeves, 2020). As suggested by the members of the PG, friends and family can be accessible protective factors (Reeves, 2020), and they can also support clients by becoming emergency contacts (Samra & Monk, 2007). Barnett and Kolmes (2016) mention that emergency contact should be included in the informed consent, as suggested by the PG members. These emergency contacts will be used should an emergency event arise.

This intervention is covered by KEHPI (HIMPSI 2010) and KEPKI (IPK Indonesia 2021), which allows CP to break confidentiality for the sake of the client's safety or as ordered by the law. However, aligned with the answer from P7, Reeves (2020) has emphasised that not all high-risk clients will be involved in an emergency. The Code of Ethics does not justify CPs communicating with clients' emergency contacts about every suicidal thought would damage the ethical aspects of the therapeutic relationship. At the same time, Daly (1993) postulated that every practitioner has a duty of care which requires one to provide the appropriate standard of therapy; failing to do so constitutes professional negligence. This makes the decision to call the emergency contact difficult for CPs. CPs need to make a valid and justifiable clinical judgment if they ever decide to communicate with the emergency contact (Monk & Samra, 2007).

As suggested by P1, the literature says that breaching confidentiality is justified if the CP believes that there is imminent risk for the client (Darby & Weinstock, 2018; Hicks, 2005; Lloyd-Richardson et al.; 2015; Monk & Samra, 2007). The concern is with defining imminent risk and when a CP must breach confidentiality. A range of evidence from the literature could be of help on this matter. Bond, Brewer and Mitchels (2009) have suggested that CPs need to assess whether clients can understand the potential consequences of their actions or whether they lack the mental capacity and are thus at high risk of harming themselves. Indicators of lack of mental capacity are as follows: 1) difficulty with recall or has memory loss; 2) disorientation; 3) deterioration in personal presentation or mood, and social withdrawal; 4) limited ability to interact with others; 5) lack of mental flexibility; 6) problems with simple calculations (American Bar Association & APA, 2021). Later on, the label of imminent risk can be applied if the CP believes that clients will self-harm in the 48 hours following the communication (Hirschfeld & Russell, 1997). In this scenario, it is justified for the CP to breach confidentiality.

The final stage of the protocol was based on the opinions of P5 and P7, who suggested that the CP could continue the session if they found that the client has stabilised and does not intend to self-harm and is at low risk. Returning to the previous sections, the CP could conduct an assessment using interview questions from Carr and McNulty (2016) and then assess the information obtained using their framework (Table 24) to decide whether the clients fall within the categories of high risk or low risk.

should stress that such a behaviour do not make them bad. A diagram to visualise the protocol can be found in the page 80 of the manual (Appendix A, p. 307)

The Cultural Aspects

The culture section comprises several themes which emerged from multiple discussions with the clients across multiple stages in the data collection. The presentation of this section does not follow the sequence of the data collection but rather is set up in an order of deduction, from general to more specific discussion. The discussion starts with participants' views on the concept of culture and how it affects the process of CT. After that, the general values that should be practised and upheld in the CT are discussed. Later on, specific discussions about language, responding to cultural aspects, and cultural considerations in determining goals are outlined.

Opinions about Culture

The section discusses how the participants view cultural aspects in relation to CT in general. Seven participants (P1, P3, P5, P6, C1, C4, & C6) joined the discussion which resulted in four subthemes: ongoing harmony, learning opportunities, negative aspects, and suggestions.

Ongoing Harmony. It suggested the ongoing practice of CT in regard to cultural aspects has been harmonious. CP were able to make unbiased judgements in regard to the client's culture and both sides do not see culture as something that is intrusive.

So far I have never experienced any difficulties in terms of cultural diversity. If I have to communicate with clients that come from, Papua, Sumatra, or Borneo, never have I like...[thought] why do the clients behave like this? Or vice versa...so far, never. Everything has been good, free from bias and any ethnicity-related problems. (P1).

Cultural diversity has never been a deterrent for us. [I see] no extreme differences from their culture when they talk to us. (P3).

I don't see differences in culture or customs as much as I see the things in common, that everybody does. I see that psychologists also do something common (C1)

Learning opportunities. Cultural differences can be seen as opportunities to experience and learn something new.

This is a good opportunity for us to learn. (P5).

I come from Sumatra and had a psychologist from Semarang and West Java. They are much nicer and calm. I feel comfortable, while here, they are more direct when speaking. (C6).

I can understand the ways people from other cultures think. Because during sessions, we communicate and disclose ourselves. So I can understand whether my behaviour is different compared to theirs or even whether people from different cultures also do the same things as me (P8)

Negative Aspects. Cultural differences may cause problems in the therapeutic relationship. Participants mentioned how different traditional languages could influence the chat communication between CPs and clients. While Indonesian is the official language of Indonesia, the dialect, tone, the vocabulary, and structure can vary between people, depending on their cultural backgrounds. Different ethnicities may use different titles to address each other according to their age and gender. Addressing others by unsuitable titles may cause discomfort. Finally, cultural differences may create contradictions to the point that they create inconvenience.

Some clients who come from different cultures, often use traditional phrases rather than Bahasa (referring to Indonesian Language). (P5)

Some clients' language is difficult to understand. The sequences of the sentences are different, for example, the adverb is in a different place—it's just confusing. (P6)

I am still young, but the psychologist called me Sir. I feel uncomfortable with that. Another example is I come from Lombok, and the word "Kamu" (You) is rather rude in my culture. I don't have a problem with that, but others might feel uncomfortable. (C3)

I did have a counselling experience, not chat but face-to-face, where the psychologist was from Bali, and the psychologist was also Hindu. When the psychologist opened up about himself, it was more about his own culture in Bali, due to that, I felt uncomfortable listening to it. It made a distance between us as I realised we are different. (C8)

Suggestions. Some suggestions from the participants included how the CP should have an open mind and be knowledgeable and sensitive about the cultures in Indonesia. It is also best if clients can choose the CP for their CT as clients might have expectations in regard to a CP's cultural characteristics.

It would be easier for us if the clients were the ones who chose their psychologist. Race is important with clients. I had a client who did not know who would be helping them as my workplace does not allow clients to choose a psychologist. Later I discovered that the client had preferences regarding religion and other background characteristics. In a nutshell, if the clients could choose their psychologists, there would not be any problems. (P8).

As Psychologists, we need to improve our general knowledge about the traditions of different ethnicities. When the clients tell stories about their environment and culture, we might think... "oh, it does not make any sense". But this is because maybe we are

not part of their culture, so we don't understand. (P5).

So I suggest that whether the psychologist should call the client by name or another title should be confirmed first with the client. (C3).

I suggest that for self-disclosure, just tell the clients general things. (C8)

As previously discussed, Indonesia is a multicultural country (p. 15). This feature alone could explain some of the answers given by the participants. As seen above, the negative aspects of CT in relation to Indonesia's multiculturalism involve communication, customs, and values. Even though Indonesia has an official language, this official language might not be every Indonesian's first language. According to Effendi and Mu'in (2018), up until the age of six, an Indonesian might still speak their local regional language. The official language of Bahasa Indonesia might only be acquired in school. Tita (2017) investigated what language teenagers in the Sundanese territory of Indonesia use to communicate on a daily basis. The study showed that 44% of the sample used Sundanese-Indonesian, in which Sundanese vocabulary was included in their daily Indonesian language conversation.

Some of the differences in values and customs between ethnicities might also create contradictions between different ethnicities. As an example, participants mentioned how Indonesians from Batak and Java ethnicities differed regarding communication style. Rikastana et al. (2015) described that while people from Java tend to be gentle and more indirect in their style of communication, people from Batak are more direct. Another example is that Indonesian people from the Minangkabau ethnicity follow matrilineal values while Javanese and the majority of other ethnicities in Indonesia follow patrilineal values. (Bhanbhro, et al., 2020; Gultom, 2017; Riani, et al., 2020).

Despite that, P3 and C1 still answered that they did not find any extreme differences between people from different cultures in Indonesia. This might be explained by the fact that Indonesia, in a broad sense, is a collectivist country. As previously discussed, in collectivist societies, individuals always consider themselves part of a larger community (Minkov et al., 2010; Suharnomo & Syahruramdhan, 2018). It can be assumed that even though some values are different between ethnicities, they still prioritise interrelatedness within the community.

Being very limited in number, Indonesian CPs are likely to experience this cultural diversity in their clients. Thus, it is important for Indonesian CPs to be prepared by becoming familiar with this diversity, as suggested by P5. In the third edition of *CBT Basics and Beyond*,

Beck (2020) established the importance of understanding clients' values. The therapist needs to understand the client's values and aspirations at the beginning of the therapy. Huey Jr. et al., (2014) emphasises the importance of cultural competence in psychotherapy.

There have been many definitions of cultural competence, however, the basic idea of cultural competence is the ability of a helper, in any therapeutic relationship, to have an awareness of clients' needs, beliefs, attitudes, and behaviours, to be able to later tailor the interventions to accommodate these aspects. Furthermore, tailoring strategies in the psychological interventions to accommodate those aspects are mostly efficacious (Huey Jr. et al., 2014). This can explain several answers given by the participants. P8, who mentioned the importance of the client's preference for their CPs, and C3 who mentioned how they wanted to be addressed by the CPs, provided examples of clients' preferences that the CPs need to attend to. In a study by Swift et al., (2018) it was found that accommodating clients' preferences can lead to fewer dropouts and better treatment outcomes.

Becoming culturally competent requires the psychologist to develop certain kinds of characteristics. The answer from C4 about the need for the psychologist to be an open-minded person is aligned with the model by Van der Zee and Van Oudenhoven (2001) which includes five characteristics of a multicultural personality, which are: 1) cultural empathy: the ability of a person to empathise with the feelings, thoughts, and behaviours of other people from different cultural background; 2) open-mindedness: the ability to have an open and unprejudiced attitude towards other people's cultures; 3) social initiative: the ability to initiate and approach others in social situations; 4) emotional stability: the ability to reflect on and respond calmly in stressful conditions; and 5) flexibility: the ability to interpret novel situations as positive challenges and adapt to them accordingly. Furthermore, P5's mentioned using the events of meeting clients from other cultures as opportunities to learn something new, which aligns with a study by Hatcher et al., (2012) that found that psychotherapists could not only learn about culture from their clients but also about relationship, ethics and morality, coping strategies, personality and psychopathology, life stages, and other life lessons.

C8 mentioned feeling uncomfortable when the CP decided to use self-disclosure with them. C8 later suggested that CPs should not self-disclose too much and should keep it general. The topic of self-disclosure has been comprehensively discussed by Johnsen and Ding (2021) under the label of therapist self-disclosure (TSD). They suggested that TSD is not

uncommon. However, therapists do need to make a thorough consideration before disclosing their thoughts, feelings, and personal information to their clients. Zur (2007) suggested that deliberate self-disclosure must be based on the client's needs, with a high sensitivity to clients' situations. Some considerations could be age, the issue itself, values (for example, cultural and spiritual), and cognitive abilities. The case of C8 aligned with the description of Johnsen and Ding (2021) in which the CP decided to share their values (culture) with C8 who did not have the same values as the CP, resulting in the C8's demotivation to be open with the psychologist. Other possible negative outcomes could include role confusion and clients feeling they are being neglected or ignored (Johnsen & Ding; 2021).

Cultural Identity and Promotion

The previous discussion found that the client should be able to choose a CP aligned with their culture before the CT started. Sensing the importance of the topic, I then elaborated on the topic by discussing what kinds of information should be put in promotional descriptions to provide cultural information for the client. Five participants (P3, P5, C4, C7, & C8) contributed. The findings suggest that while ethnicity is explicitly mentioned, it might not be required. Participants found that a name alone and a photo would be more than enough. P5 suggested that CPs could list their areas of practice and provide the most information about those rather than more cultural and personal information.

In the company I work for, they make us list our ethnicity, even for clients to see. So we both know each other's ethnicity. (P3)

For me personally, I do not describe my ethnicity. Just list my area of practice. People can also learn about my ethnicity from my name. Specific names are tied explicitly to particular cultures (P5)

Ethnicity information is unnecessary; every ethnicity in Indonesia is Indonesian by default. CPs must follow and be sensitive to clients' cultural needs. A photo...is essential; I usually pick a CP by their photo. (C8)

For me, names are enough. [Someone with] the name "Asep" will not be from the Celebes region but the Sundanese region. I think over describing ethnicity is unnecessary for choosing a CP, and clients will get to know it eventually during the sessions. (C4)

Looking at the code of ethics for Indonesian CPs, there is only one specific guideline on how CPs should advertise themselves. According to KEPKI (IPK Indonesia, 2021), Indonesian

CPs must avoid any behaviour that aims to make the CP stand out or advertise themselves as better than others. This shows that Indonesian CPs have significant flexibility when advertising their services. Further inspection of advertising for two online companies in Indonesian that offer online psychology services showed that there were several pieces of information included within the advertisements, including, 1) names and titles related to qualifications; 2) photographs; 3) education history; 4) physical practice location, 5) alma mater, 6) practice license number, and 7) specialities. As suggested by the participants, this information alone is enough to capture the cultural backgrounds of the CPs. A photo of the CP can provide cultural references. For example, specific attire could link the CP to a specific culture (Misbahuddin, 2019). Names can also be linked to specific cultures (Isnendes, 2020; Widodo, 2013). Higher education institutions could provide information about shared values, spirits, and behaviour norms within the institution (Shen & Tian, 2012). It could also provide socio-economic culture of its students (Bathmaker, et al. 2013).

One distinctive finding came from the specialities listed by one of the CPs. In the description, the CP listed sexual identity as one of the specialities. This could potentially attract people who belong to a particular group in regard to their sexual identity or orientation as clients of that CP. Thus, it can be seen from this example that speciality descriptions can be one way to advertise the cultural background of the CPs. This aligns with Kim (2006), who asserted that practitioners with knowledge about cultures other than their own should advertise such knowledge to distinguish themselves from others.

General Values within Chat Telepsychotherapy.

Realising how this vast diversity could affect therapeutic relationships in Indonesian CT, I then inquired what general values should be upheld in CT. The topic was then brought to both CG and PG for discussion. The following table shows the result of the discussion.

Table 27

General Values within Chat Telepsychotherapy

Subthemes Participants	Result and Discussion
Being on-time P3 & P8	CPs and clients arriving on-time can positively impact the process of CT. In a study by Yang & Jin (2020), being on-time during psychotherapy (Punctuality) is negatively correlated with client cancellations and no-show rates. Not being punctual means clients have shorter sessions and miss out on the most optimal session, as planned for the client. Therapists also tend to want to discuss the lateness with the client; thus, more time is used to address this matter.

Subthemes Participants	Result and Discussion
	Furthermore, unpunctual clients risk compromising the therapy's efficiency and they may not even finish the overall therapy. However, Drum & Littleton (2014) have recommended that although a telepsychology practitioner can talk with the client about punctuality, the practitioner should be aware that perceptions about punctuality vary between cultures and not assume any underlying therapeutic significance from it. Several industrial psychology researchers have found the trait of not being punctual is linked with Indonesians (Martha & Arvianto, 2018; Nugroho, 2011; Santi, 2020; Widiyanto, Endri, & Sakti, 2021) <i>Being on-time [is important], regardless of whether it is the CP or the clients. So if both parties come on-time it will contribute as well (P8).</i>
Commitment P1	CT demands a strong commitment from the clients to follow the therapy from start to finish. The clients are expected to commit to the therapeutic interventions that may be provided during therapy, such as assignments. The concept of commitment being tied to clients' attendance towards therapy sessions has also been studied by Zimmerman (2019). The study found that clients who consistently came to psychotherapy experienced decreased symptoms. In a CBT study by Callan et al. (2018), high adherence to homework was significantly correlated with higher levels of remission from depression. Hara et al. (2016) found that adherence to homework correlated to a lower level of posttreatment worry. In a distance therapy setting, Richards and Viganó (2013) suggested that clients' commitment could be increased through willingness on both sides to communicate with each other outside session hours. For example, a simple reminder could reduce the impact of forgetfulness on the clients in the therapeutic relationship. The postulation of the importance of no coercion during therapy is aligned with a study by Sheehan and Burns (2011) which found that perceived coercion during therapy resulted in a poor rating of the therapeutic relationship. <i>The client's commitment to attend and continue the CT sessions is one of the most important things. To establish this, I will try to make a health plan—what the health plan will be like for the client. What aspect are we focusing on, what homework would be given, and what would they gain in the future session. (P1)</i>
Here and now (client engagement) P4 & P5	The psychologists and the clients are expected to focus on the current session. CT is very vulnerable to distractions from the environment. CPs are advised to tell the clients that CT is ideally done at a time when there are no other activities happening. The here and now in Psychotherapy refers to a concept in which both the clients and the therapist focus on the experience in that very moment (Carnevale, 2015). Ideally, when this concept is applied in the session, there will not be too much focus on the past (APA, n.d.d). CBT and Gestalt therapy are two schools of psychotherapy that use this method as their main principle (Carnevale, 2015; Fenn & Byrne, 2013). Focusing on the here and now is also one way to increase mindfulness (Ericson et al., 2014). Aligned with the answers from P4 and P8, being mindful may increase engagement in the present moment, and thus, increase focus on the therapy (Gordon, 2020; Lopez, 2016; Stephenson, 2017). Furthermore, being in the here and now also helps clients with facilitating goals and values (Ericson et al., 2014). Finally, clients in psychotherapy who are engaged with the therapy are likely to have a better outcome (Holdsworth et al., 2014;

Subthemes Participants	Result and Discussion
	Yoskowitz, 2018)
	<i>For me, the first thing is that the client should practice being in the "here and now". If the client fails to do that, we cannot make the client attend in the session. The client should have free time to actually attend in the sessions. (P4)</i>
Politeness C1 & C4	Politeness in CT is reflected in the communication between clients and the psychologists, including the choice of words, the use of titles when they address each other, and how they respond to each other. In general, being polite is expected in professional behaviour (Priebe et al., 2011). One way to establish this relationship is by using a helpful and cooperative communication style, which is polite, diplomatic, and Flexible (Niess & Diefenbach, 2016). <i>I mean, if we meet in real life, I imagine that the CP would have a soft voice, and be calm. They won't have an aggressive manner like a salesperson. They won't corner us with their words (C1)</i>
Authenticity P1, P2, C1, C5, C6, & C8	Psychologists are expected to demonstrate authenticity by showing sincerity and empathy towards the clients, and use self-disclosure to a reasonable extent, if appropriate. The clients who use CT are also expected to demonstrate authenticity by disclosing truthful information regarding their problem without any falsification. Burks and Robbins (2012) defined authenticity as matching one's inner thoughts, beliefs, and feelings with one's outer presentation and behaviours. It involves honesty, realness, openness, transparency, and truthfulness. Vymetal (2002) suggested that a therapist's authenticity leads to clients' spontaneity and an increase in the clients' authenticity. <i>Genuineness is important for me. This means us truly being sincere and not faking it. We really want to help the clients. (P1)</i> <i>Willingness to help and not just educate. If there is a will, the way they speak will be different...not just giving orders. (C6)</i>
Neutrality C5	CPs are expected to be neutral and objective in assessing and helping their clients, not leaning towards any particular viewpoint without clear reasoning. CPs are also advised not to push their values onto the client. Aligned with this answer, Selvini-Palazolli et al. (1980) described the concept of neutrality as actively avoiding accepting any one position as more correct than another. Many practitioners then perceived this to mean noninvolvement, not having strong opinions, and having a relativist's cold and aloof position. Later, the concept was delineated by Cecchin (1987), as more of a state of curiosity to explore other possibilities rather than to accept descriptions as given. For example, taking clients' explanations about an issue at face value would not be seen as neutral; neutrality would require the therapist to explore other explanations that could have resulted in the same outcome. Later on, the concept of neutrality has also been used to mean that therapists do not impose their own beliefs and values on the client during therapy (Jackson, 2013). <i>Being neutral, regardless of ethnicity and religion (C5)</i>

Subthemes Participants	Result and Discussion
Acceptance (positive regard) P2, P6, P8, & C7	CPs are expected to be able to accept the client's situation as it is: accepting in the sense of acknowledging the client's stories even though they may not conform to general norms or values. CPs do not have to justify the client's story but rather accept and understand it without judgment. P2 and P6 emphasised the concept "to accept but not to validate." The participants' descriptions of the concept of acceptance were aligned with the concept of unconditional positive regard (UPR). Bozarth and Wilkins (2001) defined UPR as "acceptance of every momentary experience of the other. The good, the bad, and indifferent momentary experiences are accepted with equality" (p. 12). In a literature review by McHenry (2018), UPR was found to have positive impacts such as, 1) increased unconditional positive self-regard (UPSR), in which an individual perceives himself in such a way that no self-experience can be discriminated as being more or less worthy of positive regard than any other (Rogers, 1959); 2) decreased conditions of worth, which is the idea that one is only worthy of love and belonging once one has fulfilled certain demands (Maurer & Daukantaitė, 2020); 3) increased autonomy and congruence; 4) increased ability for self-awareness and focus; 5) increased ability for self-regulation. <i>To accept but not to validate. For example, there is a student who has a certain lifestyle in which she has a relationship with a married man. We cannot challenge her about that, we cannot even make a judgement and condemn it as a wrong thing to do. (P6)</i>
Consensus C8	The CPs are advised to prioritise consensus in every decision made regarding the clients. Consensus in the sense that there is an agreement reached by both the CPs and the clients regarding how the intervention is proceeding. In a study by Wampold (2015), goal consensus was defined as a mutual agreement between the patient and the therapist on the tasks, goals, and expectations for treatment. Similarly, Tryon et al. (2018) mentioned that in general, therapists and clients can agree on three things which are, 1) agreement on and commitment to the goals and the methods by which they will be achieved, 2) patient-psychotherapist agreement on the patient's problem; 3) the extent to which goals are discussed and clearly specified. Mackrill (2010) mentioned that goal consensus leads to a more efficient use of psychotherapy resources. Perhaps the best evidence of how goal consensus can positively affect psychotherapy outcomes can be found in a study by Tryon and Winograd (2011) that found the effect of goal consensus and collaboration on therapy outcomes was strong. <i>The value of consensus. If there is a suggestion, it is best to discuss it first. If the client agrees, then we can proceed. Clients need to be able to have a say as well. (C8)</i>

Language

As language was one of the negative aspects of culture mentioned earlier, I then opened up a specific discussion about language with the participants. The discussion was started with the PG with five members (P1, P4, P5, P6, & P7) joining the discussion. Firstly, three members (P1, P4, P7) mentioned that in real life, the official Indonesian language (OIL)

would often be prioritised as therapy is a formal process. However, learning traditional languages would be helpful as sometimes clients might not speak OIL fluently and are more comfortable and expressive in telling their stories in their traditional languages. CPs who speak the language could switch the language of delivery, either completely or partially; CPs could use some traditional language in their replies. Another option for CPs is to let the client speak their traditional language but still respond in OIL. While this may seem strange, P5 responded by raising an interesting concept where clients who speak a traditional language may understand OIL but not speak it.

I once had an offline client who first tried to use OIL to communicate during therapy because of the formal setting of the hospital. However, the client was having difficulty in conveying their story. Their language was often a mixture of the traditional language and OIL. I proceeded, allowing the client to speak their traditional language. Once I did this, the client's delivery became smooth. The clients could express their emotions, convey their anger, and find the right words to symbolise their feelings in their traditional language. Luckily, I am from the same area and understood the client's words. However, I still replied to the client in OIL. (P7).

Honestly, we can only learn some of the traditional languages in Indonesia. Since we are professionals, we tend to use OIL in our communication. OIL is rarely a foreign language for Indonesians. I once had a client who only spoke a traditional language but understood OIL. The client understood what I said but not vice-versa. What happened then was I used a translator to translate what the client said to me. The translator did not need to translate what I was saying to the client but still needed to translate what the client said to me. (P5)

This behaviour from the offline setting was then carried into the CT setting, where OIL tends to be used as the language of delivery and occasionally traditional languages are used during chat, if necessary. If the latter happens, the CP must be aware of the spellings of words as traditional languages may use different spellings from OIL, different cultures might have different ways to shorten words; which could lead to misunderstandings.

In CT, I use the OIL. I have never conducted CT in a traditional language. Even though the client might say something in a traditional language, I reply in OIL, and what usually happens then is they change their language to OIL as well. (P4)

I have never had a specific problem with language. In CT, we use OIL. Even if they use a traditional language in CT, they don't mind if we reply in OIL. (P1).

If we use CT, we must also adapt the spelling. For example, "buruk" (bad) in the Palembang language is spelt "borok", But in OIL, "borok" means something else (wound). So yeah, we need to adjust. Otherwise, the client could become confused. (P7)

Text abbreviations could be unique in different cultures. For example, A person from Nusa Tenggara Timur prefers to use "Sa" than "Saya" [Saya means I / Me / Myself].

(P6)

Clients might need to help understand any jargon the psychologists bring into the session. For example, clients might not understand the word "assertive." In this case, psychologists need to find other words that are more understandable for the clients. CP should double-check with the clients whether the clients have a complete understanding of the message and re-explain the concept using more understandable phrases if the clients do not.

In CT, we might use jargon that makes the clients confused. For example, I thought assertive was a common word, only to discover that some people do not understand it. (P5se)

Usually, every time I say something to the clients, I double-check with them to make sure they understand what I am saying. (P3)

Bringing the discussion to the CG, four CG members (C3, C4, C6, & C7) contributed to the discussion, agreeing that CT should use OIL as the language of delivery. It would not be realistic for CPs to understand all the languages in Indonesia. Nevertheless, using traditional language is allowed as long as both the clients and the CPs understand the language.

I think we should speak Bahasa Indonesia properly if we are in Indonesia. So that we understand each other (C4)

It would be better to speak Bahasa Indonesia, however. Still, if the client comes from a certain ethnicity and the psychologist also understands the language, that would be okay too. (C6).

The previous discussion about language has described how some Indonesians would only be exposed to the Indonesian language later in school, and this causes them to continue using their native (traditional) language when they are growing up (Effendi & Mu'in, 2018; Tita, 2017). Regardless, Bahasa Indonesia is the official national language of Indonesia under the constitution (Saputra & Aida, 2019). The latest data from the Indonesian government in 2010 asserted that 90.18% of Indonesian people could speak Bahasa Indonesia fluently (BPS, n.d.c). This fact corresponds with P4 and P5's answers about their rare experience with clients who do not speak Bahasa Indonesia.

The answers from P1 and C6 align with a study by Suryadi (2018) that found Indonesian counsellors who meet clients who use Bahasa Indonesia as a second language allow their clients to freely express themselves in their traditional language

and vocabulary. By practising this intervention, clients are more comfortable with and receptive to the empathy the counsellors provide. However, it must be noted that both the counsellor and the client need to come from the same cultural background and speak the same traditional language.

The use of jargon, as P5 discussed, has also been criticised as it may hinder effective communication between therapists and clients, especially when clients do not have sufficient mental health literacy (Deuster et al., 2008). Lilienfeld et al., (2015) have also emphasised how the word anxiety might refer to anxiety and fear, while those two are different experiences, leading to a false understanding of the concept.

The difference in abbreviation between culture, as mentioned by P6 is discussed by Gorney (2012), which suggests that the language does develop from its original state, and those developments depend on culture and technology. Texting, for example, has led to noticeable changes regarding the forming of words. A combination of culture and technology resulted in different changes between cultures. An example given in the article is the word "two" which can be spelled as "to" or "too" between different users.

The Use of Translators. One thing that also stood out from the language discussion is the possibility of using translators in therapy. I then asked about the probability of such an occurrence in the CT setting and how to best handle the ethical and practical issues when using a translator. P5 replied that such an event would rarely occur in a CT setting as clients could choose the therapist beforehand and choose a therapist who understands them in the first place. Regardless, if such an event does occur, the CP would need to ask for the client's permission and probably request informed consent from both the client and the translator. P4 suggested that if such an event occurs in CT, it is the client's job to provide someone close to them to help them with the translation.

I have no experience of such an occurrence in an online setting. Clients can usually choose a therapist from their culture in a CT setting. Clients who only speak a specific language would find CPs that speak the same language. However, if such an event occurs in CT, I would need to ask permission from the client because it is about confidentiality and comfort in the therapy. We will also go through the informed consent process because it is also about confidentiality. If the use of a translator is arranged beforehand, I will request special informed consent from the client and the translator. (P5)

I have personally never had any experience of language difficulties in CT. However, I once helped my colleague who had difficulty interpreting his client's text message. He

asked me to interpret the chat message that he had been sent. When I read it, the writing had no spaces, lots of abbreviations, and contained mixed vocabulary not from his culture. For me, similar to P5, we must inform the client that Bahasa Indonesia will be the language of delivery in the CT. If the clients have difficulties with language, P5's solution is most suitable, if the CPs are the ones who have access to a translator. In my opinion, they are the ones who need to find someone that they can trust who could also help them with the language. (P4)

As discussed earlier, chat is unique. It is a mixture of written and oral communication, with oral communication becoming its main ingredient (Jibson, 2014). It has also been discussed earlier how late exposure to the official Indonesian language means Indonesians still use their native languages (Mu'in, 2018; Rostyana, 2017). Even if clients have opted to use Bahasa Indonesia as the language of delivery in CT, native language vocabulary might still be present in the conversation. The combination of these two conditions might result in the situation portrayed by P4. The idea of using a translator in a therapeutic setting is not uncommon. A translator or interpreter could be used in the case of cultural differences due to migration or for people with disabilities (Gill & Fox, 2012; Tribe & Thompson, 2011).

Regarding the ethical issues in using a translator or interpreter, the answer from P5 is supported by the literature. According to KEHPI (HIMPSI, 2010), written documents should not be given to any person who has a relationship with the psychologist or the client in the therapeutic dyad. Furthermore, the same policy also says that it has to be given to a person with sufficient education, training, or background to provide translation. This means that the translator should be a third party and cannot be someone whom the client knows and trusts, as suggested by P4. This should be done to prevent exploitation and maintain objectivity in the therapeutic process. Tribe and Thompson (2011) have taken a similar view to the HIMPSI and provided further considerations for working with interpreters in therapeutic settings. Some suggestions that might be applied to the CT setting are: 1) therapist and interpreter should have separate meetings before and after the session with the client to explain how things will running during the session and review how things could be improved in future work; 2) if possible, the interpreter should match the client's demographic characteristics; 3) working with an interpreter will take longer; this should be understood and addressed with the client; 4) the same interpreter should be used throughout the psychotherapy; 5) the use of complex language should be avoided.

Sensitive Topics.

The data suggests that culture could also become a sensitive topic needing extra caution. During the data gathering, the topic of religion became a distinct topic due to the nature of the comprehensive discussion. Six members of the PG (P1, P3, P5, P6, P7 and P8) discussed how CPs should be neutral in relation to clients' religious beliefs. CPs should only bring religious aspects into the therapy if they were deemed necessary. Some clients prefer not to include religious matters in the therapy and just to hear the point of view of someone neutral rather than an opinion that is based on religious belief. Interventions that involve religious aspects might be seen as inappropriate and out of place by the clients

Regarding religion, I always remember that my lecturer repeatedly reminded the students that, "Clients come to you to hear your point of view as a psychologist. Clients will go to religious experts to receive religious teachings or interventions. If you want to insert a religious aspect into your intervention, understand your client's beliefs first. If they have a high level of religiosity, maybe you can insert some religious intervention." So, to be safe, I never insert any religious aspects because it is a very sensitive topic. Some clients even said, "The previous psychologist told me to get in touch with my religion, to be patient." It turned out this was sensitive for them. (P1)

During chat therapy, clients come from different religions, but that was not becoming our benchmark. Still, if they come to us, they receive our point of view on their issues. (P3)

I don't have any major issues with religion. If clients talk about their religion and state that they want to practice it, that is good, and we should support it. (P6)

A further investigation of culture, in general, revealed that this neutral stance in relation to clients' culture stems from the value of respect. As Indonesia is diverse in cultures, there will be different views towards life. It would be unethical and wrong if the CP held a value that contradicted the client's and decided to challenge it. Another reason for the neutral approach was more practical in that the CPs would not have the time to become familiar with all the different cultures in Indonesia. More than learning on the spot would be required, as this would only be peripheral knowledge. It would be preferable for the CP to refer them to a cultural expert or CP with a similar cultural background. It is better for the CP to remain neutral rather than respond incorrectly in relation to clients' cultural aspects. Some clients might not practise the culture they are a part of. Thus, bringing culture into the therapy would not only be irrelevant but also damage the therapeutic relationship.

Regardless, members of the PG agreed that having a client from a different culture

provided more opportunities to get to know other cultures, and learning more about culture could help build therapeutic relationships. For example, different religions use different greetings. CPs could use these greetings to create rapport. Culture also becomes one of the primary considerations when deciding the clients' treatment. CP must ensure that any goal setting produced within therapy can realistically be done without any potential cultural clashes in the clients' lives.

[A primary] value in Indonesia is respect, so when clients express their cultures, it is not that we ignore them or don't want to be a part of it. It is more about respecting the culture and not getting involved with it. It is about being respectful and tolerant when we meet others from different cultures. (P1)

This is about the CP not imposing their own culture onto the clients. For example, I had a client with a free-sex lifestyle the other day. She lived in a suburb and was in relationships with multiple married men. She lives that lifestyle with enjoyment and no pressure. So, as CP, I definitely cannot insert my values with the intent to correct her lifestyle. We cannot say, "You should not do that!" (P7)

From my experience, CT sessions are often short. Some of us may have several clients at the same time. So, learning about the client's culture on the spot would be difficult. Reading the literature, for example, discussing how a woman should behave in a particular culture would consume a lot of session time. So, it is better to focus on the current problem they are experiencing. We don't ignore culture. However, we might learn something for future clients. So far, if the clients focus on the problem, I am still willing to help them. However, if the clients focus on their culture or religion, for example, according to their faith, things are supposed to be like this, but why what happens contradicts my religion, I will refer them on. (P3)

Some cultural background is usually good for opening and closing greetings. So, if the client is Muslim, I use, "As-salamu alaykum," as the opening greeting. If the client is Christian, I might use, "God bless you," as the closing statement. The clients seem more comfortable if we use words aligned with or familiar in their faith (P8)

For example, some Javanese women are somewhat conservative, so we need to adjust to those conservative values. There are also Javanese students who are modern and open, no longer holding traditional values. If the client focuses on the psychological discussion rather than bringing their cultural beliefs, I will take them on as a client. However, if the client emphasises their culture, and I do not understand their culture comprehensively, I will ask them to consult a local psychologist instead. So far, I have always referred on that type the client as learning new culture will require more effort. I don't think I can do it. I would like to understand it, but not to learn on the spot. (P8)

To determine how an intervention relates to culture or religion, I will ask them whether it is appropriate or confronting. Automatically, the clients will consider it in relation to their own culture and religion. I am usually really neutral in cases like this. For example, I took on a client with a marital issue a few days ago. I don't understand their culture at all. Their culture is entirely the opposite of my culture and religion. The client told me briefly about their culture to the point that I understood

the basic ideas in the culture. Understanding that, I was still neutral and managed to give the clients some insights. At the end of it, I still asked the client whether what I said to the client contradicted any of their values. The client said, I quote, "I will take your advice into consideration. As I am not sure myself, I will discuss it with my family before deciding because this is strongly related to my culture." (P5)

As discussed in the literature review, religion, ethnicity, race and intergroup (suku, agama, ras dan antar golongan [SARA]) are considered sensitive topics in Indonesia. Being a multicultural country with a history of several civil wars caused by SARA requires CPs to be extra careful in regard to these four variables. As previously discussed, cultural competence means that the CPs understand the clients' preferences and needs. That includes whether or not the participants prefer to bring sensitive topics into the therapy session. If it is deemed suitable for the CPs to approach these sensitive variables in the therapy, then the CPs need to ensure they can have such a discussion. Otherwise, it would not be ethical to continue the treatment. According to KEPKI (IPK Indonesia 2021), one of the principles that needs to be upheld is that CPs must show self-capacity, such as the behaviours, knowledge and skills, to conduct the clinical psychology practice optimally. Furthermore, KEPKI (IPK Indonesia 2021), mentioned that the CP must refer the client to another CP or other professionals if they cannot help them. Being a religious country, in Indonesia there is a high probability that the CPs will meet clients with a high level of religiosity or even have a high level of religiosity by themselves. As previously mentioned, spiritual therapy in many forms was the most researched therapy in Google Scholar and the second most researched in the Indonesian National Library in Indonesia between 2012 – 2022. This shows that there is a place for both CPs and clients with high religiosity to engage in therapeutic relationships.

The concept of neutrality when dealing with a client's cultural beliefs has been previously discussed in the general value section (p. 187). Here, a new concept was raised, which was respect. As seen from P1's answer, CPs do not want to interfere in clients' cultures out of respect and tolerance. This answer from P1 is aligned with the concept of cultural tolerance defined by UNESCO as "the respect, acceptance, and appreciation of the rich diversity of our world's cultures, our forms of expression and ways of being human" (Agius & Ambrosewicz, 2003). However, it needs to be said that the concept of tolerance is more complex than it seems. Verkuyten, Maykel, and Kollar (2021) have discussed two types of tolerance. The first concept of tolerance is about acceptance towards something, despite any disapproval that comes with it (Cohen, 2004). A tolerant person would be able to control

themselves and continue accepting something they disagree with. The other type of tolerance is a more positive version, and is more about openness, being well-disposed toward cultural others, and having a generally positive attitude toward them (Hjerm et al., 2019). In this type of tolerance, one would not need to have complete disapproval towards a particular concept to tolerate it but rather disapprove a little. Based on this understanding of tolerance, it is unclear which type of tolerance P1 means. However, if we look back to P7, it can be seen that P7 might have a kind of tolerance rooted in disapproval, which could be the basis of P1's or other Indonesian CP's acts of tolerance.

Nevertheless, as mentioned before, the importance of cultural competency for the positive output of therapy requires CPs to be aware of clients' needs, beliefs, attitudes, and behaviours, and tailor their interventions accordingly (Huey Jr. et al., 2014). The answer from P8 about giving greetings tailored according to the client's culture and beliefs is a perfect example of such a concept. In New Zealand, therapists with Māori clients would start the session with Māori prayer (karakia; Te Moemoea, 2010). Further to P8's answer, the CP would need to be aware of the complexities of cultural identity and not be stuck on basic cultural information such as race, gender and ethnicity. If CPs believe that culture plays a major role in the clients' issue, Fontes (2008) have provided some interview guideline on correctly identifying clients' cultural beliefs. These guidelines seem to sit well with the multicultural nature of Indonesians. The questions as follows

- Where were you born?
- Whom do you consider family?
- What was the first language you learned?
- Which other language(s) do you speak?
- What language or languages are spoken in your home?
- What is your religion? How observant are you in practising that religion?
- What activities do you enjoy when you are not working?
- How do you identify yourself culturally?
- What aspects of being _____ are most important to you? (Use the same term for the identified culture as the client.)
- How would you describe your home and neighbourhood?
- Whom do you usually turn to for help when facing a problem?
- What are your goals for this interview?

Culture, Goal Setting and Giving Advice.

After the general discussion about culture had concluded, I also asked more practical questions about how culture affects CT. This section discusses the effects of culture on goal

setting. The topic was discussed with PG members in two separate sessions, along with additional feedback from the CG members. Eleven out of 15 participants joined the discussion (P2, P3, P4, P5, P7, P8, C1, C3, C4, C6 & C7). An extra finding about advice giving was also revealed.

In the beginning, a discussion about goal setting and culture was conducted. PG members suggested that CPs would be better to extract or use a psychological framework, as that tends to be culture-free, to analyse the situation and approach goal setting with the client. Another option was to follow client-centred therapy in which the client themselves is the one who sets the goals and the role of the CP is more about guiding the clients. The CP might use culturally based goal setting only if they are sure it is relevant and suitable for the clients. Clients who explicitly suggest or request culturally based goal setting would be better referred to cultural experts.

When dealing with clients, I try my best to be professional in that I don't include any culture, norms or religion. Accept the clients and talk about them. Even though I understand the cultural aspect their clients are talking about, I always bring it back to psychology. If the clients asked for a religious opinion, I would say I am not an expert in religion. It would be best if you went to the religion expert. Here, I am more about psychology in general. If you want to have psychological consultation, I'll focus on the psychology and let go of religion and culture. (P4)

We live in Indonesia, which is highly multicultural. If the client's culture is part of the issue, it has a determining effect towards the client's mental health. I don't discuss culture directly but focus on how it impacts mental health and what the client can do about it because the person who understands the most about their culture is the client themselves. Especially if the clients come from different ethnicities than me, I would just let the client decide what to do and weigh whether the proposed action is aligned with the client's cultural values. I had an experience with a client who came from different ethnicity from me; I did not understand the client's culture at all. I would say that I look at [the culture] from a mental health perspective. If a client asks about aspects to do the client's cultural, I would say that is not my expertise. I would again ask what the client could do, that is, I would not confront the client's culture while still inform the client what the psychological effect would be. If we have another session, I would talk with my colleague from the same culture as the client. Even then, I was reluctant to do that; I would give it back to the client to determine their subsequent action. (P2)

For me personally, I choose to learn about different religions. I joined a discussion and webinar about it. I also learn about other cultures. This is going to be helpful for clients who need behavioural activation. For example, if the clients come from a Buddhist background, they might understand more about meditation rather than relaxation. I could spark their interest by giving them familiar information about meditation. I could inform them about places or communities to practice mediation. In some cases, I would refer them to my connection, a religious figure who is also interested in mental health, to collaborate. (P8)

I once had a client who was satisfied with my service, saying that I do not bring any religious aspects into the discussion, even though the client and I share the same religion. The client said that I only included the psychological element, which was considered neutral by the client. (P4)

If the CPs were the ones who came up with goal-setting proposals, the next stage was to discuss with the clients the appropriateness of the proposed goals in the client's environment. Cultural considerations might come up in this process, depending on the client. The basic idea of this discussion was to find out whether the goals could realistically be achieved. In terms of goal setting, we might need to understand their culture. Learning about it very quickly seems impossible. We usually discuss whether goal setting might become a burden. Should we improve the goals, or is there something in the goals that is unsuitable for their personality or violates their religion? We don't just go, "Please do that, do this." Furthermore, in the way I usually do it, especially with depressed clients, the goal setting and action plan will be general. Very rarely will I touch on cultural or religious aspect. (P5)

I then investigated further how CPs could provide neutral goal setting if the clients' issues include concrete cultural aspects. Two CPs then offered examples of how it should be done. The examples from the CPs suggested that CPs should avoid cases requiring them to have comprehensive knowledge of a culture. CPs may continue to help clients with issues that only need CPs to have basic knowledge about the culture and a clear psychological framework.

I once had a client who came from the Javanese ethnicity and had just relocated for work to Sumatra. He got a bit of culture shock and was overwhelmed by the new place's work culture. This client had a problem with saying, "No," but then, he was working in a Sumatran culture where the people tend to go straight to the point. Dealing with this, I could not say that Sumatran culture is like this or that. I would then choose to enter the psychological dimension, discussing how his approach clashed with that of co-workers. (P7)

My client who comes from Sumatra (which is a more direct culture) going to college in Yogyakarta (a more laid-back culture) and experiencing culture shock. This is because when he relates his ideas, he tends to be direct and assertive; he then feels his fellow students and friends do not feel comfortable in his presence. I then think that this client had started to over-generalise the reactions of his friends... "There are Javanese; they are like that." I then analysed that his main need is to continue to focus on his education. I then discussed his communication skills; I encouraged him to be assertive but not aggressive or passive. So, I am addressing the communication skills and not the culture. I won't discuss his background as a Sumatran, and more direct, and his fellow students as Javanese, who are more laid back. (P8)

Finally, this intervention proposal was brought to the CG for feedback. The general feedback from the CG members showed that they agreed with how the CPs deal with the cultural aspect of cases.

What they have done is correct; as we know, Indonesia has so many ethnicities. If we need to get into the cultural aspects, it will never end. If the CP needs to get into the religious aspects, I don't think it is appropriate for CP with different religious beliefs to even advise about it. SARA is not something that can easily be compromised. It is not something that they should be bothered with. (C4)

What the CP has done is correct. It is a compulsory move for the CP. SARA is a problematic issue. Just stay on the issue and don't touch the SARA aspect of the client. (C3)

SARA is a private and personal topic, so I think the job of the psychologist is to dissect the issue in a general way. (C7)

Furthermore, CG members also suggested that CPs learn about cultures in Indonesian and find common themes that might apply to Indonesians in general.

If the psychologist does still want to help the client, the psychologist does need to learn first about the psychological aspects of all the cultures in Indonesia and all the religions so that he can give a general solution that is not tied to any culture but rather to the psychological aspects only. (C1)

The key terms are generality and universality. Every religion discusses kindness, so the psychologist should aim to get there. If we put people in boxes, they can fall into stereotypes. Let's get back to us as humans, universal humans. (C3)

Psychologists do not need to touch on any cultural aspect because we come to psychologists to get general advice, not religious or cultural advice. We want to improve our mental health. I had an experience when the psychologist gave religious advice, and I felt puzzled. (C6)

However, If the client urgently needs a solution and the issue is closely related to culture, then the psychologist might refer the client to their family or cultural expert. I agree that the psychologist doesn't need to touch on those personal topics. (C7)

A study by Liem (2020) tried to comprehensively understand how Indonesian CPs address the aspects of spirituality and religion in relation to psychotherapy in Indonesia. This study found that Indonesian CPs were aware that the elements of spirituality and religiosity (SR) could not be detached from Indonesians, and this principle applied to both the clients of the psychologist and the psychologist themselves. However, CPs were reluctant to bring SR aspects into psychotherapy because of three things.

Firstly, as the CP is most likely religious or spiritual themselves, including SR as an element in the psychotherapy makes it prone to the personal bias of the CP. CPs were cautious because they might somehow project their values into the psychotherapy. CPs' own personal values might only be accepted by the clients due to the intense multiculturalism in Indonesia. Masturi (2015) has proposed the concept of encapsulation, in which a therapist

conceives the truth based only on their own cultural beliefs and is resistant to other cultures. This adds to the possibility of introducing bias into psychotherapy. Finally, as promoting personal preferences is against the ethical code, CPs prefer to be professional and neutral and not bring SR aspects into psychotherapy.

For the second reason, it was found from the study that introducing SR into psychotherapy would mean that CPs must make use of unconventional intervention techniques that often lack scientific validation.

For the third reason, it was found that CPs did not have enough knowledge about how to best incorporate SR aspects into psychotherapy and what kind of SR techniques could be integrated with psychotherapy, or sufficient knowledge about the clients' SR aspects. The last could be because the CP has a different faith from their clients.

Another significant finding from the study suggested that Indonesian CPs, as a profession, were trying to incorporate SR with psychotherapy in the best ways they could because that could be one of the ways for conventional psychotherapy (referring to psychotherapy without any SR aspects) to become more accepted in Indonesia. As Indonesia has the largest Muslim population in the world, Islamic universities have started to conduct courses to teach its students to integrate SR aspects into psychotherapy. Indonesian CPs who are also beginning to include elements in their therapy must ensure that SR would benefit the clients and not contradict their values. CPs should also use simple, logical SR techniques, that have been scientifically proven to be helpful. For example, *zikir* (Islamic chanting) is one way to induce client relaxation. CPs who have clients from different religions must use a universal value of faith, such as compassion, as appropriate for the client. Finally, CPs might find that clients want or need more comprehensive SR techniques. In this case, CPs should refer them on to a person or organisation with more knowledge about techniques or collaborate with them to benefit the clients.

While the article by Liem (2020) only specifically discussed the spiritual and religious aspects, these two aspects are aspects of culture (Edara, 2017). Thus, the same reasoning might explain how the participants in the current study, and probably most Indonesian CPs, approach the concepts of spirituality, religion and another aspect of culture in psychotherapy.

The notion of being neutral and that SARA is sensitive topic was brought up again by the CG in this discussion. The matching opinions show that culture (previously discussed as

SARA) is indeed something that should be explored carefully in the therapeutic process. Being aware of this common conception, the answers from the PG in this section of discussion indicated that CPs tend to extract the psychological dimensions or framework of cultural aspects that might emerge or be brought up by clients. As mentioned by P7 and P8, who picked up the concepts of personality, character, and communication skills as cultural aspects that appear in the clients' issues, Gerber and Murphy (2021) have proposed eight variables within cultures, as summarised in the following table:

Table 28

Psychological Variables within Cultures based on Gerber and Murphy (2021)

Variables	Brief Description
Human Nature	People either support each other (good), control each other (bad), or a combination of both.
Time	People put a value on tradition (past), make quick and fast payoff decisions (now), or focus on long-term effects (future). People also use their time to focus on a single task or multiple tasks.
Actions	People could either be driven by external standards to the point of being overworked or placed more value on the internal motivation of personal satisfaction.
Context and Formality	People could express their opinions explicitly (low context) or implicitly (high context). People could emphasise protocol or rather be loose about it (formal/informal).
Space	This concerns how comfortable people are with sharing personal space (private/public space).
Power Distance	High power distance means inequality is seen as usual, while low power distance means inequality is seen as unsatisfactory.
Individualism and Collectivism	People from individualistic cultures emphasise individual expression and independence, while people from collectivist cultures emphasise group interests over one's own.
Competitiveness and Cooperativeness	People from competitive cultures emphasise ambition, decisiveness, performance, speed, and size, while people from cooperative cultures value emphasised consensus and intuition.

The notions of giving advice and solutions have been previously discussed (p. 138 & p. 199). CPs are encouraged not to provide direct solutions and guidance to the client but to perform collaborative goal setting and solution production (Fiske, 2017; Nezu et al., 2013). CPs were also encouraged to give process rather than substantive advice (Anderson and Handelsman, 2011). As previously discussed, understanding clients' cultural values is a must when conducting psychotherapy (Beck, 2020). A lack of knowledge leads to behaviours which

would not allow the therapist to be culturally competent therapist (Huey Jr. et al., 2014; Liem, 2020). The answer from C7 about being pragmatic, knowing boundaries and referring on rather than discussing sensitive areas without enough knowledge is aligned with the previous discussion (p. 197) where it was discussed how CPs must stop therapy if they do not have enough knowledge to continue the treatment (KEPKI IPK Indonesia, 2021).

That said, if CPs want to provide any advice or solution driven by clients' cultural values, the answer from the CP members might be relevant in such a scenario. Without being knowledgeable about the culture, CPs might provide general and universal values-driven advice or solutions that might apply to any cultural group in Indonesia. As previously discussed, Indonesia is generally a collectivistic culture that emphasises a social framework where people tend to value the aspects of family and conformity to social norms. (Hofstede Insight, n.d.b). Another example of this comes from the United Nations (2006) statement to promote compassion, solidarity, and respect for the human person: the golden rule of "do as you would be done by" as a common value applicable to all religions.

CT for Indonesians with Minor depression

The Treatment Stages

Having an understanding of how treatment for minor depression should be conducted, I then discussed a more structured intervention for treating minor depression. I brought the discussion not only to the PG but also to the CG as well. The following table summarises the result of the first discussion with the PG.

Table 29

CT Stages for Minor depression

Stages	Description	Summarised from	Comments
Stage 1 • First contact • Administration • Information sheet • Informed consent	- This is the stage when the client first contacts the CP. CPs can establish rapport and proceed to get a preliminary understanding of the client's issues and prior therapeutic interventions. To make the process easier, the CPs could provide an online form for the clients to complete. - Reading the information sheet to know what to expect from CT, such as advantages, disadvantages, norms, and rules. The clients then proceed by agreeing to the terms and conditions in the informed consent document. - Payment - Scheduling	P2, P6, P8	C1 and C4 mentioned that they didn't feel comfortable when the CP set the number of the session at the beginning without fully understanding the issue. C1 suggested that CPs conduct a standard screening before determining the number of sessions needed and the charges. C4 gave the opinion that they should have one session before the CP determined the number of sessions. These comments from C1 & C4 were then responded to by P5, who held firmly to the original design. P5 mentioned that having an initial form for the clients to complete would be enough for the CP to determine how many sessions should be conducted to help the client. P5 also mentioned that providing a more comprehensive assessment without discussing payment is against the code of conduct.
Discussion. The step-by-step process proposed by the CPs is aligned with the literature. Rapport building is paramount in the first contact between CPs and clients (Bor et al., 2017; Cynkar & Schwartz, 2007). While not every practitioner provides initial intake forms to their clients, it is still acceptable to let the clients complete an initial intake form. Hence, the CPs have as much			

Stages	Description	Summarised from	Comments
	information as possible before the first session (Wheeler, 2020). There are four different ways of determining the number of sessions: 1) by psychologist experience; 2) a fixed number of sessions numbers as the psychologist might be following a treatment manual; 3) contingent determination based on routine check-ups; and 4) collaboratively negotiated with clients (Flückiger et al., 2020; Schnurr et al., 2015). Informed consent, which should be given before professional service is provided, contains: 1) the nature and anticipated course of therapy; 2) fees; 3) involvement of third parties; 4) limits of confidentiality; and 5) scheduling (Barnett & Kolmes, 2016; Macewan, 2008). Clients should be given enough time to query the contents of the informed consent and receive answers (Barnett & Kolmes, 2016). IPK Indonesia (2021) emphasised the importance of conducting risk assessment in the early stage of depression treatment. It is also suggested that CPs need to inform and educate clients with depression characteristics about the possibility of self-harm behaviour to be mindful of ones' thoughts and take actions such as contacting the CP or help-line if necessary. Ernhout and Whitlock (2014) suggest that the best way to bring up the topic of self-harm towards the clients is to have an honest communication with the clients about how people often choose self-harm to cope with distressful events; It is important to not label self-harm behaviour as negative but rather provide an understanding of the prevalence of self-harm behaviour and how people often do it to cope with stressful situations.		
Stage 2 Assessment	• The stage where the CPs listen and analyse clients' issues • For minor depression, the clients could be provided with online questionnaires such as BDI, PHQ, SRQ or DASS • At the end of this stage, CPs provide a summary for the clients about their issue • In this stage, CPs are encouraged to find the urgent complaints/symptoms that must be addressed immediately • CPs are not recommended to give out diagnoses. Should clients expect formal diagnoses, CPs could refer them for face-to-face meetings with a psychologist or psychiatrist.	P1, P2, P3, P5, P8	C4 and C6 emphasised the lack of treatment/intervention between sessions during the assessment stage. C4 based this on an experience with a CP who only asked C4 questions in a session without giving anything in return. C4 said that a suggestion or something to provide motivation between the assessment sessions would have been appreciated. Like C4, C6 also mentioned that a quick solution between sessions is appreciated. C8 did not feel comfortable when CPs asked too many questionnaire-like questions during the assessment. C8 suggested that the assessment stage should be more comprehensive and focus on the problem. CPs could provide online questionnaires to avoid having to ask the

Stages	Description	Summarised from	Comments
	Should the CPs suspect or find that clients have severe issues or self-harm tendencies, execute the self-harm protocol.		same question in the assessment session.
	Discussion The main idea of assessment is to seek a comprehensive overview that could help the psychologist understand the issues (Morrison et al., 2004). Ideally, an assessment will seek information about 1) presenting problems, 2) history, 3) risk assessment, 4) contextual factors, 5) vulnerabilities, and 6) strengths (Edwards & Young, 2013). Aligning with the answer from C8, psychologists must conduct a thorough assessment and ask the right questions to gather the needed information (Morrison et al., 2004). Psychometric tools are used to discover particular characteristics that psychologists consider important supplementary data for the assessment (Geisinger et al., 2013). In these cases, all the psychometric tools proposed by the psychologists group are valid and reliable (Ginting et al., 2013; Onie et al., 2020; Prasetio, et al., 2022) The product of assessment is often called case formulation (Taylor, 2014). The main essence of case formulation is to describe the client's problems (Edwards & Young, 2013). One of the standard models used to present case formulation is the five Ps by Macneil (2012) which include: 1) presenting problem; 2) predisposing factors; 3) precipitating factors; 4) perpetuating factors; and 5) protective factors. The case formulation could be shared with the clients or their families to be later used as a base for a treatment plan (Taylor, 2014). Diagnosis in CT would be risky as it might be inaccurate due to a lack of data (Aisa, 2020). Furthermore, a diagnosis could lead to social alienation, invalidation and stigmatisation (Connor et al., 2018). A lack of physical presence or hands-on intervention would damage the possibility of treating diagnosed clients optimally (Malliaras et al., 2021). The discussion about self-harm in general can be found on page 168 while the self-harm protocol can be found on page 178. While the data gathering suggest that the end of this stage is the case formulation, Groth-Marnat & Wright (2016) suggest that practitioners should also come up with treatment plan based on the case formulation. A framework by Barnes and Ward (2000) called SMART Goals can help CPs to create goals that are appropriate for the client. SMART is an abbreviation of Specific, Measurable, Attainable, Relevant and Timebound. The framework is often used in any health profession that require making goals as the part of the therapy (Tichelaar et al, 2016). All goals could be evaluated using SMART goals framework; it can also be divided into short-term and long-term goals (Dobson & Dobson, 2009)		
Stage 3 Urgent	In this stage, CPs aim to treat urgent complaints or symptoms that might hinder effective treatment in	P6, P8	No Comment from the CG members

Stages	Description	Summarised from	Comments
complaints/symptoms	the future. Urgent complaints or symptoms usually relate to lifestyle, such as sleeping and eating habits or outdoor activity.		
	Discussion Special attention to urgent symptoms and the provision of early intervention during assessment has been previously discussed (p. 128), and it was found that the process as described aligns with the guidelines from the IPK Indonesia (2021).		
Stage 4 Treating emotional symptoms	- The stage where CPs focus on dealing with clients' emotional states - It deals with how to handle clients' negative feelings towards themselves or their surroundings - CPs can provide interventions to induce positive emotions, such as psychoeducation and relaxation.	P3, P4, P6, P8	C5 and C8 commented on Stages 3 and 4, agreeing with the process. C5 said this process makes sense as people are unable to think if they are emotional.
Stage 5 Treating cognitive symptoms	- The stage where CPs focus on dealing with clients' dysfunctional thoughts - CPs can perform CBT techniques such as Socratic questioning to induce alternative thoughts	P1, P2, P8	
Stage 6 - Checking - Follow up	The stage where CPs continue the treatment and check the clients' progress. A positive output will result in termination, 'while limited progress may indicate the need to refer to face-to-face session	P8	C8 commented on Stage 6 by suggesting that CPs should also provide an intervention where the CPs and clients discuss possible scenarios for distress in the future and how clients should best handle them.
Discussion for Stages 3-6 The sequence of intervention in which emotions are dealt with first to be later followed by cognitive intervention has been previously discussed (p. 128). This sequence is found to be aligned with the CBT model (Beck, 2020). The CBT model is based on that understanding emotion is a window to discover the dysfunctional thoughts held by clients that lead to the perpetuation of mental health issues (Beck, 2020). Placing checking as the final stage is also aligned with the CBT model which calls the final sessions tapering sessions (Beck, 2020).			

Initial Quotes from PG Members

In my case, since there is a website already, they would have already chosen their psychologist and their schedule. After that, they will fill out a form regarding their issue before they finally pay. After that, the counselling starts. During CT, I will ask them how I should address them and about their current emotions and confirm that their issues are the ones they already put in the form. I also ask them to give much more

comprehensive details about the issue. If their complaints include self-harm, I will ask them to book themselves in with a psychiatrist. In the first session as well, I often assess their lifestyle. What do they do from when they wake up until they go to sleep at night? Have their sleeping, eating and drinking patterns have changed in the past two weeks. If I find that these aspects need to be treated first, in that same session, I will give them psychoeducation about how lifestyle could be affecting their mental health and well-being. I would then give them "homework" to improve their lifestyle first. I would also ask them to make a journal to monitor themselves. For example, if they exercise, how does that affect them? In the second session, my main goal is to determine or assess how the client manages their emotions. What do you do when you feel uncomfortable? If the client describes healthy techniques to do it, I will affirm them. If not, I will provide psychoeducation about simple stabilisation techniques—for example, breathing relaxation. I usually teach them by sharing a link to a video or picture from YouTube or other platforms, so the client can do it by themselves. I will give other homework as well. In a nutshell, the second session is about emotional self-management. Later in Session 3, I will focus on the cognitive aspects. What disturbing thoughts do you have? What inner critics do you have, and what do you do when these inner critics appear? If the clients have good alternative thoughts production, I will strengthen it. However, if I find alternative thoughts that make them more uncomfortable, I provide them with alternative thoughts. Usually, from assessment through to intervention only takes three sessions. The fourth session is more about follow-up. If the client feels much better, they will usually say so, and that would be it. However, if the client still experiences difficulty, I will offer them a more advanced online treatment such as a voice call or video call. (P8)

Following what P1 has said about commitment, the importance of informed consent suddenly comes to mind. This could be a reminder for the client to attend the sessions. Points in informed consent can be simple, like a two-way agreement, hoping to establish the client's insight that there should be a reciprocal relationship between the client and psychologist in therapy. It is not a one-man show. The content of informed consent could include the schedule, duration, late attendance tolerance, and re-scheduling policy. (P2)

Comments by CG Members

Some psychologists informed me how many sessions would be needed even before discussing the issue. For me personally, I am afraid I have to disagree with that. What I want personally is for us to talk first in the first session. Later, after the first session, the psychologist might say, "All right, for your issue, we need at least three sessions." I would be fine with that. However, if out of nowhere, the psychologist says "three sessions," when we have not even talked about the issue, I would say it is more like a business. Yes, I am aware that psychologists conduct businesses, but the way they do it should have a more embracing philosophy. (C4)

In the first session, the psychologist only asked questions and then asked me to continue to Session 2. I understand they want to understand the core of my issue. However, I did hope the psychologist would give me suggestions or some motivation even in the first session. It is like first medical aid. (C6)

For the assessment, I did not feel comfortable when the psychologist asked too many questionnaire-like questions. It felt like I was not the one who was venting but rather answering questions from the psychologist for their benefit. I once had an experience with an application when I completed a questionnaire about depression and anxiety, and the result came out immediately, which made me feel better. So I feel like for questionnaire-like questions, let the technology run it, but when it comes to meeting the psychologist, let us focus more on the problem. Later, the psychologist should also discuss the treatment with the client because an inexperienced client might feel that the issue is already resolved in the early session. Having another session would seem like the psychologist was milking the client. (C8)

I would suggest that the checking and follow-up stages also include preventive measures. So, in the future, what issues can the clients prevent? If such an issue arises, what can be done by the clients? (C8)

Psychotherapy Intervention Techniques

Psychotherapy types section (p. 127) have shed some light on therapeutic orientation and examples of techniques that could be used to treat clients with minor depression. This section aims to dig further into various techniques that can be used to treat minor depression via CT. Six members of the PG (P1, P2, P3, P4, P5, & P8) contributed to the discussion, resulting in the following themes.

Table 30

Psychotherapy Intervention Techniques

Techniques to Use	Description
Psychoeducation P1, P8	It can be used to educate clients with some knowledge or information that might be useful for their mental health. Psychoeducation has been effective not only in decreasing depression severity (Suryani et al., 2016) but also in improving treatment adherence (Tursi et al., 2013). In CT, psychoeducation should be given in the most practical and easiest way possible. As P8 mentioned, CP could use informative pictures (posters) as media (Siswanti et al., 2022) or other media such as videos (Tsai et al., 2020) or online modules (Van der Vaart et al., 2014).
Strengths identification P5	CP could reflect on the strengths that might help clients in their treatment. Gorlin and Otto (2018) used homework containing a list of potential strengths clients could use to help them identify their own strengths. These strengths will help the client in the cognitive restructuring intervention later on.
Emotional thermometer P5	The CP can use the thermometer to understand the degree of emotion that clients were experiencing at the time. Bernard and Pires (2006) briefly explained that an emotional thermometer is a 10-point scale of emotion where 1 is the weakest and 10 is the strongest emotion clients could feel.
Socratic questioning P2, P5	This CBT technique can help identify automatic thoughts and cognitive distortions held by the clients. Carey and Mullan (2004) have mentioned that Socratic questioning refers to "a procedure in which therapists attempt to change clients' minds and also a process in which therapists allow clients to change their minds. It may very well refer to other techniques as well" (p. 7). Beck (2020) has mentioned that Socratic questioning helps test the validity of pessimistic predictions and evaluate automatic thoughts.
Metaphor P4	A specific form of psychoeducation helps CP to teach a complex concept. According to the dictionary, metaphors refer to the use of word/s not in its original semantic meaning but rather to say another concept or object resembles the original thing. (KBBI, nd). The dictionary uses an example of "backbone," which has the original meaning of vertebrae but can also be used in the phrase "the backbone of a family," to mean its main support. In a therapeutic setting, metaphors can be used as a way to change the client's perceptions (Wagener, 2017).
Relaxation P2, P1	This can be used to help clients who are feeling anxious. Grounding as a form of relaxation that helps clients to focus on the session. Jorm, Morgan,

Techniques to Use	Description
	and Hetrick (2008) conducted quasi-randomised controlled trials using relaxation techniques such as progressive muscle relaxation, relaxation imagery, and autogenic training and found that relaxation reduced self-reports of depression compared to wait-list and no-treatment groups.
Homework P1, P2, P4, P5	Homework is usually given to clients at the end of the sessions to be done between sessions. Homework should be tailored to fit the clients' personalities and issues. Homework can be paper-based, such as journaling or completing a worksheet to learn skills, such as identifying automatic thoughts, or practical, such as gardening or enrolling in a community club. It has been previously discussed how doing homework can improve clients' mental health (Hanton, 2011; Strong & Massfeller, 2010)
Journaling P1	This is technique in which the clients are asked to write about their experiences between sessions. A recent systematic literature review involving 31 journal articles about journaling by Sohal et al. (2022) found that journaling created a statistically significant 5% average reduction in patient scores on mental distress measures compared with controls. However, the high degree of heterogeneity of the data makes it difficult to draw robust conclusions from this meta-analysis. However, the article proposed that journaling is a low-cost, low-side effect adjunct therapy that can help manage common mental distress symptoms supported by randomised controlled trials.
Worksheets P1	This is a technique in which the clients are given a paper that contains a template on a particular topic for the clients to complete. Worksheets are common in CBT. Wiltsey Stirman et al. (2018) mentioned that worksheets are used in CBT to teach skills and support clients' development. Evan-Jones (2011) stated that CBT worksheets are a learning process for therapists and clients. Wright et al. (2017) mentioned that worksheets are a way to enhance the implementation of CBT.

Quotations:

CBT techniques used in the face-to-face session can also be used in CT. For online sessions, I have prepared worksheets. For CBT, I have got several of them, such as one on negative automatic thoughts. The trademark of CBT is homework. There is always something to be done. I always try to find out about clients' interests. For example, if the clients like to write, I will give journaling homework. (P1)

Since I use CBT, I would help clients to get to understand their negative automatic thoughts. I would use this to be the first assignment for the clients. Later, from the client's answers, we will identify their cognitive distortions. There are many cognitive distortions, so I help clients, by pointing out the cognitive distortions in their answers. I then help clients understand which are facts and which are just the clients' negative thoughts. I do this with the help of Socratic questioning. (P2)

I often teach them to be expressive. I have clients who have parents who are ignorant about the client's mental distress. They have already tried to talk to their parents only to receive a cold response. In some sessions, I allow the clients to be as expressive as they can as emotions have built-up inside them. By being expressive, they can openly judge whether this behaviour is appropriate or not in the future.

What are the drawbacks of such inappropriate behaviour? They can also express, admit, and accept their own emotions. (P3)

I often give homework to clients that is related to their issues. Everyone might have different homework; I cannot say here. For example, I often give lifestyle modification homework; however, I would give different homework if their lifestyle is already healthy. So, we have to look at the agenda. I usually know it based on our sessions. I also often ask how they feel at the beginning of the session, about their levels of anxiety or confidence. From one to a hundred, I would ask, what number is your anxiety? We also need to see the clients' prognoses. What are their strengths? We can use these strengths in their treatment as well. (P5)

I read some research that says depressed clients get worse if they stay home for a long time. Furthermore, if they get sunlight, their situation will improve, which is what I have been saying. If they are depressed, I ask them to go outside and see some sun. I say, please do whatever you want outside, whether it is exercise or gardening. I also often use metaphors. So when I talk to clients, especially teenagers or young adults, I use metaphors to help them to understand the material quickly. (P4)

When I am giving psychoeducation, I usually use a poster that contains all the information they need. This is such a time saving rather than typing it out over and over again. For example, if the clients have a problem with sleeping, I already have a pdf poster I can send them. (P8)

Forming the Initial Treatment Plan

It was found that clients felt uncomfortable when the CP came up with an intervention without understanding what the intervention would be like for the clients. Responding to this comment, I then asked PG members about the use of treatment plans. I also asked how flexible a treatment plan could be and how the client could contribute to the design of the treatment plan. Three members of the PG (P2, P5, & P8) joined the discussion, with similar ideas. A treatment plan can be given to the clients as the clients have already completed the online form that was previously given. Providing an initial treatment plan can also increase clients' commitment towards CT. However, there is a need to stress the wording stating that this preliminary treatment plan is still subject to change if necessary.

The treatment plan can indeed change from time to time. The changes can be based on clients' characteristics, previous sessions' findings, and urgent issues that might arise in the sessions. Some clients might not be suitable for some intervention techniques. Brainstorming between the CP and the clients could be used to achieve consensus on the treatment plan.

Usually, I make a treatment plan when I receive informed consent and understand the client's complaint. I will show the client the plan and tell them it is still flexible.

For example, if we realise in the middle of a session that the core problem is different, then we will change the treatment plan. From my experience, when we give clients a treatment plan, the clients are more committed. (P8)

Interventions can change based on the client's capabilities. For example, if we planned to use guided imagery but the client does not have the ability to visualise, then we will change the method. Also, we have a treatment plan (for the therapy as a whole) and an action plan (for each session). We will discuss these with the client, and I usually ask the client whether they feel capable of implementing such plans. (P8)

...similar to P8, theoretically and planning-wise. This can be done. However, there should be some disclaimer stating that the treatment plan might change, depending on the client's situation. We can do brainstorming even though we already have a plan. I have a principle that I often use when making treatment plans. That is, "If the client aims for the sky, we ground them; if the client aims for the ground, we show them the sky." (P5)

I also agree with P8. With treatment plans, I inform them at the beginning How many sessions and what will be done are talked about with the clients at the beginning. For the goals, I usually discuss these with the clients, and I will focus on the issues that bother the clients the most, at the time. So, each session's goals are later differentiated from the original treatment plan. These are still flexible, in case we find something new in the therapy process; these plans and goals are subject to change and revision. However, I will still try to focus on the original plan. (P2)

It needs to be restated that this section initiated following protest from CG members who wanted to start the therapy knowing what they were signing up for. This means the clients have yet to be thoroughly assessed by the CP, and the only information that the CPs would have would be from the online form that clients may have completed superficially prior to the session. The answers from the three PG members suggested that providing a treatment plan for the clients is expected and practised by the PG members. Looking at the literature, some concepts align with the answers from PG members. The terms intake form and initial hypothesis might explain why the CPs could create a treatment plan based solely on an online form. The intake form which is used to collect identifying information is the first document that any therapist gives potential clients (Jungers & Scott, 2013; Liang & Shepherd, 2020). This would be similar to any online form the CP use with their clients in CT. The CP could then use the information in this form to make an initial hypothesis which includes a judgment or idea about the client's issue (Jacinto et al., 2018; Jungers & Scott, 2013). The hypothesis could include a possible cause and the perpetuating factors for the client's issue (Persons et al., 2013). Later on, a CP could develop a brief treatment plan based

on the initial hypothesis that could help clients understand how the treatment will proceed (Raylu & Oei, 2010). Finally, this brief treatment plan should be included with the informed consent documents and other matters such as scheduling (Fisher, 2021).

Technical Issues

Another new theme that emerged during prototyping is handling technical errors the clients experience. C5 and C6 raised this topic. C6 also suggested that a clause or policy on these issues should be written into the informed consent. The discussion also brought up another similar situation, where the technical errors are experienced by the CPs themselves. CT is mainly delivered by cellphone; the only technical errors would be cellphone-related. Technical errors could last for periods ranging from a short amount of time due to temporary loss of signal, to days due to running out of internet quota, and up to weeks due to cellphones getting damaged or stolen.

When this topic was raised with the PG, three members of the PG (P5, P7, & P8) contributed to the discussion. It was noted that the delivery indicator in the app is one indicator that shows that clients might be having technical errors. Every chat app has some indicator that messages have been successfully sent to the other party. Another feature, "Last seen" could help CPs and clients to predict whether the other party has technical issues or is not open to communication. A person last seen a day before would probably not be available to communicate in the moment or soon. If an error does occur, the CP could ask the administrator they work with to contact the client using chat or other methods such as a voice call to make sure that the client is all right and ask whether they want to continue the session. A similar approach was also proposed to work with clients who experience long periods of technical issues. The CP should regularly contact the client to try to have further communication to confirm what has happened and plan the next moves.

If the technical issue is brief such as minutes long, the CP could extend the session out of generosity. On the other hand, the CP needs to make sure that their device is ready to be used for CT to prevent errors. The CP should also provide communication options for clients if the CPs are the ones who are missing from the sessions.

It would be better to state the possibility of technical errors in the informed consent. I did CT using an app, and the app hung. So the CT was rescheduled. (C6)

What if a client has done several CT sessions and suddenly has issues over a long period for reasons such as losing or damaging their phone? Furthermore, the client is not able to contact the CP due to the issues. Will the previously agreed contract be

voided? (C5)

In the place I work, we have an admin. Any communication about schedules would be via the admin. So, we could ask the admin to follow up if the client is absent or missing during the session. They do it via chat or even call them. I will wait for five minutes; if they are not responsive, I will ask the admin to follow up, just to make sure everything is fine. If there is a technical error, then the session can be rescheduled... and vice versa. A client can also contact the admin if the CP is absent or missing. (P8)

I once was doing CT then the client suddenly stopped responding. The delivery report showed they the message had not been delivered. I waited 15 minutes until I finally understood the client had run out of internet data. I think putting this kind of scenario in the informed consent is a good idea, so the client knows what to do if technical errors occur. (P5)

I had an experience in online counselling where it took a while for the client to join the session due to technical errors. So then, I decided to allow an extra 30 minutes from the agreed schedule out of generosity. (P7)

The technical issues surrounding online therapy, as described by C5, P5, and P7, have been well documented and are always an element in the practice (Békés et al., 2021; Dowling, 2015; Eysenbach, 2001; Green, 2006; Kura, 2022). However, these technical issues are decreasing as technology develops (Amichai-Hamburger, et al., 2014). Aligning with C6 and P5's answers, both the therapist and the client need to be aware of possible issues at the beginning of the therapy (Amichai-Hamburger, et al., 2014). As suggested by P7 and P8, therapists need to find options for solutions to best handle those issues (Dowling, 2015).

The Structure of a Regular Session

The stages for treating minor depression were established in the "Common Stages of Treatment" section (p. 128). Being said, the number of sessions in CT will most likely number more than just one session. Thus, further discussion is needed to understand the structure of regular sessions. Discussions were held with both the PG and the CG, which resulted in the following template.

1. What has the client gained from the previous session?
2. What happened in the time between the last session and this session?
3. Evaluate completed assignments (if any).
 - a. Give an appraisal if the assignment was done.
 - b. Ask why any assignment was not done along with the difficulties in completing it. This is then a potential topic for the current session.
4. Assess emotions and/or cognition.
- 5A. If emotions and cognition have not improved or new negative emotions or cognition have arisen, then these become the goal/topic of the current session (i.e., repeat previous emotional or cognitive interventions).

- 5B. If emotions and cognition have improved, then the CP can give an appraisal and ask client to reflect on their behaviour that led to such an improvement; encourage them to maintain such behaviour. CPs could continue by ask the clients about their goals or any topic they would like to discuss in the current session (i.e., progress to the next emotional or cognitive intervention).
6. Summarise and evaluate the session. What has the client gained from the session? What is the state of their cognition and emotions at the end of the session?
7. Discuss the next session and to give assignments (if any).
8. Provide positive closure with motivation and greetings.

If there is an action plan already, we would start with evaluating whether or not the clients completed the planned action. If the client did not do it, we ask what difficulties hindered the client from doing it. We need to evaluate what happened, whether there was any new stressor or possibly a new event. If the client did it, we need to give them motivational feedback and appraisal. This is good; you have done it. So if the clients experienced difficulty, we will discuss that. If not, I will ask what we will discuss today, or we will continue working on another issue on the client's list. I would also monitor the clients' emotions; if a new emotion has emerged, we will deal with it. Later, we will summarise the session and ask the client what they have got out of today. (P5)

CPs could ask what behaviour led to the improvement of their cognition and emotion and encourage them to maintain such behaviour (P8)

In every session, I will also ask what the client got from the previous session. This is to refresh the client's memory. (P1)

We also need to ask in every session about their goals for the current session. What obstacles are they currently facing? We can also evaluate the current session at the end of each session. What have the clients got out of it? Is there still something bothering them, in their mind, their thinking and emotions? It could be that the CP feels the clients have already achieved insights despite not having voiced them. We have to make sure. (P7)

The design from the PG was then brought to the CG for their feedback. Two members of the CG (C4 & C6) participated in the discussion, suggesting that a rigid structure like this might make clients feel bored and uninterested in the session and there should be something different in every session to keep the clients interested. The summarising part of the session should go both ways between the clients and the CP, with both the CP and the client providing a summary of the session.

If the session is like this frequently, the clients might get bored. However, clients might get excited if there is something new and exciting in every session. The psychologist could tell the client in advance that there will be something exciting in the next session, so the client would feel excited before the session. (C4)

Summarising what the client has got out of today could be done by both the client and the psychologist. Sometimes when the psychologist says something, I am too

emotional to grasp what they have said. I suggest that the psychologist recap what they have said, and the session as a whole. (C6)

As previously discussed, PG members tended to use CBT when working with depressed clients. Therefore, the structure proposed in the discussion for each session is similar to the ones proposed by Beck (2020), the current leading figure in the CBT approach to psychotherapy. However, the first stage is not found in Beck's book and Beck does not ask clients to reflect on the previous session. This particular stage was mentioned by Nelson-Jones (2002). P6 mentioned the need for the CP to summarise the session, which was also mentioned by Kraus, Stricker, and Speyer (2011), where the summarising aims to establish the clients' focus and review their understanding of the session that just has finished. The CP can do this by listing key points and reviewing the ongoing issues that need to be addressed in the next session.

Session Duration and the Period Between Sessions

This section discusses how long a CT session should be and the length of time between sessions. A discussion was held with the PG group and three members (P1, P5, & P8) contributed to the discussion. A standard session duration of 60 minutes is sufficient as clients of CT tend to want quick interventions. However, 60-90 minutes per session is more suitable. In terms of the duration of the time between sessions, the data suggested that weekly to fortnightly meetings are acceptable, depending on several factors, such as the severity of the symptoms and the client's financial situation.

For one session, I usually do between 60 to 90 minutes. For me, 60 minutes is far from being enough. I have had clients who asked for more time because they still have a lot of things to say. However, if the session is finished within 60 minutes because they do not have more questions, I can end the session. (P5)

People go to CT because they need quick solutions. If I put myself in my clients' shoes, they might just be thinking, "What should I do?" So therapy sessions will be more like, "Okay, what do you need at the moment? Then, what is the solution?" So for me, an hour should be enough. (P1)

I usually do fortnightly; it depends on the client's situation. If the first session went very badly and the client's condition is unstable, I schedule it for fortnightly. However, if their functioning in daily life is still okay, I will do it once a month. Another consideration is the client's financial status; sometimes they are students with limited funds. I try my best not to overburden the clients. I also try to find the middle ground between me and the clients. I feel that once a week is too much for students, so fortnightly is better. However, fortnightly is for urgent problems; if the clients just need some coaching, that will be given once a month. Also, the amount of homework will be commensurate with the length of time between sessions. (P1)

I usually ask the clients to contact me again after a week, for me to evaluate the client and the progress they have made after a week. In real life, some clients do commit and contact me after a week, but some have yet to schedule for another session two weeks, a month, or even months later. (P8)

The session duration proposed by the members of the PG aligned with suggestions in the literature. The 50-minute hour concept usually applies for a traditional face-to-face psychotherapy session (Dryden, 2018). However, a longer or even shorter session is not necessarily uncommon as it depends on the case and the client. For example, single session therapy (SST) can range from 10 minutes to 90 minutes (Dryden, 2018). Nieuwsma et al. (2012) mentioned that psychotherapy sessions for acute-phase treatment of depression could be 30 minutes. However, a single session for phobias, where the client faces their fears in a hierarchy of intensities, can last up to three hours (Zlomke & Davis III, 2008).

A chat-based online therapy could last anywhere between fifteen minutes to three-and-a-half hours (Hanley, 2012; Vossler & Hanley, 2010). However, it must be noted that an online session longer than 100 minutes might need more emotional capacity and failing to allow for this might lead to ineffective treatment (Bambling et al., 2008). P5's need for a more extended session duration aligned with the discussion in previous stages about CT needing longer session times as there will be time delays in the communication due to writing the chat.

A similar pattern was found in the literature for the time between sessions. Session frequency can range from twice a week to once every two weeks. Shorter periods between sessions can lead to better treatment outcomes (Erekson et al., 2015; Tiemens et al., 2019). A weekly schedule was also found in Richards and Viganó (2013), while twice weekly sessions were found in Hanley (2012). The evidence suggests that the longer times between sessions postulated by P1 and P5 are not uncommon. Several online therapy companies schedule fortnightly sessions (talkingworks, n.d.; theindigoproject, n.d.; therapyco, n.d). Therapyco (n.d.) suggest that weekly sessions are needed at the beginning of the therapy to give the therapy momentum. The answer from P1 about long times between sessions can also be explained by the fact that CT is generally more affordable than face-to-face therapy, which might reflect the clients' socioeconomic status.

The Strengthening Stage

As previously mentioned in “The Treatment Stages” section (p. 205), one of the stages for treating clients with minor depression is the strengthening stage, where the CP continues the treatment and checks the progress of the client. A question was then raised about the indicators that help the CP determine when the client has finished with the previous stages and is ready to enter the checking or strengthening stage. Bringing the questions to the PG, two members (P2 and P8) joined the discussion and a theme developed. Both P2 and P8 agreed that when clients can use cognitive processing when they experience a challenging situation is the best time for the CP to enter the checking stage. In the quote below, the word “default” refers to when the ability to produce better cognitive processing has become automatic without guidance from the CP.

I will assess the clients' awareness about themselves and the ways they cope. And also, how often the client exercises the techniques from therapy and whether or not they have already become the client's default. So when the client experiences something emotional, the client knows what to do. Finally, I assess if the client has gradually improved. For strengthening, I will assess the client's confidence in their new abilities. When the client understands the techniques given in therapy already but still needs some guidance, I will move into a strengthening session. (P8)

Since I use CBT, the primary basis of consideration on when I will give strengthening sessions to the client is when they can produce alternate thoughts successfully. Since we are dealing with cognitive distortions, the ability to produce better cognitive outcomes will be the threshold for when I will move to strengthening sessions. So they could consistently produce them in their daily lives and similar situations. (P2)

The concept of strengthening the acquired skill set is commonly found in CBT. Milkman and Wanberg (2007) proposed three phases of CBT treatment which are: 1) challenge to change; 2) commitment to change; and 3) ownership of change. Phase 1 is when the client is still in the reflective-contemplative process, and the therapist's main objective is to help the client develop the motivation to change. Strengthening starts to come into the sessions in Phase 2 and continues in Phase 3. In Phase 2, clients start actively demonstrating and practising the essential skills for change. This phase also includes strengthening the essential skills being taught to better facilitate the changes; once the changes have already happened, these changes will again be strengthened in Phase 3. The answers from P2 and P8 seem to be more aligned with Phase two of the model since both members' answers emphasised the situation where the clients are still in the early stages of understanding the new skills being taught and

still need more guidance to further cement these new skills.

According to Beck (2020), strengthening is an intervention that happens in the middle part of the therapy and is used to establish the newly and positively adapted beliefs that the therapist worked on with the client as a way of restructuring the client's cognitions. To strengthen the new beliefs, Beck recommends several methods, which are a) eliciting positive data and drawing helpful conclusions about their experiences; b) eliciting the advantages of believing adaptive beliefs; c) pointing out the meaning of positive data; d) referencing the client's behaviour towards other people that the client perceives as having positive belief. client's behaviour towards other people that client believe has positive belief; e) using a chart to collect evidence; f) inducing images of current and historical experiences; and g) acting "as if". These methods are appropriate for CPs to use in their CT sessions.

Final Session

Every programme of therapy will have a final session. I wanted to know how the CPs organise the final therapy sessions and what the final sessions look like. Bringing this question to the discussion, one member of the PG (P4) answered the question by explaining that during the final session, the CP should ideally recap the progress the clients have made and give final encouragements to the client to make sure that the client will try all the skills they have learned during the therapy and apply them in their daily life.

I will remind the clients about their progress and what they have achieved. I will recount those to the client and show appreciation. I also ask the client to summarise their progress in their own words. I will also tell the client that what you have learned during the process can also be applicable with other issues. Lastly, I will remind the client that they are not dependent on me. I will ask the client to have faith in the process that they have gone through with me and say that they are now stronger and better equipped to face other challenges. (P4)

The answer from P4 is aligned with the discussion by Schlesinger (2013), who points out that the therapeutic process can include indicators of when to end the psychotherapy. A therapist might have "landmarks" they look for in the client's behaviour to determine whether they have been able to resolve their problems. A more detailed reference to decide when to end therapy could also be based on the number of goals the clients have completed (Schlesinger, 2013). This is also supported by Beck (2020), who suggested that the therapist would need to prepare and even set the termination conditions at the beginning of the therapy by producing therapeutic goals to be accomplished. The summarising part of P4's

answer is aligned with Sperry and Carlson (2013), who mentioned that reviewing progress would be a practical intervention to be done in the termination session. Norcross et al. (2017) investigated the common interventions in termination sessions from various therapy modalities. Eight common tasks were found: 1) process feelings of patient and therapist regarding the ending of the therapy; 2) discuss patient's future functioning and coping; 3) help patient use new skills beyond therapy; 4) frame personal development as invariably unfinished; 5) anticipate post therapy growth and generalisation; 6) prepare explicitly for termination; 7) reflect on client gains and consolidate; 8) express pride in patient's progress and the mutual relationship. It can be seen that some of the research findings were aligned with P4's answer. The CP could express some appreciation for the client's progress and suggest future plans for the future to create more independence for the clients.

Relationship After Therapy.

This section discusses the relationship between CPs and clients after the therapy ends. The possibility of receiving gifts is also discussed in this section. A discussion was held with the PG and the CG with a total of eight members from the PG and the CG (P7, C1, C3, C4, C5, C6, C7, & C8) contributing to the discussion. From the CG, two contradictory subthemes emerged. On one hand, some clients expected to still have some communication and maintain a positive relationship with the CP. C3 used the word *silaturahmi* (friendship), suggesting that they expected a relationship with the CP that is not just professional, and that feelings of discomfort might arise if the CP rejected gifts from the clients. C4 also mentioned the word "networking", which suggested that some other type of relationship was expected other than a professional relationship after the therapy ended.

For me, the relationship between the psychologist and the client is over, but the friendship between us as humans is still ongoing. I won't feel comfortable if the psychologist rejects any gifts. Maybe the client wants to say thank you. If my gift is rejected, I might feel a bit insulted. (C3)

Like C3, if the CP is from the same area, I guess a little thank-you gesture such as having lunch together would not hurt. Because the relationship has now becoming more like networking; who knows, a benefit could be found either by the CP or the client. (C4)

On the other hand, some clients expected the opposite compared to C3 and C4, in that they expected the CP and the client to maintain a professional distance even after therapy has ended, to maintain the CP's credibility. A formal check-up or exchanging social media accounts might still be acceptable.

I prefer the [relationship with the] CP to remain formal. After the therapy, they could still communicate but not as a friend—to maintain credibility. (C1)

I respect the boundaries set between psychologist and client. So when counselling comes to an end, that would be it. (C6)

After the sessions end, that is it. Communication could only be within professional boundaries. (C7)

A similar answer to this also came from the PG. P7 mentioned that CPs are not supposed to accept gifts from clients. However, P7 also mentioned that sometimes clients insist and rejecting those gifts could have a detrimental effect on their mental health.

We cannot accept those gifts, but I had an experience with my old client who happened to be healthy at the time, contacting me to give me some thank-you gifts. Even after I used every kind of way to refuse, the client ended up leaving the gifts in the hospital's front office where I work. And then I thought, well since the gift is already there, I could not return it. I was afraid the client would feel bad after all their effort. Finally, I just accepted it and thanked the client and asked them not to do it again. (P7)

The answers from C4 and C3 suggest the clients might expect to have two types of relationships after therapy. The word “networking” from P4 suggests that P4 might expect a professional, business-like relationship after therapy, while the word *silaturahmi* (friendship) used by C3 is quite explicit. Looking at the KEPKI (IPK Indonesia, 2021), the post-termination relationship is not explicitly discussed. However, a similar topic of discussion can be found in KEHPI (HIMPSI, 2010). It is written that CPs are not allowed to have any intimate or sexual relationship with former clients for at least two years after termination unless under extremely uncommon circumstances.

Looking at the bigger perspective, this matter might be captured under the concept of a dual relationship, as discussed KEHPI (HIMPSI, 2010) and KEPKI (IPK Indonesia, 2021). A dual relationship is described in KEHPI (HIMPSI, 2010) as a situation when a psychologist is currently in a professional relationship with a client but at the same time, also has another type of relationship with the client or with someone close to the client. Both organisations' ethical codes of conduct suggest that psychologists are encouraged not to have dual relationships as they could damage the objectivity, competency, and effectiveness of the psychologist in relation to the client. Furthermore, an immediate intervention is needed to end such a relationship. A question might arise in relation to the above argument that such an ethical policy might only be relevant when the clients are still under treatment and the

professional relationship is still ongoing. Several works in the literature have suggested that professional relationships end after the termination sessions (Davis & Younggren, 2009; Norcross et al., 2017; Sarkar, 2009) and therefore, such ethical codes might not be relevant anymore. However, Schlesinger (2013) has emphasised that an end to therapy could become another beginning, and further contact could still be possible in the future. This possibility encourages therapists to maintain postprofessional relationships with their ex-clients and thus, make such codes relevant even after termination sessions.

Kramer et al. (2016) conducted mixed-method research looking at the experiences of former clients in non-sexual posttherapy relationships with their former counsellors. The research started with open-ended questionnaires, and later, nine participants were interviewed to understand the phenomenon better. There were several important key points found as the results of the study. According to the study, three types of posttherapy relationships could develop between former clients and counsellors besides sexual relationships. In one case, a former client of a counsellor who was also a teaching assistant formed a new relationship with the counsellor when the client became a student. While the former client then had regular weekly contact with the former counsellor, the relationship never developed into anything more than a normal relationship between a student and a teacher. In another case described in the study, a former client formed a professional relationship with their former counsellor as both were involved in a similar industry. The participant said that the relationship was then more supervisory and no longer therapeutic. The last type of relationship found in the study was that former clients could develop personal relationships with their counsellors. One relationship went as far as having a dinner and family event together. The findings suggested that former clients and the counsellors could start these relationships. The contacts could be initiated through formal, professional contact which then led to something more personal; it could also be personal from the beginning, involving exchanges such as sending Christmas cards to each other. Regardless of the type of relationship, this study suggested that no relationship could be created with the former counsellors without complications. Instead, the relationship could become disorienting and confusing in terms of whether the client has successfully become independent or whether the therapeutic relationship be restored.

One thing that hinders the formation of uncompromised relationships is the power imbalance. In the therapeutic setting, clients may know very little about their therapist but

not vice versa, since clients are opening up about their thoughts and feelings to the therapist (Williams & O'Connor, 2019). Some clients are young, distressed, and impaired to the point that the therapist could easily influence them (Zur, 2014). These are the basic understandings of power imbalance in the therapeutic setting. Power imbalance may not be relevant for cases where clients are not distressed but have sessions to improve their lives (Zur, 2014). The power imbalance may also lessen as the therapy progresses and even significantly decrease once the therapy is terminated (Appelbaum & Jorgenson, 1991; Zur, 2014). However, Sarkar (2009) has suggested that there is still a possibility that both parties will maintain or even exploit the former power imbalances. For example, a therapist who became friends or a couple with a former client might become dominant in decision-making involving the two.

In terms of professional relationships after termination, Schoener (2021) has suggested that if former clients are employed by the therapist or involved in a business with the former therapist, the false sense of security that the client might feel might become a liability for the therapist. A failed business relationship might create disappointment, frustration, and anger in the former client. Such a relationship might also hinder further independent growth or even diminish the excellent results that the previous therapeutic relationship might have produced.

Warranties and Refunds

The notions of warranties and refunds were first raised during the "relationship after therapy" discussion, where it was found that some clients would like to maintain a therapeutic relationship even after the termination session.

Sometimes clients say, "If ever I need to ask more questions, please allow me." Usually, if they do ask after the termination session, I will assess their questions. If the questions are general in nature, I will not charge them. But if the questions are more than that, I will say to them, "What if we have another session?" (P5)

While the word warranty was not mentioned, a client implied through their answer that they wanted the CP to provide some service continuity even after the sessions were over without needing to pay fees. In the service industry, as counselling is, this might be called a warranty (Santosa, 2004). In further discussions, other PG members thought the opposite to P5. P1 and P4 mentioned that best practice would be to work towards independence in the clients and terminate sessions only when the CP was confident, they were already back on their feet.

There have been lots of clients who have asked me whether they could still contact me after therapy. I say yes, but I will always say something along the lines of, "I am sure everything that I have taught you will help you overcome the situation. Everything that we talk about today are capital skills to help you overcome any adverse situation." (P4)

Given the inconclusive results from the PG members, I then brought the discussion to the CG to find more understanding. All members of the CG (C1, C3, C4, C5, C6, C7, & C8) contributed to the discussion. The warrantee expected for CT was about the ability for the clients to contact the CP after the therapy was terminated. From the client's perspective, the contact was more about asking for more guidance or interventions if the clients ever felt discomfort due to the same issue that the CP had previously treated.

Warranty in therapy is like when the sessions are over and the client experiences the same symptoms. Even when the client already knows what to do, they still need someone to motivate them. (C4)

In my opinion, if the client has the same symptom, they could go back. Like, I have done your therapy. Why is it still like this? That means the therapy is not effective. (C3)

In some cases, a warranty could be applied. For example, maybe I want to ask, "If I experience something like this, should I go to another counsellor, or would self-therapy be enough? What is your suggestion?" Maybe those kinds of questions. (C6)

The CG members also asserted their expectations regarding how this "warranty" should be given to clients and when clients feel prepared to pay for another session.

The warranty should be regulated in terms of time. For example, the client could return if they relapse in under three months. If the relapse happens after three months, they need to pay. If the psychologist asks the client to enter another therapy session with the same symptoms in under three months, I would feel slightly disappointed. Like, I have done your therapy. Why is it still like this? That means the therapy is not effective. (C3)

There could be some requirement or policy attached to it. For example, it only applies for two or three sessions. In terms of the length of the warranty, it depends on the severity of the symptoms. For clients with severe symptoms, probably two months would be suitable. (C4)

Only some clients expected a warranty; C5, C7 and C8 did not. They thought the CP could, however, provide some follow-up communication and determine whether the clients need more sessions.

I don't think CT needs a warranty. The psychologist should provide a scenario for what might happen and how the client could handle it. I am afraid that if a warranty exists, the client will keep contacting the psychologist and become too dependent. It would be good if the psychologist asked about how we are as a sign of care.

However, the negative side of this might be that, clients could then vent without any warning, when the CP is not ready for it. So rather than having unclear communication, the client could pay for [more therapy] when it is needed. (C8)

I agree with C8; the therapeutic process can only be done when we pay for the service. If the therapy process is finished, it is finished; there is no need for a warranty. If the clients want more consultation, they need to pay for it. If the therapy ended just like last time, it is okay. This is because [the CP] is a professional and they are actually working. They could contact us to ask about how we are, and if they tell us that we need more paid sessions, that's okay. I am using their professional service to help me with my problem. (C7)

The warranty is more appropriate is it is like a transitioning phase, as in catching up about how the clients are after therapy. A warranty sounds to me like it's for electronics. (C5)

Bringing back the topic to the PG members for comments, two members (P5 & P7) accept these thoughts and had similar ideas about the warranty concept.

I'd suggest that CPs allow the clients to contact them two or three times after therapy to ask about the issues they consulted on. And the questions should be pretty straightforward. (P5)

I used to attend [Professor X]'s lectures, and according to her, psychologists can still respond when a client makes contact again (after termination sessions) to just do a little venting, up to two times. (P7)

Similar to the CG, not all members of the PG agreed to the concept as it creates dependency, and it is also challenging to control clients' environments. CPs could avoid the warranty concept by ensuring clients are well enough before termination or by providing a so-called health plan to help clients with their lives after therapy. P4 suggested that a warranty in a CT relationship should be about clients' rights and not the relationship after therapy.

I oppose the concept of giving a warranty to the client. This is because the success of CT also depends on the client. We as psychologists will have given our best to the client but the client and their environment are beyond our control. When I think about the word "warranty," it is more about what service the client will get or the necessary rights the client has during CT. For example, if a client pays x amount of money, how many sessions will the client get? So it is more about the process during the therapy but not after. (P4)

I once joined a seminar by Doctor X. She adopted a theory about health plans. It is like a recipe for ourselves; the psychologist teaches the client. There are three parts to a health plan: 1) What can the client do to keep their daily functioning? 2) What things need to be improved? 3) What can the client do during a crisis? This health plan should be given in the termination session. (P1)

The answer from P1 found a middle ground between the clients' demands and what the psychologist could give at the end of treatment for the clients. This answer was then

brought to the CG for their feedback. Four members of the CG (C3, C4, C6, & C8) gave their opinion and feedback on the topic. CG members seemed to agree with the solution proposed by P1. The solution was to use the health plan as a reminder for the client about the whole psychotherapy process, even though C8 mentioned that more detail should be added in the notes such as potential adverse scenarios and possible remedies in such an event.

It is excellent. It is more like a review of all of the sessions. Later when the sessions are finished, the client could reopen the notes. They could also be a motivation for the client (P4, CG)

It would be beneficial since I know I am forgetful, so these notes could be a reminder. However, it is not guaranteed that clients will not go back to the therapy. Because the environment could change and is not covered by the health plan. (C6)

I agree with that solution. That is more flexible and makes clients more independent of the CP. It feels like an evaluation and appreciation that I have achieved the end of psychotherapy. I would also like to see a summary of the issue, the dates, the conclusion of the treatment, and the solution. What things, should be done how often in the future to prevent relapse? For example, identify any possible events that could induce depressive symptoms. The CP could then provide some remedy for such events. So clients would have the tools to carry on their lives in better ways. (C8)

Continuing on from the warranty discussion, I was then curious about whether or not refunds might be issued if the clients felt dissatisfied with the CT. Bringing this topic to the PG, five members of the PG (P1, P3, P5, P6, & P7) joined in the discussion. The common theme from the participants was that refunds could be issued, but only related to the initial agreement. This included the number of sessions and the scheduling. P5 suggested that it is unsuitable for clients to ask for refunds based on the outcomes since there will be external factors that are hard to control. P6 suggested that the most clients could do is give their review to the CP.

I saw somewhere in private practice where there is a policy to refund the customer's money if the clinic commits wrongdoing. The wrongdoing is not about the outcome; for example, if the clinic promises five sessions and the final number of sessions is less than that, the client will be refunded. So it is more about attendance. (P1)

If the clients are finding it challenging to schedule sessions with the CP and the clients have already paid at the beginning, a refund would be reasonable. (P3)

If the clients feel that their case is unresolved, I don't think any psychologist actually has that kind of policy. This is because there are external factors that we cannot control contributing to the therapy's success. A refund would be appropriate if the CP did not attend the scheduled session. If the client did not attend, that would not be appropriate either. (P5)

We can never promise the outcome of therapy. Because if we do that and the promised outcome is not achieved, it could make the clients feel worse. (P7)

In CT apps, there won't be any refund but you can give feedback on the service. So if the CP does not deliver, they will get bad feedback. If CPs often get a D in feedback, they would most likely not achieve a high ranking in the app. (P6)

In a therapeutic relationship, the first thing that needs to be understood is that making a guarantee or promise about the success of the therapy is discouraged. Mozdzierz, Peluso, and Lisiecki (2014) mentioned that guaranteeing success is against ethical codes, defies sound therapy principles, and even negatively impacts the therapy. Looking at the ethical codes in the Indonesian setting, such clauses do not exist. However, CPs are expected to honour professional psychologists' professional promises, such as maintaining client confidentiality, obeying the code of ethics, and helping the community. Both KEHPI (HIMPSI 2010) and KEPKI (IPK Indonesia 2021) talk about respecting the promises or agreements that have been made with the clients in terms of the output report of the therapy; Semiun (2006) from Indonesia has also suggested that a responsible therapist will not promise any positive outcome for the therapy but rather instil hope in the clients so that they are able to better direct their behaviour. Quoting Constantino et al. (2011), a therapist could say something like, "I am confident that working together we can deal effectively with your depression," as an example of an inspiring hope statement. From this discussion, it can be seen that a therapist should never make promises about the outcomes of therapy. Providing a warranty for the outcome of therapy seems impossible in any psychological therapeutic setting.

Another concept that also needs to be understood in mental health is the concept of relapse. APA has defined relapse as the recurrence of a disorder or disease after a period of improvement or apparent cure (APA, n.d.c). Various factors can lead a person with any mental health disorder to relapse. In a study by Adebisi et al. (2018), sociodemographic factors such as gender, religion, and marital status, and clinical factors such as the type of mental illness, duration of illness, and drug compliance have been found to be factors associated with relapse. The same study also suggested that out of 37 clients with mood disorders, 16.7% of them did experience relapse. A study by Sánchez-Guarnido et al. (2021) found that loss of employment, economic hardship,

and lack of interventions were the factors that contributed to the relapses of people with severe mental health disorders during the COVID-19 pandemic.

Therapists often provide a maintenance stage to try to prevent possible future relapse. In psychotherapy the maintenance stage can refer to different concepts. Whisman (1990) used the term "maintenance booster" sessions for sessions one to two years after the termination to ensure the clients are continuing to use the skills that they acquired during the psychotherapy sessions. Similarly, White et al. (2012) and Stangier et al. (2013) mentioned "maintenance CBT," a stand-alone CBT treatment that aims to sustain the skills clients have already acquired in the previous psychotherapy. The maintenance CBT schedule can change from weekly to monthly as the therapy proceeds. One thing that needs to be considered in relation to the maintenance stage is the effect of dependency, as suggested by P1. A booster session immediately after termination might create dependency on external monitoring instead of relying on improving the internal locus of control (Lochman et al., 2014; Lochman & Wells, 2002). Overall, booster sessions have been found to help lower the possibility of relapse and maintain the skills the clients have gained during their active psychotherapy sessions (Craske et al., 2006; Fleig et al., 2013; Gearing et al., 2013; Kroll et al., 1996; Yates et al., 2005).

P1 also mentioned using a health plan, describing it as notes for the client to help them with possible relapse, that the CG agreed would be helpful. The mental health literature has labelled this kind of note a termination note. Luepker (2012) mentioned that a termination note should include: 1) the problems for which the client requested help, 2) the treatment given, 3) the progress, 4) the reason for termination, 5) a statement on whether the therapist and client mutually agreed on the termination, and 6) the status of the termination. The inclusion of future scenarios that C8 suggested aligns with a note called a termination summary as suggested by APA. One of the reports that a therapist needs to complete is the form titled "Anticipated Need for Continued Care and Resource Referrals." Therapists can include in this what clients need to do to care for their mental health in the future.

In terms of refunds, the evidence from the field suggests that such policies do exist. However, as suggested by P1, P3, P6 and P7, offers of refunds are often related to administrative matters and not the quality of the therapy. For example, Springer-

Kremser and Jandl Jager (n.d) and Rosenbaum et al. (2021) have implied that clients can get refunds either through their health insurance or general public insurance. Halodoc, an Indonesian company offering chat therapy, mentions in its policy that a refund is possible when a client cancels their appointment. Other telecounselling and therapy companies, such as Ohanaspace and Bicarakan, do not issue refunds but allow clients to change their schedules to something more suitable for them.

In another scenario, a refund could be offered in relation to business matters. Amis (2017) has discussed the dilemma in the psychotherapy setting of whether therapists should charge clients for the contracting sessions (where clients and therapists discuss and agree terms). On the one hand, psychotherapists are providing their time and professional skills regardless of the type of sessions. On the other hand, the client's issues are not discussed in the contracting sessions. Therefore, some therapists adopt a middle-ground solution in which the therapist will refund the fees for contracting sessions if the clients decide to continue with the therapy and book further sessions.

There is, however, evidence in the literature of refunds being offered based on the quality of the therapeutic relationship. Finlay (2019) mentioned an example of a therapist who refunded the client because the therapist could not relate to the client. In the description, a therapist was approached by a client who had undergone a sex change. Throughout the session, the client was reluctant to discuss sexuality in depth which meant the therapist failed to understand the story. The therapist then openly discussed with the client how a therapeutic relationship had failed to develop, and the therapist felt that he was not the best therapist for the client and offered a refund for the session they had just conducted.

To summarise, the data from this study, along with the findings from the literature review suggest that a refund, in most cases, would only apply in case of administrative matters such as scheduling conflicts and cancellations. However, there are some situations in which a refund can be given based on therapeutic matters (Amis, 2017; Finlay, 2019). It is up to CPs to assess whether a refund is suitable in such a situation.

Theoretical Discussions

As mentioned in the previous chapter, several theoretical frameworks were considered in the design of the manual: the theories of culturally sensitive psychotherapy (p. 59) developed by Bernal et al. (1995) and a combination of theories of the therapeutic relationship as described by Norcross and Lambert (2018) which has been proposed as the most important factor (p. 60) and one that is found in all types of psychotherapy (Cuijpers et al., 2019; Rosenzweig, 1936). This section aims to describe how the findings from the data gathering align with these two theoretical frameworks.

Culturally Sensitive Psychotherapy

Synthesisations from the data gathered explained the different aspect of Culturally Sensitive Psychotherapy as follow:

Language

This aspect talks about different language that CPs and clients might have and how it affects the therapeutic relationship. The data suggested that the use of the Indonesian official language Bahasa Indonesia is predominant in the CT setting in Indonesia. Indonesia consists of hundreds of traditional ethnicities and hundreds of traditional languages are spoken. Unfortunately, the number of CPs is not proportionate to the population of Indonesian and they are mostly centralised in one island. This means that CPs speak a limited number of language and may not be able to cater to all clients. This issue was raised by the PG as one of the potential disadvantages of CT in Indonesia. PG members asserted that even though it is quite rare, they sometimes face unfamiliar words, tones, or sentence structure which limit the effectiveness of the communication. The PG members acknowledged the positive effects when clients can speak their traditional languages in CT, as client are able to find the most suitable words to express their feelings at that moment and it helps them to feel more comfortable with the therapeutic process. Traditional language is not the only potential issue in CT. PG members suggested that the use of jargon could also jeopardise the effectiveness of the therapy as the client might not understand it.

The data suggested that there are several interventions that CPs can provide to make therapy culturally appropriate, starting from the very beginning even before the CT has started. In the promotion of their service, it is important for CPs to provide information about their cultural backgrounds. CPs could include their photos in their profiles and some cultural background such as where they are from. Doing so, potential clients are able to choose a CP

from the same cultural background and they could communicate using the language that both parties understand. Although it is unlikely, CPs who are faced with clients who do not speak the same language could use skilled third-party translator in the sessions. Further ethical and technical consideration such as confidentiality, and the length of the sessions should be explored with this option. In regard to jargon, CPs are advised to use simple words that lay people can understand. Should an unfamiliar term come up in a session, CPs need to double check with the clients whether they understand it and explain if not.

Persons

This aspect talks how individual differences could affect the therapeutic relationship. Ethnicity play a significant role in this aspect. In this particular study, the main groups of clients were millennials and Gen Z. Knowing about the characteristics from these two generations will help CPs to understand their clients. A specific aspect that was unveiled in the data gathering was the type of personality that these generations expect the psychologist to display during the therapy. These generations expect the CPs to be “cool” and “friendly” as they would be in a friendship relationship. This can be seen as whether the CPs align with their clients’ modern and up-to-date characteristics as a generation. This can also be seen in the CP’s conversational tone during therapy. These characteristics which are productive in therapy are expected to persist even after the therapy is terminated. Further data collected suggests that the clients in this research also expected the CPs to be sensitive to their cultural backgrounds. One simple example that was found in the data gathering was the need for CPs to address clients using their correct titles—which are dependent on the culture and age of the person. There are also general values in Indonesia that the CPs are expected to meet which can be found in page 187. Furthermore, these specific and general values should be reflected during the therapy. Clients expect that the goals created during the course of therapy will be sensitive to and plausible to be achieved in their cultural setting. The data gathered also suggested that beside cultural sensitivity, clients have other practical expectation of the CP. For example, clients expect CPs to provide them with a platform for venting, short- and long-term solutions for their issue, and quick responses to their chat, among others. These practical expectations are discussed in the sections “Clients’ Expectations of CT” (p. 134) and “Creating Therapeutic Relationships” (p. 140).

All the elements listed in the paragraph above are deemed to be supportive in creating healthy and productive relationships between CPs and clients. However, such warm

relationships may create a certain kind of informality on the clients' side, to the point that psychologists might need to intervene and set boundaries. This potential issue was discussed "Limiting Informal Behaviours" section (p. 143). Finally, some clients can be difficult and resistant at times and uncooperative with the CP in the therapy sessions. Clients could go silent and drop out suddenly. Some clients might also become hostile and suicidal at times. This potential issue was also discussed in the section "Manipulative Clients and Self-Harm Behaviour" (p. 172) and "Dealing with Different Types of Clients" (p. 146).

Metaphors

The aspect discuss about metaphors revolves around the idea of the existence of distinct metaphors, symbols, and concepts that are mutually understood by both CPs and Clients which help them to understand each other better. It has been mentioned previously that the vast number of different ethnicities in Indonesia leads to a diversity of languages and cultural customs. How CPs who might not be able to cater to such diversity should handle the challenge has also been discussed. Each ethnicity will have their own distinct metaphors, symbols, and concept. The general solution to this potential problem is for CPs and clients to come from the same cultural background.

Another concept that stood out from the data which also falls under this topic is the concept of emojis. In CT relationships it has been found that emojis are one way to convey emotions. Emojis, which consist of a lot of symbols, all have different meanings. Failure to understand the symbols might lead to negative outcomes for the therapy while being able to understand and communicate using emojis will help CPs to understand clients better. Therefore, it is very important for CPs to become familiar with the meanings of different emojis and how to use them appropriately. A discussion about this can be found in chapter 4 section "Multiple Interpretations of Emojis" (p. 155)

Content

This aspect talks about how CPs should be aware of the unique values, customs and traditions of their client and tailor the assessment and treatment plan to suit their needs. From the data, it is suggested that adjustments of the treatment should be made very early, from the beginning of the contact, and continue to be made until the end of the therapy, and after. Earlier discussions showed how the large number of ethnicities in Indonesian means there is a high probability that CPs will meet clients with different cultural preferences. One example unveiled in the data gathering was that some Indonesian cultures are more

assertive and dominant than others. This means CPs could be in contact with clients who are not afraid to state their minds in ways that CPs might find offensive in their own cultures. CPs have to be aware of this and adjust their mindsets to avoid being confused and offended. CPs who are from dominant and assertive cultures might also need to adjust their delivery tone to avoid offending clients who might come from more submissive cultures.

Another important thing is how CPs might find some clients' ways of life, values, and traditions are different, and even opposed, to the CPs'. The data suggests that clients expect CPs to be neutral and exercise positive regard for the clients without judgment. Examples found in the data gathering include how clients and CPs from two different and opposing religions might meet and how a CP met a client who was in a relationship with a married person. These two scenarios are sensitive and an unskilful intervention by a CP could lead to the therapy being ineffective and even resulting in early termination. The data also suggested that millennial and Gen Z clients do not like unnecessary assessment questions that are superficial and questionnaire-like. They prefer the CPs to provide quick questionnaires that they can complete before they proceed with more essential questions in the assessment stage. They also expect summaries that highlight the important parts of their stories to help them to understand their problems. As instant satisfaction is one of their values, clients don't want to wait long for any temporary remedies for their issues. Simple guidance to help clients emotionally is appreciated while they wait for a more complete therapeutic intervention.

CPs should also adjust their therapy sessions and treatment plans to make them suitable for clients from these generations. One characteristic that stands out with these generations is how embedded they are in technology. Technology provides them with instant access to up-to-date information about almost everything. These characteristics suggest that CPs should conduct their therapy in a way that is aligned with the technology and provide easy access to the content of the therapy. Homework and exercises which are usually done on paper might need to be converted to online formats. Making use of online platforms such email and online videos to share material and knowledge during the therapy would be useful. Aligned with the value of instant satisfaction, time is an essential consideration. Clients from these generations do not like to wait very long, meaning CPs need to put all their focus on the client during therapy and provide fast responses to their chat messages. Should the CPs need more time to write the chat messages, CPs should

inform clients of that beforehand to avoid the client becoming anxious while waiting. Information is essential for these generations. Being from assertive generations, clients expect to be informed on the reasoning for every intervention in therapy. This means that CPs need to provide information about why a specific treatment is being given. Clear reasons for homework, whether is written or behavioural, should be given, including how the homework could actually help them with their issues. CPs might need to provide direct solutions for some clients.

The data gathered suggests that clients want solutions and may not keen to wait for insights to come. Client-centred therapies might not work for these clients. The CP could have comprehensive discussions with clients about potential solutions and how the solutions might be applied in the clients' situations. Finally, post-therapy interventions are important for these clients. Some clients might still want to have some kind of relationship with the CPs for future support. Examples from the data gathered included expectations to follow each other on social media and for the CP to be available for questions related to the therapy. The concepts of warranties and refunds might also need to be considered by the CPs. Clients tend to be assertive about asking for what is their right in terms of congruency between the contract and the actual therapy. Make sure CPs need to make sure to pay attention to every detail in the contract, such as the number of sessions, the types of intervention and other therapy-related materials that are expected by the clients. Some clients might query the outcome of therapy if it is not as expected. This could be problematic, and CPs should address this from the beginning by not promising any outcome for the therapy, but rather state that therapy is an effort to make things better for the client.

Concepts

This aspect discusses the theoretical models used in the treatment and how to convey them to the clients. The data suggested that CPs tend to use CBT as the preferred approach to treatment for depression: Other therapeutic approaches that might be used as well are humanistic and solution-focused. The theoretical aspects of CBT include several concepts that might unfamiliar for clients, such as cognitive distortions, automatic thoughts, cognition, and emotions. Adding to the argument, the data suggested that Indonesians might not have enough information to understand most common concept, i.e., emotions. Thus, there is a need for CPs to teach clients about these concepts.

The data shows that CPs do not tend to make special cultural adjustments to these

concepts but rather treat them as if they are fixed pieces of knowledge or jargon terms. CPs introduce these concepts using psychoeducation techniques and make these concepts part of their teaching. For example, one PG member used picture templates to introduce the concepts. Another example would be to use an emotions table to teach clients about the variety of emotions that humans have. Finally, one PG member used one of the many cognitive distortions that clients might have as an example to introduce client to the concept.

Goals

This aspect talks about how CPs should set therapeutic goals that are sensitive to clients' values, customs, and traditions. The data collection included a rather complex discussion about this topic, as mentioned several times previously. The enormous number of Indonesian ethnicities is a big consideration in relation to this topic. The history of Indonesia is filled with dark periods when ethnic differences have resulted in the loss of lives. This makes ethnicity a sensitive topic that must be approached cautiously. In regard to CT and psychotherapy in general, it is best for CPs to explore the background and the issue of the client through thorough assessment prior to start of the therapy. It is important to know whether the client's issue is tightly related to their own culture (e.g., intercultural marriage) or whether culture is only one aspect that the CP needs to consider as part of the client's background, and not the main consideration in the issue (e.g., an academic issue for a client of a certain ethnicity). Furthermore, some members of both the PG and the CG mentioned that some clients are moderate and no longer live according to their ethnic traditions and values.

All of these findings then affect how goals are best formulated in CT or psychotherapy in general. Before making an attempt to set the goals for the therapy, it is important for the CPs to understand that the CPs themselves have their own cultural backgrounds and these are not always compatible with the client's culture, and may even be in opposition. What is considered acceptable in a CP's culture might be seen as insulting in a client's culture. Therefore, the data suggests that CPs need to be as neutral as they can in terms of not being biased and not bring their own culture into the therapy. No judgements or interpretations should be made towards clients based on the CP's values, traditions, or customs. Once this is settled, the CP needs to formulate goals for the therapy that are suited to the client's values, traditions and customs, unless, as the data showed to be possible, the client does not live by

their own ethnicity's values, culture, and customs, in which case the goals need to be suited to the client's own personal values, culture, and customs. Any goals made in the therapy should be communicated to clients and clients should be able to give feedback on whether the goals are achievable in their daily life and culture and whether any cultural aspects need to be further examined. Any irrelevant and inappropriate goals that clash with a client's culture should be revised.

Methods

This aspect discusses the steps taken to achieve treatment goals and how they should be aligned with the client's culture. The data suggests that in a CT setting, procedures have to be considered even before the therapy begins and goals are set. As CT is conducted online with no physical contact between CPs and clients, it is prone to early termination. One wrong move can cause the client to simply sign out from the chat room and not reply to further chat messages. With consideration for potential clients' cultural responses, CPs should start with appropriate types of promotions for their services. A combination of cultural and generational characteristics plays a major role at this stage. Promotions should be put up online, most probably on social media as these are the platforms the current generations of clients most often use to look for information. CPs should put up cultural information such as where the CPs come from (places of origin are closely related to cultural origins) along with a photo to help clients identify the CP's culture and enable them to pick CPs from the same backgrounds.

Initial and early contacts between CPs and clients are also crucial to ensuring the continuity of the therapeutic relationship. As CT is basically a digital remote therapy, all communication will be and should be done electronically. The current generations expect CPs to be able to catch up with their culture as digital natives and be able to provide treatment materials digitally. These include intake forms, informed consent and any mental health questionnaires. Data suggests that clients do not like to use the time they have paid for to answer questions aimed at gathering information that could be simply gathered using an online questionnaire (clients label these as questionnaire-like questions). Assessment sessions should be used by CPs for much deeper and more comprehensive questions and not these superficial ones. Early contact should also be used by the CP to build an honest and therapeutic relationship by being aware of and sensitive towards the client's culture. It is important to be aware of where a client is originally from. Calling them by their ethnic title

and greeting them using phrases that are familiar in their culture can also help to earn the client's trust. Communication that is mainly through chat messages should also be taken seriously by the CPs. CPs must understand the features of the chat applications, including delivery and read reports along with the different emojis that can be used by the clients to avoid any misunderstandings. Throughout the therapy, the qualities mentioned above need to be employed to maintain the therapeutic relationship.

The setting of goals has been discussed earlier. In the data gathering, it was found that CBT has been the main focus in the theoretical aspects of the therapy. Some other therapy orientations that were mentioned in passing were solution focused and humanistic therapies. CBT has its own techniques that need to be employed in CT in its current form. Techniques such as Socratic questioning, identifying cognitive distortions and emotions, and relaxation techniques were identified during the data gathering process. Again, these techniques should be delivered in a way that is suited to the characteristics of the clients. Given that clients are digital natives, the use of online videos, worksheets, and questionnaires should always be considered by the CPs.

Finally, the right procedures also need to be undertaken towards the end and after therapy. The current generations value summaries and final notes that serve as reminders of the therapy and provide motivation. CPs should make succinct yet informative health plans for their clients to keep on their smartphones in case they experience future relapses. As assertive generations, they will not hold back from asking for their rights, making complaints and asking for warranties or refunds if they deem it necessary. CPs should also look into this discussion to avoid missteps.

Context

This aspect talks about how CPs should consider clients' broader social, economic, and political contexts; social supports; acculturative stresses; and phases of migration if applicable in clients' cases. The data shows that all of these have been directly mentioned. In relation to the social and economic aspects, CPs must realise that other than being quick and easy to access, clients often choose CT because it is generally more affordable compared to face-to-face psychotherapy. Some clients cannot even afford to have CT. The data suggests that CPs should be aware of this and since CPs will charge different fees for their service, CPs need to equip themselves with knowledge about affordable mental health services throughout Indonesia to help clients who cannot afford their own service.

The CPs also suggested that social supports are important for a client's therapeutic process. One example from the data gathered was how social supports such as parents, peers, and next-of-kin play important roles should clients be found to have self-harm tendencies. CPs should get these social supports' contact details in case of emergencies. Some parts of the therapeutic intervention also involve clients' social supports, for example, a member of the PG suggested that social supports can help clients by simply reminding clients about their sessions.

Generational and cultural characteristics align with political and acculturative stresses. It has already been mentioned a number of times how Indonesia's vast diversity can be a source of issues. Some aspects of Indonesia's dark history are rooted in the diversity and CPs should be careful when dealing with diversity. CPs are expected to be neutral, objective, and unbiased in providing their services and not bring any of their own cultural references with them into sessions, if deemed inappropriate. Acculturative stress was found in the data gathering where clients' issues were rooted in by their ethnic and cultural expectations. Some examples found in the data gathering were issues caused by interethnic marriage or different communication styles due to migration. When dealing with this kind of issue, it is important for the CPs not to make generalisations about any ethnicity but rather discuss the psychological aspects that can be extracted from the cultural aspects. As an example of a solution for a previously mentioned cultural issue, it is best to encourage negotiations between people in interethnic marriages and to teach different kinds of communication styles for the clients with communication issues following migration.

The Therapeutic Relationship as the Common Factor

A discussion covered in Chapter 2 revealed that the therapeutic relationship is the most important common factor, regardless of the theoretical orientation, that correlates with the therapeutic outcomes. A study by Norcross and Lambert (2018) has suggested that there are six potential therapeutic relationship components that lead to better outcomes in psychotherapy; these are 1) collaboration; 2) empathy; 3) alliance; 4) goal consensus; 5) positive regard and affirmation; and 6) giving and receiving feedback.

The Therapeutic Alliance and Goal Consensus

The root of the alliance concept in the meta-analysis study by Norcross and Lambert (2018) can be traced back to an article by Hatcher and Gillaspy (2006). This research talked about the making of a psychometric tool to measure the working alliance between the

therapist and the client, based on Bordin's 1980 model of the alliance. The alliance itself was described as having three main aspects: (a) agreement between patient and therapist on the goals of the therapy; (b) the patient's agreement with the therapist that the tasks of the therapy will address the problems the patient brings to treatment; and (c) the quality of the interpersonal bond between the patient and the therapist.

It can be seen from the explanation that therapists and clients need to mutually agree on the goals and changes in the client's life in order to produce a better mental health outcome. Goal setting in the CT context has been discussed several times in the course of this thesis: "Culture and Goal Setting" and "Culture, Goal Setting, Solutions and Giving Advice." The "Eight Cultural Elements" discussion offers a discussion about goal setting under the heading "Goals." To quickly summarise, CPs need to produce goals for therapy that are aligned with a client's culture and achievable under the client's circumstances. The goals need to be agreed on by both parties.

The tasks of therapy which form the second aspect of the alliance include the homework and psychotherapy intervention techniques discussed in this research. This aspect talks about the specific interventions that CPs and clients agree to make in order to achieve the goals that they have already set. The data from the research suggests that these interventions could include Socratic questioning, identification of cognitive distortions, or using tables of emotions. These techniques are part of the CBT theoretical framework used by most CPs and are taught to the clients as skills through psychoeducation and practice.

The measure of the interpersonal bond which concerns the emotional connection between the CP and the client has also been discussed several times in this chapter. These bonds go back to the very beginning before the therapy even starts when CPs are warm, open, and accepting towards clients and their issues. An appreciation of clients' cultures and an awareness how one's own culture might affect judgment and goal setting in regard to clients' issues would be one of the main elements in the CT relationship.

Collaboration

Tryon and Winograd (2011) have defined collaboration as the mutual involvement of psychotherapist and patient in a helping relationship. A large number of studies have used homework compliance as an indicator of collaboration (Tryon et al. 2018). However, Kazantzis and Kellis (2012) have suggested a more comprehensive understanding of the concept; a consideration of the therapeutic model; development of the formulation; and the

maintenance of emotional, cognitive, physiological, behavioural, and interpersonal experiences as topics for discussion in collaboration. Tryon et al. (2018) used two items from a California Therapeutic Alliance Rating Scale (CALPAS) (Gaston, 1991, mentioned in Tryon et al., 2018) to expand the measures of collaboration beyond homework compliance. Those items were, "Did you feel pressured by your therapist to make changes before you were ready?" for the client and, "Were your interventions tactful and well-timed?" for the therapist. It can be seen from those examples that collaboration can also be about consent, timing, being sensitive, and choosing the right intervention.

A specific discussion during data gathering aimed to understand what Indonesian CPs do to encourage clients to take a collaborative approach towards the course of the therapy. This discussion can be found in chapter 4, "Creating Collaboration in CT" (p. 157). The discussion yielded four interventions which were a) understanding the client's expectations, b) written contracts and informed consent, c) encouragement and appraisal, and d) referrals. All these interventions are generally carried out by psychologists to encourage the clients to engage in psychotherapy sessions in general. Furthermore, other discussions chapter 4 "Homework Compliance" (p. 159), offer some guidance on how CPs can best design homework to support their therapeutic interventions and ways to persuade clients to do such homework.

Empathy

In Norcross and Lambert's (2018) article, empathy was found to be one of the components of a therapeutic relationship that is demonstrably effective in supporting better outcomes from psychotherapy. The analysis was done using clients' ratings of the therapists' empathy and their own outcomes at the end of the treatment. Clients who had more empathetic therapists showed more progress and improvement (Norcross & Lambert, 2018). In the data gathering in the current research, there were several discussions that could be seen to align with the topic of empathy. The current research does not focus on how empathy can help in creating better outcomes but rather how empathy can be conveyed in a CT setting, as voice and face-to-face communications are not options. As a starter, a discussion in chapter 4, "Showing Empathy" (p. 152) suggested how CPs could convey their empathy through chat messages. It was found that the use of emojis, written words that symbolise the acts of empathy, and also quick responses, are said to be some of the ways to show empathy. Another option for communicating empathy via CT is by using voice notes. It

was found during the data gathering that voice notes can be effective to convey one's feelings, as the clients can sense the CP's feelings by their tone of voice. The only concern that might arise during the process is the multiple interpretations that can happen when emojis are used to communicate. Specific discussion on this potential issue can be found in chapter 4, "Multiple Interpretations of Emojis." (p. 155)

Positive Regard

The current research showed that the exact term, "positive regard," was mentioned in the data gathered. In a discussion about, General Values (p. 187), members of both the PG and the CG suggested that CPs should provide positive regard for the clients they help. CPs need to accept clients' situations as they are, even though their behaviours may not conform with general norms. The only data that needs further discussion is an expression that was contributed by a member of the PG: "to accept but not to validate," meaning that CPs may need to accept clients' stories and understand where the behaviour is coming from but the CPs still need to know what is right and what is wrong based on the general norms that apply. An example raised by one member of the CP was a client's story about being in an intimate relationship with a married person. The member of the PG suggest that no judgment or condemnation should be made for such a life choice, but one should know that such behaviour is wrong and because it could lead to negative outcomes. Later on, another member of the PG suggested that it is the job of the CP to help clients to see the potential adverse effects that might result as a consequence of such a behaviour and how this behaviour is probably based on mental processes that need to be examined.

Feedback

The reasoning in one example in the article by Norcross and Lambert (2018) comes from another article by Lambert, Whipple, and Kleinstäuber (2018) in which feedback was shown to help therapists effectively treat clients and prevent deterioration. Eubanks-Carter, Muran, and Safran (2015) mentioned that therapeutic feedback from clients, in the form of expressions of negative or vulnerable thoughts or feelings about the therapist and/or the tasks or goals of therapy, can help in resolving any ruptures that might occur during the course of therapy. In this current research, there were several discussions where feedback was involved. Firstly, in "General Values" discussion (p. 187), it was mentioned that clients and CPs need to agree on the goals set during therapy. The term goal consensus was used for the agreement between CPs and clients on what goals are deemed suitable to mark the

clients' progress. These discussions require each party to provide feedback on each other's ideas about the goals. Secondly, a discussion about "Providing Solutions (p. 138)," about clients and CPs brainstorming together to find the best solution would also provide feedback to each other on proposed solutions. Another example of providing feedback can be found in the homework discussion in which it was agreed that CPs are expected to provide feedback on any homework given to clients.

Chapter 5—Conclusions

Overall Summary of the Study

This study originated in the need for Indonesian CPs for comprehensive, evidence-based guidelines on the best ways to conduct CT, a treatment with rising popularity among Indonesians. The lack of such guidelines could make this manual a welcomed contribution to the Indonesian clinical psychology community. As depression is a mental health illness with a high prevalence in Indonesia, minor depression, which is the mildest form of depression, was chosen as the type of mental illness to be treated using the manual. Psychotherapy was chosen over other interventions, such as counselling or guidance because the literature suggests that minor depression needs to be treated with adequate and long-term treatment that includes proper assessment and diagnosis. Millennials and Gen Z were chosen as the subjects of the study because they are probably the primary users of CT.

This study used a collaborative design method which allowed me to explore the thoughts, experiences and opinions of not only Indonesian CPs, who will be the primary users of the manual, but also representatives of the millennial and Gen Z generations, who are the primary users of CT (Thabrew et al., 2018). The nature of the collaborative design was an iterative process in which the data obtained from any group was given to the other group for feedback and comments. The feedback and comments were brought back to the original group for further comment and discussion for further development. By doing this, I believe the manual has acquired depth and comprehensiveness. The data gathering included regular weekly sessions with the participants to develop the basic foundations of the manual. Later on, the raw data was analysed to create the prototype of the manual. The prototype was then given back to the participants for their feedback. Further sessions were held with both participant groups to clarify their feedback. In writing the manual, I also used findings and evidence from the literature to validate and add more depth to the data and, later on, the manual.

The final draft of the manual is now finished. It is a 118-page manual (excluding references) divided into nine chapters. The manual offers practical guidance and theoretical discussion about CT and other concepts. The following table briefly summarises the content of the “Chat Telepsychotherapy Manual for Indonesian Millennials and Generation Z with Minor depression”.

Table 31*Summary of the Manual Chapters*

Chapter	Chapter Title	Description
1.	Introduction	This chapter aims to explain the manual's rationale and the method used to develop the manual.
2.	The Concept of Chat Telepsychotherapy	This chapter explains the concept of CT and how it differs from other mental health interventions, such as counselling and guidance. It also provides information about the advantages and disadvantages of CT.
3.	Starting CT Practice	The chapter explains how interested Indonesian CPs could start offering CT as one of their services. It gives information on pathways to entering the business and the considerations before choosing different pathways. This chapter also includes other practical considerations before starting CT, such as choosing the best application, fees, contact details, and workplace.
4.	General Guidelines for Conducting CT	This chapter provides guidelines on the general aspects of conducting CT. These include confidentiality, the therapeutic relationship, culture, and collaboration in the CT setting.
5.	Specific Guidelines for Conducting CT	This chapter gives more specific guidelines for conducting CT. These include discussions on verbal and non-verbal communication, first contact in CT, session duration, not providing diagnoses, dealing with client responses, client absences, solutions, homework, warranties and refunds, and managing technical failures.
6.	Characteristics of Indonesian Millennials and Gen Z	This chapter offers some information about the characteristics of millennials and Gen Z in Indonesia and how these characteristics affect the CT process.
7.	Minor Depressive Disorder	This chapter discusses some of theoretical aspects of minor depression. It also discusses preliminary findings about the physical manifestations of depression in the Indonesian setting.
8.	Self-Harm	This chapter discusses the possibilities for handling self-harm during CT. It discusses the following themes: manifestations of self-harm, the reasons behind self-harm, and assessing self-harm, as well as providing a protocol to handle self-harm during CT.
9.	CT Stages for Indonesian Millennials and Gen Z with Minor Depression	This chapter gives specific guidelines for conducting CT for Indonesian millennials and Gen Z who suffer from minor depression. The guidelines are designed to support Indonesian CPs from the earliest stages of CT through to the final stages, as follows: first contact, administration and informed consent, assessments, treatment plans, urgent symptoms, emotional interventions, cognitive interventions, regular sessions, strengthening sessions, termination session, and finally, the relationship after termination.

It can be seen from the table that the manual comprises a comprehensive discussion of the topic of CT. That was foreseeable as the manual is the first of its kind. The manual is suitable for Indonesian CPs with no CT experience because it offers information and basic knowledge about CT and pathways for the novice CP to enter the world of CT and offer it as one of their services. The manual also discusses several aspects to consider while doing CT, such as confidentiality, therapeutic relationships, and culture. The manual also offers some specific guidelines for the CP on conducting CT. For example, a discussion about verbal and non-verbal communication is broken down into more specific discussions on topics such as style in chat messages; showing empathy in CT; and using emojis, voice notes, the clipboard, and voice typing. These detailed discussions can also be found in the same chapter with the six other specific guidelines.

The manual also offers some discussion related to this study's subject: Indonesian millennials and Gen Z who suffer from minor depression. It can be seen from the table that the manual has two stand-alone chapters that discuss the characteristics of Indonesian millennials and Gen Z and also Minor depression. This shows that while the manual is wide-ranging in terms of discussing CT, It is also specific to this study. By including these two chapters in the manual, Indonesian CPs with clients who fall into this study category, i.e., Indonesian millennials and Gen Z who suffer from minor depression, are provided with comprehensive guidelines that are not limited to CT. Another important chapter in the manual is the self-harm chapter. Self-harm is highly likely to occur in people who suffer from depression (Guo et al., 2021; Sadath et al., 2023). Even though people with other mental disorders may also self-harm (Singhal, 2014). This chapter included here to ensure that the manual is comprehensive and responsive to the crucial matters in the treatment of risky mental health illness.

Chapter 9 of the manual offers specific step-by-step guidelines on how Indonesian CPs can treat Indonesian millennials and Gen Z who suffer from minor depression. As described in the table above, this chapter contains other comprehensive guidelines on best supporting clients using CT. This chapter provides theoretical and practical guidelines, reasonings, and examples in one chapter. This chapter also contains hints and references to previous chapters for more discussion on the topics. Doing this allows the reader to continually refer to the previous chapters for more comprehensive discussion.

Finally, it needs to be emphasised that this study never made any claim that the CT manual is an already effective treatment for minor depression for Indonesian millennials and Gen Z. The manual was indeed created with a comprehensive process that involved clinical psychologists and people with minor depression along with to support of existing research to ensure the quality. Being said, this study did not include an effectiveness examination of the CT manual; further study still needs to be done. Without further information about the effectiveness of the manual, it should be treated carefully. The reader should take every content of the manual critically and not take it at face value. Readers should also consider the current research's strengths and limitations and consider them before making any therapeutic or academic decision related to this research.

Strengths and Limitations

The strengths and limitations of this study are mainly associated with the data-gathering process and the manual, which is the main product of the study. The next two subsections explain the various strengths and limitations based on the said aspects.

The Data Gathering Method

As previously mentioned in Chapter 3, this current research used a collaborative design that included Indonesian CPs and Indonesian clients who suffer from minor depression as the participants. The process meant that the manual was created by considering the opinions of both parties, who were the stakeholders for the CT manual (Thabrew et al., 2018). This research has tried to understand the best options for delivering therapy for clients with depression from the CPs' point of view while considering client feedback. By doing this, each party's expectations for such therapy have been considered and catered to as much as possible. Of course, CPs might have more robust requirements regarding theoretical orientation and therapy design. However, the iterative back-and-forth process of gaining the data between the PG and the CG has found a middle way discerning where the two sides differ. Several ideas listed in the manual that the CPs had never even considered came from clients.

Another strength of the data-gathering method was that the arrangement of the focus group discussion FGD in this research followed the ideal rule of thumb for FGD according to the literature. With seven participants in the CG and eight in the PG, this study had the optimal number of participants for FGD sessions (Krueger & Casey, 2000; Rabiee, 2004; Stagi, 2000). A small number of participants in FGDs can allow some participants to dominate the

discussion, while too many can result in a loss of control of the dynamics (Escalada & Heong, 2014). The sessions were two hours long, which is also recommended for FGDs; sessions longer than two hours can negatively affect clients' physical and mental health (Muijeen et al., 2020).

The main limitation of this research was the group dynamics during the data-gathering process. Often participants did not contribute to any discussion or interactions but instead answered the questions from myself consecutively one after the other. This made the discussion more like a group interview (Brown & Edmunds, 2011). Similarly, Sha et al. (2020) found that Chinese and Vietnamese participants generally had low involvement in FGD, which was characterised by no interaction between the participants, and answering the moderator's questions without commenting on one another's responses. One of the possible reasons for this in the study by Sha et al. (2020) was that participants were hesitant to be more vocal because of the distribution of power among the participants. Younger participants were not willing to contradict older participants.

In this study, however, I was unsure that the same reason applied. Firstly, the age gaps between the participants were insignificant, with only 10 years in the CG and 12 years in the PG. Furthermore, some contradictory opinions did emerge from time to time. What happened during the data gathering was that the participants tended to agree with the first answer given and then complete or add to it rather than make a discussion out of it. A possible explanation for these findings is that the participants come from a collectivist culture that tends to avoid interpersonal conflict (Merkin, 2015). Regardless, this meant the data had low variance as one answer was often agreed by all. Many themes in the manual derive for only one answer. This may be considered unsuitable in thematic analysis (Kiger & Varpio, 2020), however, Maguire and Delahunt (2017) have suggested that overlaps between codes and themes can happen in a minimal data set. It is also possible that a single code has enough depth and detail to tell its own story (Neale, 2020).

Myself who acts as the moderator can play a role in the flow of the discussion. The current research was only the second time I has conducted an FGD in qualitative research. It is also my first use of online FGD in a qualitative study. Thus, the lack of experience may have played a role in the lack of flow (Baral, Uprety, & Lamichhane, 2016)

The Manual

The manual for chat telepsychotherapy, as the main product of this research, has

several strengths. As the first ever scientifically backed (Sale & Thielke, 2018) manual on chat telepsychotherapy, it offers guidance for Indonesian CPs who want to start providing a CT service as the first four chapters of the manual were written for such a purpose. Furthermore, the manual provides detailed discussion to enable CT practitioners to understand the whole concept of CT. The manual provides a general foundation for CT, including a definition of the concept, its advantages and disadvantages, and guidance on how to start providing CT. It also provides general and specific guidelines on best practice when delivering CT to clients. Readers are guided in the practice of CT from the very beginning. Moreover, all discussions in the manual were based not solely on a review of the literature review but also on iterative discussions between CPs and Clients. It includes more than just theory but also empirical data (Broeder, 2010). Going into further detail, this manual was also written for clients who are millennials or Gen Z suffering from minor depression. As stated before, this manual also provides future readers with a theoretical framework and information about the practical aspects of CT. It can be seen from the manual that Chapters 6, 7 and 9 were written explicitly for these specific clients, starting with theoretical information about the generations and mental illness and continuing with stage-by-stage guidance on how to best treat these clients using CT. This manual also provides illustrations such as chat balloons, which are very specific to this type of intervention.

The main limitation of the manual is its focus on a specific group of clients. Chapters 2-6 and 8 of the manual can indeed be helpful for practitioners working with many types of clients. However, CPs will usually have clients with specific issues, and this manual is intended to help CPs with millennial and Gen Z clients with minor depression. Considering the possibilities of comorbidities in depression (Anker et al., 2018; Baranyi et al., 2022, Veisani et al., 2017), this manual could only do so much.

Another limitation can also be found in the specificity of the manual. Human interaction is complex, and there are many possibilities for ways communications between CPs and clients can eventuate. The process of gathering data from the CPs and the clients has tried to cover the interactions between CPs and clients as far as possible. For example, from the beginning with the assessment, the manual discusses how to best deal with clients who are anonymous, underage and even suicidal. Throughout the CT process, this manual also discusses how to best respond when clients are silent, absent, or hostile. Given the volume, the data was gathered from just 15 research participants, and they could only

describe their experiences so far. There is no guarantee that this manual will cover all possibilities for human interactions between CPs and clients. There might be other unique experiences that this manual will not cover. This manual might not yet be in its best version and might need further improvement.

The last limitation of the manual is that it is vulnerable to technological advances. CT is a therapeutic relationship that uses technology as its primary foundation. The chat communication between CPs and clients is conducted using software usually installed on mobile devices. These technologies are subject to the rapid and ever-accelerating pace of advancement (Pollard et al., 2022). The software has many features (clickable links, voice notes, emojis, and the ability to send images) and is also prone to technological advancement. These lead to questions as to how long this manual might stay relevant as technological advances make older versions of products obsolete (Ates & Acur, 2022). For example, this manual could only cover voice-typing so far as it is still a new technology and prone to errors. The data suggests that voice typing is not commonly used in the CT relationship, however, one cannot know how the advancement of voice typing technology might change CT dynamics in the future.

Theoretical Significance

This study significantly contributes to several theories and discussions in the literature. These are depression, telepsychology/telepsychotherapy, cultural sensitivity and collaborative design.

Depression

At the beginning of this research, the lack of evidence and literature regarding the physical symptoms of people with depression in Indonesia was discussed. This topic was discussed during the data gathering and resulted in preliminary findings. Twenty-six possible physical symptoms related to depression were found in the data gathering. The association of each of these physical symptoms with depression is supported by previous studies, even though they are not from the Indonesian literature. This shows that such findings are supported. These findings are raw and need to be further investigated by other researchers interested in the topic using more focused research methods, such as descriptive research with a larger sample, to clarify the findings (Singh, 2020). Regardless, this study suggests that there is a possibility that depression in an Indonesian setting can manifest in physical symptoms. Furthermore, these preliminary findings add to the theory of depression,

especially in the Indonesian literature.

Telepsychology/Telepsychotherapy

This current research aimed to create the first-ever evidence-based guidelines (manual) to conduct psychotherapy using synchronous text based (chatting) communication. According to my knowledge, no comprehensive manual has previously been produced such as the one produced in this research that discusses the multiple aspects of conducting CT. While effectiveness study might strengthen the position of the manual, the current version of the manual could still provide some understanding and could become a stepping-stone study that provides the foundation for future telepsychology/telepsychotherapy research (Flick, 2007). The term psychotherapy, as used in the manual, could be considered a strong word. Therapists using other relevant therapeutic practices such as counselling, consultation, guidance, and even coaching might utilise this manual as a reference for future research. Chapter 2-6, and 8 of the manual provides guidance on how to conduct a therapeutic relationship remotely via chat messages. It focuses on creating comfort for the younger clients receiving input from the CPs. This, again, is relevant to other mental health disorder and other distance therapeutic relationships. Future researchers from other disciplines who are keen to find out how the manual could be adapted to their needs could follow transdisciplinary research practices (Archibald et al., 2018). In a nutshell, transdisciplinary research practices could make the manual as the focus for future researchers or used as a methodological tool to help achieve the primary goals of future research.

Cultural Sensitivity

Another attempt made in this manual was to provide guidelines for culturally sensitive CT for the subjects of the research. The cultural discussion was one of the significant discussions in the making of the manual. There has been back-and-forth discussion on best ways to deal with culture in the CT setting. This is because SARA is a sensitive topic in the Indonesian setting (Taqwa et al., 2019). A careful approach is needed for the practitioner to touch on the topic safely. These findings could also enrich the literature on social psychology, especially in dealing with cultural differences in therapeutic settings.

Collaborative Design

The current research could provide additional evidence for the collaborative design literature. The practice of codesign used in the research is somewhat unique in the literature as the whole process was done via online group conference. As discussed, this method

comes with strengths and limitations that could be the foundation for future research that uses codesign as its method of data gathering. The current research followed the codesign stages described by Bowen et al. (2013), but the content of the stages in this research was set up differently. While the names and the stages were the same, the original research by Bowen et al. (2013) was full of in-person activities. These activities acted as a data-gathering method that helped myself build the intended product. In this research, there were no activities but rather a set of questions that moved from general to being more specific and practical with each successive stage. The only activity other than group discussion was when the participants reviewed the prototype of the manual and gave feedback. Even then, more comprehensive feedback was given and discussions about the manual prototype were held again using the group discussion method. This unique codesign method could inspire or become a foundation for future research.

Practical Significance

Other than the theoretical significance, this study also has practical significance, mainly for the community of Indonesian CPs. However, the practical significance for other mental health practitioners is also explained.

Indonesian Clinical Psychologists

The practical aspect of the manual is the primary significance of this research. The purpose of the manual is to help the Indonesian CP community conduct proper CT interventions for Indonesian millennials and Gen Z who suffer from minor depression. As there has not previously been any comprehensive manual to guide Indonesian CPs, this manual could be helpful for the community. Even though there is a need to test whether the manual is effective, the current protocol version of the manual could be cautiously reviewed by the practitioner and acted upon with thorough and critical consideration. Should finally the manual proven to be effective, the manual could be formally introduced to the IPK Indonesia, the highest association of clinical psychologists in Indonesia, and for them to introduce such a manual to its members (i.e., the Indonesian CPs). This ensures that every CP in Indonesia can use it in their practice.

With the manual within reach, CP who practises CT, whether a novice or has been in the field for some time, can access guidance about the concept of CT from the beginning when they want to start practising CT up to the specific issues they may encounter during the sessions. Furthermore, this manual could ultimately help CPs who have millennial and

Gen Z clients with minor depression from the start of therapy through to the termination stage. Chapters 6 - 9 of the manual are dedicated to such a purpose. CPs can see how the stages are laid out, with the content of the sessions and the type of interventions CPs should give their clients.

Other Mental Health Professionals

As previously discussed in the section on theoretical significance, other mental health professionals who conduct distance therapeutic relationships, including counsellors, social workers, consultants, and life coaches might also benefit from this manual. The main idea of this manual is to create positive relationships between the practitioners and the younger clients via chat messages. Chapter 2-6 and 8 of the manual provides guidance on how the practitioner could provide empathy, deal with multiple adverse outcomes of therapeutic relationships, administer therapy, and familiarise themselves with the features of chat applications used in mental health therapeutic relationships conducted via chat messages. Once the therapeutic relationship is created, other mental health professionals can continue to support clients with their own specific types of interventions.

Future research

The findings and limitations in this study demonstrated gaps that could be filled by future researchers. The following suggestions would be good directions for future studies.

Testing the Manual

The main suggestion for future research is to make a test study of this manual. This research aimed to create the first manual for conducting CT for Indonesian millennials and Gen Z suffering from minor depression based on a collaborative design method. While the method included an iterative feedback process between the clients and the CPs, such a procedure could not guarantee that any treatment based on the manual will effectively treat an actual subject. A well-structured study such as a usability testing (Lattie et al., 2019) or randomised controlled trial (RCT; Grenon et al., 2018) should be undertaken to determine whether the manual can be used to effectively treat Indonesian millennials and Gen Z who suffer from minor depression.

Other Mental Health Disorder

As stated before, chapter 2 – 6 and 8 of the manual discussed the common ground in CT that could be useful for any mental health disorder. Future studies could focus on just making CT programmes for specific mental health conditions and use the common ground

chapters to support such programmes. One of the most common mental illnesses besides depression in Indonesian is anxiety (Jeharut et al., 2021, Kemenkes R.I., 2018). A programme similar to chapter 7 and 9 of the manual could include treatment orientation, homework, and specific techniques. By doing so, future studies could also test the common ground chapters of this manual, and find potential weaknesses and report on those findings in their study.

Online Collaborative Design

It is recommended that future researchers improve the data-gathering method to increase the flow of the discussion during FGD. Reflecting on the current research, participants tended to take turns answering the questions I asked and did not comment on other participants' answers unless required to. There were times when participants gave answers which contradicted that of previous participants. However, the previous participants never defended their answers and tended to stay quiet. Most of the time, participants agreed with each other's answers and instead added more detail to complete the previous answers. Two possible reasons were mentioned in the earlier discussion: culture and the moderator's level of experience. While it would be more difficult to intervene in culture, I believe that increasing the moderator's ability to carry on an online FGD would increase the chance of having a more fruitful and flowing discussion.

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Appendices

Appendix A - Chat Telepsychotherapy Manual for Indonesian Millennials and Generation Z with Minor depression

Chat Telepsychotherapy Manual for Indonesian Millennials and Generation Z with Minor depression

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Chapter 1 - Introduction

Changes are inevitable and people must adapt. These are perhaps the right words to begin with, which explain why this manual was developed in the period from September 2019 to September 2023. Indonesia has been experiencing, rapid development in information technology (IT), a development that is affecting various aspects of Indonesians' lifestyles. One of the most obvious effects is the digitalisation of goods and services transactions that, in the past, were generally carried out by meeting face-to-face. The rapid developments in IT have made it possible for them to delivered remotely through online technology. Some online services are now collaborating with the government to provide Indonesians with easy access to transactions such as paying taxes and accessing health care.

This manual deals with one aspect of Indonesians' lifestyles impacted by digitalisation which is the provision of mental health services. During the period of writing this manual, a large number of clinical psychologists (CPs/Psychologists) in Indonesia were already offering therapeutic interventions remotely, which had previously been conducted in person, using different types of software programs. In general, the communication tools used by CPs are video conferencing (or video calls), telephone (voice calls), and also synchronous text communication, commonly referred to as "Chat". The manual is designed to give guidance to CPs conducting psychotherapy using chat. This manual labels the concept of psychotherapy that uses chat as the medium of communication as *chat telepsychotherapy* (CT).

CT has captured the interest of many Indonesians, particularly the younger generations, for several reasons. First, chatting has become a common way of communicating in Indonesia. Over 78% of the population of 275 million Indonesians are recorded as active internet users who primarily use the internet to connect with others using social media and chat applications (Asosiasi Penyelenggara Jasa Internet Indonesia [APJII, Indonesian Internet Provider Association], 2023). The second reason is, in a country with thousands of islands, 2,725 or 71.82 % of the 3,794 registered Clinical Psychologist (CP) in Indonesia are located on Java Island, according to the Ikatan Psikolog Klinis Indonesia [IPK Indonesia, Clinical Psychologist's Association of Indonesia] (2023). Finally, although 16 million people in Indonesia experience depression as one of the most common mental health issues (Kementerian Kesehatan Republik Indonesia [Kemenkes R.I., The Ministry of Health of the Republic of Indonesia], 2018), Indonesian people still face stigma regarding mental health issues (Asti et al., 2016). People are reluctant to seek direct face-to-face therapy because Indonesians tend to think that mental health issues are a sign of weakness or that those with such issues must be cast out.

CT also became popular in Indonesia during the COVID-19 pandemic (Khan et al., 2020). During the pandemic, Indonesia imposed several levels of restrictions on movements of its citizens after its first COVID-19 case was detected in the country on 2 March 2020. The first restrictions, *pembatasan sosial berskala besar* (large scale social limitations) was mandated on 17 April 2020 (Nasional Tempo, n.d). The term changed several times, but the principles remained the same. Movement restrictions meant Indonesians were required to practice safe distancing between individuals. They were encouraged by the government to stay at home as much as possible and to use remote services instead of physically visiting shops to buy goods and services. This regulation then affected how Indonesians sought professional help for their mental health. Due to stress generated not only by the pandemic, but also by life in general, many Indonesians chose CT for professional mental health support. While the effects of pandemic may have subsided and everything has started to return to how it was, the practice of online mental health treatment has continued to grow, due to the switch of behaviours by Indonesians in terms of communications as a result of the pandemic (AM, 2022).

This manual focuses on using CT to treat younger Indonesians, especially millennials and Gen Z, who suffer from minor depression (referred to here as clients). It has previously been mentioned that younger generations might prefer CT as they are used to communicating via text. Depression affects approximately 16 million Indonesians (Ministry of Health of the Republic of Indonesia, 2018). Although there are no official numbers on how many Indonesian millennials and Gen Z suffer from depression, the Ministry of Health of Indonesian has estimated that 5.8% of the population aged 15 to 34 (of whom millennials and Gen Z are subsets) suffer from depression. This number may increase as a result of the COVID-19 pandemic due to the loss of livelihoods and even the loss of relatives and family members. Based on these considerations, it is safe to assume that more accessible mental health interventions such as CT have become necessary.

Unfortunately, even though the need for CT in Indonesia is great, evidence-based guidance for CPs on how to best execute it has been lacking. This might have discouraged Indonesian CPs from providing CT services due to being unfamiliar with and uncertain about the whole concept. At the time when this manual was developed, the educational curriculum for Indonesian CPs does not include courses focused on CT or other distance psychological services.

This manual contains guidance for Indonesian CPs on ways to conduct CT for Indonesian Gen Z and millennials who are experiencing mild depression.

Specific Purposes of this Manual

1. General and Specific Guidelines in Conducting CT.

The chapters in this manual, with the exceptions of Chapters 1, 7 and 9, offer general and specific guidance that can be helpful for CPs who intend to provide CT services for different types of mental health disorder. The manual may also be useful for CPs who are already practicing CT who are looking for more guidance. This manual contains guidance covering the stages of CT from initial contact through to termination and the relationship between the CP and the client after the sessions have ended.

2. Guidance on Conducting CT for Indonesian Millennials and Gen Z with Minor Depressive Disorder

The manual also provides general guidance for CPs on the characteristics of depression and of millennials and Generation Z in Indonesia. In a nutshell, minor depressive disorder is on the milder end of the spectrum of depression, a mental illness that causes mood to be persistently low. This is thoroughly discussed in Chapter 6 and 7. Chapter 9 of this manual contains guidance for CPs conducting CT with Indonesian millennials and Gen Z who suffer from minor depressive disorder.

The Method Used to Develop the Manual.

The manual was developed using a collaborative design (CoDesign) method that involved a process of collective creativity between stakeholders (Thabrew et al., 2018). The researcher chose the method in order to create a manual that includes the opinions and experiences of the parties involved in CT: the CPs, as the ones who provide CT services, and the clients, who are the recipients of CT services. The collaboration between representatives of these two groups and the researcher aimed to create a manual that meets the needs of both CPs and clients, rather than being primarily oriented towards one party.

The process involved eight Indonesian CPs (seven female and one male) and seven clients (four males and three females) who contributed as participants. The collaborative design method that was used to create this manual was adapted from the model by Bowen et al. (2013). It consisted of five stages: 1) understanding and sharing experiences; 2) exploring blue-sky ideas; 3) selecting and developing blue-sky concepts; 4) converging on a practical proposal and 5) prototyping, with one additional stage, evaluation. An outline of the process can be seen in Figure 1.

The design process for this manual also gave special consideration to the concepts of culturally sensitive psychotherapy to ensure the manual is sensitive to the Indonesian culture. Two theories were used to explore the concepts. The first theory comes from Bernal et al. (1995) who identified eight factors to be considered for psychotherapy to be culturally sensitive, including 1) language;

2) persons; 3) metaphors; 4) content; 5) concepts; 6) goals; 7) methods, and 8) context. The second theory comes from Rosenzweig (1936) who proposed that all psychotherapies have common factors despite any differences. Cuijpers et al. (2019) identified the therapeutic relationship as a primary factor in all types of psychotherapy. This manual looks into how the therapeutic relationship is created in the Indonesian setting.

Recommendations for Future Research

The manual offers two suggestions for researchers pursuing similar topics. One is to conduct CT trials or usability testing based on the manual. Chapter 2-6, and 8 provide comprehensive guidelines on how to conduct CT, for different types of mental disorder. Researchers could also conduct specific trials aimed at treating Indonesian millennials and Generation Z with minor depressive disorders using the entire contents of the manual.

Presentation of the Manual

All the content provided in this manual is evidence-based. Some statements are supported with references to the literature and some are the result of the data gathering for this study. Readers who want to understand the full reasoning behind this manual can consult the researcher's Massey University of New Zealand PhD thesis.

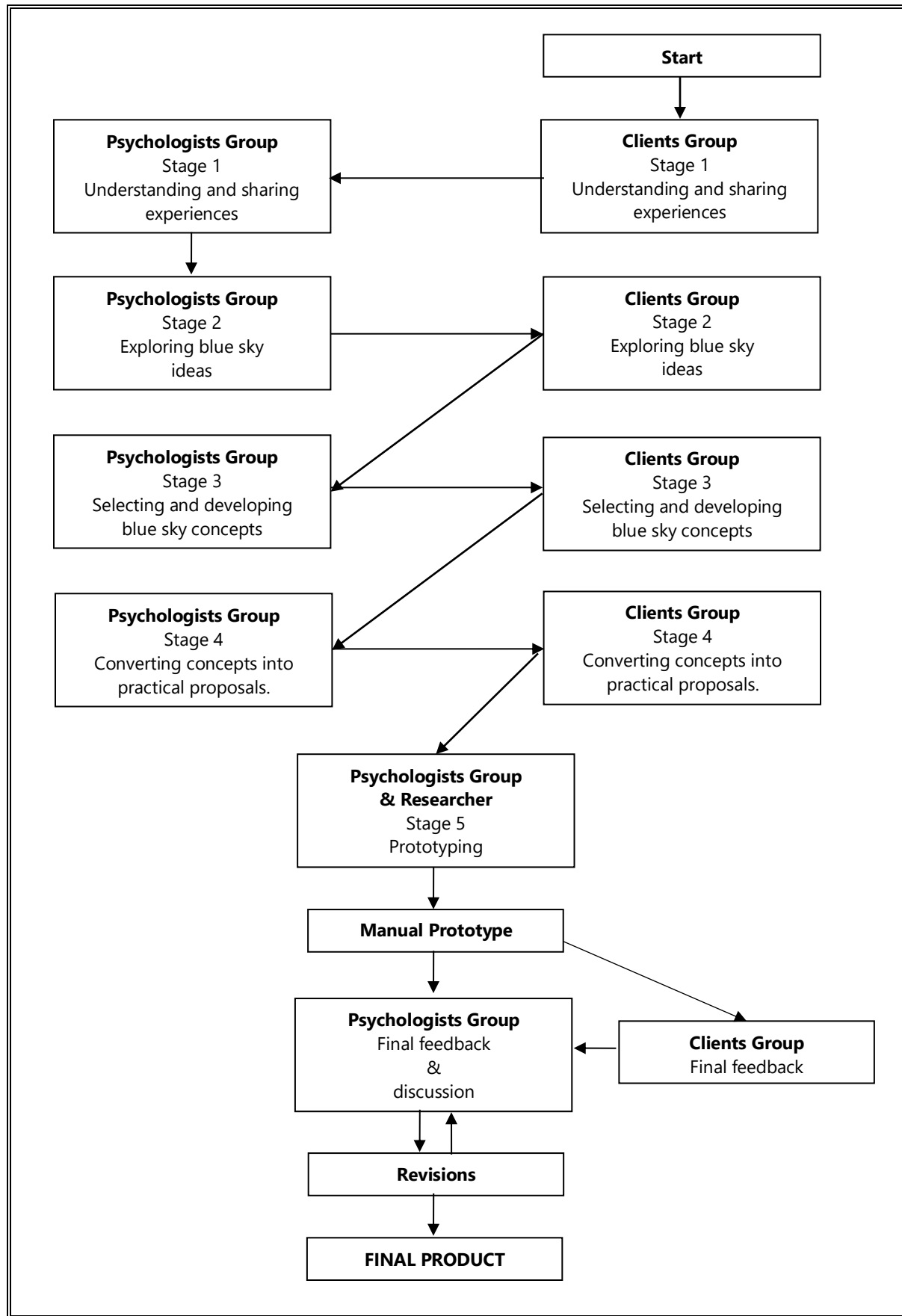


Diagram 1 – Data Gathering Process

Chapter 2 - The Concept of Chat Telepsychotherapy

The purpose of this chapter is to introduce the concept of CT, along with its advantages and disadvantages. It is probable that the first use of the term “Chat Telepsychotherapy” (CT) is in this manual. Therefore, the CT concept needs to be explained.

Definition of Chat Telepsychotherapy.

Two aspects were considered in the process of defining the concept of CT. The first aspect was the semantic traces in the term. The second aspect was the opinions of the CP participants in the study.

From semantic perspective, chat telepsychotherapy contains three concepts: 1) chat, 2) tele, and 3) psychotherapy. The following discussion outlines the understandings of each concept before explaining the concept of CT as a whole.

- *Chat*
Originally meant small talk (Merriam-Webster, n.d.a). The term was then adopted into communication technology, creating a new meaning. According to Derrig-Palumbo (2016), chat involves real-time text communication that is carried out via an internet network. Chat in the era of this manual is carried out via a smartphone application over an internet connection.
- *Tele*
An Indonesian Dictionary defines “tele” as distance or at a distance.
- *Psychotherapy*
Psychotherapy contains the concepts of “psycho” and “therapy,” originating from the Latin words *psukhē*, or breath, life, or soul, and *therapeia*, or curing, or healing. (oxfordreference, n.d.; etymonline, n.d.).

The CP participants of the study deemed it essential to include the concept of “providing help” in the definition as according to the CP participants, CT is about providing help for people in need that is curative in nature and helps them feel better about themselves. People in need include people with mental health issues and those seeking personal development and the help may take many different forms; some people might need a direct solution, while others might need some insight into their situations.

Based on the discussion above, this manual defines CT as follows:

Chat telepsychotherapy is a therapeutic online synchronous text-based communication (chatting) relationship that is curative in nature with the aim of providing help for clients who suffer from mental health problems or are in need of guidance to improve their lives

CT and Other Mental Health Interventions

The concept of psychotherapy in CT is different from other mental health interventions. The following table compares psychotherapy with several other mental health interventions such as guidance, coaching, consultation, and counselling.

Concept	Understanding
Guidance	Guidance is often tied to a vocational or academic setting (Jan & Mattoo, 2018). It involves showing the way, regulating, giving advice, and even giving instruction (Winkel, 2008). In guidance, individuals receive continuous support from someone who has a better understanding of the subject and is there to help them improve their abilities in the subject and develop confidence, independence, and self-esteem (Miller, 1961; Surya, 1988)
Coaching	The basic idea of coaching is to facilitate someone to learn (Whitmore, 2002). Coaches do not necessarily need to be knowledgeable in the subject as their speciality is the process of learning (Hall & Duval, 2004). Coaches ask questions aimed at prompting clients towards self-directed learning and growth (Grant, 2001). Finally, people who seek coaching are often wanting to improve their performance in something they are already doing well (Page, 2005; Williams, 2005).
Consultation	A consultant is a knowledgeable person with experience in a particular field who gives professional advice or opinions to people seeking specialist expertise (Falender & Shafranske, 2020). Through consultation, problems can be solved and conflicts resolved to prevent similar issues in the future and make further consultation unnecessary (Sweeney, 2019). In psychology, a consultation might revolve around a third person (Caplan, 1970), for example, a junior psychologist who is having difficulty with a client could consult with a senior psychologist about the case.
Counselling	The most similar concept to psychotherapy, counselling deals with the client's private logic, emotions, and behaviour (Sweeney, 2019). It refers to a therapeutic process that aims to empower clients so that they can meet and cope with regular developmental challenges (Nystul, 2015). Counselling focuses on short-term goals and preventive action for potential issues that might occur in the future (Nystul, 2015).
Psychotherapy	Psychotherapy is remediative rather than preventive and people who receive psychotherapy have more complex issues that may be classified as mental disorders (Nystul, 2015). Sommers-Flanagan and Sommers-Flanagan (2018) have mentioned that although counselling and psychotherapy work in similar ways, psychotherapy tends to be less directive than counselling, to go a little deeper, and the work lasts longer. Jones-Smith (2019) has suggested that psychotherapy is a more reconstructive process for people with serious issues in coping.

Table 1—Various Types of Mental Health Intervention

In summary, compared with other psychological interventions, psychotherapy's differentiator is its ability to treat a more serious mental disorders that often need thorough assessment. The other psychological interventions listed above are designed for people who are functioning normally but are confused or unfamiliar with a particular subject or skill in their life, or who might have life challenges, or conditions that are still considered mild and not classified as mental disorders. Another important key point is that psychotherapy involves more complex therapeutic interventions compared to advice-giving or knowledge transfer.

Psychotherapy in this CT manual follows the same processes as face-to-face psychotherapy. It begins with an administrative stage and ends with deciding how the relationship between CP and client is to be managed after therapy is over (see p. 117 for a summary of the stages). Therefore, CT is not a quick or even instant procedure that can be performed in a single session.

Advantages and Disadvantages of CT

Advantages

- CT is a psychological intervention that is suitable for young Indonesians as they are accustomed to communicating via chat messages.
- The fact that CT prioritises written communication may have positive impacts on the clients who use it. Firstly, stringing words together in a chat message can be considered as a form of writing therapy for those clients who are more comfortable expressing their emotions and ideas through words. Secondly, the writing of chat messages may serve as a cathartic way for the client to vent any strong emotions that they might be feeling at that time.
- CT allows the client extra time to think of the best response to the CP. In face-to-face settings, clients may feel nervous or at a loss for words. Since clients can choose their own location for CT, they be in a better mind to think about their responses. Moreover, since chat communication allows clients to edit their messages before sending, they have the flexibility to change their responses until they are comfortable with them.
- CT is a good therapy option for clients who are unwilling to meet CPs face-to-face for various reasons. For example, a client with agoraphobia might find it difficult to leave their house to meet physically with a CP.
- CT gives the CPs as well as the clients an automatic way to document the therapy, as the chat messages are automatically saved in the apps. This helps both the clients and the CPs by allowing them to reread what was said during the sessions.
- CT gives Indonesians easy access to psychotherapy services in terms of distance and time. This may be helpful for clients with immediate needs for psychological services. This also makes CT a good way of providing mental health first aid because it can be provided quickly, by someone who is qualified.

- CT provides a better communication experience in terms of signal compared to other telepsychology therapeutic intervention methods such as video calls and phone calls. That is because chat uses far less data than these other options.
- CT offers clients the convenience of accessing services through both mobile phones and computers. Most chat apps can be accessed via computers.
- CT is a more economical mental health intervention option than face-to-face psychotherapy. Even though Indonesians are becoming more aware of psychotherapy, not all of them can afford face-to-face therapy.
- CT gives the CPs the opportunity to immediately check anything the client says that is unfamiliar to them.
- The CP does not need to prepare in terms of attire or venue.

Disadvantages of CT with Possible Solutions

- **The Patterns of Communication**
Communication within CT is mostly carried out via chat messages which lack nonverbal cues such as the client's expressions, voice, and body movements. This ultimately affects the depth of the therapy (which is discussed in the following point). From the client's perspective, losing the nonverbal aspects could possibly lead to monotonous and boring sessions. Finally, without intonation and expression, chat communication may lead to misunderstandings. This, along with possible solutions, is discussed in the section in Chapter 5, "Verbal and Nonverbal Communication" (p. 37).
- **The Difference in Depth of the Therapy**
Depth refers to the comprehensiveness of analysis of the issues experienced by their clients. In face-to-face therapy, CPs are able to analyse the difficulties experienced by the clients and create a comprehensive case formulation that explains the dynamics of the issues. This is more difficult in CT for two reasons:
 - The loss of non-verbal communication also means the loss of additional observational data
 - CT is more time consuming compared to direct verbal communication in face-to-face therapy. The main reason for this is the difficulties in compiling the chat messages (as discussed next). This limitation also affects how much information can be exchanged in a session. The amount of information exchanged in a one-hour CT session will tend to be less compared to one-hour face-to-face sessions.

In a nutshell, the lack of information from the chat communication leads to a more superficial understanding by the CP of the clients' difficulties.

As a potential solution, the CP can aim to establish a deeply empathetic level of chat to improve the possibility of extra nonverbal information such as expressions of emotion being provided by the clients. Empathetic communication is discussed in the section in Chapter 5, "Verbal and Nonverbal Communication" (p. 37). The CP is also advised to devote more time to the CT session so that the CP and client have the opportunity to exchange more information. Further discussion about session duration can be found in the section in Chapter 5 on Session Duration and Time Between Sessions" (p. 48). Should this not be suitable or possible, then the CP might need to explain to the client that CT will require more sessions compared to face-to-face therapy in order to reach the same level of comprehensiveness as face-to-face therapy.

- **Difficulty in Compiling Messages.**

CT requires that both clients and CPs express their thoughts and feelings in their chat messages. For CPs, this can be difficult as they must be careful in arranging their words so as not offend their clients. Given the lack of nonverbal cues, CPs might need time to write the messages before sending them to clients. Given the possibility of misinterpretation, any wrong choice of words could lead to misunderstandings from the clients' side. Even when the CP thinks the messages are appropriate, there are no guarantees that clients will perceive them the same as the CP intended. Typing messages can also be burdensome for the clients, especially when they are unstable and do not have the motivation to type. This situation can lead to messages that do not fully represent their actual state of mental health. As a possible solution, CPs are advised to also use the voice-note features in chat applications, as discussed in the section in Chapter 5, Voice Notes (p. 44).

- **Limitations on the Severity of the Issues**

This manual is probably the first document to provide guidance for Indonesian CPs carrying out psychological interventions using chat. At this stage, it is recommended that CT only be conducted with clients experiencing mild mental disorders rather than serious ones. Serious mental illness (SMI) refers to psychotic disorders, bipolar disorder, and either major depression with psychotic symptoms or treatment-resistant depression. SMI can also include anxiety disorders, eating disorders, and personality disorders with severe functional impairment (Adams & Aggarwal as mentioned in Swinson, et al., 2016). The severity is ascertained through the assessment of the client's issues conducted by the CP. If the CP discerns that their client has severe disorders, they are advised to refer the client to their nearest health facility for face-to-face therapy.

If a CPs does finally decide to refer a client for face-to-face therapy, the CP is still expected to provide clients with an intervention which is often called "self-help" which is general in focus but still relevant to the client. The idea behind this recommendation is to still provide clients with some practical support despite the referral. Self-help includes relaxation, meditation, and simple behavioural activation techniques. It is also important for the CP to give the reasons and explain why they are making the referral and why having face-to-face therapy would be beneficial for the client.

- Aspects of Control in Therapy

The CP has reduced levels of "control" in CT, compared to face-to-face therapy where the CP can directly guide the clients and ascertain whether the client is completing an intervention correctly. For example, if relaxation is a part of the therapy, in CT a CP cannot really check whether the clients are performing the relaxation technique correctly. Another example is that ensuring the clients correctly fills out the worksheets that are commonly given as a part of homework, is difficult in CT. CP are advised provide instruction as clearly as possible and use assistance such as videos and sample documents to be sent to the clients electronically. It is also important to check the worksheet/homework that has been completed by the clients.

- Focus Aspect

CT also has the potential to eliminate the focus that both the client and the CP should have during therapy. The client or CP may lose focus because of a physical distraction, such as someone entering the room or a phone ringing. There is the possibility that both CP and client are doing some other activities simultaneously with the CT. Such behaviour can reduce the effectiveness of the therapy. CPs are advised to schedule specific times for CT, not to combine it with other activities and choose a workplace with minimal distractions. CPs are advised to remind their clients to do the same. This can be explained in detail when informed consent is being sought and also at the beginning of each session.

- Cultural Aspects

CT allows CPs and clients from different cultural backgrounds to engage in therapy. This has the potential to introduce cultural unfamiliarity and language barriers into the relationship. The issues around culture along with some options to accommodate them are discussed in the section in Chapter 4, "Culture and Chat Telepsychotherapy" (p. 24).

- Technical Aspects

CT is dependent on technology which is prone to problems such as signal loss and errors in the app or in the device itself. Both CPs and clients might lose their device. Such events could lead to anxiety for both the CP and the client which may then affect the process of therapy. CPs are advised to be aware of updates in applications and operating systems on the device used and to remind the client of them. CPs can also lay out contingency plans or protocols for such an event occurring during therapy as part of the informed consent process. More discussion about this matter could be found in the section in Chapter 5, "Missing or Absent Clients" (p. 52).

Chapter 3 — Starting CT Practice

This chapter provides Indonesian CPs with guidelines and understanding on how to start a CT service within their practice.

Pathways to Starting a CT Service

This section describes several different paths that CPs can choose to embark on CT in their practice.

- **Starting an independent CT practice**
CPs can independently start CT practice by simply downloading chat applications from a smartphone app store. There are multiple considerations in choosing an application. These are discussed in the section in Chapter 3, The Selecting a Chat Application. (p. 15).
- **Collaborating with telepsychology companies**
CPs can join existing telepsychology companies that offer CT as one of their services. Not all companies are specifically suited to providing CT services. Sometimes companies are more engaged in teleconsulting or telecounselling. CPs are advised to work with companies that can facilitate CT by being able to provide longer and ongoing sessions between the CP and the clients. Working with these companies can also help CPs find clients that are in need of mental health interventions.
- **Collaborating with companies with an IT focus**
CPs who have independent practices or work in institutions (such as hospitals or mental institutions) can work with information technology companies to create their own CT applications. This can be considered by CPs and agencies who want to have a separate, independent CT application and not use the existing chat applications.

Considerations Before Choosing a Path

Each pathway listed above has its advantages and disadvantages. This manual recommends that CPs consider the following aspects and choose the path that is most appropriate in the CP's circumstances.

Control

While practicing CT, the CP would want to control several things such as the practice schedule, the format of psychotherapy sessions, policies regarding the psychotherapy practice, data confidentiality, among other things. Control will certainly be greater if a CP has their own CT

practice, although joining existing companies does not mean that the CP loses all control. It all depends on the company's policy. CPs are advised to do thorough checks on how the company manages CT sessions in regard to the concepts mentioned above. On the other hand, existing companies might already have established knowledge about CT which may help CPs who are completely unfamiliar with CT.

Service Promotion

CPs also need to explore how to best promote their services. A CP who undertakes private CT practice will take full control of these promotional activities. This will not be an issue for CPs who are naturally creative or have a creative team. However, a CP who joins an existing company will not need to worry about promotion as it will be done by the company. Regardless, CPs need to consider the extent to which the company promotes the CPs as individuals.

Ideally, CP should provide some personal information that can help clients to choose the CP who is most suitable for them. Helpful information could include, but not be limited to, the CP's expertise, cultural background, and prices. Examples of expertise may include the treatment of depression and anxiety, provision of career guidance, or working with youth issues. A special discussion about cultural description can be found in the section in Chapter 4, "Cultural Descriptions in CT Promotions" (p. 25).

Convenience in the interface and features of the application

Being familiar with the chat application is important when conducting CT. If the CP uses chat applications that are widely used in the community, both the CP and the client will be more familiar and comfortable with the interface and the features of the application. Specially created chat applications might have unfamiliar interfaces and features, and be of variable quality. Feelings of unfamiliarity might hinder the outcomes of the CT.

Numbers of Clients Served Simultaneously

Indonesian telepsychology companies might ask CPs to serve several clients concurrently. This has an impact on the depth of the intervention, the intervention communication patterns, and the focus, and energy that must be allocated by the CP while providing therapy. Serving multiple clients can also lead to potential errors such as misremembering the clients or sending the wrong messages. This manual focuses on one-on-one therapeutic relationships.

Session Duration

Some telepsychology companies might apply specific time limits per session while others end their sessions based on agreement between clients and CPs. CPs must consider this as a session without a time limit might cause clients to overshare their problems with a lack of focus. Later on, CP might have difficulty discussing all the issues in a timely manner. On the other hand, sessions with a time limit would lead to more focused discussions and treatment.

Income Earned and Ease of Payment.

The incomes earned by CPs practicing in independent practices, working for agencies (e.g., hospitals), and CT companies are likely to differ. CPs practicing independently can determine their own desired fees and receive the full fee. This might not be the case if CPs work in agencies or collaborate with companies. The fees will be determined by them, and the CP might not receive the full fee or even might receive a monthly salary irrespective of the number of clients helped. Should a CP decide to join one of the telepsychology companies, the CP must also consider whether the company makes on-time payments.

Other Consideration for Telepsychology Companies

Companies consist of groups of people in different positions with different job descriptions. It is important for the CP to consider the ease of communications between different departments. Some companies also offer opportunities for professional development and networking by providing training and collaboration with other companies. Finally, the CP also needs to consider whether the contract with the company allows the CP to also collaborate with other telepsychology companies for the CP to gain more exposure to clients.

Selecting a Chat Application

CPs who want to practice CT independently need to choose an application to communicate with the clients. As there are many applications that the CPs could choose from, below are some considerations for CPs to choose the most suitable application:

- Using an application on a smartphone that can also be linked to a computer with a large screen and keyboard makes the CT process easier
- Using applications with emojis or voice-note features allows the use of nonverbal information (refer to section “Verbal and Nonverbal Communication,” p. 37).
- Using applications that have certain features such as read and typing status helps CPs and clients to know whether messages have been sent and read by the other party; and when the other party is in the process of typing a message. Another feature, “Last seen” could help CPs and clients to predict whether the other party has technical issues or is not open to

communication. A person last seen a day before would probably not be available to communicate in the moment or soon.

- Choosing applications with encryption functions optimises confidentiality between the CPs and the clients. However, these encryption features require both the CPs and the clients to use the same application. The concept of encryption is discussed further in the section in Chapter 4 on confidentiality (p. 19).

CPs are advised to familiarise themselves with different applications and use the ones that are preferred by the clients. Clients might only be familiar with specific chat applications that differ from the CP's first choice. Clients might also want to choose chat applications that clients do not usually use on a daily basis in order to be discreet. That said, it is important for the chat applications to meet the criteria discussed above. At the time of the development of this manual, the chat applications in use for CT, included WhatsApp, Line, Telegram, and Google Chat.

Fees

While CPs who join telepsychology companies may not need to think about fees, CPs who want to practice privately do. There are several considerations for CPs in determining the fees, including: 1) fee structure; 2) single sessions or plan payment plans; 3) upfront payment information; and 4) pro-bono service.

Fee Structure.

Careful calculations are recommended to determine fees for the first time, Stout and Grand (2004) suggested that practitioners should consider set-up and ongoing costs to appropriately determine the baseline fees. Examples of set-up costs could include a computer, software, internet service, and a website, among other things. Examples of ongoing costs could include marketing costs, billing, networking, and utilities among other things.

CPs also need to take practice experience into consideration. Although there is no fixed formula for this matter, the common assumption is that the more experienced the CP, the higher the fee. However, this may not always be the case. Junior-level CPs might set higher fees compared to their senior counterparts. Possible reasons could include the differences in the set-up and ongoing costs. However, according to McWilliams (2004), more fundamental reason for this is that the more experienced CPs avoid charging high fees so that the clients do not put too much hope in the therapy. High expectations by clients are not healthy in a therapeutic setting.

Single Session Fees or Payment Plans

CPs can choose whether clients should pay for sessions singly or on payment plans. There is mixed evidence that payment plans increase the client's attendance commitment to the therapy (Clark & Kimberly, 2014; Sammons, 2019), however, payment plans also require the CP to commit to times in the future with little room for incidental events such as work trips. CPs who are not keen on such arrangement can use single-session payment instead. CPs could use payment plans as a promotional opportunity by offering more economical fees overall compare to single sessions, plan payment plans would then be more expensive upfront compared to single sessions which some clients might not be able to afford. In the end, it is up to CPs to choose which arrangements are most favourable for the CP.

Upfront Payment Information

Ethically, CPs should inform the client about payment arrangements upfront. However, there are no strict policies on whether clients should pay the fees upfront. The basic idea is to let the client know about the fees involved so that they can decide whether to continue with the therapy or not. It is suggested that CPs explore more affordable psychotherapy options for referrals in case clients decide not to continue with therapy due to cost. It is up to the CP to consider the situations of the clients and their ability to make upfront payments on a case-by-case basis.

Chamberlain (2009) suggested six options for CPs to help clients in difficult financial situations, which are: 1) propose flexible scheduling where clients could meet with the therapist fortnightly instead of weekly; 2) suggest a progressive payment plan, where therapist would accept payment with the amount that corresponds to the client's ability to pay and increase the fees if the client's financial situation improves; 3) offer a sliding fee scale, where the fee corresponds to the client's situation without any possibility of increase; 4) accept what the client offers, when the CP asks the client directly how much they can afford; 5) see them pro bono; or 6) refer them to community or pro bono mental health services.

Pro Bono Service

Some CP might consider giving some service pro bono if their circumstances allow. For example, some community organisations often provide pro-bono psychological services to help the community. While this might not be monetarily beneficial for the CPs, CPs could still count this as practice hour to be later used for licensing matters. The correlation between payment and the outcomes of therapy has been extensively researched. Traditionally, practitioners have been certain that payment should be required for psychotherapy in order to avoid low-quality service and lack of commitment by the CP, and the loss of perceived value by the clients (Forrest, as cited by Herell, 1993; Freud, 1913; Menninger, 1961). However, more recent research has shown that

payment did not predict therapy outcomes (Clark & Kimberly, 2014). Yoken and Berman (1984) found that pro bono service actually has better outcomes, as therapists who offered free treatment were perceived by the clients as warmer and more welcoming which provided a more conducive environment to change.

Personal and Professional Contact Details

It is recommended that CPs have separate lines of communication to maintain the boundaries of personal and professional communications with clients. There are risks with using personal contacts when practicing CT. Clients would be more likely to make after hours' contact with the CP and the possibilities of confusion between personal and professional communications could also damage the therapeutic relationship. However, the downside of having two lines of communication is that CPs need to make extra effort to maintain those two lines, for example, if using two different phone numbers results in two monthly bills.

Workplace

Although CT is a fully online service, CPs still also need to consider their workplace. Ideally, CPs are advised to use a dedicated place without distractions so they can concentrate and be mindful during the CT sessions. The room should ideally have good temperature controls, lighting, and a good internet signal. CPs are also advised to maintain sitting position to prevent falling asleep during the sessions. This recommendation should also be given to the clients.

Chapter 4 — General Guidelines for Conducting CT

CPs are expected to have enough knowledge to start practicing CT. This chapter discusses some psychotherapy concepts in CT which are still commonly found in face-to-face practice but may have different manifestations in CT practice, including 1) confidentiality; 2) therapeutic relationships; 3) culture; and 4) creating collaboration.

Confidentiality

In the practice of psychotherapy, CPs are required to maintain the confidentiality of their clients. This section discusses how confidentiality is applied in CT.

The Concept of Confidentiality in CT

The paramount thing to understand about confidentiality in CT is the fact that all messages sent between clients and CPs are in the form of digital data sent via applications. These applications have their own servers and internet connections. This means that all the therapeutic data are not kept purely between the CP and the client and a third party can potentially access the data created during the psychotherapy via the chat application.

CPs who are planning to join a telepsychology company, should know and understand how the company manages client information, including: Can the company see information provided by the clients when using the company's application?

- If it can, how does the company protect the client's information? Is the information used for promotions? If so, how much detail is used? Does the company destroy the information after a given time?
- Given that client consent is important, does the company ask for the client's consent to store their information and possibly use it for company purposes?

As a general guideline, Undang-undang Perlindungan Data Pribadi [Personal Data Protection Act], 2022) says that every *penyelenggara sistem elektronik* (PSE, or electronic system provider) must prevent personal data being accessed, revealed, amended, misused, damaged, or erased by unauthorised parties. A PSE is defined as any person or business entity that provides, manages and/or operates electronic systems by themselves or together with the electronic system user in its own interests or those of another party/s. The act also says that there should be a minimum of two people who are responsible for the processing of personal data. Finally, the act also suggest that personal data should be destroyed after the retention time is over, requested by the people whose personal data it is, or determined by other laws. In terms of medical records, Indonesian constitution allows any medical professional to destroy any medical data after twenty-five years

after the last visit (Peraturan Menteri [Permen] Kesehatan Republik Indonesia Tahun 2022 Tentang Rekam Medis [Ministry of Health of Indonesia Regulation concerning Medical Records 2022]). Should CPs choose to provide CT using popular chat apps the CP needs to research the confidentiality clauses in the terms and conditions for use. CPs might also want to clarify these with customer service or the sales team for the application.

CPs should choose telepsychology companies and chat applications that use extra measures to secure the personal data of the clients. A minimum standard protection practice is the use of encryption. According to Ayuningsih (2019),

Encryption is a method that can secure information by changing the information into a certain pattern so that it is not easy to read and understand. Encryption is part of securing data so that it is not misused by irresponsible parties.

Encryption can increase the security of information that is sent digitally from one party to another or secure folders that contain personal data. There are various encryption systems with differing levels of complexity, depending on the application, however, encryption does not mean that systems are impenetrable. CPs and their clients must understand that encryption only increases security but does not guarantee total protection of the data.

The Classification of Personal Data

In CT, confidentiality applies to 1) the clients' identity and 2) the CT process data.

Identity. Includes not only names but also age, ethnicity, place of residence, and other data. According to the Indonesian Personal Data Protection Law, identity falls under the category of "general personal data". This information creates contextual data which helps the CP to understand their clients. In practice, the clients of chat-based remote psychology services are often unwilling to reveal their identities and clients often choose distance psychological services because of the possibility of remaining anonymous during the whole process.

It is important to reiterate that CT is a channel for psychological intervention that does not rely solely on giving psychoeducation. There will be more comprehensive intervention to change the behaviours of the client and this could have profound and legal consequences. Therefore, for the safety of both the CP and the clients, it is recommended that CPs only accept clients who are willing to reveal their full identity and emergency contact details. A more detailed example of what information is needed in CT can be found in "Initial Form of Chat Telepsychotherapy" (p. 85). Despite that, the CP does not necessarily need to immediately reject the client who is reluctant to provide identification at their first contact. This manual offers some procedures for working with

clients who are unwilling to provide identification—discussed in the section in Chapter 5, “First Contact: Clients Who Need Special Attention” (p. 46).

CT Process Data. CT produces several kinds of electronic data through the interactions between the CP and the client. These include: 1) administrative documents such as informed consent forms, 2) the chat history between the CP and the client, and 3) completed worksheets provided to the client. According to the Indonesian Personal Data Protection Law, these kinds of data fall into the category of “specific personal data”. Completed forms and worksheets may be sent to the CP via email or the chat applications, while chat history is usually obtained by backing up chat conversations between the CPs and the clients. In general, CT process data is useful to help CPs remember the process and history of the therapy that has been undertaken with the client.

Personal Data Storage

It is recommended that identity and CT process data are downloaded and backed up from emails and chat applications and stored in an encrypted folder on the CP’s computer that is only accessible by the CP.

Data Confidentiality Limits

As in face-to-face therapy, CPs may need to disclose the clients’ data to an emergency contact, emergency health services, or the police if any of these situations occur: 1) when clients may potentially hurt themselves or others; 2) when clients may potentially commit criminal acts, 3) the data is requested by the police, or 4) the data is needed for psychological research, in which case, the data must be anonymised according to the Code of Conduct for Indonesian Clinical Psychologists Chapter 2, Article 2. This policy also aligns with the Indonesian Health Practitioner Law Chapter 7, Article 73, Paragraph 2 where it is written that confidentiality can be waived in the interests of the subject’s health, at the request of a government legal officer, the request of subject, and in accordance with other constitutional laws that deals with confidentiality limits.

CPs need to be careful in deciding whether clients might hurt themselves, others or even potentially commit criminal acts. CP are not advised to give out clients’ data on the basis of superficial information or hunches. Clients might become emotional at times and say things they don’t mean. Should this happen, it is important for the CP to try to calm the client first. Any suspicion that the client has the potential to carry out a dangerous or extreme act has to be confirmed using comprehensive and evidence-based reasoning. The wording from the clients must be detailed and convincing before the CP decides to take further action. Finally, it is recommended that the CP seek legal advice before deciding to call authorities and give out a client’s data.

Therapeutic Relationships in CT

Research shows that therapeutic relationship is one of the keys to successful therapy. This section discusses how to build therapeutic relationships in CT.

Implementation of Psychotherapy Techniques

Several strategies and techniques used in face-to-face therapy can be applied in CT, including:

- Empathy, which is specifically addressed in the section in Chapter 5, "Showing Empathy and Giving Praise in CT Sessions" (p. 41).
- Providing opportunities for the clients to tell stories and vent. In CT, CPs can allow the clients time for venting by letting them send messages without interruption from the CP. See the section in Chapter 6, "Clients' Expectations of CT" (p. 65).
- Developing rapport. Given that CT does not allow for face-to-face communication, it is very important for the CP to establish rapport through chat communication. See the section in Chapter 4, "Prior to Starting CT" (p. 25) as well as the section in Chapter 5, "Verbal and Nonverbal Communication" (p. 37) for discussions of ways to establish rapport.
- Not judging the clients. Given that the practice of CT allows clients and CPs to come from different backgrounds, it is very important for CPs to remain neutral and objective in the CT process. Please see the section in Chapter 4, "The Importance of Culture in the Process of CT" (p. 25).
- Having cultural sensitivity. This topic is specifically addressed in the section in Chapter 4, "Culture and CT" (p. 24).
- Ensuring that the CP understands the situation experienced by the client and requesting clarification if needed. See the section in Chapter 9, "Assessment" (p. 95).
- Applying counselling skills, including: 1) attending, 2) paraphrasing, 3) clarifying, and 4) reflecting. See the section in Chapter 9, "Counselling Skills" (p. 96)

Etiquette in CT

Below are some examples of practices that will help to establish a therapeutic relationship in CT.

- Using the client's title appropriately and correctly
- Waiting for the client to finish typing and not interrupting. However, there are times when the CP might send a quick short reply to show the client that they are indeed attending. This is especially pertinent when clients are telling a lengthy story.
- Practicing patience towards clients who are aggressive or resistant to talk about their difficulties. See section "Managing Clients' Responses" (p. 49) for further information.
- Being friendly and semi-formal, in the sense that the CP is not too rigid but also not too friendly, thus remaining approachable and professional

- Being responsive to clients' humour, but not to make any inappropriate jokes. CPs need to maintain professionalism during therapy sessions.
- Responding quickly and not making the client wait too long for responses
- Providing "balanced" responses to clients' messages and avoiding short responses if clients have sent long messages. To balance the clients' messages, the CPs can also paraphrase and summarise clients' messages and check whether the summaries are correct or not.

Client Challenging Behaviours

Clients may behave unprofessionally or informally towards CPs if they feel too comfortable with a CP during the therapy. This section lists some scenarios and how to best handle them.

- Clients contact CPs outside the agreed schedule
There are several reasons as why clients might do this. Some may be ignorant of the agreed schedule and assume they can contact the CP anytime they want to. Some may be impulsive and feel the urge to send chat messages every time they feel anxious, to ease their feelings. Some of them may want to ask questions so they are not forgotten. The basic response to all of these is that CP could respond briefly, acknowledging the questions and clarify the schedule agreed upon at the beginning of the therapy.
- Clients forget the purpose of therapy
Clients may get too comfortable and vent constantly without any particular focus and not allowing the CP to perform therapy. To respond, CPs need to regain control by interrupting them and bringing the discussion back to the original course of the therapy.
- Clients become aggressive
This is specifically discussed in the section in Chapter 5, "Problematic Interpersonal Style" (p. 50).
- Clients develop transference
Prasko et al. (2010) list 11 possible manifestations of transference. They include positive types such as euphoria and negative types such as fear and anger. The basic response in this scenario is to address the transference and provide feedback accordingly. Depending on the type of the transference, the CP could have an open discussion about the feelings that the clients have, provide homework to help the clients with their feelings, or give feedback on the feelings.
- Clients become manipulative
Manipulative clients behave in similar ways to impulsive clients and often contact the CP outside the agreed schedule. The difference is that manipulative clients often request immediate responses and may become aggressive if the CP fails to give one. They might make threats of suicide in order to provoke a response. This scenario is further discussed in Chapter 8, "Self-Harm" chapter (p. 71)

Culture and Chat Telepsychotherapy

Culture can support the development of a therapeutic relationship. There is confusion about how to correctly define culture. As mentioned by Dayaksini and Yuniardi (2022), some people describe culture as patterns of behaviour while others relate culture to traditional art forms. This manual focuses more on the former understanding. The definition below summarises how culture is considered in this manual.

[Culture is] a unique meaning and information system, shared by a group and transmitted across generations, that allows the group to meet basic needs of survival, pursue happiness and well-being, and derive meaning from life. (Matsumoto & Juang, 2017)

Culture can also be divided into two types: the macro cultures, or of large complex social systems in countries or regions, and the micro cultures of small groups such as religious and ethnic groups, or even family groups (Nofiawaty, 2010; Zhuravlova, 2016). Throughout this section, the manual describes the importance of culture in relation to CT and how CPs can acknowledge, respect and respond to culture.

Sensitive Cultural Issues

It has been discussed previously that culture can have beneficial impacts in psychotherapy. However, culture can also have detrimental effects. The term SARA (*suku, agama, ras, dan antargolongan*; ethnicity, religion, race and intergroup) describes topics that are considered sensitive in Indonesia. Therefore, CPs must be very careful about bringing SARA variables into therapy. Some considerations related to the concept of SARA in psychotherapy are as follows:

- each aspect of SARA is subject to stereotypes and generalisations, which could compromise the effectiveness of the therapy.
- SARA is a private area, particularly the religious aspect. CPs who bring religion into therapy without being prompted can potentially cause discomfort. Some clients may come to the CP for a neutral perspective not a religious point of view.
- Indonesia includes a large number of ethnicities and races. Indonesia also recognises five religions. CPs who are not from the same SARA may not necessarily have sufficient knowledge to understand and incorporate SARA concepts into CT. Doing so, without sufficient knowledge and understanding, can lead to the therapy being ineffective.
- Client do not necessarily practice or live their lives following their SARA. CP need to find out about this during the initial assessment and not simply judge clients by their SARA.

The Importance of Culture in the Process of CT

As previously mentioned, culture plays a big role in CT. Below are some considerations on how culture might affect different stages of CT.

Prior to Starting CT. Below are some considerations about how culture might affect the stage when clients make their first contact with a CP and express their need for or interest in CT.

Cultural Competence

As previously mentioned, culture applies at different levels and is sometimes sensitive. CT is borderless, and CPs could be contacted by clients from different cultures. To be able to cater to this, CPs need to be knowledgeable and open-minded about cultural differences. Clients might come from totally different cultures which may clash with the CP's beliefs.

Therefore, it is important for CPs to have "cultural competence and awareness of clients' needs, beliefs, attitudes and behaviours to be able to tailor intervention that accommodate these aspects. Van der Zee and Van Oudenhoven (2000) have provided some guidelines for mental health practitioners cultural competence, which includes 1) cultural empathy, or the ability to empathise with the feelings, thoughts, and behaviours of people with different cultural backgrounds; 2) open-mindedness, or the ability to have open and unprejudiced attitudes towards other people's cultures; 3) social initiative, or the ability to initiate and approach people in social situations; 4) emotional stability, or the ability to reflect and respond calmly in stressful conditions; and 5) flexibility, or the ability to interpret novel situations as positive challenges and adapt accordingly.

- Cultural Descriptions in CT Promotions

As Indonesia is a multicultural country, clients might seek CPs from similar cultures. CPs are advised to provide information that can indicate the CP's SARA background. This information could vary between CPs. Cultural information could be shared by a CPs using the following:

- Photos as the simplest way of communicating cultural information as appearance and attire can indicate the CP's SARA background
- Names, as some names in Indonesia are specific to particular cultures.
- Practice location: some locations in Indonesia are also related to specific cultures
- Alma mater: lead to not only geographical but also socio-economic culture.
- Written information: clear written information regarding the CP's culture might also be helpful, specifically when photos, names and locations do not match for any reason. Some CPs might have names that are not related to any specific culture or practice away from their hometown.

CPs do not necessarily need to provide all the information listed above in the promotion poster. Other than their name, they could also include other options listed above which they are comfortable with. CPs who practice CT must be ready to help everyone who contacts them, regardless of their cultural background.

- Culture as a factor to consider when accepting clients

Psychological therapy is most effective when the CP understands the client and the issues that the client brings to the session. This will however be a big challenge if clients' issues are strongly related to a culture that the CP is unfamiliar with.

CPs who encounter potential clients who have cultural issues are advised to refer them either to cultural experts for consultations or to CPs who share the same culture. CPs who still accept the client should either collaborate with cultural experts or work under the supervision of another CP from the same cultural background as the client. It is not ethical for CPs to accept clients with strong cultural difficulties without having enough knowledge or connection to the culture to be able to help the clients.

To understand what kinds of issues are strongly related to culture, below are three examples:

1. *A man who is soon to be married comes with a complaint of feeling depressed because his wedding preparations have collided with elements of his fiancée's culture that is different from his own.*
2. *A woman comes with a complaint of feeling pressured because she has to follow cultural demands that require women to behave in specific ways that are not comfortable for her.*
3. *A male teenager comes with a complaint of feeling pressured and confused as he feels his religion does not align with his internal values and beliefs.*

Essentially, all CPs could help clients with the issues above. However, CPs who are unfamiliar with the culture might need to spend a significant amount of time studying the clients' culture. Furthermore, considering the nature of CT, the time required for the CP to study the client's culture and clarify their understanding about the culture is likely to be longer than face-to-face therapy which causes the therapy to be ineffective therapy. It will be much more effective if the CP understands the client's culture.

Not all client issues related to culture require comprehensive and detailed knowledge by the CP, for example,

A regional student came to a CP because he felt pressured in his new environment. The student gave an example that in his hometown, students can easily express their opinions and conduct open and vocal discussions during classes. But when he came to the new city, he said that the students in the new city tended to be passive and silent. When this student expressed his opinion, he was considered rude and was even shunned by his peers.

With an issue like this, the CP does not need a comprehensive knowledge of the culture and could make an interpretation of the case based on a psychological framework. From the description, it can be seen that the most suitable psychological framework for the case would be the difference in communication styles in the old and the new environments. The CP could educate the student to understand the different communication style of his new environment and how to best manage it.

- Culture as a Tool to Develop Rapport

Despite Indonesia being multicultural in nature, CPs are still advised to enrich themselves with basic knowledge of the cultures in Indonesia. Knowing simple details of a client's culture will help them feel more comfortable with the whole process and help to slowly establish rapport. For example, the CPs can address clients using terms that are specific to their culture, e.g., *Mas* or *Mba* for Javanese clients and *Akang* or *Teteh* for Sundanese clients. Another example would be to greet the clients according to their religion.

During Ongoing CT. It needs to be understood that cultural aspects and clients cannot be separated. Even though CPs might refer clients with cultural issues to a more appropriate CP or another profession, clients, and CPs as well, are always part of larger societies with particular values and customs. This also needs to be considered. Below are some discussions on how culture might affect the ongoing process of CT.

- Being Sensitive and Inquiring towards Clients' Cultures

During the process of CT, a client might provide direct information about their culture or hint about it. CPs must be sensitive in acknowledging any explicit information or implicit hints from a client that might indicate any cultural contributors to the client's issues. CPs need to be curious and not take the information only at face value but continue to probe to ensure a comprehensive understanding of a client's case.

- Being Neutral and Tolerant towards Clients' Cultures

When the process of assessing a client's culture results in new information, this information might not be to the CP's liking. There might be times when a client's cultural values might not be

held by the CP or even contradict the CP's own beliefs and values. Therefore, it is very important for CPs to be neutral and tolerant towards clients' cultures and neutrality is one of the behaviours expected from CPs. The central concept of neutrality might be best explained by Selvini-Palazolli, et al. (1980) and Cecchin (1987) who described that neutrality means that CPs do not accept one position as more correct than another and continue to explore other possibilities. This means that CPs are not allowed to impose their belief and values on clients during therapy (Jackson, 2013). CPs should try to find other possibilities to explain what could have happened in the situations experienced by the clients and not accept clients' points of view at face value. This kind of thinking pattern is useful during the stages of assessment and intervention in CT.

While neutrality might bring more benefit to the clients, being tolerant is of benefit for the CP. Literature suggests that there are two types of tolerance. Cohen (2004) has described tolerance as acceptance of something despite any feelings of disapproval that accompany it. Bringing this attitude to CT, a tolerant CP (according to this explanation) would be able to control themselves and to continue to accept something they do not agree with as the therapy processes. It will not decrease the CP's motivation to provide effective treatment. Hjerm et al. (2019) have described tolerance as openness, being well disposed toward other cultures, and having a generally positive attitude toward them. Bringing this attitude to CT, a tolerant CP (according to this explanation) might feel only mild disapproval if any, and rather have a positive attitude towards a client's culture despite it being contradictory to the CPs' own culture.

In practice, tolerance might be difficult in some cases. An example from a CP perfectly reflects this.

This is about the CP not inserting their own culture to the clients. For example, the other day I had a client who follows a free sex lifestyle. She lives in the suburbs and is in relationships with multiple married men. She follows that lifestyle with enjoyment and feels no pressure. So, as a CP, I cannot insert my own values to correct her lifestyle. I cannot say "You should not do that!"

It can be seen from the excerpt that the CP might strongly disagree with the client and want to correct their behaviour, however the CP chose not to follow their emotions and continue to be neutral and tolerant.

- Understanding Clients' Cultures

CPs can choose to use a questionnaire to understand more about clients' cultural values if deemed needed or relevant. This can be done during the assessment stage or even earlier in

cases where culture will be an important aspect of the therapy. Fontes (2008) has provided some questions CPs could use to find out more about a client's' culture:

- Where were you born?
 - Whom do you consider family?
 - What was the first language you learned?
 - Which other language(s) do you speak?
 - What language or languages are spoken in your home?
 - What is your religion? How observant are you in practicing that religion?
 - What activities do you enjoy when you are not working?
 - How do you identify yourself culturally?
 - What aspects of being _____ are most important to you? (Use the client's term for their culture)
 - How would you describe your home and neighbourhood?
 - Whom do you usually turn to for help when facing a problem?
 - What are your goals for this interview?
- Other General Values that need to be upheld in Chat Therapy
There are some general values that need to be upheld in the implementation of CT. These values apply to both parties, namely the CP and the client.
 - Being on time
As with therapy in general, both the CPs and the clients are expected to be on time for the start and end of the session. Being punctual has a correlation with a positive outcome for the therapy (Yang & Jin, 2020). However, CPs also need to understand that the perceptions of punctuality vary in different cultures. Not being punctual may not have any underlying therapeutic significance (Drum & Littletona, 2014). Some research has shown that Indonesians tend not to be punctual (Martha & Arvianto, 2018; Nugroho, 2011; Santi, 2020; Widiyanto et al., 2021). Therefore, leniency and tolerance should still be applied. Keep in mind as well that the implementation of CT is prone to technical problems, therefore CPs are advised to take the time to do routine checks on technical factors before starting each session.
 - Commitment
CT requires a strong commitment from the client to attend therapy from start to finish. The client is expected to commit to the therapeutic procedures that may be provided during therapy such as assignments, while the CP must be committed to providing appropriate interventions for the client. It has been found that consistent attendance and adherence towards homework result in better outcomes for therapy (Callan, et al., 2018;

Zimmerman, 2019). Keep in mind that the lack of face-to-face interactions along with the minimal opportunities for the CP to control the course of the therapy (see p. 9 & 14) might result in a higher likelihood a client will drop out of therapy. In this case, the CP should be sensitive to any signs that show the client is losing their motivation towards the process and quickly do what is necessary to re-establish motivation. However, there should not be any kind of coercion in psychotherapy as it can damage the therapeutic relationship (Sheehan & Burns, 2011)

- Being in the "Here and Now"

This concept refers to both the clients and the therapist putting emphasis on their experience in that very moment (Carnevale, 2015). The CP and client are expected to focus on the current session. It has been found that being in the here and now increases engagement in the present moment, and thus, increases focus on the therapy (Gordon, 2020; Lopez, 2016; Stephenson, 2017). This could also improve the outcomes of therapy (Holdsworth, et al., 2014; Yoskowitz, 2018). CT is very vulnerable to distractions from the environment. CPs are advised to tell clients that CT is ideally done at a certain time that is free from other activities (refer to p. 18 for further discussion). Being in the here and now can be achieved using grounding techniques, in which the CP asks the client to focus on the present moment (Burgoyne & Cohn, 2020; Robinson, 2021; Ronen-Setter & Cohen, 2020). For example, the CP may ask the client to name some objects in the room or describe the room the client is in to help a client focus on the present moment (Zerubavel & Messman-Moore, 2013).

- Patience

The process of collecting information in a CT assessment session may sometimes require more time and effort as some clients might be resistant in the beginning (Beutler et al., 2002; Westra, et al., 2009). It is important for CPs to be patient about it and treat it with sensitivity (Fréchette, 2021). Patience also refers to the possibility of CPs encountering expressions of emotion from their clients, which may be unpleasant. Discussion related to this can be found in section "Managing Client's' Responses" (p. 49). CPs are expected to be patient and tolerant as it can help them to understand more about their clients and how to find resolutions to their difficulties (Markowitz & Milrod, 2011).

- Politeness

Politeness in CT is reflected in the communications between clients and CPs. It is about the choice of words, the choice of forms of address between CPs and clients, as well as how both CPs and clients respond to each other. It has been found that politeness benefits the CP as it leads to better relationships and predicts whether a client will stay in the

therapy (De Angelis, 2019). One way to establish this good relationship is by performing a helpful-cooperative style of communication, which characterised by being polite, diplomatic and resilient (Niess & Diefenbach, 2016).

- Authenticity

CPs are expected to demonstrate authenticity by showing sincerity and empathy and practicing appropriate self-disclosure. Clients are also expected to demonstrate authenticity by providing accurate information. Burks and Robbins (2012) have defined authenticity as the matching of one's inner thoughts, beliefs, and feelings with one's outer presentation and behaviours. It involves honesty, realness, openness, transparency, and truthfulness. Vymetal (2002) has suggested that therapists' authenticity leads to clients' spontaneity and an increase in the clients' own authenticity.

- Acceptance

CPs are expected to be able to accept the client's situation as it is, in the sense of acknowledging the client's story even though it may not conform with general norms or values. CPs do not have to justify and agree with the client's story but rather accept and understand it without judgment. The concept of acceptance might be aligned with the concept of unconditional positive regard (UPR). Bozarth and Wilkins (2001), UPR meant "acceptance of every momentary experience of the other. The good, the bad, and indifferent momentary experiences are accepted with equality." In a literature review by McHenry (2018), UPR was found to have positive impacts such as: 1) increased unconditional positive self-regard (UPSR) in which the individual perceives themselves in such a way that no experience of the self is seen as more or less worthy of positive regard than any other (Rogers, 1959); 2) decreased conditions of worth, which is the idea that one is only worthy of love and belonging once one has fulfilled certain demands (Maurer & Daukantaitė, 2020); 3) increased autonomy and congruence; 4) increased ability for self-awareness and focus; and 5) increased ability for self-regulation.

- Consensus

CPs are advised to prioritise consensus in every decision made regarding the clients, in the sense that there is an agreement given by both the CP and the client regarding how the intervention should proceed. Tryon et al. (2018) mentioned that in general, therapist and clients should agree on three things: 1) agreement on and commitment to goals and the methods by which they will be achieved, 2) patient-psychotherapist agreement on the patient's problem, and 3) the extent to which goals are discussed and clearly specified. Mackrill (2010) mentioned that goal consensus leads to a more efficient use of psychotherapy resources.

Determination of Treatment in Relation to Culture

There is a stage in every psychotherapy where the CP needs to design a treatment to help the clients with their difficulties. The basic aspects of treatment include creating action plans and setting goals accompanied with intervention techniques to achieve those. It is best for CPs to consider the cultural aspects when determining the kinds of treatment to offer to clients. The following discussion could help CPs to understand the best ways to design treatment that is sensitive to clients' cultural values.

- By the time CPs need to design the treatment, they are expected to already have a good understanding of client's cultural values and beliefs. Action plans and goals should be adjusted to the client's culture, in the sense that they are realistic to achieve in client's cultural environment.
- The treatment plan created by a CP might be influenced by the CP's own culture. Therefore, it is best for the CP and the client to be transparent and open-minded about the reasoning behind the plan. It is important for the client to have a say on the plan and the CP should welcome and consider any possible amendments to suit the client's situation. Another scenario would involve CPs and clients brainstorming and planning treatments together.
- CPs are advised to design treatments that are pragmatic, culture-free and psychological in nature as much as possible. As previously discussed, culture could be a sensitive area for both clients and cps. If CPs provide treatment that is based on culture (e.g., religious beliefs), this could potentially damage the therapeutic relationship as clients might feel uncomfortable. In a study by Liem (2020), it was found that Indonesian CPs avoid including spirituality and religiosity (SR) in the therapy for three reasons:
 - The CP is likely to hold their own religious and spiritual beliefs. Including SR in the therapy makes it prone to bias as CPs could project their own values on the therapy.
 - Bringing SR into psychotherapy means that the techniques used are not scientifically based.
 - A CP might not have enough knowledge about the concepts of religiosity and spirituality.
- Should CPs choose to include culturally based treatment, the CP could use logically and scientifically proven SR techniques that are beneficial to the clients, for example techniques such as *zikir* that are essentially relaxation techniques. CPs could also choose to promote universal values that applicable in all cultures. For example, it would be acceptable for the CP to promote compassion to their clients as this would be accepted in every religious belief. Another example is for the CP to discuss the concepts of family and social norms as these concepts are accepted in all Indonesian cultures.
- If ever clients want a more comprehensive treatment that is related to their culture, CP are advised to refer them to appropriate cultural organisations with more knowledge about the techniques or collaborate with them for the benefit of the clients.

CPs must understand that even though they are advised to be sensitive to and appreciative of clients' cultural values, it does not mean that the CP can design therapies that could involve clients' cultural values. The treatments need to be sensitive towards the cultural values but not directly intervene in the cultural values. CPs should be able to interpret clients' cases based on psychological frameworks even when the cases are mildly related to the clients' cultures. For example, it would not be appropriate for a CP to give homework requiring a client to behave in certain kind of way following the teaching of a religious holy book. It would not be appropriate for a CP to ask a client to be rebellious and assertive when the client's culture teaches them to be passive and submissive. However, it would be more acceptable if the CP asked the client to visit their religious leader and ask for suggestions on how to calm themselves. It would be more appropriate to discuss with the clients how they could convey their thoughts and feelings in ways that are still polite and respectful so they do not create confrontations with their culture. For further explanation, Gerber and Murphy (2021) provides some psychological variables that are embedded within cultures. CPs could refer to this following table as a psychological framework for interpreting clients' difficulties.

Variables	Brief Description
Human Nature	People either support each other (good) or controlling each other (bad), or a mixture of both.
Time	People put value more on tradition (past), quick and fast payoffs (now), or long-term effects (future), when making decisions. People might also prefer to focus on a single task or multiple tasks simultaneously.
Action	People are driven either by external standards to the point of being overworked or by an intrinsic motivation of personal satisfaction.
Context and Formality	People can express their opinions explicitly (low context) or implicitly (high context). People can place emphasis on protocol or be relaxed about it (formal/informal).
Space	People can be more or less comfortable sharing personal space (private/public space).
Power Distance	A community with high power distances may experience inequality that might not be experienced by a community with low power distance.
Individualism and Collectivism	People from independent cultures emphasise individual expression while people from collectivist culture emphasise group interests over one's own.
Competitiveness and Cooperativeness	People from competitive cultures emphasise ambition, decisiveness, performance, speed, and size, while people from cooperative cultures value consensus and intuition.

Table 2 — Psychological Variables within Cultures based on Gerber and Murphy

Language and CT

One cultural factor that could greatly interfere in CT processes is language. Given that Indonesia is a country with numerous traditional languages and dialects, the Indonesian official language (i.e., Bahasa Indonesia) should be prioritised as the language of delivery in CT. The research for this manual revealed that it is unlikely any CT user will be unable to speak any Bahasa Indonesian, but clients may not understand psychological jargon (e.g., the words assertiveness or relaxation). However, research has found better outcomes when clients are able to speak in their own language during therapy. This is because they are able to find the right words to express their thoughts and emotions. Asking a non-native Bahasa Indonesia speaker to speak the language might create a barrier affecting the treatment of the client's condition. Thus, the language of therapy may be changed to a traditional language if the CPs and the clients both understand and agree to use the traditional language as the language of therapy. CPs can ask clients what language they prefer. Furthermore, CPs are encouraged to avoid using complex jargon and always make sure that the clients understand the words that are being used in the CT, using clarification techniques.

Despite the rarity, CPs may meet clients who are not fluent in Bahasa Indonesia or cannot speak it at all. Specifically, to texting behaviour, different cultures may have different word abbreviations. In this scenario, CPs could continue to use Bahasa Indonesia to give further instructions because the clients might read and understand Indonesian but not really speak it. This, however, must be confirmed with the client. CPs could use a formal Indonesian language to query whether the client can indeed read and understand the Indonesian language.

There are several options for working with clients who do not really speak the Indonesian language. The first and best thing to do is to try to refer them to other CPs who might speak their language as continuing with the therapy might be difficult for both parties. The second option is to ask for assistance from a professional translator who has sworn to maintain confidentiality for both the client and the CP. All parties involved must sign an additional informed consent dedicated to securing confidentiality for the CT. Tribe and Thompson (2011) have provided some considerations for the use of translators: 1) the therapist and interpreter should meet separately before and after the session with the client to explain how things will run during the session and how things could be improved for future work; 2) if possible, the interpreter's demographic characteristic should match the client's; 3) working with an interpreter will take longer, this should be understood and addressed with the client; 4) it is best to use the same interpreter throughout the psychotherapy; and 5) complex language should be avoided.

Creating Collaboration

The establishment of collaboration between the CP and the client is very important for the effectiveness of CT. As this manual uses a cognitive behavioural therapy (CBT) model, collaboration concerns client receptivity to the intervention that is introduced by the CP (Dattilio & Hanna, 2012). Signals of collaboration include: 1) commitment to undergoing sessions in accordance with the agreement, 2) willingness to help the CP analyse the problem by answering and providing comprehensive information, and 3) willingness to undertake interventions provided by the CP such as worksheets, or other tasks that are useful for the clients. Clients would show an internal motivation to receive, respond to, and implement those interventions without any coercion from the CP. In addition, it is very important for the CP not to impose any intervention forcefully on the client and act as a facilitator, not a decision-maker.

Here are some suggestions for the CPs to help create a collaborative relationship:

- Understanding clients' expectations

CPs should understand clients' expectations for the therapy. Some clients want to have a discussion and find a different perspective or a solution, or probably just want to be heard. These expectations need to be known as early as possible prior to the start of therapy. Collaboration can be established when the clients and the CP share the same understanding in regard to the goals of the therapy.

- Using informed consent

The CP could clearly state the need for collaboration in the informed consent form signed at the beginning of therapy. The form could indicate the need for the client to be willing to carry out tasks assigned by the CP during the sessions. The CP could state, without any coercion, that collaboration will be beneficial for the outcomes of the psychotherapy.

- Encouragement and praise

The CP can encourage the client before a task is given and praise the client for completing the task or behaving collaboratively. During the sessions, encouragement does not need to be comprehensive. Minimal encouragements such as "I understand," "I see," or "go on," can also lead to collaborative behaviour.

Encouragement could be given by CPs in the form of explanations as to why collaboration and intervention is needed, along with the benefits of doing so, to persuade the client. When assigning a task to the client, the CP should also explain why the assignment is appropriate in the clients' situation. In terms of praise, this manual adopts the framework from Sweeney (2009) which advises care to be taken with evaluative compliments, such as, "Wow, you're great. All the work is done," as such praise can become a form of extrinsic motivation. Ideally, CPs want clients to use intrinsic motivation rather than seeking approval or reinforcement from external parties. Process-focused compliments, such as, "I see you have taken your

assignment seriously," or noticing positive feelings and behaviours exhibited by the clients, such as, "You seem happy with the task," are expected to be able to foster internal motivation.

- Addressing the issue and potential referral

Essentially, a lack of collaboration could be considered as a manifestation of resistant behaviour (Aviram et al., 2016). CPs are advised to be sensitive and aware of when collaboration has not really been established as it could potentially make therapy ineffective. As discussed, CPs should be patient and confront it with sensitivity (Fréchette, 2021). If the techniques are still not working, the CP is advised to terminate therapy and refer the client to another CP, or allow the client to find another CP who may be more suitable for the client.

Chapter 5 — Specific Guidelines for Conducting CT

Having explained the general concepts of psychotherapy in CT practice, this chapter explains more specific and practical concepts related to CT. Some of the concepts discussed in this chapter are 1) verbal and nonverbal responses, 2) first contact with clients who need special attention, 3) session duration and period between sessions, 4) no diagnoses, 5) managing clients' responses, 6) missing and absent client, 7) solutions and therapy, 8) homework, 9) warranties and refunds, 10) technical failures.

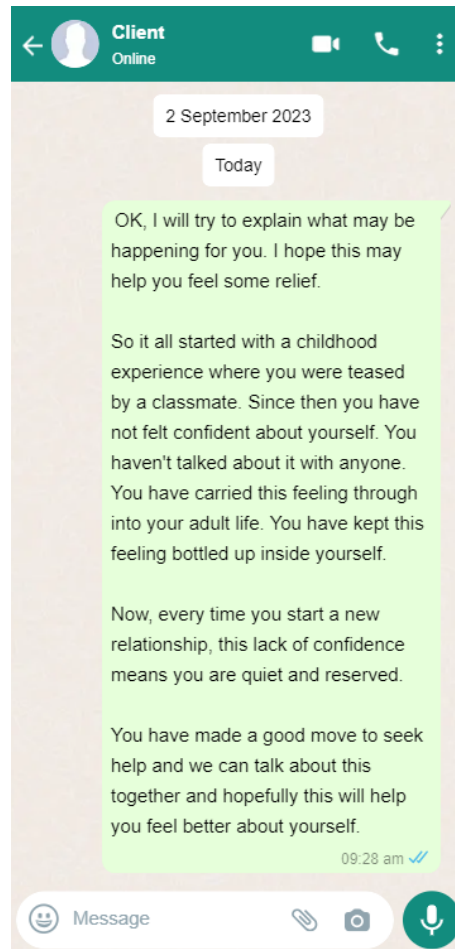
Verbal and Nonverbal Communication

Psychotherapy is essentially talk therapy. In a face-to-face setting, the CP and the client can talk easily. In CT setting, the main way of communicating is through the direct exchange of chat messages. Even though live chat is almost like direct conversation where both the CP and the client convey their thoughts and feelings through words), CT requires both clients and CPs to type these words into chat messages and send them to each other. It is also worth noting that face-to-face therapy provides the CP with an abundance of nonverbal information. Intonation, articulation, body language, and expressions provide additional data that is meaningful for the CP. In CT, this nonverbal communication takes a different form.

Chat Style and Length

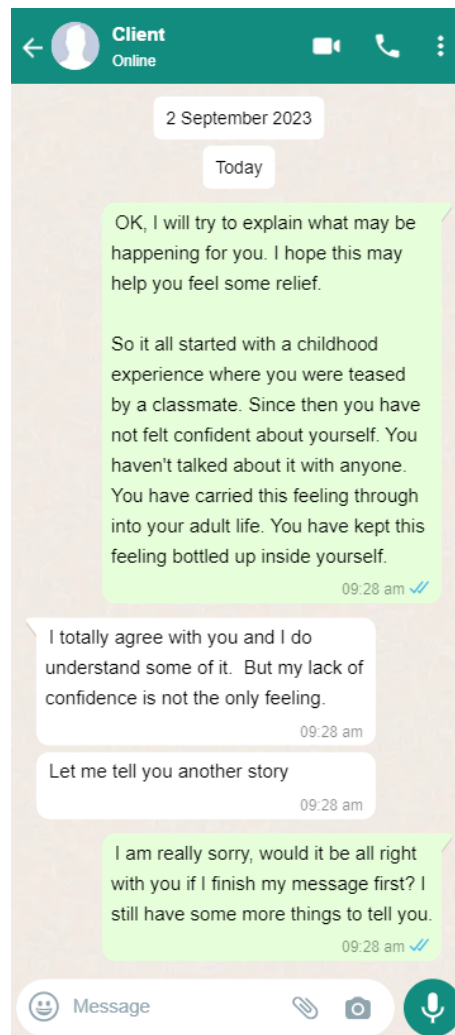
How the CP arranges their chat messages, or chat style, can affect the course of CT. This is because each chat style can make different impressions on the clients.

- Long and comprehensive style
CPs can provide long and comprehensive messages with a single message "balloon" containing all the information that needs to be conveyed. There are clients who prefer long, detailed messages because of the amount of information they get. This style tends to be formal and minimises the chances of sudden changes in topic during the conversation, but this style has the potential to make the client wait a long time while the CP types the message.



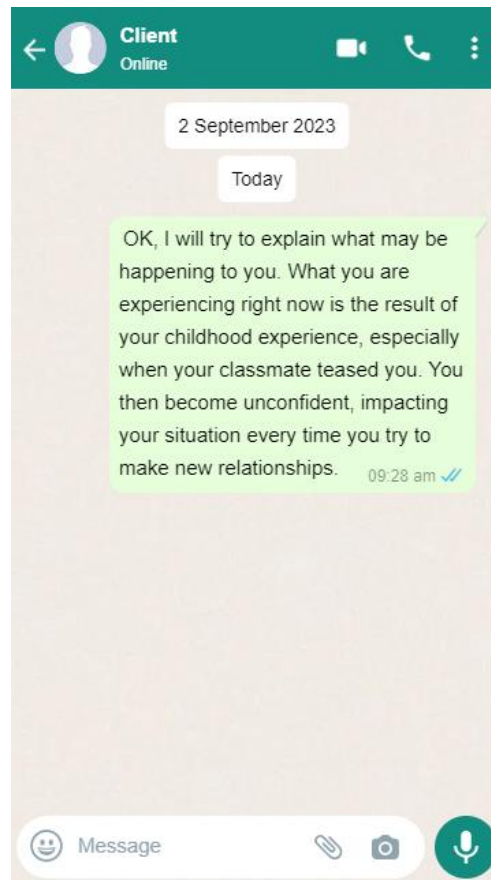
- Split Messages

Alternatively, CPs may break long messages into several separate message balloons. This method has the potential to create disconnection because clients may want to respond immediately to the part of the message that has been delivered or leave clients curious about the rest of the message that is yet to be delivered. Another risk with this style is sudden changes of topic because a client may reply to a message that has only been partially delivered with new information that leads to a new discussion. There is a need for understanding and good timing in this chat style to avoid sudden topic changes. Both clients and CPs should be sensitive and aware when the message sent is not yet finished and more is to come. Alternatively, if a sudden topic change occurs, the CP is advised to acknowledge the client's message and inform them that they will return to this message once they are finished with the previous message.



- Short Style

CPs can also create concise messages. This style of message may be favoured by clients who don't really like reading lengthy or complicated messages. However, some clients might feel uncomfortable with short messages because they may appear less friendly. Clients might also feel that short answers seem like unbalanced responses if they have sent long messages to the CP.



The choice of chat style really depends on the particular personalities of the CPs and the clients. The CP's main priority in therapy is to help the clients feel comfortable and make the intervention effective. CPs are advised to be sensitive to what styles are most effective with their particular client.

As a middle ground, CPs are advised to adopt all three styles as above and use them at the appropriate time. Below are two scenarios along with the most suitable chat style to be used.

- Long messages can be used if the CP and the client come to the stage where the CP must summarise something such as their analysis of the client's situation.
- Shorter or split messages can be used if the therapeutic relationship is still at the rapport development stage. Short messages can also be used as a way to demonstrate that the CP is attending to the clients, using phrases such as "I understand." Lastly, short comforting messages can also be used to affirm or reassure the client, for example, "I know it is difficult, but you can do it."

Finishing Typing

As a way to avoid sudden topic changes when using split messages, the CPs may ask client to wait for particular closing words or phrases such as, "That's all," or "I am finished," to show that their messages are completed, and vice versa.



Showing Empathy and Giving Praise

In CT setting, this can be done in several ways.

- Empathy can be shown using emojis. This concept is discussed further in the next section. Briefly, CPs can show appreciation by using thumbs up emojis, empathy using hug emojis, and asking permission or giving thanks using thank you emojis.



- Empathy can also be shown using words, which is known as emotional validation. Emotional validation provides assurance for the client that their emotions are real, important and acceptable. CPs could simply write words to show that they understand how the client feels.



- An ellipse, or three dots (...) is a grammatical tool to show a pause, or silence (Siddique, 2017). Ellipses can be added to sentences to symbolise an opportunity for the client to pause and feel their emotion. It can be seen from the example below that the sentences with the three dots appear slightly more empathetic than the ones without.



- Empathy can also be communicated by indicating an understanding of the clients' needs during the therapeutic process. For example, a client may seem to be agitated or showing signs that they need a fast response from the CP to calm them down. CPs could indicate sensitivity and awareness of this by sending quick split messages rather than a lengthy one.
- Empathy can also be shown by applying counselling skills. These skills include: 1) attending 2) paraphrasing 3) clarifying and 4) reflecting. These concepts will be specifically discussed in the section in Chapter 9, "Assessment" (p. 95).

Emojis

One way to provide nonverbal responses in CT is to use emojis or small images, symbols, or icons used in text fields in text messages, email, and social media to express the emotional attitude of the writer, convey information succinctly, and communicate a message playfully without using words (Merriam-Webster, n.d.b).

- It is recommended that the CP does not initiate the use of emojis but waits for the client to use them first. Not every client will be comfortable using emojis. However, responding with emojis when the clients use them shows appreciation, which is good for the therapy. Using the same style of communication is a way of demonstrating synchronicity, which can strengthen a therapeutic relationship. However, if the CP feels the need to initiate the use of

emojis, it is recommended to use very general emojis, such as a smiley faces, to demonstrate a friendly attitude towards the client.

- If the use of emojis has already been established in the CT sessions, CPs are advised to still use emojis that are general and not too specific. This is because there are potential differences in the interpretations of emojis. A CP might think that an emoji is positive when it actually has a negative interpretation which may have a negative therapeutic effect and embarrass the CP. CPs should only use more specific emojis if they believe that the client shares the same understanding. One way to know is to wait until those emojis are actually used by the client and then the CP could use the context to uncover the meaning the client gives to the emoji.
- Should CPs experience difficulty in interpreting the meaning of an emoji, they could simply clarify it by asking the client a direct question. This, however, should not be done often as it may cause clients to feel uncomfortable. It is not the client's place to teach the CP about the meaning of an emoji. Clients would expect the CP to be familiar with the meanings of emoji they use.
- CPs are also advised to consider the age and gender of the client. Older clients may not understand specific emojis or not use emojis at all. For CPs who have a different gender from the clients, the use of emojis can potentially lead to misunderstandings.
- The nonverbal function of emojis is not only to symbolise emotions but also to prepare the clients for sensitive messages or questions. The CPs could offer a thank you emoji when asking for permission.
- CPs are not advised to use too many emojis as it could actually damage the therapeutic relationship. Research has shown how excessive use of emojis could cause clients to judge the CP negatively and question their professionalism (Chapin, 2016; Yoo, 2007).

The table below shows the possible meanings of emojis that CPs might see during CT sessions. Again, the CP needs to observe whether the client uses the emoji in the same way.

Emojis	Possible Meanings	Generality
	Slightly Smile	General
  	Smile	General
   	Laugh	Specific
	Hug	Specific
	Thinking	Specific

	Afraid	Specific
 	Sad	General
 	Slight Crying – Loud Crying	Specific
  	Angry	Specific
	You are correct!	Specific
	Hello!!	Specific
	OK	Specific
	Good job!	General
	Clapping Hands	Specific
	It's a deal!	Specific
	The original meaning is “High Five”. However, it is often used to mean “Thank You”, “Excuse Me”, and “Let’s Pray”	General
	You can do it!	General

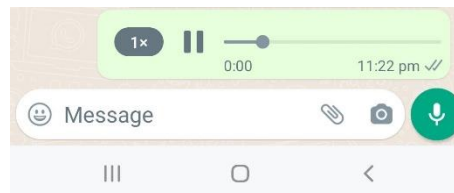
Table 3 — List of Emojis

Voice Notes

Voice notes are a feature that is available in some chat applications where users can record voice messages and send them to other parties. Voice notes can be used to convey empathy. They can also be used when the client is having difficulty understanding the message. Some concepts that might arise during therapy might be easier to explain using voice notes rather than chat messages. Voice notes can also be useful when clients are in distress and in need a fast response from the CP. The CP could record a calming message for the client. If done right, a calming voice that is soothing and gentle can help clients to control their emotions. The intonation and style of speech in voice notes from the client, could be used by the CPs to get additional information about the client. For the CP, the voice-note feature is most suitable for clients who are not comfortable using chat messages to convey their thoughts. Some of the reasons clients may not be comfortable

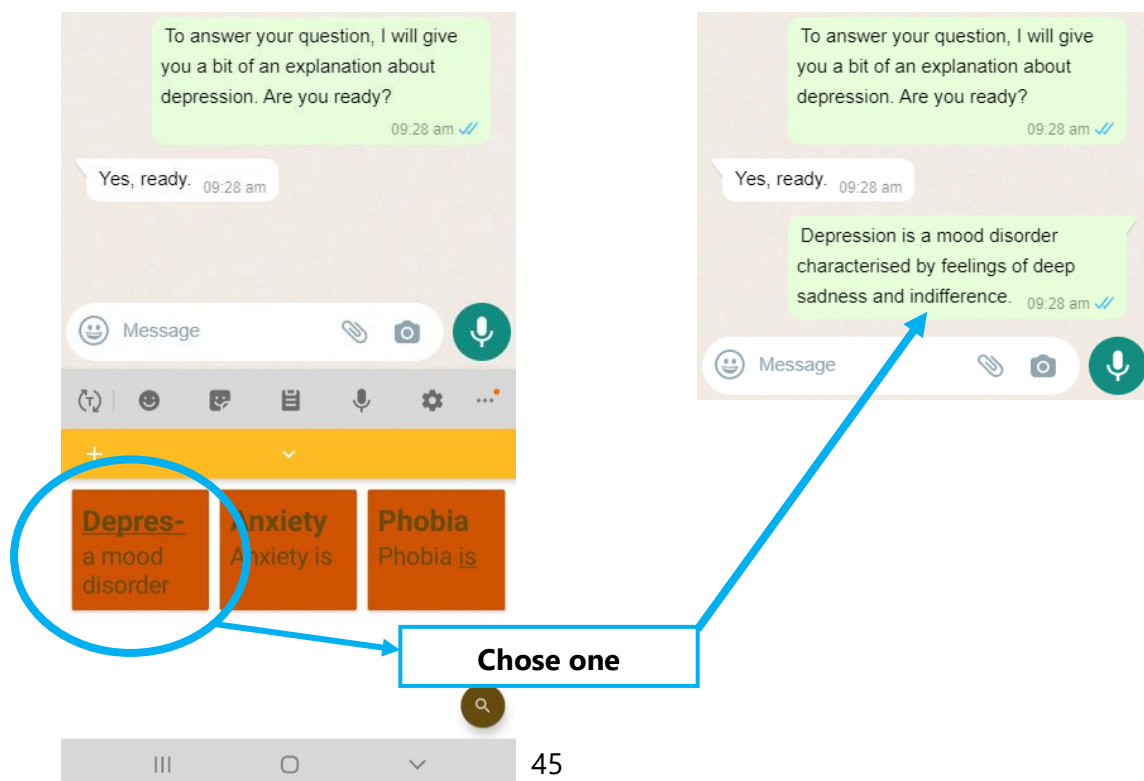
using text are discussed in the section “Disadvantages of CT with Possible Solutions” (p. 9)

CPs who perform CT are still encouraged to prioritise the use of chat in their communication. CPs might be collaborating with telepsychology companies who may not allow CPs to send voice notes as the clients has chosen CT and not voice/video telepsychotherapy. Clients may provide voice notes but the CPs are encouraged to reply to them with chat messages.



Clipboard

During CT, CPs are naturally advised to build professional relationships with the clients where the chat messages are contextualised to the clients' issues. In practice, CPs may often assist clients who share the same or similar issues. This then leads to the CP discussing the same concept with different clients. CPs can save time and effort by creating standard psychoeducational messages that they can simply copy and paste to send to the clients, rather than typing the same message over and over again for different clients. The clipboard is a feature in smartphones that can store messages for later use. CPs could create a message and name it before saving it to the system. They can then have multiple ready-made messages at hand and simply choose messages to send to clients as needed.



As can be seen in the illustration above, when the CP wants to provide an explanation about depression, they do not need to type it in manually but already have a message stored in the clipboard to be selected and sent to the client.

Voice Typing

Voice typing is another feature that might be useful and suitable for some CPs. Different to voice note, voice typing does not send the recording of the CP's voice but rather converts the CPs' spoken words into a chat message. At the time this manual was developed, it was still a new technology with several drawbacks. Furthermore, a higher level of technological literacy is needed to use this feature. Below are some of the advantages and drawbacks:

Advantages

- Voice typing is potentially faster than manually typing the message.
- CPs are able to double check the message written before sending it to the client.
- At the time this manual was developed, voice typing was able to differentiate content not meant to be written in letters. For example, if the CP wanted to indicate a specific time, the voice-typing feature could capture this and write it in a numeric time format.
- words in more than one language can be identified. This is necessary because English words are often used by Indonesians.

Drawbacks

- To use the function, the user must connect to a stable internet. If such a requirement is not met (i.e. unstable internet), it could make typing longer than manual typing.
- The most well-known voice typing keyboard is Gboard. The installation process might not be as easy as installing most application. Changes in settings might be required and not all CPs are familiar with this type of installation.
- Certain words or the required format, e.g., time, may not be recognised. This requires the CP to take the time to double check messages.
- At the time this manual was developed the sender must say "dot" to signal the end of a sentence, however, sometimes the system writes the word "dot" instead of inserting a full stop to end a sentence. This again requires time to double check messages.

First Contact: Clients Who Need Special Attention

When practicing CT, CPs cannot control who makes first contact to seek help. Some clients need to be treated differently in some circumstances. The following discussion tries to categorise some types of potential clients and how to best manage their needs.

Anonymous Clients

In practice, CT is often preferred by Indonesians because of the possibility of remaining anonymous during therapy. The data shows that clients may be reluctant to provide identifying information, either 1) for personal reasons such as the fear of embarrassment, or to protect their family's reputation, or feeling anxious that their identity will become known to others; or 2) they are trying to find out if they are compatible with the CP before moving into more serious interventions. Being anonymous has advantages in that clients feel free to express themselves in ways they might not if their identity was known. However, as mentioned in the previous chapter, CT is different from other online mental health interventions and clients need to clearly identify themselves.

The most appropriate approach by CPs who encounter this type of client is to engage with them initially and let the first session run without the client needing to provide an identity. It is possible that after the first session, the client will feel comfortable with the CP and be willing to share their identity before continuing with formal CT sessions. CPs can apply the counselling techniques discussed in the section in Chapter 9, Counselling Ability (p. 96) in the first session in an effort to make the clients feel comfortable.

It is still possible that clients may still be reluctant to share identity details with the CP even though they want to continue the therapy. In this scenario, the CP could respond by assertively explaining that identity details are required in CT and the CT cannot continue if the clients are reluctant to provide identity details and emergency contacts to the CP. If the client still insists and not willing to reveal their identity, but wants to continue the therapeutic relationship, CP might only give basic therapy such as psychoeducation and will not provide deeper intervention such as assessment and plan an intervention.

Underage Clients (Minors)

Minors may have smartphones and be able to access the virtual world just like adults. It is probable that these minors will see CT promotions and may decide to contact a CP and request CT services. In this scenario, CPs are advised to not engage in CT with minors as clients as minors in Indonesia receive different mental health interventions. As in face-to-face therapy, minors need permission and assistance from their parents in any mental health interventions. This is very difficult and risky to be done in CT settings as the CPs cannot be certain that their parents have actually given consent and are accompanying them in the CT process even though the client says they are.

The CP can use the communication that has already been made by the minor as an opportunity to let them tell their story as a form of vent but it is not recommended for the CP to provide any

kind of intervention. The CP could also use the communication to provide some psychoeducation to the minor and inform them that they must tell their parents about their difficulties and how face-to-face therapy would be more helpful for them. If, however, the CP decides to provide interventions for minors as clients, it has to be with the knowledge of the parents and the intervention should be rather mild with no potential to cause harm.

Clients with Economic Difficulties

If the client is unable to proceed with CT because they cannot afford it, the CP can use the communication that has already been made by the client as an opportunity for the clients to tell their story and vent. The CP could offer different options for payment as discussed in the section "Upfront Payment Information" (p. 17).

Clients with Self-Harm Tendencies

This topic is discussed in detail in Chapter 8 (p. 71).

Session Duration and Time Between Sessions

The length of each CT session might be different from the traditional 50 minutes in a face-to-face setting because of the lack of nonverbal cues that can lead to difficulties and the time needed to write the chat messages (p. 10). A duration of 60-90 minutes for each CT session is suggested. There is evidence that 100-minute sessions for online text therapy require more emotional capacity, and without this the treatment might be ineffective.

A week is the standard period between sessions, however, the literature suggests that frequencies between twice a week and once every two weeks are possible. The decision usually depends on two aspects: the client's financial situation and the severity of the difficulties. Other possibilities are to begin with a one week interval and extend the period once the client has shown some improvement.

No Diagnoses

CPs should not make any diagnoses during CT interventions. Diagnosis in CT is risky as it might be inaccurate due to lack of information. Furthermore, a diagnosis could also lead to social alienation, invalidation and stigmatisation. The lack of physical presence and hands-on intervention mean best treatments cannot be provided. If a client insists on a diagnosis, the CP should inform them that they need a face-to-face session with either a CP or psychiatrist. The closest thing for CP to do in CT is to provide tendencies but not official diagnosis. Another scenario is to work on the previously given official diagnosis.

Managing Clients' Responses

Clients who are experiencing psychological issues are often unpredictable and give inappropriate responses. This section discusses some of the situations and types of client responses that CPs might encounter in CT along with appropriate ways to respond to these.

Informal Language

Given this manual is focused on engaging with millennials and Gen Z, CP may receive responses or chat messages from clients written in informal language, for example, , "Hi there, has the session started yet?" or "What's up?" Clients from these generations may also use informal abbreviations such as "LOL," for "laugh out loud," "BRB," for "be right back," or "slowres," for "slow response," along with other abbreviations.

In responding to messages like this, we advise the CP to be flexible and accept these messages as long as they are still polite. In replying to these messages, the CPs are advised to maintain boundaries and authority by replying in a more formal or at least semi-formal style. CPs do not need to use the same abbreviations. For example, the CPs may respond to "What's up?" with the sentence "Hello, I'm fine, how about you?". A response to an abbreviation such as "BRB" could be, "Alright, I'll be waiting."

Silent Clients

In the course of the session, some clients might become silent and unresponsive. The best way to deal with this situation is to remain calm and not react too quickly. Two observational guidelines can be used to decide if the silence is something to be worried about: 1) If the client does not reply to the CPs within 10 to 30 minutes; or 2) the response time from the client is unusual, for example, if the client usually replies within less than a minute and it has been two minutes without any reply. Should either of these occur, it can be treated as a sign that the CPs must intervene.

Some reasons why clients become silent:

- The client is thinking or feeling something and needs time to calm themselves before sending the next message.
- The client feels "stuck" and is thinking about how to reply to the CP's message.
- The client is not focused on the CT process and is doing something else at the same time.

Things CPs can do:

- Reflect on the silence by saying, "You are so quiet, what are you thinking?" or "It's not easy is it?"
- Directly address the client by saying, "Hello, are you still there?" or "Are you still online?"

- Gently remind the client about the response timeframe and the need for the client to be cooperative in the therapy, if the CP is certain that the reason for the silence is lack of focus.
- If the client is slow to respond or silent, the CPs could ask the client what they want to talk about.
- Be observant and notice whether the silence is repeated and has pattern. For example, if the client always pauses in discussions about certain topic, that is a sign for the CP to explore the issue.

Clients can also simply go missing in the middle of therapy, by not replying for at least for 30 minutes, or not presenting for their session. These two scenarios are specifically discussed in the section in Chapter 5, “Missing and Absent Clients” (p. 52).

Problematic Interpersonal Style

There might occasions when clients become hostile towards the CP. The research for this manual found that clients could become aggressive, make threats, harass and even stalk CPs in their personal lives. More specifically, the aggression included swearing at the CP. One example of threat from the research for this manual was of a client threatening to report the CP to the police. CPs may experience different levels of harassment. Examples obtain from the research included clients purposely flirting with the CP and sending them inappropriate images, take screenshots of the conversation to be later shared on their social media along with negative remarks. Physical stalking might be difficult in the CT setting, but clients may cyber-stalk CPs through social media and obtain personal information. Stalking might lead to unwanted and inappropriate communications with the CP. In the worst case, the literature has suggested that cyber stalking could become physical, with clients violating the CP’s private space and damaging property.

There are some ways for the CP to avoid these kinds of problematic interpersonal styles. Firstly, CPs must use prevention measures, by giving out minimal personal information. Avoid using or giving out a personal address or contact details (email, phone numbers, social media handles) in the online world in general. If possible, do a little research on potential clients to investigate whether or not they might have problematic interpersonal styles. It is also best to address the subject of these problematic interpersonal styles early, at the beginning of the CT. All of these issues could be listed in the informed consent that the client need to read, agree to, and sign.

If all these measures have been taken and these problematic behaviours still emerge, then CPs need to manage them in a way that does not breach CPs’ ethical code. CP are advised not to simply cut off all communication when these types of issues arise. On the contrary, Gutheil and Brodsky (2008) have suggested that the first thing the CP can do is use this behaviour as an opportunity to get to know the client better by finding out the reasons why the client is sending

the messages. By doing this, the CPs can find out more about the client's behaviour patterns that may contribute to a more comprehensive case formulation. Sending explicit pictures and videos may be a sign of genuine issues they want to solve. The CP could also use the behaviour as an example of the problematic patterns of behaviour that may be the source of client's difficulties in the first place.

CP are advised to act if the messages are too explicit and obviously sent intentionally to cause discomfort for the CP. Gutheil and Brodsky (2008) also suggests that CPs follow a number of steps to try make the clients stop sending problematic messages. These steps needed to be undertaken as allowing such messages from the clients could cause discomfort for the CP.

- Stage 1. The CP can respond unemotionally to the client's messages without paying them too much attention and divert the client's attention to other questions.
- Stage 2. The CP can send a friendly but firm message asking the client not to continue their behaviour because it makes the situation uncomfortable.
- Stage 3. The CP can actively reprimand the client using polite language saying that the client's behaviour is inappropriate and remind the client about the terms and conditions the client has agreed to at the beginning of the sessions.
- Stage 4. If the messages continue despite all efforts, the CP can stop the therapy and refer the client to another CP. CPs who work with a company can inform the administrator and let the administrator carry out the referral procedures. An example of termination statement is as follow:

Unfortunately, Mr. A, the message you just sent me is inappropriate and violates the ethics of CT. Following the initial agreement that you signed at the beginning of treatment, I am ending this therapy. I will refer you to another psychologist who may be able to help you. I would highly recommend that this behaviour is not repeated with the next CP. Please wait while I look for a CP who can help you.

If the CP decides to refer the client to another CP, the CP must write a letter to the next CP and describe the reason for termination without giving too much detail. Gutheil and Brodsky (2008) have given an example of a referral letter, as follows:

I'm referring this patient to you because of the patient's behaviour. I don't have permission to tell you what that behaviour was, but the patient knows this is the reason for termination.

For the worst cases of physical stalking, the CP could carry personal safety devices such as a Taser or pepper spray or report it to the police.

Missing and Absent Clients

It is possible that a client who is undergoing therapy will disappear in the middle of the process. This could happen in the middle of a session, when a client suddenly stops responding, or could happen between sessions, when clients do not attend the next scheduled session. There are many possibilities for why clients leave therapy. Some examples are:

- Emergencies
- Technical failures (see p. 62)
- Problems with the therapeutic relationship (Smyth et al., 2018), for example, 1) where the challenge of creating the therapeutic relationship decreases the client's motivation to attend therapy; 2) the emotional effects of talking, when the client fears that talking to the therapist could lead to more distress; 3) a lack of hope, when the clients feel little hope the therapy can help them.

Some strategies from Swift and Greenberg (2015) and Binnie and Boden (2016) for managing these scenarios are listed below

- Provide information about what the CP and the client can expect from each other during psychotherapy. This could include administrative matters such as payment, or therapeutic matter such as self-disclosure and collaboration.
- Make sure to accommodate the client's preferences and characteristics during the process of treatment.
- Outline expected goals and an action plan so that the client knows what to expect by the end of the therapy. The CP could also inform the client that there is nothing wrong with discussing any desire to end the therapy early. Sometimes clients are hesitant to discuss this because they are afraid of disapproval from the CP or that it will hurt the CP's feelings.
- Inform the client that there will be ups and downs in therapy. There might be some setbacks along the way and it is best for the clients to talk about them and discuss possible changes rather than dropping out.
- Strengthen hope by demonstrating credibility as a CP and being certain about the intervention chosen, and increase the client's self-efficacy by describing how their strength can help them get through their difficulties.
- Be sensitive and responsive to the client's levels of motivation towards the therapy. For example, if the client is feeling unmotivated, the CP could adjust the session so that it is not too intense for the client. If the client is unmotivated to do the homework, the CP could adjust the homework to suit the client and increase their motivation towards the homework.
- Make sure a therapeutic alliance is established.

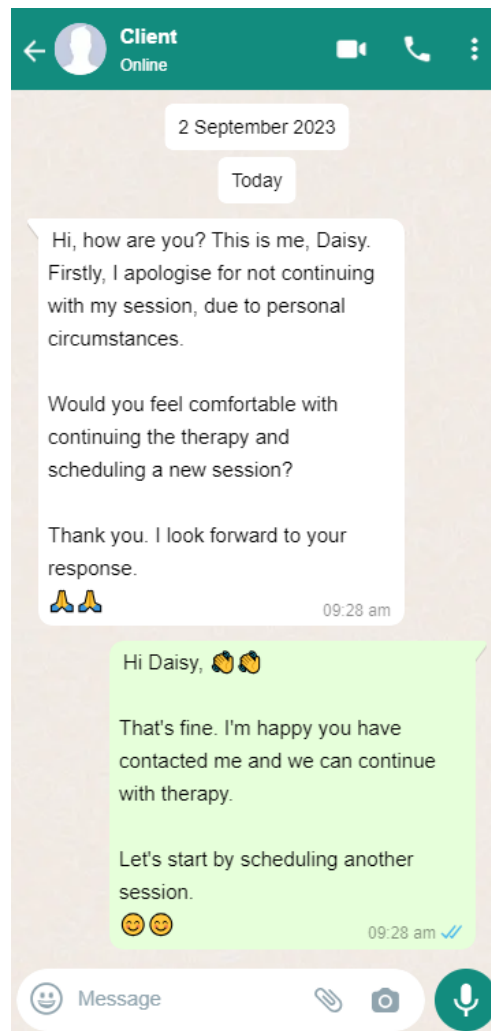
- Monitor the progress of the therapy and discuss it. Make changes if needed and show appreciation for the positive progress that has been made.
 - Use other, more practical strategies, such as, 1) convenient scheduling, 2) reminders, 3) attendance of the CP at the scheduled time, 4) social influence theory—where clients asked to write down their next appointment to create more involvement in the booking activity, and 5) providing an end date for the therapy.
- If a client suddenly goes missing in the middle of a session, the CP could continue to try to contact the client through the chat app. If there is still no response from the client, the CP could try contacting them through other ways such as SMS, email, or even a phone call. Failing these, the CP should leave a message and ask the client to contact them. It is important for CPs to have alternative contacts for clients.
 - If clients miss a session, the CP can ask the client directly why they did not attend and check everything is alright. This can be done on the same day as the scheduled session, as they might have simply forgotten about the session. The CP could also wait as long as two weeks as the client's personal situation might be interfering with their motivation to attend therapy. An example of how to re-initiate the contact could be:

It's been over a month after our last contact. How have you been progressing since our last meeting? Have any new experiences been affecting you?

- CPs are encouraged to send a reminder before every session. This can be achieved by manually contacting the client or by setting an electronic calendar notification using a calendar app. CP need to be careful to ensure the content of the reminder does not make it obvious that the client is having psychotherapy. Labelling it as "Meeting with [CP's Initials]" is safer than "Session with [CP's name]."
- It is also acceptable to indicate the consequences for clients who suddenly disappear during the session or do not attend their scheduled session. Some examples of possible consequences are:
 - If the client suddenly goes missing during the session, the client will lose the session with no refund.
 - CPs might allow clients to give, say, 2hours prior notice of absence for emergencies or conflicts in schedules. Failure to do so will result in the loss of the agreed session.
- For clients on payment plans, the CP could apply greater flexibility and schedule the next session with clients at the end of each session rather than determining the schedule of

sessions at the beginning (see "Scheduling and Payment", p. 87). This may help minimise absences. Another consideration for clients on payment plans is the need for the CP to respect the contract in terms of the validity period stated in the plan, for example, for four sessions within two months. If clients miss sessions then decide to come back to therapy within the validity period, CPs are advised to find some way to have makeup sessions. However, it should be understood that clients will lose their payments if they return to sessions after the validity period.

That being said, another perspective in dealing with no-show clients is just let them be. DeFife, Smith, and Conklin (2013) suggest that CP does not need to make a call but lets the clients choose whether or not to attend. It is better to focus on creating excellent therapeutic experiences that lead to low no-shows by the clients. Should the no-shows happen frequently, CPs could end the therapy but keep the door open in the future. In any event, CPs are advised to remain open and welcoming if clients decide to come back and continue therapy after being away for some time. If this happens, CPs do not need to mention the absence or ask the clients for reasons as this might make the clients feel uncomfortable. The CP should focus on the current issue and look forward to the future therapeutic relationship.



Solutions and Therapy

Depending on the CP and the type of intervention, the CP may or may not offer possible solutions to clients' problems in their therapy. Some CPs might prefer to guide clients to think about possible solutions and find own solution that is best for them. Some considerations include: Some clients are comfortable when the CP leaves it up to the client to produce solutions, on the grounds that the client understands their own situation best and solutions proposed by the CP may not apply in the situation they are experiencing. This method however could potentially result in multiple sessions as the clients might need time to obtain insights and develop solutions.

- Some clients prefer solutions to be the result of a discussion. The client provides possible solutions and shares them with the CP for feedback. Alternatively, the CP provides possible solutions but asks for the client's feedback on whether the solutions proposed are practical in the client's situation.
- Some clients feel more comfortable when possible solutions are suggested by the CP. Such clients might be uncomfortable with brainstorming solutions due to inadequate capacity or energy to think.

The provision of solutions is not uncommon in psychotherapy. However, psychotherapy theories tend not to favour solutions being given to clients. Even solution-focused therapy, in which finding solutions to the clients' issues is the main focus, still requires the clients to have brainstorming discussions with the CP to find the solution. Fiske (2017) has emphasised the need to continue to ask open questions, even with clients who are desperate.

A middle ground in this discussion has been suggested by Anderson and Handelsman (2010). They have discussed two types of advice in psychotherapy: substantive and process. Substantive advice is defined as "suggestions for specific solutions to the problems, or for how to live," while process advice is defined as "suggestions for how to go about solving problems, or how to make the most of therapy." Substantive advice is described as counterproductive since it may reflect the therapist's values and it does not help the client become independent or enable them to make future decisions. As a concrete example, coaching clients in critical thinking skills is better than providing quick opinions on a matter.

It is common for millennial and Gen Z CT clients to seek instant solutions. CPs should learn about these expectations as early as possible. It is recommended that CPs ask about preferences at the informed consent stage. Even so, data suggests that usually clients do not mind if CPs try to engage them in brainstorming activities aimed at helping the client to produce their own possible solutions. However, the client might think this kind of intervention will take a long time and is not something they wish to engage in at the beginning of CT.

When providing solutions, CPs are also advised to put consider cultural norms (see "Determination of Goal Setting and Action Plan Related to Culture", p. 32)

Homework

One of the common interventions given in psychotherapy is homework. In any psychological therapeutic relationship homework refers to any tasks given by the therapist to the client to be done between the sessions (Strong & Massfeller, 2010). It is often practical and aims to improve client's mental health. Some clients welcome the provision of the homework, as they believe that homework can bring positive changes to ease their difficulties. However, some clients do not have the necessary motivation to complete homework given by the CP. The reasons for such resistance could include: a high level of difficulty, a lack of understanding of the rationale, a lack of perceived benefit, failure by the CP to review the last assignment given, incongruences between the homework given and the last session attended, and a lack of any effect after completing previous homework. This section provides some guidelines for CPs to consider when designing and giving homework to clients, to increase clients' compliance in completing the homework.

- Tailored and engaging homework
Homework should be a mixture of exciting, challenging, fun and practical activities that are uniquely designed for each client. Homework should be aimed at helping client gain new perspectives and test hypotheses outside the therapeutic sessions. The considerations for the design include culture, developmental stage, strengths, and personality.
- Knowledge of the homework
CPs should inform the client about the rationale and aim of the homework given. Clients show higher compliance towards homework when they understand the reasoning behind it. CPs should also explain the importance and how to successfully complete the homework.
- Client involvement
Homework is not a one directional intervention that CP gives to the clients and clients should be involved in the process of designing their homework. Such involvement could alter the type of homework that the CP originally planned. Clients should not only be involved in assessing the appropriateness of homework but also in the determination of the goals. CPs could ask for client feedback when they assign homework to uncover potential obstacles and explore potential solutions. Such an intervention may be referred as collaborative homework, which leads to clients feeling more motivated compared to clients given directive homework.
- Alignment with the last session. Literature suggest that clients are more likely to complete the homework if the assignment was congruent with their latest session. CP could ask the client what they took from the last session and use that as a basis for the next homework assignment.
- Deadlines and feedback
All homework should have a deadline and receive feedback. Flexible deadlines and CP leniency towards the completion of homework is associated with negative treatment outcomes, as it slows the progress. Providing feedback on homework is useful for finding out what the client needs which can help with tailoring the intervention.
- No coercion
There should be no coercion in therapy and clients are responsible for their own mental health. The job of a CP is to facilitate change and not to determine their client's beliefs. Coercion might not contribute positively to homework compliance and could negatively affect the therapeutic relationship.

Warranties and Refunds in CT

In CT, warranties apply to administrative matters. Warranties usually revolve around the schedule and number of sessions. In practice, it is more than likely that clients will inquire about another type of warranty which is a guarantee of certain mental health outcomes (warranties of results). The client expects their issue will be completely resolved by the end of the CT sessions, and they can return to therapy at no extra charge if the issue persists. CPs are advised to explain the nature

of the warranty as clearly as possible to clients to avoid confusion. An example of a consent form can be found in the section in Chapter 9, "Administration and Informed Consent" (p. 86).

In response to questions from clients about warranties of results, CPs are advised not to make any promises that could be construed as a warranty of results by clients. CT attempts to assist the client but does not guarantee a particular outcome. Making such a promise will have negative impacts on the therapy. Furthermore, warranties of results are difficult to implement because 1) therapy involves a collaboration between the CP and the client. If the client does not commit to the therapy, it will certainly have an impact on the effectiveness of the therapy; and 2) The success of therapy is certainly influenced by the larger environment which cannot be fully controlled by the CP.

The CP must understand that from the client's point of view, warranties of results are common for purchased goods or services. Clients may not understand and may not have experienced CT before and may assume that CT is the same as other services. That said, there are several ways CPs can navigate the different understandings about warranties:

1. As a first step, never make any promise to the clients; instead, the CP can instil hope in the clients that they would be able to direct their behaviour better. The wording below is acceptable:

I am confident that working together we can deal effectively with your depression.

2. The CP can inform the client that therapy may not produce the desired results but that it is an attempt to make things better. This attempt can be guided by creating SMART goals (p. 102) and establishing collaboration between the CP and the client to achieve those goals. By establishing this at the beginning, it is hoped that the clients are informed about the absence of a warranty of results in CT.
3. To avoid warranty of result claims by the client, the CP may terminate the sessions only when they are sure the client has indeed improved. A truly independent and improving client will not ask for or make claims regarding a warranty of result.
4. CPs are advised to provide termination notes for clients (p. 61). A termination note could include: 1) the problems for which client requested help, 2) analysis, 3) treatment given, 4) progress, 5) reason for termination, 6) a statement about whether the therapist and client mutually agreed on the termination, and 7) status of termination. Furthermore, the therapist could also describe what APA refers to as "anticipated need for continued care and resource referrals." The CP might include the things the client needs to do to care their mental health in the future. This might include some scenarios of possible adverse events and how to best

manage them. The CP could also include some motivational words for the client to refer to during any adverse event (See p. 61 for an example).

5. CPs can explain the concept of relapse to clients and how the CP could support them with maintenance sessions.

The Concept of Relapse and Maintenance Sessions

CPs should also be considering the concept of relapse. This concept is defined as the recurrence of a disorder or disease after a period of improvement or apparent cure (APA, n.d.). Relapse can occur due to a variety of factors. In a study by Adebisi et al. (2018), sociodemographic factors such as gender, religion, marital status, and clinical factors such as the type of mental illness, duration of illness, and drug compliance were found to be associated with relapse. The concept and associated factors should be discussed with clients so they know the possibility exists of a recurrence of their difficulty

To accommodate these potential issues, CPs can offer maintenance sessions. There are many definitions and understandings about maintenance sessions but the basic idea is to help the client maintain the skills they have developed and the positive change that developed during therapy. Maintenance sessions only happen after therapy is terminated. The maintenance sessions could last for one to two years and be held weekly or monthly, or start as weekly and move to monthly.

The only thing that CPs need to consider is that maintenance sessions could create dependency in the clients. Lochman et al. (2015) have mentioned that maintenance sessions immediately after therapy create dependency on external monitoring instead of relying on the improvement having an internal locus of control. Thus, it is recommended that CPs do not conduct any maintenance session immediately, but rather allow the client the opportunity to practice self-help. All in all, maintenance sessions have been found to help lower the possibility of relapse and maintain the skills the clients have gained during their active psychotherapy sessions (Fleig et al., 2013; Gearing et al., 2013)

Free Post-Termination Contact

The data suggests that clients want to be able to make contact with the CP once the sessions have ended, without charge. To accommodate this, CPs could arrange some limited opportunities for the clients to make contact after the final session to ask questions about or discuss any aspect of the therapy that was already provided without having to register for more sessions. If they do this, CPs are advised to give a time limit (e.g., two months), limit the number of questions (e.g., two questions) after the final session. Exceeding the limit on the number of questions means that the clients must register for another set of sessions.

CPs also need to assess the content of any questions and whether they relate to the therapy given. Should the question not be relevant or indicate that the client needs further therapy, the CP may ask the client to reregister and return to therapy. If the questions indicate relapse, the CP could offer maintenance sessions.

Refunds

There are some scenarios when clients could expect a refund from the CT. Firstly, refunds could be given due to administrative matters, for example, if clients decide to cancel a session with the CP with enough notice. Secondly, clients could get refunds if the sessions are covered by their insurance. Thirdly, clients could get refunds when the therapeutic contract cannot be fulfilled, for example, if the client has paid for five sessions but the CP managed to attend only four sessions.

There is a possibility a client may ask for a refund due to dissatisfaction with the service itself. This matter is complex. One view is that CPs should not provide refunds due to dissatisfaction because CPs are bound by ethical codes to provide the best help they can. This manual also encourages CP to explain the CT process and what the client can expect from the CP. The client will have already agreed with the explanation and signed the informed consent. Another reason for not providing refunds due to dissatisfaction is the same as given in the discussion about warranties of results; there will be external factors in clients' lives that the CP cannot control which might contribute to feelings of dissatisfaction. For these reasons, CPs should not offer refunds but ask clients for feedback on the service instead.

There are however, examples from the literature that discuss policies on refunds based on the quality of the therapeutic relationship. Finlay (2019) mentioned an example of a therapist who refunded a client because they could not relate to a client who had undergone a sex change but was reluctant to discuss their sexuality in any depth which meant that the therapist could not understand their story in any depth. The therapist then openly discussed with the client how a therapeutic relationship had failed to initiate how they felt that they were not the best therapist for the client and then offered the client a refund for the session they had just had. This case serves as an example for CPs to consider when deciding whether they are willing to provide refunds to clients.

Termination Note

Summary of the Problem

The client came to the CP due to having difficulties in establishing new relationships which prevent the client from creating positive relationship in terms of career or personal relationships. The client feels frustrated about this.

Summary of Analysis

The client suffers from low self-esteem due to unpleasant experiences (being teased) when he was 12 years old. This unpleasant experience then created unpleasant feelings (low self-esteem). The client has never communicated or processed these feelings until now and when the client wants to initiate a relationship, they don't feel confident to start communication.

Treatment Progress

The client had weekly meetings from 2 February to 2 April 2022. In the early phase of the treatment the therapy focused on identifying the source of the low self-esteem. A case was formulated (see above) and the treatment continued to the next phase. We then revisited the unpleasant experience which produced a lot of strong emotions for the client. We started to analyse the situation and look at ways of changing the client's perspective on the unpleasant experience. We performed some thought checking using Socratic questioning with any assumption that the client had about the unpleasant experience, which resulted in alternative thoughts. The clients were receptive and motivated throughout the process. In the final phase of the therapy, we focused on communication styles and scenarios for starting new relationships. We did some roleplaying with various scenarios to ensure that the clients know what to do should any obstacle occur in the future. Some homework was given with the client being asked to join a community group for people with the same interests as the client, which would give the client the opportunity to meet new people and socialise. The homework was considered to be successful as the client indeed started to make new friends and become more involved in the community.

Reason for Termination

More sessions had been done to ensure that clients are thriving in the new community and we made sure we discussed all difficulties clients is facing (in term of social behaviour) in the new community. The therapy was terminated as clients feel more confident and ready to be on his own. At the end of the therapy, clients are in much better state compared to the first we met. Clients seems to be more confident in social relationship and also in himself.

Lessons to be Remembered

- It is never too late to acquire new skills
- Change starts with one small step

Behaviours to be Maintained

- Try to join more social circles and groups to experience different types of people.
- All members of the community want to build relationships. Stay humble and open to everyone.

When Your Kindness is not Reciprocated

- Don't be disheartened, they probably are having a bad day.
- If you feel uncomfortable, step back and find a quiet place to calm yourself
- Practice relaxation breathing techniques
- Remember that communities have more than one member
- Try again when you have calmed down

The client and CP agreed on the termination on 2 April 2022.

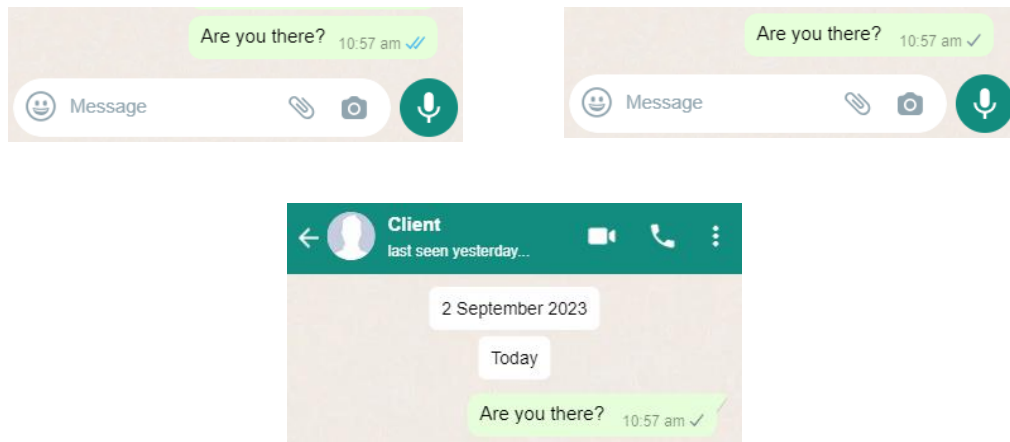
Signature of the CP

Signature of the Client

Technical Failures

It has been mentioned several times that CT is prone to technical failures. These issues range from basic issues such as loss of signal, running out of data, flat batteries, and errors in apps or devices, to more serious issues such as a lost or stolen phone. These issues could potentially make clients lose contact with their CP for periods ranging from several minutes to weeks. It is best for CPs to avoid these technical issues by maintaining and preparing their devices, for example, by regularly updating their chat application, making sure the battery is full prior to the sessions, making sure that they have enough data and making sure the signal is strong prior to the start of the session. It is also best to remind the client to do the same things prior to CT sessions.

- As discussed in the previous section, it is important for the CP to discuss these potential issues at the beginning of the therapy. CPs need to include relevant clauses in the informed consent to address such issues and provide some guidelines on what to do when these issues occur. This to inform clients about what to expect and what to do in such an event.
- It is important for the CP to know how to identify when technical failures are occurring. Most applications include delivery reports which show whether messages are being sent and delivered or not. For example, WhatsApp uses a tick to indicate this. One tick means that the message has been sent from the sender's phone, two ticks means that the message has been received on the receiver phone, and two blue ticks mean that the recipient has read the message. If the CP sees only one tick during an ongoing session, it is likely there is a technical error. Different apps use different kinds of delivery and read reports, but it is important for the CP and clients to have this function. Another feature, "Last seen" could help CPs to predict whether the other party has technical issues or is not open to communication. A person last seen a day before would probably not be available to communicate in the moment or soon.



- CP should respond according to the situation if technical issues happen during a session. CP could be lenient in terms of the scheduling and extend the session but the duration of the technical issue. For example, if the client was absent for 10 minutes during a one-hour, it is acceptable to extend the session by 10 minutes.

Chapter 6 — Characteristics of Indonesian Millennials and Generation Z

This chapter discusses the main subjects of this manual: Indonesian millennials and members of Gen Z. This chapter briefly describes general demographic characteristics and looks at how these characteristics affect the process of CT. It is important for CPs not take these characteristic descriptions at face value and still engage with their millennial and Gen Z clients individually. The contents of this chapter are generalisations to serve only as guidance and explanations for certain expectations and behaviours that CP may observe in clients.

Millennials

According to the Kementerian Pemberdayaan Perempuan dan Perlindungan Anak Republik Indonesia dan Badan Pusat Statistik Indonesia [The Ministry of Woman Empowerment and Child Protection of Republic of Indonesia and Statistic Bureau of Indonesia] (2018) millennials are Indonesians who were born between 1981 and 1996. Millennial characteristics are listed below.

- The main characteristic of the millennial generation is their increased exposure to digital communication through digital technology which means they are accustomed to using digital technology in all aspects of their daily lives.
- Millennials have close relationships with social media. Furthermore, millennials use social media as tools and sources of information.
- Millennials are also considered to be more creative and informed, and more enthusiastic and productive in their daily lives than the previous generation. Millennials are able to create new opportunities that can increase their productivity through digital technology.
- Millennials have open, free, and forthright communication styles and mindsets. They are also more alert and responsive to changes in the environment around them. This is due to the fact that they have more opportunities to pursue higher levels of education.
- Millennials' lives are fast paced. This characteristic may be influenced by the high levels of exposure to information technology that allows them to access everything quickly.

Generation Z

According to Rakhmah (2020), Gen Z includes people born from 1997 to 2012. Furthermore, Rakhmah (2020) based their description of the characteristics of Gen Z on the work of Francis and Hoefel (2018) as well as Stillman and Stillman (2017). The description is summarised as follow

- Gen Z is much closer to the digital world than millennials. Gen Z have grown up in a time when all aspects of the real world can also be found in the digital world which means this generation does not distinguish between the real world and the digital world. A simple example of how Gen Z lives is making transactions such grocery shopping through an app on their phones.

- In terms of communication, Gen Z resemble the millennials who also use social media as a medium for communication. However, unlike the millennials who grew up with the modernisation of communication technology, Gen Z was born with modern communication technology. This means Gen Z does not recognise the concept of social alienation, that is, a state of detachment from society (Lobato, et al., 2022). GenZ is used to everyone being able to connect through social media. In addition, Gen Z has a global mindset in which connecting with others globally is something that is important and may even be prioritised. They do not want to be miss out on the latest information in the world.
- Gen Z tends to do everything independently, because they are very accustomed to finding resources such as online videos on how to solve daily problems. This also makes Gen Z more confident because they feel they can do everything themselves.
- In line with the millennials, Generation Z also has an open-minded mentality that accepts different views of life. This characteristic affects the ways they define their own identities. As identity is developed based on knowledge and experiences, their identities tend to be different and distinctive from each other.
- Gen Z also has a pragmatic mindset when it comes to decision-making and planning. They tend to observe what is going on around them and use that information as a guide when making decisions rather than taking by theoretical or idealistic positions.

Therapeutic Dynamics of Treating Indonesian Millennials and Gen Z with Depression.

- These generations tend to be technologically literate and accustomed to using technology in their daily life. Therefore, CPs need to design therapies that are in line with such technological preferences. For example, CPs may prefer to use electronic worksheets as a part of the intervention.
- They also have a high awareness of mental health and often know about new symptoms or disorders that have not yet been included in the official mental health guidelines in Indonesia.
- They can also search for any mental health related information quickly. This often leads to self-diagnosis marked by inaccuracies. This could require the CPs to provide extra psychoeducation about the conditions to improve clients' understanding.
- Given their stages of development and their ages at the time this manual was written, millennials may present with common issues, for example, marital concerns, while Gen Z who are still adolescent may present with rather unclear issues.
- Millennials and Gen Z tend to value immediate satisfaction They may expect immediate solutions or remedies for their difficulties and not be willing to embark on the long haul of therapy.
- Gen Z tends to focus on outputs over process. They tend to be vocal in asking questions about the therapy they are receiving. For example, when given an activity or homework, they want to know what the function of the homework is, what impact it might have, and whether

it will immediately “cure” the disorder they are experiencing. Millennials, who are older, tend to trust CPs more when they are given activities or homework.

- Both tend to expect CPs to be friendly and use the informal style of communication they use with their friends rather than figures of authority.
- Since they are working with younger generations, CPs need to be aware of the latest trends impacting these generations. For example, at the time this manual was created, K-Pop was particularly popular. CPs can enrich themselves by knowing what K-pop music is and why this type of music has become popular among young people.

In summary, CPs who practice CT in Indonesia will most likely have Indonesian millennials and Gen Z as clients. Similarly to other generations, these two generations have their own characteristics which affect the process of the therapy. CPs who practice CT are advised to be aware of these characteristics to enable them to work effectively with clients from these two generations. Exposure to technological advances and global communications are the key influences on their characteristics. CPs are advised to become technologically literate and include this modern technology in the therapy. CPs are also advised to learn the communication styles of these two generations. As written above, CPs need to be familiar with and know how to effectively manage clients who may be assertive and demanding.

Clients’ Expectations of CT

It has been briefly mentioned that millennials and Gen Z have certain kinds of expectations from their CP. The following section will further explore these expectations so that CPs are able to design interventions that are responsive to these expectations. As in the previous discussion, these are generalisations and CPs should still engage with every client individually.

- Solutions
Being from generations that expect instant results, clients may want to receive immediate solutions from CPs to manage their problems. Some clients might already know the cause of their issues and prefer to have a discussion that provides a remedy for their distress. From the psychotherapy perspective, this expectation might not be favoured since clients are expected to create their own solutions. To manage this expectation, further discussion about the provision of solutions can be found in the section in Chapter 5, “Solutions and Therapy” (p. 55).
- Venting Opportunity
Clients want someone (i.e., the CPs) to listen (figuratively) to their concerns without judgement. While venting can indeed relieve stress, CP should still be careful about allowing this in therapy as it can also be detrimental for clients. A further discussion about venting could be found in the section in Chapter 9, “Emotional Intervention” (p. 104)

- Information and perspective

Opposite to the clients mentioned in the first point, some clients do not know what they are experiencing or why they are having such issues. Therefore, clients want someone who can help them to understand their issues and the causes. Clients might also want to double-check their perspectives on their problems with a CP. From the psychological perspective, these kinds of expectations might better be met with a consultation rather than psychotherapy. Consultation is a relationship in which an expert provides professional advice, suggestions, or opinions to others who are seeking them (Falender & Shafranske, 2020). Thus, when clients explicitly mention that they only want information and perspective from the CP, the CP must act as an expert and label the relationship as consultation and not psychotherapy. As previously mentioned, consultation is short term and limited to one topic only. This manual does not contain information on how to best execute online consultations.

- Quick Interventions

In relation to the first point, clients from these generations might prefer quick short interventions and expect only to be given solutions and nothing else. The research for this manual, and the psychotherapy literature suggest that this expectation is difficult to meet. Should clients show this expectation either explicitly or implicitly, CPs can educate them about the nature of psychotherapy and how no form of psychotherapy is quick as appropriate assessment and interventions takes care and time. However, CPs can offer short interventions such as consultations, as discussed above.

It is important for CPs to find out these expectations early on in the therapy. One way to find them out is to provide a form for clients to complete in the initial contact. An example of this form can be found on page 85. Alternatively, CPs could explore clients' expectations in early communications with clients by using therapeutic communication skills and asking appropriate questions to try to identify expectations. One last option for the CP to identify these expectations is by observing the clients' messages. For example, if the clients send long messages in the sessions, that can be an indication that the clients are wanting to be heard. Direct questions from clients might indicate they are expecting solutions.

Chapter 7 — Minor Depressive Disorder

This manual focuses on minor depression disorder (mDD). The basis for determining minor depression comes from the Indonesian Version of the Structured Clinical Interview for DSM-4—1 (SCID-IV—1) produced by the Psychiatry Department at the University of Indonesia. Below are the criteria for mDD according to the Indonesian Version of SCID-IV—1.

A. Mood disturbance, defined as follows:

1. At least two (but less than five) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (a) or (b):
 - a. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful).
Note: In children and adolescents, can be irritable mood.
 - b. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
 - c. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month) or decrease or increase in appetite nearly every day.
Note: In children, consider failure to make expected weight gains.
 - d. Insomnia or hypersomnia nearly every day
 - e. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
 - f. Fatigue or loss of energy nearly every day
 - g. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
 - h. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
 - i. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide
2. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
3. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).
4. The symptoms are not better accounted for by bereavement (i.e., a normal reaction to the death of a loved one).

B. There has never been a major depressive episode and criteria are not met for dysthymic disorder.

- C. There has never been a manic episode, a mixed episode, or a hypomanic episode and criteria are not met for cyclothymic disorder. Note: This exclusion does not apply if all of the manic-, mixed-, or hypomanic-like episodes are substance or treatment induced.
- D. The mood disturbance does not occur exclusively during schizophrenia, schizophreniform disorder, schizoaffective disorder, delusional disorder, or psychotic disorder not otherwise specified.

Physical and Behavioural Symptoms of Depression

CPs need to realise that the criteria for mild depression listed above come from a Western psychopathology approach. Minor Depressive Disorder was formulated under the psychopathological conceptualisation of western hemisphere nations. Therefore, the diagnostic features might reflect European and Northern American understandings of psychopathology.

Several studies, such as those by Chang et al. (2017) and Saint Arnault and Kim (2008), have suggested that depression is often associated with physical manifestations in Asian populations. This manual attempts to provide some information about possible physical manifestations of depressive disorders.

The exploration of physical manifestations of depression is important in the Indonesian setting as Indonesians tend to be reluctant to express emotional complaints due to the negative stigma associated with these. Indonesians are usually more comfortable being assertive about their physical complaints because they are more accepted culturally.

The research for this manual found a number of possible physical manifestations of depression in Indonesian people, as listed below. This information, however, is preliminary and needs to be explored and validated by further research.

• Headaches	• Sore muscles	• Muscle cramps
• Dizziness	• Vertigo	• Nosebleeds
• Feeling weak	• Abdominal cramps	• Pale-looking Face
• Ulcers	• Constipation	• Heart palpitations
• Chest tightness	• Diarrhoea	• Joint pain
• Irregular breathing patterns /shortness of breath	• Eczema	• Stiff neck and shoulders
• Nausea	• Visible Eye-Bags	• Tactile numbness
• Painless bruises	• Faintness	• Vomiting
	• Hair loss	

In addition to the list above, this study also unveiled some common behaviours by Indonesians who suffer from depression. Some of the behaviours are listed already in the official guidelines for depression and include 1) excessive or reduced eating that leads to an increase or loss of body weight; 2) lack of or excessive sleep; and 3) lack of energy. However, some other behaviours are rather unique and not listed in the official guidelines. CPs should use this information only as guidance and not a clear basis for a diagnosis of depression, as further research still need to be done to confirm these behaviours. Those behaviour include: 1) social withdrawal, such as isolating oneself in a room and spending the whole time lying down and playing with devices; 2) an unhealthy diet in which the clients often eat fast food, drink little water and a lot of caffeine instead; 3) being more or less talkative, and 4) disorganised speech.

Should the CPs encounter clients with the abnormal physical or behavioural symptoms listed above, they are advised to do the following:

1. The CP still needs to conduct a proper assessment using the official Indonesian guidelines. At this stage, physical symptoms can only be used as supplementary information. The research for this manual suggests that overall symptoms of depression are aligned with Indonesia's official guidelines. CPs might also notice that official guidelines also include some symptoms that are closely related to physical manifestation as well, such as disturbances to sleeping or eating.
2. The physical and behavioural symptoms listed above may be signs that clients have other mental disorders or medical conditions. Thus, a CP could treat physical and behavioural symptoms as possible signs of depression but still perform an assessment for other mental disorders or refer them for a medical check-up to make sure that clients are not suffering from a medical condition. All in all, CPs must try to exclude other mental and medical disorders and conditions and make sure that it is a pure depression. In cases where the client is found to have two comorbid psychological disorders, the therapy must be adjusted accordingly.

How Indonesian Clinical Psychologists Deals with Depression

During the development of this manual, the researcher also asked Indonesian CPs about typical interventions they often make when working with Indonesian clients who suffer from depression. The results of the discussion are listed below:

- CPs often look for urgent symptoms first and focus on those symptoms until they subside. After the CPs feel the urgent symptoms have subsided, the next step is to intervene in the clients' emotional state before proceeding to cognitive interventions.
- Indonesian clients often have difficulties in recognising and understanding their own emotions. Thus, CPs often provide interventions that aim to raise their knowledge and awareness of emotions.

- Indonesian clients often experience dysfunctional thoughts such as negative thoughts or practice short-term thinking that contribute greatly to their depressive episodes. Therefore, CPs often target these cognitive aspects when treating depression.
- Indonesian clients who are depressed often isolate themselves and show hypersomnia, therefore Indonesian CPs often engage in behavioural activation exercises.
- Indonesian clients who are depressed often have unhealthy lifestyles such as eating fast food and not drinking enough water. Therefore, CPs often provide interventions to change these behaviours.
- Social support is very important in treating depression in clients in Indonesia. Therefore, CPs often ask about the people who can support the treatment of depressed clients. These people can often help the CP by supporting the client with the completion of assigned tasks.
- Symptoms of depression that also often appear amongst Indonesian clients are feeling insecure, feeling useless, and loss of interest. Therefore, CPs often provide interventions that target these symptoms.
- Indonesian clients often lose focus in therapy. Therefore, CPs often perform mindfulness exercises such as grounding at the beginning of sessions to make sure that the clients are able to focus on the therapy.

Common and Effective Therapies Used in Indonesia for Treating Depression

CPs in Indonesia often use several therapeutic techniques to treat clients with depression.

1. CBT

In general, CBT is a class of therapy which research has proven to be the most effective for treating depression. Specific CBT-based interventions that are often used are a) Socratic questioning, b) behavioural activation and modification, and c) relaxation.

2. Person-centered therapy

This type of therapy is often chosen by Indonesian CPs because they feel that Indonesian clients are in need of having their experiences validated.

3. Solution-focused therapy

Solution-focused therapy is a future-oriented therapy that does not emphasise the history of the issue. Solution-focused therapy is often used with Indonesian clients who are seeking a brief therapeutic engagement which provides quick solutions to their problems.

Chapter 8 — Self-Harm

Self-harm is a serious risk in every psychotherapeutic intervention. CPs cannot control the kinds of clients who come to them, and they cannot be sure whether clients might develop thoughts regarding self-harm during the course of the CT sessions. Being said, literature suggest that people who self-harm prefer CT over face-to-face due the easily accessible support, information and privacy. In this section, we discuss how to respond appropriately if the CP is faced with such a scenario.

Manifestations of Self-Harm

To begin the discussion, CPs need to understand that the concept of self-harm might have different manifestations. As discussed in Chapter 4, a client could become manipulative and make threats of self-harm. A personality trait called Machiavellianism can explain this behaviour. Such a trait is characterised by a tendency to distrust others, a willingness to engage in amoral manipulation, a desire to accumulate status for oneself, and a desire to maintain interpersonal control (Dahling et al., 2009). In a therapeutic setting with a manipulative client, self-harm threats might not be associated with intent to self-harm but rather, with a desire to communicate distress to others. Going further, Carr and McNulty (2016) have mentioned that there are clients who perform self-harm but are not actually wanting to end their life. The term for this kind of behaviour is non-suicidal self-injury (NSSI). However, at the other end of the spectrum, a client could be actively suicidal and fully intend to end their life (Carr & McNulty, 2016)

Themes in Self-Harm

Edmondson et al. (2016) reviewed 152 studies of self-harm and listed 10 possible themes for NSSI. Eight of the themes formed an initial framework derived from studies by Suyemoto (1998) and Klonsky (2007) and the other two themes were created to include extra information that did not fit into the initial framework. A brief summary of the findings is provided below. CP are encouraged to read the original articles for fuller descriptions of the findings.

- Managing distress/affect regulation
To find relief from strong emotion
- Exerting interpersonal influence
To get attention from someone else
- Punishment
To punish oneself or others because of what other have done
- Dissociation
To induce or terminate a dissociative state in oneself

- Sensation Seeking
To generate excitement
- Averting Suicide
To divert oneself from actual suicide
- Maintaining or Exploring Boundaries
To assert one's boundaries (autonomy)
- Expressing and coping with sexuality
To cope with sexual conflict or to feel sexual sensations
- Positive experiences
For comfort or to experience a new sensation or to protect others from one's anger
- Defining the self
To show superiority to others by being able to tolerate the pain, to assert one's identity, to show that one understands pain, to feel in power or in control of a situation

Edmondson et al. (2016) review study produced a model that includes internal and external factors to explain suicide. The following are a brief summary of the findings.

- Internal factors
 - Biology
A person with a family history of suicidal and mental disorder is more likely to commit suicide. Additional Biological factors also include physical needs that are unmet such as sleep disturbances (Bernert, 2007) and food insecurity (Kamdar et al., 2021)
 - Mental health
In most cases, of suicide is carried out by a person with a mental disorder, with the most common being depression and bipolar disorder.
 - Personality
Being kind, healthy, open, responsible and extroverted decreases the chances of becoming suicidal
 - Cognitive traits
People with cognitive rigidity have a higher risk of becoming suicidal.
 - Attitude
Having an affirmative attitude towards suicidality increases the likelihood of suicidal ideation
- External factors
 - Negative life experiences
People with stressful lives have a higher risk of becoming suicidal.
 - Family factors
People who have experienced family instability and problematic child-rearing styles or suffered child abuse or neglect have higher risks of becoming suicidal.

- Social and environmental factors

Research shows that the online social media are possible agents that popularise suicide.

- Culture.

Cultural environments can influence individuals' attitudes towards suicidal behaviour

Accessing Self-Harm

Self-harm, even NSSI, is a critical behaviour that CPs must assess as it could still lead to attempted suicide and loss of life. CP may encounter clients who have self-harm ideation and have harmed themselves in the past, either as new clients or ongoing clients who did not show any signs of self-harm behaviours but develop them later. Clients might suddenly harm themselves or experience self-harm ideation between weekly sessions. Clients who are manipulative might also send messages containing suicidal threats to the CP.

In a CT setting, CPs might receive chat messages, telling them about a self-harm episode or ideation. However, CP must also be sensitive to the earliest signs of self-harm. Clients may only imply they are engaged in self-harm behaviour. For example, chat messages like "I cannot stand this anymore," or "Nobody wants me here," will need further investigation. CPs need to take these statements seriously. Do not dismiss any self-harm threats or ideation even if the CP has a suspicion that it might only be a manipulative behaviour or that the client is not serious about it. The literature suggests that while manipulative people might make self-harm threats as attention seeking, the chances of them having suicidal intentions are also high (Dear et al., 2000). Given the risk, such a threat should not be dismissed. The first response to such findings is to assess the situation. CPs are encouraged to not hesitate to ask questions about suicidal thoughts

Carr and McNulty (2016) have provided an immediate comprehensive assessment that can be done to get an understanding about client's self-harm behaviour. The author has created two sets of interview questions: one is suitable for clients who have already harmed (in a failed attempted suicide or a manifestation of NSSI), and the other one is suitable for clients without previous experience of harming themselves but with the idea to do so. The two sets of interview questions are provided below.

- Clients with a history of self-harm

- How did you reach the decision to harm yourself and what alternatives did you consider?
- To what extent did you act on impulse, without thinking, when you harmed yourself?
- Did you have a plan to harm yourself and what preparations had you made?
- How exactly did you harm yourself?
- When did this happen?

- Did you believe the method of self-harm was lethal and that nothing could be done to save you if you were discovered?
 - Did you let others know about your plan to harm yourself or were you secretive?
 - Did you write a letter to anyone explaining why you are harming yourself?
 - What happened afterwards and how did you survive?
 - Do you regret having survived?
- Clients with self-harm ideation with no history of self-harm
 - How would harming yourself solve the problems you now face, and can you see any alternatives right now?
 - If you harm yourself in future, are you likely to do this impulsively without thinking?
 - Which is stronger right now on a scale of 1 to 10, your will to live or your will to die?
 - Do you have a plan to harm yourself?
 - What preparations have you made to harm yourself?
 - How exactly will you harm yourself?
 - When do you think this will happen?
 - Do you believe the method of self-harm is lethal and that there will be nothing anyone can do to save you if you are discovered?
 - Will you let others know about your plan to harm yourself or will you keep it a secret?
 - Will you write a letter to anyone explaining why you are harming yourself?
 - If you survive, will you regret this?

Through this interview, the CP could get a better understanding about what actually happened with the clients and determine the best way to respond to the scenario. A thorough protocol intended for use in response to such a scenario can be found in the next section.

Other considerations in assessing self-harm are the dynamic and static risk factors. Static risk factors are defined as those that do not change or change only in one direction. One example of this would be age and self-harm history. Static risk factors are rigid in the sense that once a client meets the conditions of one category of static risk factors, the client can be put in the risk category. Dynamic risk factors are factors that can change throughout the life course. Examples could include unemployment and peer group influences (McLeod, 2012). Unlike static risk factors, dynamic risk factors are modifiable; clients can dynamically move from high risk to low risk, depending on the circumstances. It is the job of the CP to assess these dynamic factors.

Self-Harm in CT—A Protocol

As discussed, a CP could face two possible scenarios for self-harm during the process of CT. This section discusses the scenarios and how the CP could respond.

Protocol Stage 1 – Calm the Client and Assess Their Safety.

The first thing the CP should do when encountering self-harm messages whether explicit or implicit, is to stay calm. The CP should not panic or dismiss it, or even refer the client directly to other services (such as emergency services) but rather attend to it and validate and affirm the client's courage to talk about their difficulties. Use the counselling techniques described in Chapter 9 (p. 96) to calm the client or grounding techniques to prevent emotional outbursts that could potentially be harmful for the client.

Depending on the situation and the communication dynamics with the client, the CP is advised to assess client's safety in terms of their social supports. Enquire whether the client has family who can provide support or are aware of the client's situation.

Protocol Stage 2—Emergency Contact

At this stage, the CP is advised to obtain information about emergency contacts who can be contacted if needs be. For ongoing clients, the CP should already have acquired these at the registration stage. However, if the client is in the initial or first contact stage, the CP will need to get the information as soon as possible. The CP is advised to wait until the client is in a calmer state before asking for emergency contacts. Emergency contacts can be used if the CP believes that the client is at risk.

Protocol Stage 3A—Referral

The participants in the research for this manual came to a consensus that CT is not suitable for clients who are in crisis. This means that CPs who assess that a crisis is occurring need to inform the emergency contact and also refer the client to the nearest health facility. Not all clients who report self-harm activities and ideation need this emergency response. Doing so might damage the therapeutic relationship and possibly breach the code of ethics for psychotherapy. However, failing to report an emergency could result in charges of negligence. Therefore, the CP must assess the situation and whether it is an emergency. The most common understanding of an emergency is that there is an imminent risk of self-harm by a client.

Bond, Brewer & Mitchels (2009) have suggested that CPs need to assess whether clients understand the potential consequences of their intended actions and are at high risk of knowingly harming themselves through their actions or whether they lack the mental capacity and are at

high risk of self-harm unknowingly. Indicators of a lack of mental capacity are: 1) difficulty with recall or memory loss, 2) disorientation, 3) deterioration in personal presentation or mood and social withdrawal, 4) limited ability to interact with others, 5) lack of mental flexibility; 6) problems with simple calculations American Bar Association & American Psychological Association (2021). A client can be said to be at imminent risk if the CP believes that client will self-harm in the 48 hours following the communication (Hirschfeld & Russell, 1997). In this scenario, it is justified for the CP to breach confidentiality.

Protocol Stage 3A does not mean that all clients with histories of self-harm need to be referred directly to the nearest health facility by the CP. CPs are reminded to follow the Stage 1 protocol, which is calming the client and listening to them referring them only when the client is calm. Direct referral is only suitable for clients in a crisis.

Protocol Stage 3B – Assessing the State of Clients with Only Self-Harm Ideation.

Once the client is calm, the CP could perform an assessment, as discussed in the previous section. CPs are encouraged to use careful wording to make sure clients feel they can open up and actually feel relieved that they were able to talk to somebody about their self-harm activities or ideations. From the responses in the interview, the CP can determine the seriousness of the client's intention to engage in self-harm. Four possibilities at this stage include: 1) the client was feeling so emotional they said things that they did not mean and has now regained control and is not going to follow through on their previous intention, 2) the client was being manipulative and did not really intend to hurt themselves at all, 3) the client is more likely to carry out NSSI rather than a suicide attempt, 4) the client is serious about hurting themselves and needs further appropriate help.

Further communications and assessments are needed to decide whether the client's intent falls into the second, third, or fourth category. To make these assessments, CPs can refer to Carr and McNully's (2016) indicators of the significance of clients' self-harm ideations. Additional indicators were discussed with the CPs who participated in the research for this manual. The combined list is provided in table below

Aspect	High Risk (Suicide)	Low Risk / NSSI	Notes
<i>Please note that to be categorised as high risk, clients do not need to fulfil all criteria. Even one indicator of significant suicidal ideation should be enough for the CPs to refer the clients.</i>			
General Characteristics	• Tends to have made detailed plans including when, where, and using what method • Tends to have designed the plans in such a way that no one could find them • A final letter has been written	• No plan • Tends to plan in such a way that somebody will find them: especially the person they are looking for attention from.	Clients with significant intentions may act spontaneously without any planning. This possibility arises when the client is emotional and sees an object that could help them to achieve their intention.
Implementation Methods	• Lethal, for example, using a weapon, hanging, jumping from a height	Nonlethal, for example, cutting or using cigarettes	
Triggers	• Significant stressful situations that involve feelings of loss. For example, losing a job, family, or partner • Deep feelings of shame	• Romantic problems • Disputes with partners	CPs need to assess the complexity of the problems experienced. For example, a client who is experiencing complex and prolonged romantic problems may engage in serious self-harm. However, loss does not always lead to serious self-harm. This depends on the clients' perception.
Motivation	• To end a state of unbearable stress	• Trying to change personal circumstances that are not as expected • Related to a perfectionist personality	
History	• Has a history of self-harm, bullying, abuse, difficult childhood, and loss	• None	

Aspect	High Risk (Suicide)	Low Risk / NSSI	Notes
Family Factors	• Has a history of self-harm, bullying, abuse, difficult childhood and loss	• None	
Demographics	• Greatest risk in males • Low socioeconomic status	• Greatest risk in females • Middle-upper socioeconomic status	
Collaborative Attitude (Additional finding from research for manual)	• Still willing to communicate and have a two-way conversation about the situation	• Tends to ignore or be resistant to any intervention given by the CP	
Communication Style (Additional finding from research for manual)		• Tends to be dramatise the situation and make threats • Wants an immediate response outside of scheduled times.	

Table 4 – Self Harm - High Risk vs Low Risk

Protocol Stage 4—Determination

In Stage 4, the CP determines whether they should continue the CT session or choose referral instead. Following Protocol 3B which lists four possible situations, the Stage 4 protocol provides three possibilities.

1. The client has become calm.

If the client initially intended to hurt themselves but has now calmed down, the CP can offer a follow-up CT session to regulate the clients' behaviour.

2. Manipulative/NSSI

If the CP believes the self-harm intent fall into the category of manipulative behaviour or potential NSSI, the CP could also offer further CT sessions to continue the therapy.

3. Serious intent

If the CP believes that the client is at serious risk of injuring themselves, the CP is advised not to continue with CT and, instead, refer this client to either the emergency or psychiatric services or for a face-to-face session with the CP as in Stage 3B of the protocol. The clients must be calm before the referral takes place.

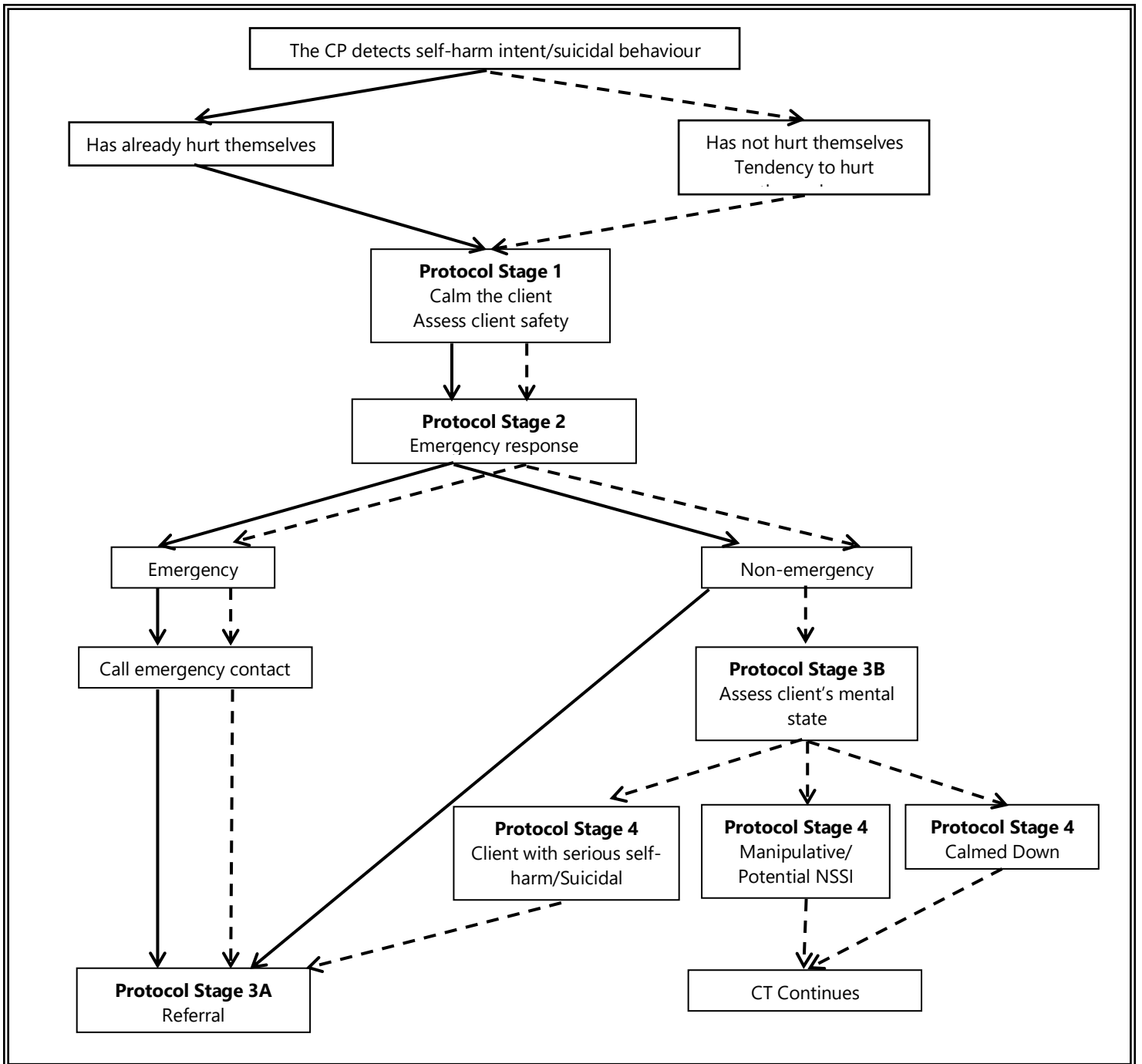


Diagram 2 – The Protocol Clients with Self-Harm

Chapter 9 — CT Stages for Indonesian Millennials and Gen Z with Minor Depression

This chapter discusses the stages for conducting CT with Indonesian millennials and Gen Z with Minor Depressive Disorder. It is crucial to have read and understood the previous chapters as this chapter refers to these chapters.

To avoid misunderstandings, these terms are used in Chapter 8.

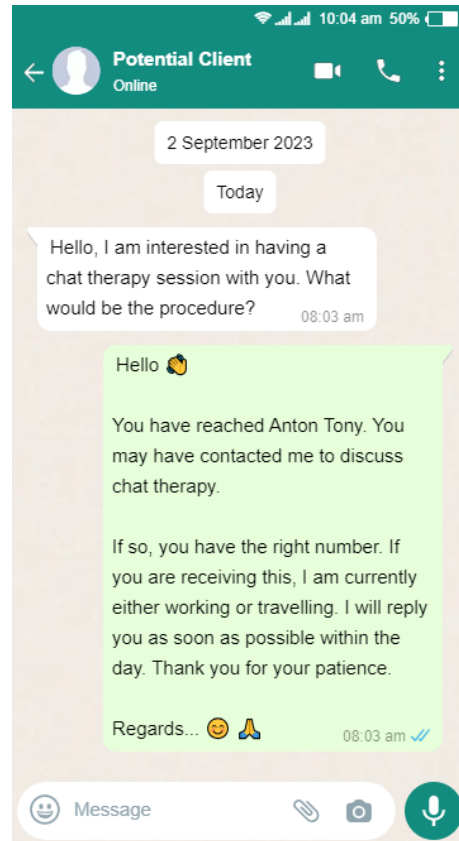
1. CT refers to chat telepsychotherapy.
2. CP refers to an Indonesian clinical psychologist.
3. Client refers to an Indonesian Gen Z or millennial who experiences mild depression. Any differences between these two generations are discussed.

First Contact

It is crucial for CPs to understand that clients who have made contact and asked for CT have realised that they need help. This needs to be emphasised as, in general, it is not easy for depressed people to seek help. They often choose to remain silent and might not have the motivation to do anything and would rather stay at home and do nothing. Furthermore, CPs must be careful in their actions because the clients are in fragile mental states. Considering that this initial communication is via chat, these clients can leave the chat at any time, without warning.

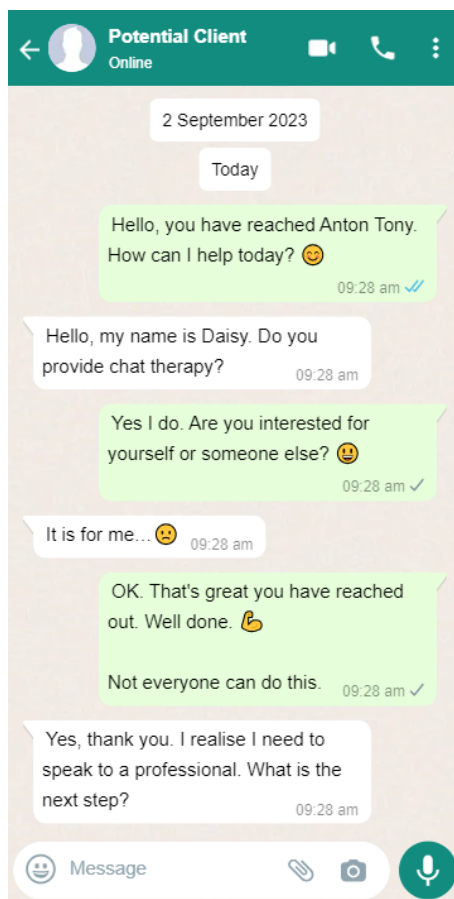
At first contact, the first important thing for the CP to do is to respond to the client as quickly as possible. It can be very reassuring for the client if the CP responds immediately, even though this cannot always be the case. CPs who offer their services on a certain fixed schedule can answer incoming first contact messages immediately. CPs who do not have a certain fixed schedule and cannot answer clients' messages immediately should send automatic replies. This is where it is important for CPs to use chat applications that can send automatic replies so the clients know that they have contacted the right number. The automatic reply message should contain information about the CT services offered as well as a calming message and a polite apology for not replying immediately.

Given the multicultural setting of Indonesia, CPs may be contacted by clients who speak languages other than Indonesian. If this happens, please refer to the section in Chapter 2, "Language and CT" for ways to appropriately address this issue.



CPs must remember that millennial and Gen Z clients often engage in rather casual communication. As discussed earlier, such clients expect friendly and quick responses. Therefore, avoid messages that are too rigid and formal and respond to their messages as soon as possible. Also ensure that they are addressed using an appropriate title.

CPs then need to find out what the client wants. This can be done using two methods. The first method is through the ongoing chat, while the second method is using electronic forms that can be shared with the clients. In the first method, CP could continue the ongoing conversation, provide small talks and ask the clients directly about their expectations of the therapy. Implicitly, CPs could be sensitive towards the client chat content and behaviour and make assumption in regards to their expectation. For example, if the client sends long messages in the session, that could indicate that the client wants to be heard. Direct questions from the client might suggest that they expect a solution. The advantage of the first method is that the exchange of chat messages can be used to develop rapport through small talk to break the ice. However, this will take longer. The advantage of the second method is speed. The CP can do other activities while the clients are completing the electronic form. As the rapport will not be established by filling in the form, the CP who chooses the second option may wish to establish some initial rapport before the electronic form is sent.



Regardless of the option chosen, CPs are expected to have a template containing questions that must be asked of the client. The CP who chooses the first option, will either need to remember the questions or have two applications open simultaneously (i.e., chat and notes) to copy and paste the questions from the template into the chat. These questions need to be asked of the clients either in the chat or in the electronic form:

1. Name, age, and gender
2. Ethnicity and whether clients follow their ethnic traditions
3. The problems experienced
4. Physical or mental symptoms experienced
5. Purpose for doing CT
6. Whether or not they have had psychological therapy before. If they have, when and what was it about? What was the outcome of the therapy?
7. Whether or not they have pursued psychological therapeutic intervention using chat before? If they have, when and what was it about? How was their prior experience with chat therapy? What was the outcome of the intervention?

From the responses, CPs will obtain information about the following:

a. Cultural Elements

From the responses to Questions 1 and 2, the CP can obtain information about the cultural background of the client. Although this manual focuses on millennials and Gen Z, ethnicity must still be taken into account. Addressing clients using ethnically appropriate forms of address can help the CPs to build rapport.

b. Initial hypothesis, suitability, and ability of the CP to help the client.

From the responses to Questions 3 to 5, the CPs can derive initial hypotheses about the client's issues. This information about CT contained in this manual could be applied with other mental health conditions, however Chapters 5, 6, and 8 are specifically focused on Indonesian millennial and Gen Z clients with mild depression and are only applicable with these clients. Furthermore, if the client's issues are deemed to be severe, the CP is advised to refer the client for face-to-face psychotherapy.

Responses to Questions 3 to 5 will also inform the CP whether or not the client's issue is strongly related to their culture. As previously discussed (see Chapter 4, "Culture and Chat Telepsychotherapy," p. 24), issues that are strongly related to culture might be best handled by more suitable professionals. Should a referral to another professional be the best way to help the client, the CP is advised to assist the clients by providing clear guidance on who to contact and how.

The response to Question 5 can help CPs to determine whether or not CT is suitable for the client. It is possible that the client might only need psychoeducation that is quick and practical and is not interested in undertaking CT which tends to be longer. There is also the possibility that client just needs to be listened to and is not seeking therapy. In either case, the methods in this manual will not be appropriate and the CP offer a consultation or counselling via chat (see p. 7). These two forms of intervention are not discussed in this manual.

c. History of Face-to-face and CT Therapy

Responses to Questions 6 and 7 can provide the CP with an overview of the client's therapeutic history, whether face-to-face or chat based. The therapeutic history will give the CP information about the client's current and previous mental health, any previous diagnoses, and how those disorders have been treated. Responses to questions about previous chat-based psychological interventions will give the CP information regarding the client's previous experiences. If they had a negative experience, the CP can try not to cause a repeat of the same bad experience.

Initial Form of Chat Telepsychotherapy

Thank you for choosing Anton Tony, Clinical Psychologist as your trusted person to give you mental health aid. For to be optimally help you, please kindly complete the questions below.

wisnu.tw.endro@gmail.com [Switch account](#)

Not shared

Full Name

Your answer

Age

Your answer

Gender

Your answer

Ethnicity

Your answer

Do you follow your ethnic traditions?

☐ Yes

☐ No

☐ Not Sure

Please describe your issue.

Please write your problem as comfortable as you are. Your problem could by physical, mental health, environment or other aspect that you feel is bothering you.

Your answer

What are you hoping to achieve in this therapy?

Your answer

Have you ever receive Psychological Therapy before?

☐ Yes

☐ No

If you have, when was it?

Please write down the date, month and year if you remember. The format is Date/Month/Year. If you don't remember it in full, please enter only the information you remember such as Month/Year or Year only..

Your answer

If you have, what was it about? Have you been given an official diagnosis, and what was the outcome?

Your answer

Have you ever engaged in a therapeutic psychological intervention using chat before?

☐ Yes

☐ No

If you have, when was it?

Date

dd/mm/yyyy

If you have, what was it about and what was the outcome?

Your answer

How would you rate your experience of this chat therapy?

	1	2	3	4	5	
Very bad	☐	☐	☐	☐	☐	Very satisfying

Please give the reason for your choice

Your answer

Submit

Clear form

Another important thing that should not be missed in the first contact is the risk assessment. This is very important as CPs might be contacted by clients with self-harm tendencies. To conduct a risk assessment, the CP is advised not to include such sensitive questions within the electronic form but rather to discuss this with the client directly. CPs are advised to have an open communication and design careful questions to find out if the client shows signs of self-harm. While doing so, CPs could also provide psychoeducation to the clients about self-harm and how to best respond to such a situation if it arises. It is essential for the CP to not label self-harm behaviour as negative but rather provide an understanding of the prevalence of self-harm behaviour and how people often do it to cope with stressful situations.

Chapter 8 (pp. 71) is dedicated to a discussion of self-harm. As a quick guideline, risk assessment in the CT setting includes: 1) whether clients have a current tendency to or a history of self-harm, and 2) if the client has these, where they are on the continuum of self-harm. Different scenarios of self-harm require different responses. Chapter 8, specifically section "Self-Harm in CT—A Protocol" (p. 75), offers a guide for CPs on this topic.

Administration and Informed Consent

CPs who deem the clients suitable for CT can then proceed to the administration and informed consent stages. The main purpose of these two stages is to create agreement between the CP and the client on how the CT will be conducted. As the client comes from a generation that tends to be assertive, they are expected to want to know the full details of the CT.

When it comes to practical matters, clients want to know how many sessions the treatment will require, how the CT sessions will work in the future, and what they can and cannot expect. It is also recommended to explain in detail the advantages and disadvantages of CT. Another important aspect is data confidentiality. Information regarding confidentiality can be found in the section in Chapter 4, "Confidentiality" (p. 19).

When it comes to the therapy, clients want to know what type of therapy they can expect in CT. CPs can describe the stages of therapy. As an additional option, CPs can also provide information about the theoretical perspective of the therapy.

Finally, clients want to know what activities will occur within each session. Although it is unlikely that the CP will fully understand the client's issue at this stage, they should be able to give a general overview of each session. CPs can talk about the tasks that may be assigned and their purposes.

It is to be noted that in this manual, all these aspects are predetermined. The therapy that is used in this manual is cognitive behaviour therapy (CBT). The main stages of the therapy could be found in Table 9 “Summary of CT Stages for Millennial and Gen Z Clients with Mild Depression” (p. 117).

As a closure for these stages, the CPs can provide two documents for clients. The first document is the “Initial Therapy Plan” which contains information about the number of sessions, the goals for each session, and the tasks to be given. It is recommended that in this first document, the CP emphasises that the proposal is subject to change at any time if necessary. The second document is the “Informed Consent” document which contains information about CT and its technical implementation.

Scheduling and Payment

CPs are advised to consider two options in regard to scheduling and payment. Option 1 is for a predetermined schedule. For this kind of arrangement, the CP can discuss the best times for the sessions and how far apart each session should be. Some CPs think sessions should be weekly and others fortnightly. Option 2 is to decide a time for the next session at each session. This option is more suitable for clients who want to have more flexibility for any reason, for example, because they need different amounts of time to implement any therapeutic assignments from the CP or for the assignments to have an effect. Another consideration might be that some clients simply cannot afford to attend weekly sessions.

Similarly to the scheduling, CPs are advised to offer two main options for payment. Option 1 is for clients to pay per session, and Option 2 is to compile a payment plan with the client paying in advance for a number of sessions. Scenarios for clients with economic difficulties or who simply cannot afford the therapy are discussed in the section in Chapter 3, “Fees” (p. 16).

When these matters are agreed, the CP can then prepare and give the client the “Initial Treatment Plan” and “Informed Consent” documents. The initial treatment plan is useful to help the client understand how the treatment would proceed. The CP needs to mention that the initial treatment plan is only based on the initial form and is subject to alteration as the therapy progresses. In practice, considering that CT will be done online, all this information should be provided to clients in an electronic form. Where possible, the CP should choose a platform that provides the client with the option to sign electronically. The following are examples of initial treatment plans and informed consents:

Initial Treatment Plan

This is the initial treatment plan for Daisy. It is understood that this plan could still be amended depending on the situation.

Stages	# Session	Rationale	Aim	Intervention
Assessment	1 – 2	To gather complete information about client's problem	To know more about the root of client's problem and also to become familiar with client's current environment	Behavioural activation for urgent problems
Emotional Intervention	3 - 5	Emotion as the main component of client's problem	To teach emotional regulation skills	Psychoeducation about emotions Possibly meditation and assertiveness to help with emotional regulation
Cognitive Intervention	2 – 4	Explore and address thoughts as contributors to the client's difficult emotions	To understand and possibly modify client's thoughts that lead to difficult emotion	Assignments about automatic thoughts Dysfunctional thoughts will be assessed and modified
Strengthening	2 – 3	New skills that need to be strengthened	To strengthen the skills that have been taught during the sessions	Similar assignments as before or discussion of the process and the outcomes of previous assignments

Information Sheet and Consent Form for Chat Telepsychotherapy

Thank you for considering chat telepsychotherapy as an avenue to address your current difficulties. The fact that you are considering therapy means that you have a great desire to improve your mental health and that is very important. This document contains information about chat telepsychotherapy to help you understand what will happen in this therapy, and a consent form. It is very important for you to understand exactly what chat telepsychotherapy is like and what you can expect from this therapy. Please read the information below carefully. Please ask if anything is not clear.

Definition of Chat Telepsychotherapy (CT)

Chat telepsychotherapy is a therapeutic online synchronous text-based communication (chatting) relationship that is curative in nature with the aim of providing help for clients who suffer from mental health problems or are in need of guidance to improve their lives.

Scope of CT

- CT can only be conducted for disorders that fall into the mild category and the severity of the disorder will be assessed professionally by the psychologist.
- CT is not the same as and cannot replace face-to-face therapy.
- CT will never result in a diagnosis. Information about any disorder will only include tendencies. If the client needs a diagnosis, then the client must undertake face-to-face therapy. However, CT could work with official diagnoses previously given to the clients.
- CT is undertaken by the client and psychologist to improve the client's mental health in relation to the issues that the client is currently experiencing. CT does not guarantee that any improvement but the interventions provided in CT are professional and evidence-based interventions based on existing best practice.

How is CT Conducted?

CT is conducted by both the psychologist and the client sending chat messages through a mutually agreed upon application. In CT, the psychologist will mostly only reply and send messages via chat but clients can also use features such as voice-notes to send messages. Communication through these chat messages will be therapeutic with the aim to improve the client's mental health. During therapy, the psychologist may send documents such as worksheets, reading materials, or links to videos or certain webpages that the psychologist thinks will help the client.

Recommended Setting for CT

For CT It is recommended that clients find a well-lighted place where they feel comfortable and able to focus without distractions. It is not recommended that clients undertake other activities during therapy sessions as it might affect the effectiveness of the therapy. It is also recommended that clients maintain a sitting position to ensure the focus throughout the sessions.

Identity and Emergency Contact

In CT, the clients cannot choose to be anonymous. CT is a serious form of intervention the identity of the clients is very important. Clients are asked to show proof of identity to the psychologist by sending three documents: 1) photo of identity card; 2) personal photograph; 3) photograph holding identity card. Finally, clients will be asked to provide the contact number of an emergency contact person. If the clients are not comfortable providing this information, then the CT cannot proceed. This information is subject to confidentiality, as discussed in the next section. The identity information will be used for administration, documentation, and as supporting information for the therapy.

Confidentiality

Confidentiality in CT is divided into two parts, namely 1) confidentiality of identity, and 2) confidentiality of psychotherapeutic content. The chat application used for CT must have a high level of security, where messages sent between the CP and the client can only be read by the CP and the client. Furthermore, the CP and client are required to keep the messages during therapy from being read by other parties in any form unless the content requires confidentiality to be broken.

- The therapeutic process can also involve other applications such as email. The email program used also needs to be secure.
- All identity-sensitive documents that the client provides to the psychologist during the CT process will be downloaded and stored in an encrypted electronic folder.
- Despite all the efforts above, there is no way to guarantee complete confidentiality of data. This is because the therapy will be carried out through online applications that have their own servers that are not controlled by either the psychologist or the client. There are still possibilities of data leakage.
- The psychologist may disclose the client's identity if: 1) the client has the potential to carry out activities that endanger themselves and others; 2) the psychologist has sufficient evidence to assume that the client has broken, or is going to break, the law; or 3) the client's identity or psychotherapeutic data is lawfully requested by the authorities.

Cultural and Language Aspects in CT

Given the diversity of cultures that exist in Indonesia, it is likely that the psychologist and client have different cultural affiliations. Here are some considerations regarding this:

- CT is not an ideal place to consult on ethnicity, religion, and race (SARA) issues. Clients who want to gain more knowledge about SARA are encouraged to consult a SARA expert.
- If cultural aspects somehow contribute to a client's issue, the psychologist will be very careful not to intervene in the cultural aspects but rather look into the psychological framework of the culture to facilitate a neutral discussion. This may be different if the psychologist and the client are from the same cultural backgrounds and the psychologist has enough knowledge about this cultural aspect.
- Regardless, humans are culturally constituted. The psychologist will acknowledge, respect and facilitate any cultural aspects that the clients might introduce during the course of the therapy.
- Unless approved by both parties, the language of CT is Bahasa Indonesia. If the psychologist and the client are willing and comfortable to use a regional language, this can be mutually agreed.
- If the psychologist and client cannot communicate due to language barriers, either the psychologist or the client might seek a third party who can translate the messages in the psychotherapy so they can be understood by both parties. Should this happen, another informed consent to maintain the confidentiality between the CP, the client, and the third-party translator, will need to be signed.

Commitment and Collaboration within CT

The success or effectiveness of CT dependant on many factors. However, it is very important for the psychologist and client to commit to and collaborate in CT to increase the success rate of CT. Some important points are as follows:

- Both the psychologist and the client will commit to the agreed to schedule of sessions.
- The psychologist will commit to providing the best therapeutic interventions for the client.
- The client will commit to collaborating with the psychologist and carry out the activities and assignments that the CPs might assign for the benefit of the client. The activities in question are usually given in the form of written assignments or activities.

Risky Behaviour

If, in the CT process, the psychologist believes that the client will engage in risky behaviour, then the psychologist is required to stabilise the situation by carrying out one or both of the following interventions: 1) contacting the emergency contact person provided by the client, and 2) directing the client to the nearest health facility.

Unpleasant behaviour

If, in the CT process, the psychologist encounters unpleasant behaviour from the client, the psychologist will carry out an intervention that aims to reduce or eliminate the unpleasant behaviour that has arisen. If this gradual intervention effort doesn't work, the psychologist can make an early termination or even report the behaviour to the authorities, if deemed appropriate.

Examples of unpleasant behaviour are as follows:

- Making offensive statements
- Making threats
- Physical or cyber stalking
- Insulting/blaspheming psychologist's ethnicity, religion and race (SARA)
- Sending inappropriate pictures or videos that are not related to the therapy
- Flirting with the psychologist

Technical Delays, Absences, and Schedule Changes

1. If either the client or the psychologist is unable to attend a session, they must inform the other person at least 2 hours before the session.
2. In this process, a replacement session will also be considered.
3. If the client arrives late for a session, the session will still finish at the scheduled time without any extension.
4. If the psychologist is not present at the scheduled session without prior notice, the psychologist will make contact as soon as possible to arrange new time.
5. If the client does not attend the scheduled session without prior notice, then the client will lose the session. This may impact the effectiveness of therapy so that needs to be considered, along with the possibility of extending sessions outside the agreed contract.
6. If the psychologist cannot fulfil the contractual side of the agreement including the number and schedule of sessions and an alternative schedule cannot be agreed, then the client is eligible for a refund.
7. If the client suddenly loses contact in the middle of a therapy session due to technical issues such as loss of signal, or a flat battery, the psychologist will try to contact the client using alternative means such as email, SMS, voice call or, if justified, call the emergency contact person.
8. If the psychologist suddenly loses contact in the middle of a therapy session, due to a technical issue as described above. The client does not need to be concerned and the psychologist will follow up with a proposal to reschedule as soon as the technical issue has been resolved.
9. Communication that is made outside scheduled hours may not be replied by the Psychologist. Clients who need urgent care could go to the nearest emergency establishment. Client could also contact the Mental Health Line by dialling 119 extension 8.

Client Rights

1. The client has the right to receive an intervention that is in accordance with the best practice procedure and is aimed to benefit the client.
2. The client has the right to end the session at any time.
3. The psychologist will uphold positivity and nonjudgement and aim for consensus in therapy
4. The psychologist must maintain client confidentiality.
5. The psychologist will not raise ethnic or religious issues in therapy in a way that is inappropriate or unrelated to therapy.

Scheduling

Below is the scheduling arrangement agreed upon by the psychologist and client.

The sessions will be held (Choose One) :	☐ Weekly	☐ Fortnightly
Days and Time (Choose One) :	☐ Fixed	☐ Flexible
Detail of the Schedule (For Fixed Schedule) :		

Payment

Below is the payment arrangement agreed upon by the psychologist and client.

The sessions will be paid (Choose One) :	☐ Per Session	☐ Plan Payment
Detail of the payment :		

CT payment will be made in advance, according to what has been agreed. If there are additional sessions outside the first appointment, the clients must make payment first before continuing with therapy.

Chat Telepsychotherapy Technical Details & Consent Sheet

CT Schedule	:
Duration of each session	:
Number of Sessions	:
Cost Per Session	:
Full name	:
Age	:
Address	:
Phone number used for CT	:
Emergency contact number	:

By signing this form, you agree that you have read this document carefully and are satisfied with the explanations given by the psychologist. By signing this form, you also consent to the agreement stated in this document, without coercion.

____/____/____

Date

Client signature

Assessment

After the administration stage has been completed, the CT sessions can begin. In the initial sessions, the CP is advised to complete an assessment with the main purpose of obtaining comprehensive information about the clients' issues. To understand clients' difficulties in a comprehensive manner, it is recommended that CPs adopt the 5P model outlined by Macneil et al. (2012). This model aims to explore a psychological case through five major aspects.

Factors	Description
1. Presenting	The problem currently experienced by the client
2. Predisposing	Any biological, environmental or personality factors that make the client at risk or vulnerable to experiencing the problem
3. Precipitating	Factors or events triggering the existing problem
4. Perpetuating	Factors that perpetuate or worsen the existing problem
5. Protective	Factors that can protect or improve the client's mental health

Table 5 - The 5 Ps

In conducting the assessment sessions, the CP needs to remember that clients who are experiencing mild depression may be in an unstable condition. Therefore, it is important for the CP to be very careful in choosing the words to use in the chat messages. CPs also need to remember that clients come from generations that typically prefer more relaxed and informal communication. As a first step of the assessment, the CPs are advised to give the clients space to retell the story in a more descriptive and complete way (compared to the initial form) with an expectation that the story will contain all aspects of the 5P framework. The CP might start with the following sentence:

Okay, as the first step in our session, I would like to ask you to describe the issue you are experiencing at the moment. Of course, you talked about it briefly in the form you filled out in the beginning, but in this session, you can explain more fully what you are experiencing. Often clients find that the more detailed unpacking of their difficulty results in them feeling a bit better.

There is a possibility that a client doesn't know where to start with the story. If this happens, the CP can guide the client using the information from the initial form filled out by the client. The basic idea in this stage is again to address all the aspects of the 5P framework as well as it being the first opportunity for the CP to build rapport with the client and provide emotional support.

Clients who suffer from minor depression may not feel motivated or comfortable speaking through chat. This is because depression is largely characterised by the loss of interest and energy, so retelling a story may seem formidable. Additionally, if the client is not comfortable telling stories in chat, they might only give a short account that does not reflect what the real problem

is. Therefore, the information may be superficial. To address this, CPs are advised to allow clients to use the voice note feature (see “Voice Notes,” p. 44) to convey their messages. Furthermore, the voice note feature can also provide additional information such as their emotional state through the tone of the client’s voice.

The assessment section in CT is vital because it is the first opportunity for the CP and client to interact deeply. Depending on the intensity and the richness of the information, assessment sessions in therapy sessions can last from one to three sessions. Although, considering that clients come from generations who typically like things to move quickly, it is recommended that the CP finishes the assessment in one session or a maximum of two sessions. Having the skills to build a therapeutic relationship is very important as this contributes substantially towards the success of therapy. Some aspects that the CP can consider in an effective therapeutic relationship in CT include.

1. Cultural Sensitivity

The interaction between culture and CT has been discussed in Chapter 4 (p. 24). As a quick guideline, CPs are advised to have a basic knowledge of the client’s culture such as culturally specific titles or religious greetings which help clients to feel more appreciated and comfortable during the session. Depending on the client, the effect might be improved by the CP delivering the whole session using the client’s traditional language. All of this will lead to a greater chance of therapeutic relationship developing. It is also important for the CP to be sensitive to, respectfully curious, and neutral (see p. 27) regarding any cultural details that a client might share during assessment as such details may facilitate a better understanding of the client’s issue.

2. Interview Techniques

In order to get the best responses from their clients, CPs are advised to ask open-ended questions that can encourage clients to give long and comprehensive answers. Clients are likely to feel uncomfortable if CPs ask a series of formal questionnaire-style questions. Finally, as clients might send messages split across several chat bubbles (see p. 37), CPs must ensure the client has finished their message before proceeding to the next question or topic.

3. Counselling Skills

Counselling skills that focus on communicating empathy can be used in the assessment process because they can create a sense of comfort that leads to the establishment of a therapeutic relationship between the CP and the client.

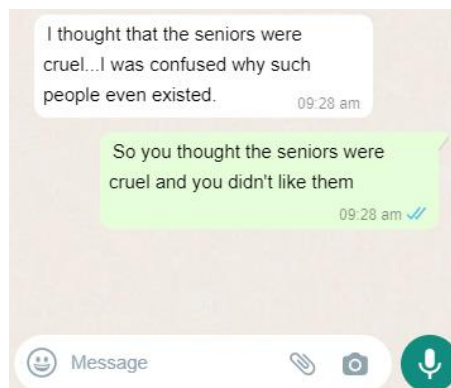
a. Attending

Given that the CT assessment session is not face-to-face, clients might not know for sure whether the CP is attending to them. Thus, it is recommended that the CP provide short affirming messages to clients during their storytelling to reassure them that the CP is indeed attending and focusing on their messages.



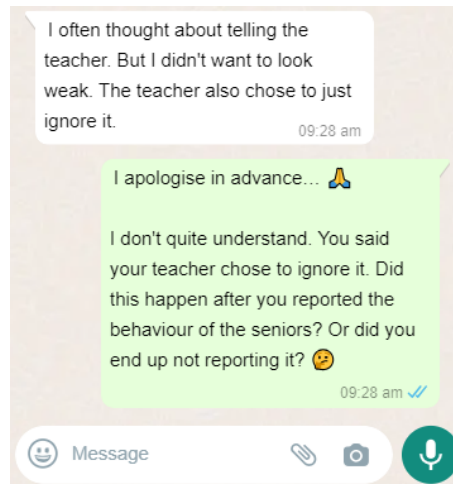
b. Paraphrasing

A skill where the CP repeats back in their own words the message sent by the client. This activity can facilitate the client feeling fully understood by the CP.



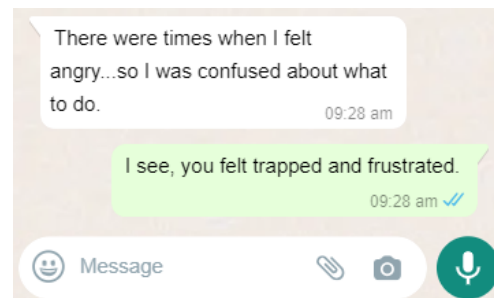
c. Clarifying

A skill where the CP clarifies with the client whether the CP's assumption about clients' problem or situation is true.



d. Reflecting

A skill where the CP shows that they understand how the client feels by providing a genuine and sensitive statement.



As well as using the counselling skills mentioned above, CPs can also use emojis to represent the feelings that they experience when listening to stories of the clients. Emojis are discussed in detail in Chapter 5 (p. 42).

4. Acceptance and Neutrality

Acceptance and neutrality are two very useful guiding principles in this assessment stage. when the clients will tell detailed stories about their situations which may not be in accordance with the common norms and values . It is very important for CPs to be impartial and to accept the stories told by the clients without any judgment. Further discussion about this could be found in section "Being Neutral and Tolerant towards Clients' Cultures" (p. 27).

5. Technical Aspect of Chat Communication

One of the drawbacks of chat is the possibility of misinterpretation by both parties. Therefore, if the client send an ambiguous message, it is very important for the CP to clarify right away. Thus, it is important for CPs to always send clear messages to clients.

Should the CP need to ask sensitive questions, the CP could first ask for permission by using emojis before proceeding to ask the questions. The CP can also choose words to show their good intentions. A quick response is also necessary to help the client feel comfortable. If the CP has to type a long message, they should ask the client to be patient and wait for the upcoming message.

It is also important for CPs to be aware of the unique manifestations of depression in Indonesians (see Chapter 7, p. 68), and assess any physical manifestations and urgent complaints that need to be addressed quickly.

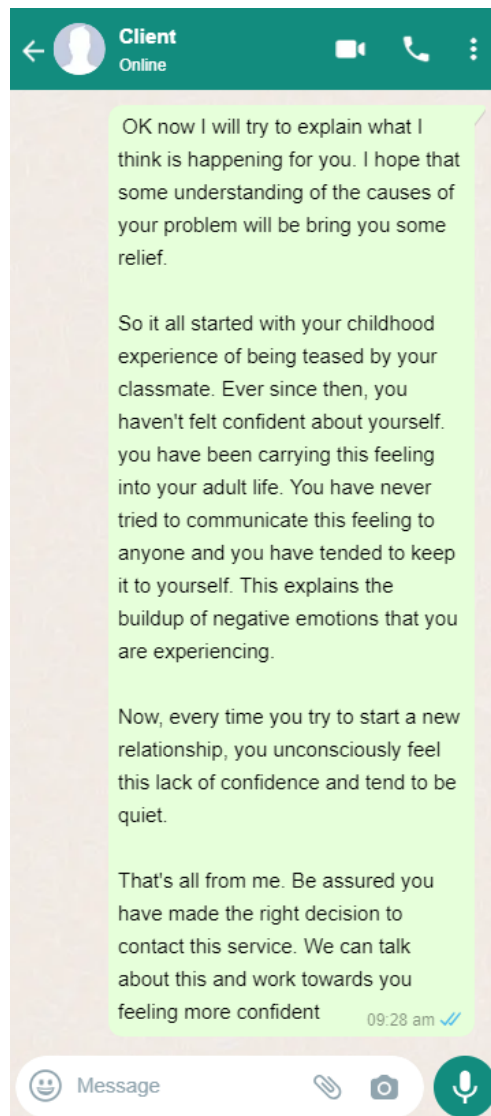
At the assessment stage, CPs can also use several questionnaires to assist with their understanding of the client's mental health status. There are several measuring tools for depression that can be used by CT practitioners in Indonesia:

Author/ Researchers Names	Article / Thesis Title	Year Published	Original Measurement Tools
Sri Adaiani	Analisis 20 Butir Pertanyaan Self Reporting Questionnaire pada Masyarakat Indonesia	2009	SRQ-20
• Henndy Ginting • Gérard Näring • William M.van der Veld • Wilis Srisayekti • Eni S.Beckera	Validating the Beck Depression Inventory-II in Indonesia's general population and coronary heart disease patients	2013	BDI-II
• Retha Arjadi • MH. Nauta • DB. Utoyo • CLH. Bockting	The Inventory of Depressive Symptomatology Self Report (IDS-SR): Psychometric properties of the Indonesian version	2017	IDS-SR
Cut Nyak Dian	Validitas Dan Reliabilitas The Patient Health Questionnaire (PHQ-9) Versi Bahasa Indonesia	2020	PHQ-9

Table 6 – Depression Measurement Tools

The depression measurement tools listed above are the results of studies where the researchers created Indonesian versions of already existing depression measurement tool. All measurement tools were tested for validity and reliability with Indonesian samples. CPs are advised to contact the research team for each measurement tool to obtain permission to use it. CPs could ask permission to convert the measurement tools into electronic forms (such as online questionnaire) or to send the existing electronic format (pdf) to clients.

Once the CP is confident about the results of the assessments and all 5P aspects have been explored, the CP can compile a summary report and share this with the client. The delivery of the conclusions is one of the crucial stages that will affect whether the therapy continues because the client will also assess the CP's conclusions. Millennial and Gen Z clients are typically used to finding information online and it is possible that they already have an opinion about their condition. A superficial conclusion by the CP will be disappointing for the client as they might feel that they have paid a professional to give the same level of analysis they themselves are capable of using online resources. Below is an example of a summary of case formulation using the 5Ps model.



Treatment Plan

Once the CP and client are comfortable with and in agreement about the case formulation, the next step is for the CP to compile a treatment plan for the client. Some clients may not yet be fully ready for an immediate intervention. They may still have inconsistencies in their stories, or not be able to identify their strengths to enable them to continue to the intervention stage. The CP needs a firm case formulation to be able to continue to the intervention stage. Should this not be the case, consider returning to the assessment stage and reformulating the case.

At this point, the client will already have an initial treatment plan. The new treatment plan will be more specific to the client's situation. This manual uses a predetermined intervention for depression which focuses on the relevant emotional, cognitive and behavioural aspects. Therefore, the design of the treatment plan will be focused on creating goals for the therapy. Below are some guidelines in compiling goals in CT.

1. General Consideration

From Gutierrez (2018), there are some aspects for consideration in designing a treatment plan. Firstly CPs should be aware of client preferences on what they want to do and achieve in their therapy. Secondly, CPs should be aware of the clients' coping system and incorporate the system within the treatment plan. For example, if a client's coping system is meditation, CPs could consider bringing meditation into the treatment plan. Lastly, CPs should consider potential family dynamic that may be affecting clients' therapeutic process; either as potential obstacle or potential supporting factors

2. SMART Goals

This framework developed by Barnes and Ward (2000) can help CPs to create goals that are appropriate for the client. It is possible to make SMART Goals that are short term and long term in nature.

Aspects	Explanation
Specific	Clear and specific goals are easier to achieve as they give better guidelines on where and how to start.
Measurable	Measurable goals allow progress to be reviewed. They also provide clarity as to when a goal has been achieved.
Attainable	Goals are ideally challenging but still realistic.
Relevant	Goals are ideally relevant to the long-term goals.
Timebound	Goals should have an appropriate time limit.

Table 7—SMART Goals

3. The Sequence of Intervention

The default sequence of the main interventions of this manual is: 1) emotional intervention, 2) cognitive intervention, and 3) strengthening (p. 117). Even though there is a rationale behind this sequence, each client is unique and this sequence might not be suitable for all clients. CPs are advised to use their expertise to tailor-fit their treatment plans to the client's needs.

4. Culture

A comprehensive discussion about how culture affects treatment plan can be found in the section "Determination of Treatment in Relation to Culture" (p. 32)

5. Discussion and Consensus

CPs are advised to discuss the goals for each session with the clients. This goal setting process can follow the solution development process discussed in Chapter 5 (p. 55). It is recommended that the client and the CP reach a consensus on these goals.

Urgent Symptoms

As previously mentioned, the generations of clients referred to in this manual typically prefer quick responses and resolutions. A client might expect that their problems and depression will be easily resolved in just one session. As previously indicated, this manual focuses on psychotherapy that extends beyond one session. Should a CP believe that a client's problem can be resolved in just one session, then this manual may not be suitable. The CP can refer to the section in Chapter 1, "CT and Other Mental Health Interventions, " for guidance.

If the client expects a "quick fix," the CP needs to explain the nature and structure of the approach being offered. The client needs to understand this in order to be motivated to proceed with their sessions. However, motivation can be maintained by acknowledging and addressing the expectation and that "the client wants something to take home"—even after the first session. This is where treating urgent symptoms plays an important role.

The urgent symptom intervention may need to be maintained during the assessment process. The main goal of the urgent symptom intervention is to provide quick "first aid" aimed at reducing the urgent symptoms experienced by the clients. It is based on the pre-case formulation stage where these reported difficulties are placed in a coherent context. In this way, clients do not need to wait until the assessment is over to have "something to take home." Furthermore, the urgent symptom interventions at this stage are still general in nature.

In cases where the CP assumes clients are experiencing mild depression, the CP needs to first understand the behaviours associated with Indonesians experiencing depression (see Chapter 7, p. 69). To review, behaviours associated with depression in Indonesians include 1) social withdrawal, such as locking oneself in a room; 2) drinking less fluids; and 3) poor diet. This information can be used to provide urgent symptom intervention. The CP must also remember to assess for physical symptoms associated with depression and may also use those as evidence for urgent symptom intervention (which could include referring the client to a medical doctor or specialist).

To treat urgent symptoms, CPs can provide psychoeducation and/or behavioural activation. These interventions are discussed in the next stage but in simple terms, the CP may provide information to the clients about the consequences of their behaviours. With behavioural activation, the client is asked to perform certain therapeutic activities that could result in an improvement in mood. The CP may suggest activities such as 1) going out more often and being exposed to the sun, 2) routine morning exercise, 3) drinking more water, and 4) improving diet. These interventions are simple and general in nature, however they have been shown to have a positive impact and provide the quick first aid often expected from therapy.

Emotional Intervention

Depression is a mental health disorder centred on emotion, characterised by persistent feelings of sadness and difficulties regaining a positive emotional state. The disorder also interferes with peoples' daily functioning as individuals and socially. One approach to understanding this is that depression is caused by the individual's inability to recognise and/or regulate their feelings. In the emotional intervention stage, the client is taught how to regulate their emotions. Below are the stages of emotional intervention:

1. Emotion Labelling

The aim of this method is for clients to become aware of how they feel. Young clients, who are the main focus of this manual, are often not able to understand the types of emotions they are feeling, hence their ability to manage these emotions is reduced. Furthermore, if they don't understand what emotion they are feeling they won't understand how best to handle those emotions. The method can be used as the beginning of the emotional intervention stage.

In CT the best way to teach emotional regulation to clients is through psychoeducation and discussion. The CPs can provide tables of emotions to the client either via email or using the link feature in the chat application. At this stage as well, the CPs can discuss the origin of emotions, how these emotions affect the clients physically, as well as the influence of emotions on thoughts and behaviour.

This manual uses the descriptions of emotions developed by Makmun (2014) in his book Psikologi Pendidikan (Educational Psychology). Here is a summary table:

Main Emotion	Specific Description
Shyness	crushed, disgraced, humiliated, upset, ashamed, guilty, regretful
Irritation	dislike, hatred, sick, disgusted, humiliated
Surprise	stunned, amazed, aghast
Love	love, infatuation, respect, devotion, closeness, kindness, trust, friendship, acceptance
Enjoyment	joyful, satisfied, fulfilled, awed, amused, proud, happy
Fear	panic, phobia, horror, alertness, restlessness, anxiety, nervousness, fear
Sadness	depressed, rejected, lonely, melancholy, gloomy, sad
Anger	hostile, offended, bitter, angry, disturbed, resentful, irritated, furious, hateful, rage, violent

Table 8—List of Emotions

2. Emotional Acceptance

The main goal of this stage is to teach the client to acknowledge their emotions and accept them. Clients who can accept their emotions will be better able to consider their next actions. This can be addressed through two methods:

a. Metaphor method

Metaphor is a psychoeducation method for explaining complex concepts to clients. Explaining difficult concepts using big, complex words may create confusion in the client. Clients might not be able to follow and grasp the underlying ideas. Metaphors involve the use of words in ways that go beyond their original semantic meaning, to describe other concepts or objects. In psychotherapy, the CP converts complex knowledge to something that is easy-to-understand and relevant in the client's situation.

Example of the metaphor method

Imagine emotions are debt collectors who come to your house. If you don't open the door, the debt collector won't leave and will aggressively knock on your door. But if you accept the debt collector and open the door for them, there will be no aggressiveness in the communication.

b. Meditation Method

In meditation, clients find a quiet place, assume a comfortable sitting position, and focus on themselves. During meditation, clients are asked to examine themselves and identify their feelings. In CT, this method cannot be used easily as the CP and the client are not in the same location, however, the CP can provide videos or audio for the client to watch or listen to. CPs can also suggest certain applications that clients can download to their phones.

3. Emotional Expression

The main goal of this stage is for clients to be able to voice their feelings. Despite having accepted their feelings, sometimes clients still find it hard to express their feelings. Expression and communication of emotion allows a person to feel acknowledged by others and to explore and clarify issues with others. Furthermore, emotional expression might be useful for both the CP and the client. For the client, voicing their emotions may provide a sense of relief. For the CP, the client's self-expression provides further information to be utilised in the treatment. In a non-therapeutic setting, this method may be incompatible with the client's culture, especially in collectivistic cultures where the expression of certain feelings might be responded to negatively by others. In such cases, this method can only be pursued in therapy.

In CT, this method can be taught to clients using the "I statement" method, where the clients are asked to communicate what they are feeling along with the reasons on why the feelings have arisen. The template for an "I statement" is: "I feel ____ because ____." CPs can send the "I statement" template then ask the clients to complete the template. An example of an "I statement" is: "I feel disappointed because he didn't reply to my messages."

Emotional expression can be labelled as venting, and further information about venting can be found in the next section.

4. Emotional Regulation

The main goal of this stage is to teach the client how to regulate the feelings that they have already recognised, accepted and articulated. In this stage, the CP and the client discuss the best ways to deal with the negative emotions that the client feels. Two methods can be utilised by the CP in this stage.

a. Emotional Thermometer

The emotional thermometer is a simple method of describing the level of emotion that clients are experiencing at the time. The emotional thermometer is a 10-point scale of emotion where 1 is the weakest and 10 is the strongest emotion the client could feel. The CP can then associate 1 with being calm and 10 with feeling out of control or even wanting to hurt oneself.

b. Verbal Ventilation (Venting)

Venting is defined as an activity in which clients express their feelings and emotions. This intervention can be useful if done occasionally during sessions. Too much time dedicated to venting negative emotions (negative venting) can negatively affect the therapeutic sessions as it can lead to aggressive behaviour. Venting alone might not be useful and need to be countered by another intervention such as problem-solving or changing negative venting into positive venting. In positive venting, clients try to relate their frustration to the contextual aspects of a person or situation that cause the stress. The following sentence would be considered as positive venting, "I am frustrated by his behaviour, but I know he is on a deadline at the moment." By doing this, emotion is released but at the same time the client also increases their feelings of compassion in the situation.

c. Relaxation

Breathing techniques that reduce feelings of stress and provide a sense of comfort to clients are a method of relaxation which also has a distraction effect by diverting the

client's focus to the effort of relaxing their breathing. Similar to meditation, this relaxation method can be taught with the help of videos.

d. Behavioural Activation (BA)

This method was addressed in the section on urgent symptom relief section. The difference between behavioural activation in the urgent symptom and emotional intervention stages is that the tasks become more contextual and based on the case formulation. Behavioural activation involves assigning the client activities that potentially evoke positive emotions. These positive emotions are expected to reduce or replace the negative emotions typically experienced by the client.

Clients who are given BA assignments are asked to commit to completing them regardless of the emotions that they may experience before performing the task. If the client fails to perform the activities, the therapy session then will focus on the reasons for this.

In CT, BA assignments are given through chat discussions. Based on the results of the assessment, the CP can ask the client to perform activities that the CP expects will have a positive impact. The assignments may be experimental in nature and the client may have never undertaken such an activity before. The CP needs to communicate the purpose, reasons, and expected impacts of the activities to the client. The client must be willing to perform the assignment without any coercion from the CP.

Cognitive Intervention

The main theory underlying this stage is cognitive behaviour therapy (CBT). The theory posits that cognitive aspects play an important role in the emergence of depression. In simple terms, the thoughts that emerge when a person perceives an event are understood to impact their emotional state. Negative thoughts will most likely create negative emotions. The purpose of the cognitive intervention stage is to restructure the cognitive aspects of the client's presenting problem. The CP will seek to identify dysfunctional thoughts that play a role in evoking and maintaining negative emotions.

Cognitive interventions should only be carried out once the client already knows how to manage their emotions. It will be difficult to proceed if the client's emotions are still unstable. This stage will also focus on helping clients to find insights into their situations. Thus, a lot of energy is needed by the clients to think, and this cannot be done while clients are not able to manage their emotions. There are several steps that can be carried out by the CPs to perform this type of intervention.

1. Psychoeducational Theory of Cognitive Behaviour

The main goal of this stage is to educate the clients about CBT. CPs can introduce the importance of mindsets and how they affect emotions and behaviour. Psychoeducation can also focus on introducing the concepts of automatic thoughts and cognitive distortions. To help, the CP can compile a document and provide this to the client to read.

2. Automatic Thoughts Identification

In CBT, the concept of automatic thoughts describes the thoughts that spontaneously arise without reflection when an individual is exposed to an event. For depressed people, these automatic thoughts are often negative and distorting.

In CT practice, CPs can try to identify automatic thoughts that arise by exploring examples of situations experienced by the clients. The CPs can ask what thoughts come to mind when the clients first experience the event/situation.

3. Identify Cognitive Distortions

From the thoughts that have been identified, the next thing is to identify cognitive distortions. At this stage, the CP can refer to the list of cognitive distortions in the next page.

All-or-nothing thinking	Also called black-and-white, polarized, or dichotomous thinking. You view a situation in only two categories instead of on a continuum.	<i>Example:</i> "If I'm not a total success, I'm a failure."
Catastrophizing (fortune-telling)	Also called fortune-telling. You predict the future negatively without considering other, more likely outcomes.	<i>Example:</i> "I'll be so upset, I won't be able to function at all."
Disqualifying or discounting the positive	You unreasonably tell yourself that positive experiences, deeds, or qualities do not count.	<i>Example:</i> "I did that project well, but that doesn't mean I'm competent; I just got lucky."
Emotional reasoning	You think something must be true because you "feel" (actually believe) it so strongly, ignoring or discounting evidence to the contrary.	<i>Example:</i> "I know I do a lot of things okay at work, but I still feel like I'm a failure."
Labeling	You put a fixed, global label on yourself or others without considering that the evidence might more reasonably lead to a less extreme conclusion.	<i>Examples:</i> "I'm a loser"; "He's no good."
Magnification/minimization	When you evaluate yourself, another person, or a situation, you unreasonably magnify the negative and/or minimize the positive.	<i>Example:</i> "Getting a mediocre evaluation proves how inadequate I am. Getting high marks doesn't mean I'm smart."
Mental filter	Also called selective abstraction. You pay undue attention to one negative detail instead of seeing the whole picture.	<i>Example:</i> "Because I got one low rating on my evaluation [which also contained several high ratings], it means I'm doing a lousy job."
Mind reading	You believe you know what others are thinking, failing to consider other, more likely possibilities.	<i>Example:</i> "He's thinking that I don't know the first thing about this project."
Overgeneralization	You make a sweeping negative conclusion that goes far beyond the current situation.	<i>Example:</i> "Because I felt uncomfortable at the meeting, I don't have what it takes to make friends."
Personalization	You believe others are behaving negatively because of you, without considering more plausible explanations for their behavior.	<i>Example:</i> "The repairman was curt to me because I did something wrong."
"Should" and "must" statements	Also called imperatives. You have a precise, fixed idea of how you or others should behave, and you overestimate how bad it is that these expectations are not met.	<i>Example:</i> "It's terrible that I made a mistake. I should always do my best."
Tunnel vision	You only see the negative aspects of a situation.	<i>Example:</i> "My son's teacher can't do anything right. He's critical and insensitive and lousy at teaching."

Thinking Errors
Permission to use the table given by Guilford

4. Cognitive Distortion Modification

If the client and the CP have agreed on the type of cognitive distortion that they are prone to then the next step is to address and change the distorted thought. There are several ways that CPs can address this.

a. Socratic Questioning Method

Socratic questioning involves the CP asking the client specific questions to help them identify their automatic and distorted thoughts and proceed to create a new perspective.. In CT Socratic questions can be asked via chat or using a worksheet. The following is an example of a worksheet.

1. What is the situation? You might be having thoughts about something that just happened in the environment or something that happened inside of you (e.g., an intense emotion, a painful sensation, an image, a daydream, a flashback or a stream of thoughts, such as thinking about my future).
2. What am I thinking or imagining?
3. What is the cognitive distortion? (optional)
4. What makes me think the thought is true?
5. What makes me think the thought is not true or not completely true?
6. What's another way to look at this?
7. If the worst happens, what could I do then?
8. What's the best that could happen?
9. What will probably happen?
10. What will happen if I keep telling myself the same thought?
11. What could happen if I changed my thinking?
12. What would I tell my friend or family member [think of a specific person] _____ if this happened to him or her?
13. What would be good to do now?

Testing your thoughts

Permission to use the worksheet given by Beck Institute

b. Behavioural Experiments

In this method, the CP asks the client to complete an activity that aims to examine the negative thoughts they experience. In contrast to the Socratic questioning technique where clients are asked to think critically about their own thoughts, behavioural experiments use activities that are expected to change the client's mindset.

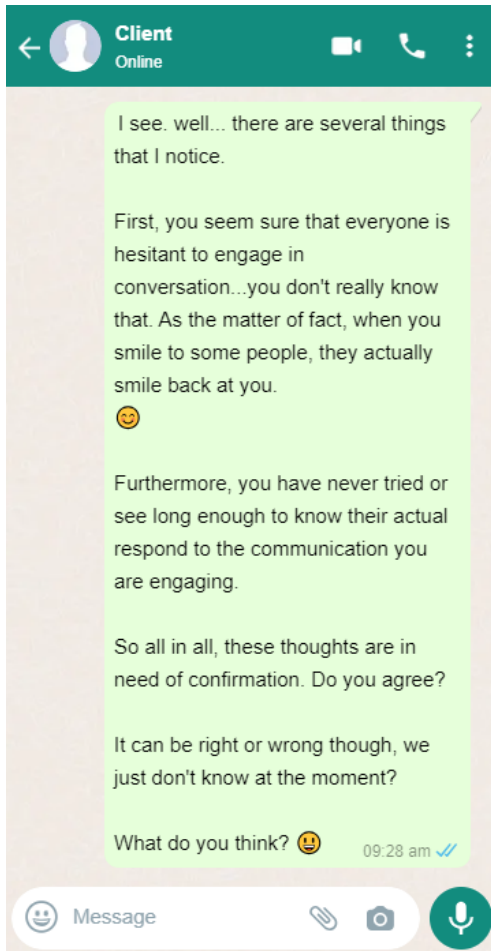
The following is an example of a conversation about a behavioural experiment.



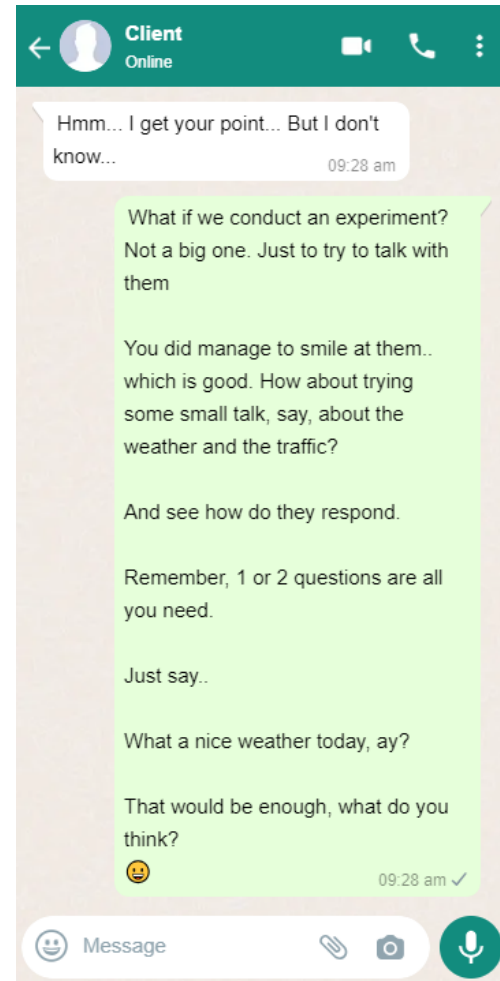
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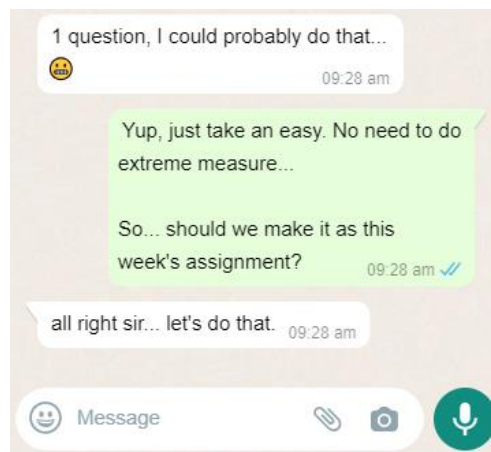
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5

The Regular Sessions

Regular sessions begin after the assessment stage, when the CP has started to use the psychotherapy techniques from the emotional or cognitive intervention stages. This section discusses how regular sessions are conducted. Regular sessions follow a template:

1. What has the client gained from the previous session?
2. What happened in the time between the last session and this session?
3. Evaluate completed assignments (if any).
 - a. Give an appraisal if the assignment was done.
 - b. Ask why any assignment was not done along with the difficulties in completing it. This is then a potential topic for the current session.
4. Assess emotions and/or cognition.
 - 5A. If emotions and cognition have not improved or new negative emotions or cognition have arisen, then these become the goal/topic of the current session (i.e., repeat previous emotional or cognitive interventions).
 - 5B. If emotions and cognition have improved, then the CP can give an appraisal and ask client to reflect on their behaviour that led to such an improvement; encourage them to maintain such behaviour. CPs could continue by ask the clients about their goals or any topic they would like to discuss in the current session (i.e., progress to the next emotional or cognitive intervention).
6. Summarise and evaluate the session. What has the client gained from the session? What is the state of their cognition and emotions at the end of the session?
7. Discuss the next session and to give assignments (if any).
8. Provide positive closure with motivation and greetings.

Alongside the psychotherapy techniques discussed in emotional and cognition interventions, there are also several general psychotherapy techniques that can be useful in the therapy sessions, regardless of the stage. These are

- Grounding
Useful to increase clients' focus in every session. See section in Chapter 3, "Being in the Here and Now" (p. 30) for further discussion.
- Psychoeducation
This technique has been mentioned in the sections on emotional and cognitive interventions to help the CP explain the knowledge behind emotions and cognition. However, psychoeducation can also be used to provide information such as knowledge about the mental illness itself.

- Homework

Giving homework to clients is common in psychotherapy, regardless of the stage. A CP can give homework that aims to strengthen clients' understanding about themselves and the issues they are experiencing. Homework can also be related to the emotional and cognitive interventions at the time. Regardless, there are several considerations when giving homework to the clients. Further discussion can be found in section in Chapter 5, "Homework" (p. 56)

- Journaling

As one example of the homework that can be given to clients, journaling involves clients writing about their experiences of daily life between sessions. This can then be used as a live document that clients learn from or bring to the therapy sessions as material.

- Worksheets

Another example of homework is where clients are given a blank template on a particular topic to complete. Worksheets can be used to strengthen learning about emotions and cognition. The templates of the worksheets can simply follow the worksheets that are used during the sessions. These could include emotional labelling, Socratic questioning, etc.

Strengthening

This is the final stage of therapy, with the main objective of reinforcing what has been discussed in the previous stages. The therapeutic structure used in strengthening sessions is similar to the structure in regular sessions (see p. 113). Several guidelines can help the CP to determine when the strengthening stage should be undertaken:

- When the client believes that they have understood the content and essence of the therapy given, such as how to regulate their emotions and challenge automatic thoughts
- When the client is able to come up with new, undistorted, alternative thoughts without CP guidance
- When the behaviour shown is in accordance with the goals agreed to

The CP and the client can return to discussing skills and strengths that have been discussed in the past but need strengthening. The techniques that have been discussed in the emotional and cognitive interventions can be reused to strengthen change in clients. It also important to provide some evidence that the skills being taught are actually working and bringing positive change.

If the CP consider that clients are yet to achieve this stage, Beck (2020) suggested some techniques that could strengthen the belief and the skills that are being taught to the clients: 1) eliciting positive data and drawing helpful conclusions about their experiences, 2) eliciting the advantages of believing adaptive beliefs, 3) pointing out the meaning of positive data, 4) referencing other people, 5) using a chart to collect evidence, 6) inducing images of current and historical

experiences, and 7) acting “as if”, in which the clients behave “as if” the clients already have a new belief—the positive experience derived from “acting as if” will reconstruct the belief later on.

Termination Session

This is the session where the CP finally ends the therapy with the client. There are two guidelines that CPs can consider before finally terminating the sessions. First, CPs are advised to remeasure clients’ depression levels. Second, CPs are advised to conduct observations and interviews to feel confident that the clients understand and believe in their ability to deal with the issues without the need for assistance. Clients are considered to be at this stage if they are able to generate new functional thoughts on their own when they encounter adverse life situations that would have previously resulted in the emergence of dysfunctional thoughts. In the other words, the new positive behaviour has become a standard default response. There are several final interventions that CPs are also advised to undertake:

1. Explore both the client’s and CP’s feelings in regard to ending the psychotherapy. Some clients might feel loss or grievance about the therapy ending and this should be processed and not ignored.
2. Discuss clients’ future functioning and coping skills. CPs can discuss possible high-risk situation that clients might experience and how to best handle them. At this point, the CP could provide a “termination note” for the client (p. 61)
3. Help clients use their new skills outside therapy. CPs could also talk about how to incorporate the newly acquired skills into future situation that might not relate to the current issue, and how the same skills can be used in other scenarios.
4. Frame personal development as invariably unfinished. CPs must inform clients that development does not finish along with the therapy. CPs can guide, direct or refer clients to other professionals for unresolved problems.
5. Anticipate post-therapy growth and generalisation. In relation to the previous points, CP could also talk about areas that still need to be developed and how to live a healthier life in general.
6. Explicitly prepare for termination. The CP could discuss the responsibilities of both the client and the CP. The CP could also talk about potential post-therapy communication between the CP and the client.
7. Reflect on client gains and consolidate. CPs can discuss the positive changes that have happened during the therapy. However, CPs should also discuss the possibility of relapse in the future.
8. Express pride in the client’s progress and the relationship they have developed. This can be done by explicitly talking about the sense of pride the CP has in regard to the client’s positive changes.

Relationships After Sessions Have Ended

Special consideration should be made in regard to the relationship between the CP and the client after the termination session. Some clients might expect to have an informal relationship with CP and be able to contact the CP more as a friend rather a professional. This kind of expectation is common with clients of the generations that expect their CP to be friendly. However, there are clients who value formality and respect the end of the therapy as the end of the formal relationship and that further contact with the CP should be considered as formal contact made through the proper channels.

CPs need to remember that continuing a relationship other than a therapeutic relationship after the termination session could be considered as having a dual relationship, which is prohibited by the both HIMPSI and IPK Code of Conduct. A dual relationship is described as a situation when a CP who is currently in a professional relationship with a client and, at the same time, also has another type of relationship with the client or with someone close to the client. The relationship between the client and the CP does not necessarily end after the termination session which leaves room for the CP and client to start a new type of relationship. Termination sessions actually create the beginning of a new therapeutic relationship where both client and CP ensure the positive changes that have happened in the clients are maintained through follow up. It is possible that the client may experience relapse and want to return to psychotherapy.

Studies have found that entirely positive relationships cannot be created between clients and former therapists. Instead, the relationship is likely to be disorienting and confusing in terms of whether the client has successfully become independent or whether the therapeutic relationship should be restored. One thing that hinders the creation of an entirely positive relationship is the power imbalance. In the therapeutic setting, clients may know very little about their therapist who knows a great deal about them, since clients are sharing their thoughts and feelings with the therapist. There is a possibility that both parties might maintain or even exploit the former power imbalances. For example, a therapist who becomes friends or romantically involved with their former client might be dominant in decision-making involving the two of them. Or, a former client who is employed by or involved in business with their former therapist could feel a false sense of security which could become a liability for the therapist. A failed business relationship might create disappointment, frustration, and anger in the former client. Such a relationship might also hinder further independence and growth or even undermine the good work that the previous therapeutic relationship had already created.

Summary of CT Stages for Millennial and Gen Z Clients with Mild Depression

Stages	Short Description	Goals	# of Session	Intervention	Other Info
First contact	The first time the client contacts the CP	• Introduction • Rapport	N/A	Electronic form	• Communicate empathy • Apply techniques for building a therapeutic relationship • Be sensitive to cultural factors
Administration & Informed consent	Client provides information about their issue The client completes administrative matters	• Equal understanding about CT • Obtain consent from the client • Obtain payment and identity documentation	N/A	• Psychoeducation • Information Sheet • Consent Sheet.	
Assessment	Comprehensive understanding of the client's issues	• Develop the client's case formulation	1-2. 3 not recommended	• Depression Measurement Tools • Case Formulation using 5P framework	
Treatment plan	The CP shares the treatment plan with the client	• Reach a consensus with the client on the treatment plan.	1. 2 not recommended	SMART Goals	
Urgent symptoms	Intervention regarding urgent symptoms	• Early intervention • Psychological first aid for grounding	Given during assessment	Behavioural activation	
Emotional intervention	Improving the client's emotional response	• Introduce labelling of emotions • Regulate emotions • Address negative emotions	3 - 5	1. Emotion labelling 2. Emotional acceptance 3. Emotional assertiveness 4. Emotional regulation	
Cognitive Intervention	Improve the client's thinking	• Restructuring client's thoughts	2 – 4	1. Psychoeducational theory of cognitive behaviour 2. Automatic thought identification 3. Identify cognitive distortions 4. Cognitive modification	

Stages	Short Description	Goals	# of Session	Intervention	Other Info
Regular Sessions	Pertain to sessions that occur after the assessment stage, where the CP starts to perform any psychotherapy techniques from emotional or cognitive intervention stages	To continue the emotional and cognitive interventions	n/a	Continue the emotional and cognitive interventions	
Strengthening	The client is more stable but still need guidance from the CP	Train the clients in mastering skills and knowledge from previous sessions	1 – 4	Dependent on the client's situation	
Termination Session	The CPs is certain that the client has improved and has mastered the knowledge and abilities that have been given during the sessions	Ending Session	N/A	Re-measurement of Depression level	
Relationship After Session	Client is no longer in therapy but is still allowed to maintain some communication	Maintenance	N/A	Communication when needed	

Table 9—Summary of CT Stages for Millennial and Gen Z Clients with Minor Depression

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Appendix B – Confirmation of Doctoral Studies at Massey University



MASSEY UNIVERSITY
GRADUATE RESEARCH SCHOOL

CONFIRMATION OF DOCTORAL STUDIES
AT MASSEY UNIVERSITY

Full name of student:	Wisnu Tri Widodo Endro		
Date of birth:	01/May/1988	Student ID number:	██████
Programme:	PhD	Study-mode:	Full-time
Start date:	01/Oct/2019	Expected date of submission:	30/Sep/2023
Length of course	4 years	Campus:	Auckland
Thesis title:	The Co-design of a Chat Telepsychotherapy Manual for Indonesian People with Mild to Moderate Depression		
Supervisor:	Dr Matthew Shepherd		
Academic Unit:	School of Psychology		
Notes:	Wisnu passed his Confirmation of registration event on 25th August 2020 and was moved to full registration.		
Date of issue:	4 September 2020		

Please do not hesitate to contact me if you require any further information.

Nicola Duffin
Graduate Administrator
Graduate Research School

To Kunenga
ki Pūrehuroa

Massey University Graduate Research School
Private Bag 11 222 (PN123), Palmerston North, New Zealand Telephone +64 6 356 9099 Fax +64 6 350 5609 www.massey.ac.nz

Appendix C – Massey University Human Ethic Committee Approval



Date: 09 March 2021

Dear Wisnu Endro

Re: Ethics Notification - NOR 20/68 - The Co-design of a Chat Telepsychotherapy Manual for Indonesians with Minor Depression

Thank you for the above application that was considered by the Massey University Human Ethics Committee: Human Ethics Northern Committee at their meeting held on Tuesday 9 March 2021.

Approval is for three years. If this project has not been completed within three years from the date of this letter, reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

Professor Craig Johnson
Chair, Human Ethics Chairs' Committee and Director (Research Ethics)

Appendix D – Letter of Support for the Research from Indonesian Clinical Psychologist Association



Pengurus Pusat
IKATAN PSIKOLOG KLINIS INDONESIA

INDONESIAN CLINICAL PSYCHOLOGIST ASSOCIATION

Sekretariat: Margoyasan PA II / 470 Yogyakarta 55111

Email : pusat@ipkIndonesia.or.id

Telp. 08112651261

Nomor : 125/EKT/PP-IPK Indonesia/III/2021
Lampiran : -
Perihal : Surat Dukungan Pelaksanaan Penelitian

Yogyakarta, 20 Maret 2021

Kepada Yth.
Anggota Ikatan Psikolog Klinis (IPK) Indonesia

Dengan hormat,

Menindaklanjuti surat permohonan ijin penelitian yang disampaikan oleh sdr. Wisnu Tri Widodo Endro, S.Psi., M.A. maka bersama ini IPK Indonesia memberikan dukungan dan ijin kepada :

Nama : Wisnu Tri Widodo Endro, S.Psi., M.A
Status : Mahasiswa Doktoral (ID : ██████████)
School of Psychology, Massey University, New Zealand

Untuk melakukan penelitian dengan judul "*Rancang kolaborasi dari panduan Telepsikotorapi Teks untuk Orang Indonesia dengan Gangguan Depresi Tingkat Ringan hingga Menengah*", serta mengundang Psikolog Klinis Indonesia yang merupakan anggota IPK Indonesia untuk berkontribusi di dalam penelitian tersebut.

Demikian dukungan ini dibuat untuk dipergunakan sebagaimana mestinya. Atas perhatian dan kerjasamanya kami ucapkan terima kasih.

Hormat kami,

Pengurus Pusat Ikatan Psikolog Klinis Indonesia



Dr. Indria Laksmi Gamayanti, M.Si., Psikolog Klinis

Ketua

Appendix E – Permit Letter from World Health Organisation to utilise WHOQoL-BREF

From: permissions <permissions@who.int>
Sent: Wednesday, 28 October 2020 6:13 am
To: Wisnu.Endro.1@uni.massey.ac.nz
Subject: GRANTED: 364228 Permission request for WHO copyrighted material

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Kind regards,
WHO Permissions Team

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15. Headings. Paragraph headings in this Agreement are for reference only.
16. Dispute resolution. Any dispute relating to the interpretation or application of this Agreement shall, unless amicably settled, be subject to conciliation. In the event of failure of the latter, the dispute shall be settled by arbitration. The arbitration shall be conducted in accordance with the modalities to be agreed upon by the parties or, in the absence of agreement, with the rules of arbitration of the International Chamber of Commerce. The parties shall accept the arbitral award as final.
17. Privileges and immunities. Nothing in or relating to this Agreement shall be deemed a waiver of any of the privileges and immunities enjoyed by WHO under national or international law and/or as submitting WHO to any national court jurisdiction.

From: permissions@who.int <permissions@who.int>
Sent: 27 October 2020 03:51
To: Wisnu.Endro.1@uni.massey.ac.nz
Cc: permissions <permissions@who.int>
Subject: ID: 364228 Permission request for WHO copyrighted material

Dear Mr Endro

Thank you for your request for permission to reproduce, reprint or translate certain WHO copyrighted material.

Your request ID: 364228 is under review

Please be assured that we are working on your request and will get back to you as soon as we possibly can.

Kind regards,
WHO Permissions team

Appendix F – Permit Letter from Dr Cipto Mangunkusomo at the Ministry of Health of Indonesia, Directorate General of Health Services, Central General Hospital to utilise SCID IV-1—Indonesian Version.



KEMENTERIAN KESEHATAN RI
DIREKTORAT JENDERAL PELAYANAN KESEHATAN
RSUP NASIONAL Dr. CIPTO MANGUNKUSUMO

Jalan Diponegoro No. 71 Jakarta 10430 Kotak Pos 1086
Call Center: 1500135 Fax : (021) 3148991,3914661 Website: www.rscm.co.id



No. : UM.01.05/VII.1/0234/2020
Hal : Izin Menggunakan dan Mengikuti Pelatihan Instrumen

22 Desember 2020

Kepada Yth.
Wisnu Tri Widodo Endro, S.Psi., M.A.
Mahasiswa Doktorat
Fakultas Psikologi
Universitas Massey, Selandia Baru

Menjawab surat Saudara, perihal Penggunaan Instrumen The Structured Clinical Interview of DSM IV (SCID IV) – Bahasa Indonesia, dengan ini kami sampaikan bahwa kami mengizinkan Wisnu Tri Widodo Endro, S.Psi., M.A. untuk dapat menggunakan instrument tersebut dengan mendapatkan pelatihan terlebih dahulu. Pelatihan tersebut akan kami jadwalkan secepatnya.

Sesuai kebijakan yang berlaku di Departemen Medik Kesehatan Jiwa RSCM-FKUI, dengan ini kami mohon kesediaannya, untuk membayar biaya institusi sebesar Rp. 10.000,- per lembar instrument, biaya pelatihan instrumen sebesar Rp. 500.000,- dan biaya pengiriman instrumen (d disesuaikan dengan bukti saat pengiriman). Instrumen hanya bisa diperbanyak oleh Dep. Medik Kesehatan Jiwa sesuai jumlah diminta.

Demikian kami sampaikan. Atas perhatian dan kerjasama Saudara, kami ucapkan terima kasih.

Dr.dr. Kristiana Siste, SpKJ(K)
NIP. 197512252014122001

“Menolong, memberikan yang terbaik”



JCI
CN.3494.1



Appendix G – Recruitment Poster for Psychologists Group in English and *Bahasa Indonesia*

English



MASSEY
UNIVERSITY
TE KUNENGA KI PŪREHURŌA
UNIVERSITY OF NEW ZEALAND
School of Psychology

RESEARCH PARTICIPANT RECRUITMENT FOR CLINICAL PSYCHOLOGIST

With an estimate 16 million people in Indonesia suffering from depression. Chat Telepsychotherapy (CT) has gained popularity among Indonesian People. This study will focus on designing a manual for CT specifically to assist Indonesian people with minor depression.

**Contribute and make significant improvement
in Indonesian Mental Health Service!**

Criteria:

- A registered Clinical Psychologist with an active permit
- Identify themselves as people who belong to the Indonesian culture
- Identify themselves as people who grown up under Indonesian customs and lifestyle
- Able to speak Bahasa Indonesia
- Technology literate (i.e. familiar with internet technology, online data management and chatting application)
- Have experience in Chat/Text Psychotherapy/Counseling for at least 6 months.



**The Co-design of a Chat Telepsychotherapy Manual
for Indonesians with Minor Depression**

- Wisnu T.W. Endro -



UNIVERSITY OF NEW ZEALAND

School of Psychology

REKRUTMEN PARTISIPAN PSIKOLOGI KLINIS UNTUK PENELITIAN DOKTORAL PSIKOLOGI

Diperkirakan terdapat 16 juta orang di Indonesia yang mengalami Depresi. Teks Telepsikoterapi atau yang lebih dikenal dengan *Chat-Counseling/Psychotherapy* telah menjadi populer di Indonesia. Studi ini bertujuan untuk merancang panduan Teks Telepsikoterapi pada Orang Indonesia yang mengalami Depresi Minor

**Marilah turut berkontribusi dan membuat perubahan yang signifikan
di layanan kesehatan mental Indonesia!**

Kriteria:

- Psikolog Klinis yang merupakan anggota dari Ikatan Psikolog Klinis Indonesia.
- Memiliki NIAPK, STR dan SIPPK yang aktif.
- Mengidentifikasi dirinya sebagai seseorang yang memiliki budaya Indonesia.
- Mengidentifikasi dirinya sebagai seseorang yang tumbuh di dalam pengaruh budaya dan gaya hidup Indonesia.
- Mampu berbahasa Indonesia dengan lancar
- Memiliki literasi teknologi (yaitu memahami teknologi internet, pengelolaan data secara daring)
- Memiliki pengalaman praktik Psikoterapi/Konseling Chat/Teks selama minimal 6 bulan.

**Bagi anda yang berminat, silakan menghubungi
Wisnu Tri Widodo Endro
WhatsApp: +628562215888
Surel: wisnu.tw.endro@gmail.com**



Judul Penelitian:

Rancang Kolaborasi dari Panduan Telepsikoterapi Teks untuk Orang Indonesia dengan Gangguan Depresi Minor.

Mahasiswa Peneliti : Wisnu Tri Widodo Endro, S.Psi., M.A.

Pembimbing : Dr. Matthew Shepherd (Utama); Dr Clifford van Ommen; Dr Heather Kempton

Appendix H – Recruitment Poster for Clients Group in English and *Bahasa Indonesia*

English



**MASSEY
UNIVERSITY**
TE KUNENGA KI PŪREHUROA

UNIVERSITY OF NEW ZEALAND
School of Psychology

IN SEARCH OF PARTICIPANTS

With an estimate 16 million people in Indonesia suffering from depression. Chat Telepsychotherapy (CT) has gained popularity among Indonesian People. This study will focus on designing a manual for CT specifically to assist Indonesian people with minor depression.

We are looking for eligible participants who are willing to contribute to a significant improvement in Indonesian Mental Health Service!

Criteria:

- Identify themselves as people who belong to the Indonesian culture
- Identify themselves as people who have grown up under Indonesian customs and lifestyle
- Able to speak Bahasa Indonesia
- Aged between 19-40 years old
- Technology literate (i.e. familiar with internet technology, online data management and chatting application)
- Have at least one experience as a client using Chat/Text Counseling/Psychotherapy



The Co-design of a Chat Telepsychotherapy Manual for Indonesians with Minor Depression

- Wisnu T.W. Endro -



MENCARI PARTISIPAN PENELITIAN

Diperkirakan terdapat 16 juta orang di Indonesia yang mengalami Depresi. Telepsikoterapi Teks atau yang lebih dikenal dengan *Chat-Counseling/Psychotherapy* telah menjadi populer di Indonesia. Penelitian ini bertujuan untuk merancang panduan Telepsikoterapi Teks untuk menangani Orang Indonesia yang mengalami Depresi Minor

Kami sedang mencari partisipan yang mau untuk berkontribusi kepada improvisasi signifikan pada layanan kesehatan mental di Indonesia

Kriteria:

- Berusia diantara 19-40 tahun.
- Mengidentifikasi dirinya sebagai seseorang yang memiliki budaya Indonesia.
- Mengidentifikasi dirinya sebagai seseorang yang tumbuh di dalam pengaruh budaya dan gaya hidup Indonesia.
- Mampu berbahasa Indonesia.
- Memiliki literasi teknologi (yaitu memahami teknologi internet, pengelolaan data secara daring).
- Pernah sekurang-kurangnya satu kali menjadi klien konseling/psikoterapi *Chat/Teks*.



**Informasi lebih lanjut mohon hubungi
08562215888 via WhatsApp atau email wisnu.tw.endro@gmail.com**

Rancang Kolaborasi dari Panduan Telepsikoterapi Teks untuk Orang Indonesia dengan Gangguan Depresi Minor.

- Wisnu T.W. Endro -

Appendix I – The Inventory of Depressive Symptomatology Self Report (IDS-SR) in English and *Bahasa Indonesia*

**INVENTORY OF DEPRESSIVE SYMPTOMATOLOGY (SELF-REPORT)
(IDS-SR)**

NAME: _____ TODAY'S DATE: _____

Please circle the one response to each item that best describes you for the past seven days.

1. Falling Asleep: 0 I never take longer than 30 minutes to fall asleep. 1 I take at least 30 minutes to fall asleep, less than half the time. 2 I take at least 30 minutes to fall asleep, more than half the time. 3 I take more than 60 minutes to fall asleep, more than half the time.	7. Feeling Anxious or Tense: 0 I do not feel anxious or tense. 1 I feel anxious (tense) less than half the time. 2 I feel anxious (tense) more than half the time. 3 I feel extremely anxious (tense) nearly all of the time.
2. Sleep During the Night: 0 I do not wake up at night. 1 I have a restless, light sleep with a few brief awakenings each night. 2 I wake up at least once a night, but I go back to sleep easily. 3 I awaken more than once a night and stay awake for 20 minutes or more, more than half the time.	8. Response of Your Mood to Good or Desired Events: 0 My mood brightens to a normal level which lasts for several hours when good events occur. 1 My mood brightens but I do not feel like my normal self when good events occur. 2 My mood brightens only somewhat to a rather limited range of desired events. 3 My mood does not brighten at all, even when very good or desired events occur in my life.
3. Waking Up Too Early: 0 Most of the time, I awaken no more than 30 minutes before I need to get up. 1 More than half the time, I awaken more than 30 minutes before I need to get up. 2 I almost always awaken at least one hour or so before I need to, but I go back to sleep eventually. 3 I awaken at least one hour before I need to, and can't go back to sleep.	9. Mood in Relation to the Time of Day: 0 There is no regular relationship between my mood and the time of day. 1 My mood often relates to the time of day because of environmental events (e.g., being alone, working). 2 In general, my mood is more related to the time of day than to environmental events. 3 My mood is clearly and predictably better or worse at a particular time each day. 9A. Is your mood typically worse in the morning, afternoon or night? (circle one) 9B. Is your mood variation attributed to the environment? (yes or no) (circle one)
4. Sleeping Too Much: 0 I sleep no longer than 7-8 hours/night, without napping during the day. 1 I sleep no longer than 10 hours in a 24-hour period including naps. 2 I sleep no longer than 12 hours in a 24-hour period including naps. 3 I sleep longer than 12 hours in a 24-hour period including naps.	10. The Quality of Your Mood: 0 The mood (internal feelings) that I experience is very much a normal mood. 1 My mood is sad, but this sadness is pretty much like the sad mood I would feel if someone close to me died or left. 2 My mood is sad, but this sadness has a rather different quality to it than the sadness I would feel if someone close to me died or left. 3 My mood is sad, but this sadness is different from the type of sadness associated with grief or loss.
5. Feeling Sad: 0 I do not feel sad 1 I feel sad less than half the time. 2 I feel sad more than half the time. 3 I feel sad nearly all of the time.	
6. Feeling Irritable: 0 I do not feel irritable. 1 I feel irritable less than half the time. 2 I feel irritable more than half the time. 3 I feel extremely irritable nearly all of the time.	

Please complete either 11 or 12 (not both)

11. Decreased Appetite:

- 0 There is no change in my usual appetite.
- 1 I eat somewhat less often or lesser amounts of food than usual.
- 2 I eat much less than usual and only with personal effort.
- 3 I rarely eat within a 24-hour period, and only with extreme personal effort or when others persuade me to eat.

12. Increased Appetite:

- 0 There is no change from my usual appetite.
- 1 I feel a need to eat more frequently than usual.
- 2 I regularly eat more often and/or greater amounts of food than usual.
- 3 I feel driven to overeat both at mealtime and between meals.

Please complete either 13 or 14 (not both)

13. Decreased Weight (Within the Last Two Weeks):

- 0 I have not had a change in my weight.
- 1 I feel as if I've had a slight weight loss.
- 2 I have lost 2 pounds or more.
- 3 I have lost 5 pounds or more.

14. Increased Weight (Within the Last Two Weeks):

- 0 I have not had a change in my weight.
- 1 I feel as if I've had a slight weight gain.
- 2 I have gained 2 pounds or more.
- 3 I have gained 5 pounds or more.

15. Concentration/Decision Making:

- 0 There is no change in my usual capacity to concentrate or make decisions.
- 1 I occasionally feel indecisive or find that my attention wanders.
- 2 Most of the time, I struggle to focus my attention or to make decisions.
- 3 I cannot concentrate well enough to read or cannot make even minor decisions.

16. View of Myself:

- 0 I see myself as equally worthwhile and deserving as other people.
- 1 I am more self-blaming than usual.
- 2 I largely believe that I cause problems for others.
- 3 I think almost constantly about major and minor defects in myself.

17. View of My Future:

- 0 I have an optimistic view of my future.
- 1 I am occasionally pessimistic about my future, but for the most part I believe things will get better.
- 2 I'm pretty certain that my immediate future (1-2 months) does not hold much promise of good things for me.
- 3 I see no hope of anything good happening to me anytime in the future.

18. Thoughts of Death or Suicide:

- 0 I do not think of suicide or death.
- 1 I feel that life is empty or wonder if it's worth living.
- 2 I think of suicide or death several times a week for several minutes.
- 3 I think of suicide or death several times a day in some detail, or I have made specific plans for suicide or have actually tried to take my life.

19. General Interest:

- 0 There is no change from usual in how interested I am in other people or activities.
- 1 I notice that I am less interested in people or activities.
- 2 I find I have interest in only one or two of my formerly pursued activities.
- 3 I have virtually no interest in formerly pursued activities.

20. Energy Level:

- 0 There is no change in my usual level of energy.
- 1 I get tired more easily than usual.
- 2 I have to make a big effort to start or finish my usual daily activities (for example, shopping, homework, cooking or going to work).
- 3 I really cannot carry out most of my usual daily activities because I just don't have the energy.

21. Capacity for Pleasure or Enjoyment (excluding sex):

- 0 I enjoy pleasurable activities just as much as usual.
- 1 I do not feel my usual sense of enjoyment from pleasurable activities.
- 2 I rarely get a feeling of pleasure from any activity.
- 3 I am unable to get any pleasure or enjoyment from anything.

22. Interest in Sex (Please Rate Interest, not Activity):

- 0 I'm just as interested in sex as usual.
- 1 My interest in sex is somewhat less than usual or I do not get the same pleasure from sex as I used to.
- 2 I have little desire for or rarely derive pleasure from sex.
- 3 I have absolutely no interest in or derive no pleasure from sex.

23. Feeling slowed down:

- 0 I think, speak, and move at my usual rate of speed.
- 1 I find that my thinking is slowed down or my voice sounds dull or flat.
- 2 It takes me several seconds to respond to most questions and I'm sure my thinking is slowed.
- 3 I am often unable to respond to questions without extreme effort.

24. Feeling restless:

- 0 I do not feel restless.
- 1 I'm often fidgety, wring my hands, or need to shift how I am sitting.
- 2 I have impulses to move about and am quite restless.
- 3 At times, I am unable to stay seated and need to pace around.

25. Aches and pains:

- 0 I don't have any feeling of heaviness in my arms or legs and don't have any aches or pains.
- 1 Sometimes I get headaches or pains in my stomach, back or joints but these pains are only sometime present and they don't stop me from doing what I need to do.
- 2 I have these sorts of pains most of the time.
- 3 These pains are so bad they force me to stop what I am doing.

26. Other bodily symptoms:

- 0 I don't have any of these symptoms: heart pounding fast, blurred vision, sweating, hot and cold flashes, chest pain, heart turning over in my chest, ringing in my ears, or shaking.
- 1 I have some of these symptoms but they are mild and are present only sometimes.
- 2 I have several of these symptoms and they bother me quite a bit.
- 3 I have several of these symptoms and when they occur I have to stop doing whatever I am doing.

27. Panic/Phobic symptoms:

- 0 I have no spells of panic or specific fears (phobia) (such as animals or heights).
- 1 I have mild panic episodes or fears that do not usually change my behavior or stop me from functioning.
- 2 I have significant panic episodes or fears that force me to change my behavior but do not stop me from functioning.
- 3 I have panic episodes at least once a week or severe fears that stop me from carrying on my daily activities.

28. Constipation/diarrhea:

- 0 There is no change in my usual bowel habits.
- 1 I have intermittent constipation or diarrhea which is mild.
- 2 I have diarrhea or constipation most of the time but it does not interfere with my day-to-day functioning.
- 3 I have constipation or diarrhea for which I take medicine or which interferes with my day-to-day activities.

29. Interpersonal Sensitivity:

- 0 I have not felt easily rejected, slighted, criticized or hurt by others at all.
- 1 I have occasionally felt rejected, slighted, criticized or hurt by others.
- 2 I have often felt rejected, slighted, criticized or hurt by others, but these feelings have had only slight effects on my relationships or work.
- 3 I have often felt rejected, slighted, criticized or hurt by others and these feelings have impaired my relationships and work.

30. Leadon Paralysis/Physical Energy:

- 0 I have not experienced the physical sensation of feeling weighted down and without physical energy.
- 1 I have occasionally experienced periods of feeling physically weighted down and without physical energy, but without a negative effect on work, school, or activity level.
- 2 I feel physically weighted down (without physical energy) more than half the time.
- 3 I feel physically weighted down (without physical energy) most of the time, several hours per day, several days per week.

Which 3 items (questions) were the easiest to understand? _____

Thank you

Range 0-84 Score: _____

Inventory of Depressive Symptomatology Self-Report (IDS-SR)

Bahasa Indonesia

Nama lengkap: _____

Tanggal: _____

Petunjuk: Pada setiap nomor, lingkariilah satu angka di samping jawaban yang paling menggambarkan kondisi Anda selama seminggu terakhir.

1. Tertidur
 - 0 Saya tidak pernah membutuhkan waktu lebih dari 30 menit untuk tertidur.
 - 1 Pada beberapa hari, saya membutuhkan waktu setidaknya 30 menit untuk tertidur (kurang dari 3 hari dalam seminggu terakhir).
 - 2 Pada kebanyakan hari, saya membutuhkan waktu 30-60 menit untuk tertidur (lebih dari 3 hari dalam seminggu terakhir).
 - 3 Pada kebanyakan hari, saya membutuhkan waktu lebih dari 60 menit untuk tertidur (lebih dari 3 hari dalam seminggu terakhir).
 2. Tidur di malam hari
 - 0 Saya tidak terbangun di malam hari.
 - 1 Tidur saya sesah, tidak nyenyak, dan saya terbangun singkat beberapa kali setiap malam.
 - 2 Saya terbangun setidaknya satu kali dalam semalam, tetapi saya dapat kembali tidur dengan mudah.
 - 3 Pada kebanyakan hari, saya terbangun lebih dari satu kali dalam semalam, dan tetap terjaga selama setidaknya 20 menit.
 3. Bangun tidur terlalu awal
 - 0 Pada kebanyakan hari, saya bangun kurang dari 30 menit sebelum waktu yang seharusnya.
 - 1 Pada kebanyakan hari, saya bangun lebih dari 30 menit sebelum waktu yang seharusnya.
 - 2 Saya hampir selalu bangun setidaknya 1 jam lebih awal dari waktu yang seharusnya, tetapi akhirnya saya dapat kembali tidur.
 - 3 Saya selalu bangun setidaknya 1 jam lebih awal dari waktu yang seharusnya, dan tidak bisa kembali tidur.
 4. Tidur berlebihan
 - 0 Saya tidur maksimal 7-8 jam setiap malam, tanpa tidur siang.
 - 1 Saya tidur maksimal 10 jam dalam 24 jam, termasuk tidur siang.
 - 2 Saya tidur maksimal 12 jam dalam 24 jam, termasuk tidur siang.
 - 3 Saya tidur lebih dari 12 jam dalam 24 jam, termasuk tidur siang.
 5. Merasa sedih
 - 0 Saya tidak merasa sedih.
 - 1 Saya merasa sedih hanya pada beberapa hari.
 - 2 Saya merasa sedih pada kebanyakan hari.
 - 3 Saya merasa sedih hampir setiap saat.
 6. Merasa mudah marah
 - 0 Saya tidak merasa mudah marah.
 - 1 Saya merasa mudah marah hanya pada beberapa hari.
 - 2 Saya merasa mudah marah pada kebanyakan hari.
 - 3 Saya merasa sangat mudah marah hampir setiap saat.
 7. Merasa cemas atau tegang
 - 0 Saya tidak merasa cemas atau tegang.
 - 1 Saya merasa cemas atau tegang hanya pada beberapa hari.
 - 2 Saya merasa cemas atau tegang pada kebanyakan hari.
 - 3 Saya merasa sangat cemas atau tegang hampir setiap saat.
 8. Respon suasana hati terhadap peristiwa yang menyenangkan
 - 0 Ketika peristiwa menyenangkan terjadi, suasana hati saya menjadi cerah selama beberapa jam.
 - 1 Ketika peristiwa menyenangkan terjadi, suasana hati saya menjadi cerah, tetapi saya tidak merasa seperti diri saya yang normal.
 - 2 Hanya sebuah hal menyenangkan tertentu yang dapat membuat suasana hati saya menjadi sedikit lebih cerah.
 - 3 Suasana hati saya sama sekali tidak menjadi cerah bahkan ketika ada hal-hal yang sangat menyenangkan terjadi dalam hidup saya.
 9. Suasana hati terkait dengan waktu
 - 0 Tidak ada hubungan antara suasana hati saya dengan waktu tertentu.
 - 1 Suasana hati saya lebih berhubungan dengan situasi (cth: sedang sendirian, sedang bekerja) daripada dengan waktu tertentu.
 - 2 Secara umum, suasana hati saya lebih berhubungan dengan waktu tertentu daripada dengan situasi tertentu.
 - 3 Suasana hati saya jelas-jelas dapat diprediksi akan menjadi lebih baik atau lebih buruk pada waktu tertentu setiap harinya.
- 9A. Kapankah biasanya suasana hati Anda memburuk? (lingkari jika ada yang sesuai) Pagi hari / Siang hari / Malam hari
 9B. Apakah perubahan pada suasana hati Anda ditentukan oleh situasi? (lingkari yang sesuai) Ya / Tidak
10. Sifat suasana hati
 - 0 Suasana hati yang saya rasakan adalah suasana hati yang normal.
 - 1 Suasana hati saya sedih, kurang lebih sama dengan rasa sedih yang akan saya rasakan jika orang dekat saya meninggal/pergi.
 - 2 Suasana hati saya sedih, tetapi agak berbeda sifatnya dari rasa sedih yang akan saya rasakan jika orang dekat saya meninggal/pergi.
 - 3 Suasana hati saya sedih, tetapi sangat berbeda dengan tipe kesedihan yang menyangkut perasaan berduka atau kehilangan.

Jawablah ANTARA nomor 11 atau 12 yang sesuai dengan kondisi Anda (tidak keduanya)

11. Penurunan selera makan 0 Saya tidak mengalami perubahan selera makan. 1 Saya makan agak lebih jarang atau lebih sedikit dari biasanya. 2 Saya makan jauh lebih sedikit dari biasanya dan hanya jika saya benar-benar mendorong diri untuk makan. 3 Saya jarang makan selama 24 jam, dan hanya akan makan jika benar-benar meniatkan diri atau jika ada yang membujuk.	12. Peningkatan selera makan 0 Saya tidak mengalami perubahan selera makan. 1 Saya merasa butuh lebih sering makan dari biasanya. 2 Saya lebih sering dan/atau lebih banyak makan dari biasanya. 3 Saya merasakan dorongan untuk makan berlebihan, baik saat jam makan maupun di luar jam makan.

Jawablah ANTARA nomor 13 atau 14 yang sesuai dengan kondisi Anda (tidak keduanya)

13. Berat badan turun 0 Saya tidak mengalami perubahan berat badan. 1 Saya merasa seolah berat badan saya sedikit turun. 2 Berat badan saya turun 1 sampai 2,5 kilogram. 3 Berat badan saya turun lebih dari 2,5 kilogram.	14. Berat badan naik 0 Saya tidak mengalami perubahan berat badan. 1 Saya merasa seolah berat badan saya sedikit naik. 2 Berat badan saya naik 1 sampai 2,5 kilogram. 3 Berat badan saya naik lebih dari 2,5 kilogram.
15. Konsentrasi atau pengambilan keputusan
- 0 Tidak ada perubahan dalam kemampuan saya untuk berkonsentrasi atau mengambil keputusan.
- 1 Adakalanya saya merasa ragu-ragu dalam memutuskan sesuatu atau mendapati diri saya sulit fokus.
- 2 Pada kebanyakan waktu, saya berjuang untuk dapat fokus atau untuk membuat keputusan.
- 3 Saya tidak bisa cukup berkonsentrasi untuk sekedar membaca, atau bahkan tidak bisa membuat keputusan-keputusan kecil.
16. Pandangan terhadap diri sendiri
- 0 Saya melihat diri saya sebagai orang yang sama berharganya dan sama layaknnya dengan orang lain.
- 1 Saya lebih banyak menyalahkan diri dari biasanya atas berbagai ketidakberhasilan yang terjadi.
- 2 Saya yakin bahwa saya menyebabkan banyak masalah untuk orang lain.
- 3 Saya hampir selalu terus-menerus memikirkan berbagai kekurangan diri, kesalahan, dan masalah yang saya buat.
17. Pandangan terhadap masa depan diri
- 0 Saya memiliki pandangan yang optimis mengenai masa depan saya.
- 1 Adakalanya saya merasa pesimis mengenai masa depan saya, tetapi pada kebanyakan waktu saya yakin banyak hal akan membaik.
- 2 Saya cukup yakin bahwa tidak akan ada hal-hal baik yang menjanjikan untuk saya dalam waktu dekat (1-2 bulan ke depan).
- 3 Saya tidak melihat adanya harapan akan terjadinya hal baik apapun pada diri saya di masa depan.
18. Ide-ide mengenai kematian dan bunuh diri
- 0 Saya tidak berpikir mengenai bunuh diri atau kematian.
- 1 Saya merasa hidup ini kosong atau bertanya-tanya apakah hidup ini layak untuk dijalani.
- 2 Saya mendapati diri saya berpikir mengenai bunuh diri atau kematian beberapa kali dalam seminggu ini.
- 3 Saya terus berpikir secara detail mengenai bunuh diri atau kematian beberapa kali dalam sehari, atau sudah membuat rencana apesifik untuk bunuh diri, atau sudah benar-benar mencoba untuk mengakhiri hidup.
19. Minat umum
- 0 Tidak ada perubahan yang terjadi dalam minat saya untuk bergaul atau melakukan berbagai aktivitas.
- 1 Saya menyadari bahwa belakangan ini saya menjadi kurang berminat untuk bergaul atau melakukan berbagai aktivitas.
- 2 Saya mendapati bahwa saya hanya berminat terhadap satu atau dua aktivitas yang biasanya saya lakukan saja.
- 3 Saya sama sekali tidak berminat untuk melakukan berbagai aktivitas yang biasanya saya sukai.
20. Level energi
- 0 Level energi saya tidak berubah dari biasanya.
- 1 Saya menjadi lebih mudah lelah dari biasanya.
- 2 Saya harus berupaya keras untuk memulai atau menyelesaikan aktivitas harian yang biasa saya kerjakan (cth: belanja, pergi kerja).
- 3 Saya benar-benar tidak bisa melakukan sebagian besar aktivitas harian saya karena tidak punya energi untuk melakukannya.
21. Kapasitas untuk merasakan kesenangan dan kenikmatan (tidak termasuk aktivitas seksual)
- 0 Saya menikmati berbagai aktivitas yang santai/menyenangkan seperti biasanya.
- 1 Saya tidak merasakan kenikmatan yang biasanya saya rasakan ketika melakukan berbagai aktivitas yang santai/menyenangkan.
- 2 Saya jarang merasakan kesenangan dari aktivitas apapun.
- 3 Saya tidak mampu merasakan kesenangan atau kenikmatan dari apapun.
22. Minat seksual (pertanyaan berfokus hanya pada minat saja, bukan pada aktivitasnya)
- 0 Saya berminat pada seks seperti biasanya.
- 1 Minat saya terhadap seks agak menurun dari biasanya atau saya tidak memperoleh kesenangan dari seks seperti biasanya.
- 2 Saya memiliki sedikit hasrat untuk seks dan/atau hanya memperoleh sangat sedikit kesenangan dari seks.
- 3 Saya sama sekali tidak memiliki minat terhadap seks dan/atau sama sekali tidak memperoleh kesenangan dari seks.
23. Merasa lebih lambat dari biasanya
- 0 Saya berpikir, berbicara, dan bergerak pada kecepatan saya biasanya.
- 1 Saya mendapati kemampuan berpikir saya melambat dari biasanya atau suara saya terdengar jemu/datar.
- 2 Saya membutuhkan beberapa detik untuk merespon hampir semua pertanyaan dan saya yakin kemampuan berpikir saya melambat.
- 3 Saya seringkali tidak mampu merespon berbagai pertanyaan jika tidak betul-betul berusaha dengan keras.

24. Merasa gelisah
- 0 Saya tidak merasa gelisah.
 - 1 Saya seringkali gelisah, merasa-ramas tangan, atau harus bergerak-gerak ketika sedang duduk.
 - 2 Saya merasa harus terus bergerak dan saya cukup gelisah.
 - 3 Saya seringkali tidak bisa duduk diam dan harus mondar-mandir ke sana ke mari.
25. Sakit atau nyeri
- 0 Saya tidak merasakan sakit/nyeri apapun.
 - 1 Kadang-kadang, saya mengalami sakit kepala atau nyeri pada perut, punggung, atau sendi, tetapi itu hanya muncul sesekali dan tidak sampai menghalangi saya beraktivitas.
 - 2 Saya mengalami sakit/nyeri yang disebutkan di atas pada kebanyakan waktu.
 - 3 Rasa sakit/nyeri yang saya alami begitu parah hingga memaksa saya untuk berhenti beraktivitas.
26. Gejala fisik lainnya
- 0 Saya tidak mengalami gejala-gejala berikut: jantung berdetak cepat, penglihatan kabur, berkeringat, panas dingin, nyeri dada, jantung berdebar, telinga berdenging, atau gemeteran.
 - 1 Saya mengalami sedikit dari gejala yang disebutkan di atas, tetapi sifatnya ringan dan munculnya hanya kadang-kadang.
 - 2 Saya mengalami beberapa gejala yang disebutkan di atas dan itu cukup mengganggu saya.
 - 3 Saya mengalami beberapa gejala yang disebutkan di atas dan saat gejala-gejala itu muncul, saya menjadi harus berhenti beraktivitas.
27. Gejala panik atau phobia
- 0 Saya tidak mengalami serangan panik atau rasa takut/phobia yang spesifik (cth: terhadap binatang atau ketinggian).
 - 1 Saya mengalami serangan panik atau rasa takut yang ringan, tetapi biasanya tidak sampai mempengaruhi perilaku saya atau membuat saya berhenti beraktivitas.
 - 2 Saya mengalami serangan panik atau rasa takut yang nyata hingga mempengaruhi perilaku saya, tetapi tidak membuat saya berhenti beraktivitas.
 - 3 Setidaknya satu kali dalam seminggu, saya mengalami serangan panik atau rasa takut yang parah hingga membuat saya berhenti melakukan aktivitas sehari-hari.
28. Konstipasi atau diare
- 0 Saya tidak mengalami perubahan dalam kebiasaan buang air besar.
 - 1 Adakalanya saya mengalami konstipasi atau diare yang sifatnya ringan.
 - 2 Saya mengalami konstipasi atau diare pada kebanyakan waktu, tetapi itu tidak mengganggu aktivitas saya sehari-hari.
 - 3 Saya mengalami konstipasi atau diare yang sampai mengharuskan saya minum obat atau sampai mengganggu aktivitas harian saya.
29. Sensitivitas interpersonal
- 0 Saya sama sekali tidak mudah merasa ditolak, diremehkan, dikritik, atau diaakili oleh orang lain.
 - 1 Adakalanya saya merasa ditolak, diremehkan, dikritik, atau diaakili oleh orang lain.
 - 2 Saya seringkali merasa ditolak, diremehkan, dikritik, atau diaakili, tetapi perasaan tersebut hanya sedikit saja mempengaruhi hubungan saya dengan orang lain atau pekerjaan saya.
 - 3 Saya seringkali merasa ditolak, diremehkan, dikritik, atau diaakili, dan perasaan tersebut sampai mengganggu hubungan saya dengan orang lain serta pekerjaan saya.
30. Tubuh terasa berat atau lemas
- 0 Tubuh saya tidak terasa berat atau lemas.
 - 1 Adakalanya tubuh saya terasa berat dan lemas, namun tidak beresif negatif terhadap pekerjaan, studi, atau level aktivitas saya.
 - 2 Tubuh saya terasa berat dan lemas pada kebanyakan hari.
 - 3 Tubuh saya terasa berat dan lemas selama berjam-jam setiap hari.

Petunjuk skoring:

- Rentang skor: 0-84
- Jumlahkan total skor dari 28 item. Perhatikan keterangan berikut:
 - o Pertanyaan nomor 9A dan 9B hanya untuk tambahan informasi, tidak termasuk dalam skoring
 - o Gunakan satu skor antara jawaban nomor 11 atau 12 (jika keduanya diisi, pilih skor yang lebih tinggi)
 - o Gunakan satu skor antara jawaban nomor 13 atau 14 (jika keduanya diisi, pilih skor yang lebih tinggi)

TOTAL SKOR: ____

If you use this instrument, please cite our article. / Jika Anda menggunakan skoring ini, mohon kutip artikel kami.

**Appendix J – World Health Organisation – Quality of Life – Bref – in English and
*Bahasa Indonesia***

**THE WORLD HEALTH ORGANIZATION
QUALITY OF LIFE (WHOQOL) -BREF**

The World Health Organization Quality of Life (WHOQOL)-BREF

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WHOQOL-BREF

The following questions ask how you feel about your quality of life, health, or other areas of your life. I will read out each question to you, along with the response options. **Please choose the answer that appears most appropriate.** If you are unsure about which response to give to a question, the first response you think of is often the best one.

Please keep in mind your standards, hopes, pleasures and concerns. We ask that you think about your life in the last four weeks.

		Very poor	Poor	Neither poor nor good	Good	Very good
1.	How would you rate your quality of life?	1	2	3	4	5

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
2.	How satisfied are you with your health?	1	2	3	4	5

The following questions ask about how much you have experienced certain things in the last four weeks.

		Not at all	A little	A moderate amount	Very much	An extreme amount
3.	To what extent do you feel that physical pain prevents you from doing what you need to do?	5	4	3	2	1
4.	How much do you need any medical treatment to function in your daily life?	5	4	3	2	1
5.	How much do you enjoy life?	1	2	3	4	5
6.	To what extent do you feel your life to be meaningful?	1	2	3	4	5

		Not at all	A little	A moderate amount	Very much	Extremely
7.	How well are you able to concentrate?	1	2	3	4	5
8.	How safe do you feel in your daily life?	1	2	3	4	5
9.	How healthy is your physical environment?	1	2	3	4	5

The following questions ask about how completely you experience or were able to do certain things in the last four weeks.

		Not at all	A little	Moderately	Mostly	Completely
10.	Do you have enough energy for everyday life?	1	2	3	4	5
11.	Are you able to accept your bodily appearance?	1	2	3	4	5
12.	Have you enough money to meet your needs?	1	2	3	4	5
13.	How available to you is the information that you need in your day-to-day life?	1	2	3	4	5
14.	To what extent do you have the opportunity for leisure activities?	1	2	3	4	5

		Very poor	Poor	Neither poor nor good	Good	Very good
15.	How well are you able to get around?	1	2	3	4	5

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
16.	How satisfied are you with your sleep?	1	2	3	4	5
17.	How satisfied are you with your ability to perform your daily living activities?	1	2	3	4	5
18.	How satisfied are you with your capacity for work?	1	2	3	4	5
19.	How satisfied are you with yourself?	1	2	3	4	5

20.	How satisfied are you with your personal relationships?	1	2	3	4	5
21.	How satisfied are you with your sex life?	1	2	3	4	5
22.	How satisfied are you with the support you get from your friends?	1	2	3	4	5
23.	How satisfied are you with the conditions of your living place?	1	2	3	4	5
24.	How satisfied are you with your access to health services?	1	2	3	4	5
25.	How satisfied are you with your transport?	1	2	3	4	5

The following question refers to how often you have felt or experienced certain things in the last four weeks.

		Never	Seldom	Quite often	Very often	Always
26.	How often do you have negative feelings such as blue mood, despair, anxiety, depression?	5	4	3	2	1

Do you have any comments about the assessment?

[The following table should be completed after the interview is finished]

		Equations for computing domain scores	Raw score	Transformed scores*	
				4-20	0-100
27.	Domain 1	$(6-Q3) + (6-Q4) + Q10 + Q15 + Q16 + Q17 + Q18$ $\square + \square + \square + \square + \square + \square + \square$	a. =	b:	c:
28.	Domain 2	$Q5 + Q6 + Q7 + Q11 + Q19 + (6-Q26)$ $\square + \square + \square + \square + \square + \square$	a. =	b:	c:
29.	Domain 3	$Q20 + Q21 + Q22$ $\square + \square + \square$	a. =	b:	c:
30.	Domain 4	$Q8 + Q9 + Q12 + Q13 + Q14 + Q23 + Q24 + Q25$ $\square + \square + \square + \square + \square + \square + \square + \square$	a. =	b:	c:

* See Procedures Manual, pages 13-15

**THE WORLD HEALTH ORGANIZATION
QUALITY OF LIFE (WHOQOL) -BREF**

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WHOQOL-BREF

Pertanyaan berikut ini menyangkut perasaan anda terhadap kualitas hidup, kesehatan dan hal-hal lain dalam hidup anda. Saya akan membacakan setiap pertanyaan kepada anda, bersamaan dengan pilihan jawaban. **Pilihlah jawaban yang menurut anda paling sesuai.** Jika anda tidak yakin tentang jawaban yang akan anda berikan terhadap pertanyaan yang diberikan, pikiran pertama yang muncul pada benak anda seringkali merupakan jawaban yang terbaik.

Camkanlah dalam pikiran anda segala standar hidup, harapan, kesenangan dan perhatian anda. Kami akan bertanya apa yang anda pikirkan tentang kehidupan anda **pada empat minggu terakhir.**

		Sangat buruk	Buruk	Blasa-biasa saja	Baik	Sangat baik
1.	Bagaimana menurut anda kualitas hidup anda?	1	2	3	4	5

		Sangat tdk memuaskan	Tdk memuaskan	Blasa-biasa saja	Memuaskan	Sangat memuaskan
2.	Seberapa puas anda terhadap kesehatan anda?	1	2	3	4	5

Pertanyaan berikut adalah tentang **seberapa sering** anda telah mengalami hal-hal berikut ini dalam empat minggu terakhir.

		Tdk sama sekali	Sedikit	Dlm jumlah sedang	Sangat sering	Dlm jumlah berlebihan
3.	Seberapa jauh rasa sakit fisik anda mencegah anda dalam beraktivitas sesuai kebutuhan anda?	5	4	3	2	1
4.	Seberapa sering anda membutuhkan terapi medis untuk dpt berfungsi dlm kehidupan sehari-hari anda?	5	4	3	2	1
5.	Seberapa jauh anda menikmati hidup anda?	1	2	3	4	5
6.	Seberapa jauh anda merasa hidup anda berarti?	1	2	3	4	5
7.	Seberapa jauh anda mampu berkonsentrasi?	1	2	3	4	5
8.	Secara umum, seberapa aman anda rasakan dlm kehidupan anda sehari-hari?	1	2	3	4	5
9.	Seberapa sehat lingkungan dimana anda tinggal (berkaitan dgn sarana dan prasarana)	1	2	3	4	5

Pertanyaan berikut ini adalah tentang seberapa penuh anda alami hal-hal berikut ini dalam 4 minggu terakhir?

		Tdk sama sekali	Sedikit	Sedang	Seringkali	Sepenuhnya dialami
10.	Apakah anda memiliki vitalitas yg cukup untuk beraktivitas sehari-hari?	1	2	3	4	5
11.	Apakah anda dapat menerima penampilan tubuh anda?	1	2	3	4	5

12.	Apakah anda memiliki cukup uang utk memenuhi kebutuhan anda?	1	2	3	4	5
13.	Seberapa jauh ketersediaan Informasi bagi kehidupan anda dari hari ke hari?	1	2	3	4	5
14.	Seberapa sering anda memiliki kesempatan untuk bersenang-senang /rekreasi?	1	2	3	4	5

		Sangat buruk	Buruk	Biasa-biasa saja	Baik	Sangat baik
15.	Seberapa baik kemampuan anda dalam bergaul?	1	2	3	4	5

		Sangat tdk memuaskan	Tdk memuaskan	Biasa-biasa saja	Memuaskan	Sangat memuaskan
16.	Seberapa puaskah anda dg tidur anda?	1	2	3	4	5
17.	Seberapa puaskah anda dg kemampuan anda untuk menampilkan aktivitas kehidupan anda sehari-hari?	1	2	3	4	5
18.	Seberapa puaskah anda dengan kemampuan anda untuk bekerja?	1	2	3	4	5
19.	Seberapa puaskah anda terhadap diri anda?	1	2	3	4	5
20.	Seberapa puaskah anda dengan hubungan personal / sosial anda?	1	2	3	4	5
21.	Seberapa puaskah anda dengan kehidupan seksual anda?	1	2	3	4	5
22.	Seberapa puaskah anda dengan dukungan yg anda peroleh dr teman anda?	1	2	3	4	5
23.	Seberapa puaskah anda dengan kondisi tempat anda tinggal saat ini?	1	2	3	4	5
24.	Seberapa puaskah anda dgn akses anda pd layanan kesehatan?	1	2	3	4	5
25.	Seberapa puaskah anda dengan transportasi yg hrs anda jalan?	1	2	3	4	5

Pertanyaan berikut merujuk pada seberapa sering anda merasakan atau mengalami hal-hal berikut dalam empat minggu terakhir.

		Tdk pernah	Jarang	Cukup sering	Sangat sering	Selalu
26.	Seberapa sering anda memiliki perasaan negatif seperti ' <i>feeling blue</i> ' (keseplan), putus asa, cemas dan depresi?	5	4	3	2	1

Komentar pewawancara tentang penilaian ini?

[Tabel berikut ini harus dilengkapi setelah wawancara selesai]

		Equations for computing domain scores	Raw score	Transformed scores*	
				4-20	0-100
27.	Domain 1	$(6-Q3) + (6-Q4) + Q10 + Q15 + Q16 + Q17 + Q18$ $\square + \square + \square + \square + \square + \square + \square$	a. =	b:	c:
28.	Domain 2	$Q5 + Q6 + Q7 + Q11 + Q19 + (6-Q26)$ $\square + \square + \square + \square + \square + \square$	a. =	b:	c:
29.	Domain 3	$Q20 + Q21 + Q22$ $\square + \square + \square$	a. =	b:	c:
30.	Domain 4	$Q8 + Q9 + Q12 + Q13 + Q14 + Q23 + Q24 + Q25$ $\square + \square + \square + \square + \square + \square + \square + \square$	a. =	b:	c:

**Appendix K – Structured Clinical Interview for DSM IV – 1 (SCID-IV—1) — Indonesian
Version - Original Written Document (*Bahasa Indonesia*) and in English**

A. EPISODE SUASANA PERASAAN

PADA BAGIAN INI EPISODE HIPOMANIK, MANIK, DEPRESI BERAT, GANGGUAN DISTIMIK, GANGGUAN SUASANA PERASAAN BERKENAAN DENGAN KONDISI KESEHATAN PADA UMUMNYA, GANGGUAN SUASANA PERASAAN YANG DIINDUKSIKAN OLEH OBAT-OBATAN, DAN CIRI-CIRI KHAS EPISODE AKAN DIEVALUASI. GANGGUAN DEPRESI BERAT DAN GANGGUAN BIPOLAR AKAN DIDIAGNOSIS PADA MODUL D.

EPISODE DEPRESI BERAT SAAT INI

KRITERIA MDE

Sekarang saya akan menanyakan lebih jauh tentang suasana perasaan Anda.

A. Lima (atau lebih) gejala berikut ada selama periode 2 minggu yang sama dan memperlihatkan perubahan dari kegunaan sebelumnya; sekurang-kurangnya satu gejala adalah (1) suasana perasaan depresi, atau (2) kehilangan minat untuk bersenang-senang.

Pada bulan lalu...

... apakah ada saat-saat ketika Anda merasa depresi atau tertekan hampir sepanjang hari setiap hari? (Seperti apa rasanya?)

JIKA YA: Berapa lama hal itu berlangsung? (Apakah selama 2 minggu?)

... Apakah Anda kehilangan minat dan kegembiraan pada hal-hal yang biasanya Anda sukai?

JIKA YA: Apakah hal itu berlangsung hampir setiap hari? Berapa lama? (Apakah selama 2 minggu?)

(1) Suasana perasaan mengalami depresi ? 1 2 3
hampir sehari-hari, hampir tiap hari, yang diindikasikan oleh laporan subyektif (misalnya merasa sedih atau kosong) atau oleh observasi yang dibuat oleh orang lain (misalnya terlihat menangis).
Catatan: Pada anak-anak dan orang dewasa bisa merupakan suasana perasaan yang mengganggu.

(2) Pengurangan minat atau Kesenangan ? 1 2 3
yang kentara terhadap semua hal, atau hampir semua hal, aktivitas sehari-hari, hampir setiap hari (seperti yang diindikasikan oleh laporan subyektif atau observasi orang lain).

JIKA TIDAK ITEM (1) atau ITEM (2), pilih Kode "3".
Dilanjutkan ke
EPISODE DEPRESI BERAT SEBELUMNYA
A.12

CATATAN: BERI PERINGKAT UNTUK ITEM-ITEM SBB, KODE "1" JIKA DENGAN JELAS BERKENAAN DENGAN KONDISI MEDIS PADA UMUMNYA, ATAU DELUSI SUASANA PERASAAN YANG ANEH ATAU HALUSINASI.

PADA PERTANYAAN-PERTANYAAN DI BAWAH INI, HARAP ANDA PUSATKAN PIKIRAN PADA 2 MINGGU YANG TERBURUK DALAM BULAN LALU (ATAU 2 MINGGU YANG LALU YANG DEPRESINYA SETARA DENGAN SEBULAN PENUH)

Selama waktu ini (periode 2 minggu)...

.. apakah Anda kehilangan atau bertambah berat badan? (Berapa banyak?) (Apakah Anda waktu itu sedang berupaya menurunkan berat badan?)

JIKA TIDAK: Bagaimana dengan nafsu makan Anda? (Jika dibandingkan dengan nafsu makan Anda biasanya?) (Apakah Anda harus memaksakan diri untuk makan?) (Makan [lebih sedikit/lebih banyak] daripada biasanya?) (Apakah hal tersebut berlangsung hampir setiap hari?)

.. bagaimana dengan tidur: Anda? (apakah Anda menghsuanaai kesulitan untuk tertidur, sering terbangun pada waktu sedang tidur, kesulitan tidur, terbangun lebih awal ATAU tidur terlalu lama? Berapa jam setiap malam jika dibandingkan dengan keadaan biasa? Apakah hal itu berlangsung setiap malam?)

..apakah Anda gelisah atau selalu ingin bergerak sehingga Anda tidak bisa duduk dengan tenang? (Apakah hal tersebut terjadi demikian menyolok, sehingga orang lain memperhatikan Anda? Apa yang mereka perhatikan? Apakah keadaan seperti ini berlangsung hampir setiap hari?)

JIKA TIDAK: Bagaimana dengan sebaliknya - berbicara atau bergerak lebih pelan daripada biasanya? (Apakah hal tersebut berlangsung demikian menyolok sehingga orang lain memperhatikan Anda? Apa yang mereka perhatikan? Apakah keadaan seperti ini berlangsung hampir setiap hari?)

...Seperti apa semangat Anda? (lelah terus menerus? Hampir setiap hari?)

(3) Kehilangan berat badan yang signifikan jika tidak sedang menjalani diet, atau berat badan naik (misalnya perubahan lebih dari 5% berat badan dalam sebulan) atau penurunan atau peningkatan selera makan hampir tiap hari. ? 1 2 3
Catatan: Pada anak-anak, harap pertimbangkan kegagalan untuk mencapai kenaikan berat badan yang diinginkan.

Cek apakah:

___ berat badan turun atau penurunan nafsu makan
___ berat badan naik atau peningkatan nafsu makan

(4) Kesulitan untuk tidur/Insomnia atau terlalu banyak tidur /hipersomnia hampir setiap hari. ? 1 2 3

Cek apakah:

___ insomnia
___ hipersomnia

(5) Agitasi atau retardasi psikomotor hampir setiap hari (diobservasi oleh orang lain, tidak hanya perasaan subyektif akan kelelahan atau menjadi lamban) ? 1 2 3

CATATAN: PERTIMBANGKAN JUGA TINGKAH LAKU SELAMA WAWANCARA

Cek apakah:

___ retardasi psikomotor
___ agitasi psikomotor

(6) Lelah atau kehilangan energi hampir setiap hari ? 1 2 3

? = Informasi tidak cukup 1=Tidak Ada / Tidak Benar 2=Hampir Benar / Ragu-Ragu 3=Benar / Memenuhi Syarat

Selama waktu ini ...

.. apa yang Anda rasakan tentang diri Anda sendiri? (tidak berharga? (Hampir setiap hari?))

JIKA TIDAK: Bagaimana dengan rasa bersalah atas hal-hal yang sudah Anda perbuat dan tidak perbuat? (Hampir setiap hari?)

.. Apakah Anda mengalami kesulitan untuk berpikir atau konsentrasi? Apa yang menyebabkannya? (Apakah hampir setiap hari?)

JIKA TIDAK: Apakah sulit bagi Anda untuk memutuskan hal-hal yang rutin? (hampir setiap hari?)

... Apakah segala sesuatu begitu buruknya sehingga Anda berpikir tentang kematian atau Anda lebih baik mati? Apakah Anda berpikir untuk menyakiti diri sendiri?

JIKA YA: Apakah Anda melakukan sesuatu untuk menyakiti diri Anda sendiri?

(7) Perasaan tidak berharga atau rasa bersalah yang berlebihan atau yang tidak pada tempatnya (yang mungkin merupakan delusi) hampir setiap hari (tidak hanya perasaan saya yang bertanggung jawab atau rasa bersalah karena sakit)

? 1 2 3

CATATAN: BERI KODE "1" ATAU "2" JIKA HANYA RENDAHNYA RASA PERCAYA DIRI

Cek apakah:

___ perasaan tidak berharga
___ perasaan bersalah yang tidak pada tempatnya

(8) Berkurangnya kemampuan untuk berpikir atau berkonsentrasi, atau tidak mampu mengambil keputusan, hampir setiap hari (oleh laporan subyektif atau observasi oleh orang lain)

Cek apakah:

___ berkurangnya kemampuan untuk berpikir
___ ketidakmampuan untuk mengambil keputusan

(9) Pikiran yang berulang-ulang tentang kematian (bukan takut akan mati), ide yang berulang-ulang untuk bunuh diri tanpa rencana yang pasti, atau percobaan bunuh diri atau rencana khusus untuk bunuh diri.

? 1 2 3

CATATAN: BERI KODE "1" UNTUK MENYAKITI DIRI SENDIRI DENGAN ATAU RENCANA UNTUK BUNUH DIRI

Cek apakah:

___ pikiran tentang kematian sendiri
___ ide untuk bunuh diri
___ rencana yang khusus
___ Percobaan untuk bunuh diri

SEDIKITNYA LIMA DARI YANG DISEBUT DI ATAS GEJALA-GEJALA [A (1-)] DIBERI KODE "3" DAN SEDIKITNYA SATU DARI JUMLAH INI ADALAH ITEM (1) ATAU (2)

CATATAN: Kriteria B DSM IV (yaitu yang tidak cocok dengan kriteria untuk Episode Campuran) telah dihilangkan dari SCID.

1 3

Dilanjutkan ke
"EPISODE
DEPRESI BERAT
SEBELUMNYA"
A.12

? = Informasi tidak cukup 1= Tidak Ada / Tidak Benar 2= Hampir Benar / Ragu-Ragu 3= Benar / Memenuhi Syarat

JIKA TIDAK JELAS: Apakah (episode depresi/kata-kata sendiri) menyulitkan Anda Untuk melakukan pekerjaan Anda, mengurus rumah, atau Bergaul dengan orang lain?

B. Gejala yang menyebabkan khawatir yang secara klinik signifikan atau kegagalan dalam fungsi sosial, pekerjaan dan fungsi lain yang penting, signifikan secara klinis.

CATATAN: Kriteria B DSM IV (yaitu yang tidak cocok dengan kriteria untuk Episode Campuran) telah dihilangkan dari SCID.

? 1 2 3

Dilanjutkan ke
"EPISODE
DEPRESI BERAT
SEBELUMNYA"
A.12

Persis sebelum ini mulai, apakah Anda sakit secara fisik?

JIKA YA: Apa yang dikatakan dokter?

Persis sebelum ini mulai, apakah Anda menggunakan obat-obatan?

JIKA YA: Apakah ada perbedaan jumlah obat-obatan yang Anda gunakan?

C. Gejala-gejala tersebut tidak berhubungan dengan efek langsung obat-obatan secara fisiologis (misalnya penyalahgunaan obat, pengobatan) atau dengan kondisi kesehatan pada umumnya.

JIKA TERDAPAT INDIKASI BAHWA DEPRESI MUNGKIN SEKUNDER (YAITU AKIBAT LANGSUNG DARI GMC ATAU OBAT-OBATAN, KE GMC / OBAT-OBATAN, * A.43, DAN KEMBALI LAGI KESINI UNTUK MENDAPATKAN PERINGKAT "1" ATAU "3".

? 1 3

KARENA ZAT
ATAU KMU
DILANJUTKAN
KE "EPISODE
DEPRESI BERAT
SEBELUMNYA"
A.12

EPISODE ALAM
PERASAAN
UTAMA

Persis sebelum ini mulai, apakah Anda minum alkohol atau memakai narkotika?

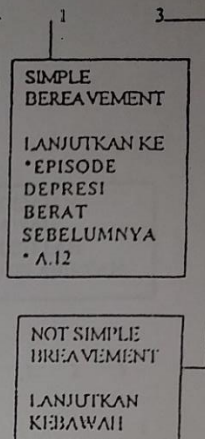
Yang termasuk dalam Faktor Penyebab Kondisi Medis Pada Umumnya adalah: penyakit-penyakit degeneratif neurologis (misalnya penyakit-penyakit Parkinson), penyakit cerebrovaskular (mis. Stroke), kondisi-kondisi metabolis (kekurangan Vit. B-12) kondisi-kondisi endokrin (mis. Hipertiroid, hipotiroid, hiper- dan hipoadrenokortisme) infeksi karena virus atau sebab lainnya (mis. Hepatitis, mononucleosis, HIV), dan kanker-kanker tertentu (mis. Carcinoma pancreas).

Yang termasuk obat-obatan yang pernah dipakai: Alkohol, amfetamin, kokain, halusinogen, inhalan, opioids, phencyclidine, zat-zat sedatif, hipnotik, anxiolitik. Obat-obatan termasuk: antihipertensi, kontrasepsi oral/golongan, kortikosteroid golongan anabolic steroid, obat anti kanker, analgesik, antikolinergics, obat untuk jantung.

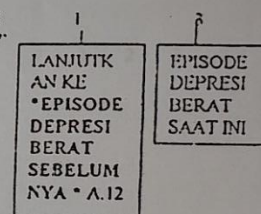
LANJUTKAN
DIBAWAH INI

(Apakah hal ini mulai segera setelah seseorang yang dekat dengan Anda meninggal?)

D. Gejala tidak membaik karena kehilangan orang yang dikasihi, gejala menetap lebih daripada 2 bulan atau yang ditandai dengan kerusakan fungsi yang jelas terlihat, adanya morbid dengan perasaan tidak berharga, ide bunuh diri, atau retardasi psikomotor.



KRITERIA A, B, C DAN D EPISODE
DEPRESI BERAT DIBERI KODE "3"



Dalam hidup, berapa kali (dalam waktu yang berbeda) Anda merasa (depresi/dengan kata-kata sendiri) hampir setiap hari selama paling sedikit 2 minggu dan mempunyai banyak gejala yang Anda sebutkan, misalnya (...)

Jumlah Episode Depresi Berat termasuk yang saat ini (KODE 99 JIKA JUMLAH TERLALU BANYAK ATAU TERLALU SUKAR UNTUK DIBEDAKAN)

CATATAN: REKAMAN PERINCIAN TENTANG EPISODE DAHULU, ADA DI J.9 (OPTIONAL)

SCID – I (DSM IV) Version - 2.0 (Final - February 1996)

MOOD EPISODES

This part of evaluation includes hypomanic, manic, major depression and dysthymia, mood disorders due to general medical condition, substance induced mood disorders and specifiers. Major depressive disorder and bipolar will be diagnosed in module D.

Presence of Major Depression Episode	Major Depressive Episode Criteria

I will now ask further about your mood.

Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

In the last month...

(1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful).
Note: In children and adolescents, can be irritable mood.

?	1	2	3

... has there been a moment when you are feeling depressed or pressured almost all day every day? (How does it feel?)

IF YES: How long has that happened? (Has that happened for 2 weeks?)

... have you loss interest and pleasure in activities that you usually like?

(2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)

?	1	2	3

IF NOT ITEM (1) or ITEM (2), choose Code "3". Continue to "PAST MAJOR DEPRESSIVE EPISODE" A.12

IF YES: Has that happen almost every day? For how long? (Has that happened for 2 weeks?)

NOTE: GIVE RATINGS FOR ITEMS AS DESCRIBED, CODE "1" IF DUE TO GENERAL MEDICAL CONDITION, OR STRANGE MOOD DELUSION OR HALUCINATION

PLEASE FOCUS YOUR MIND TO YOUR
WORST 2 WEEKS IN THE LAST MONTH
(OR IN THE 2 WEEKS WHERE THE
DEPRESSION IS EQUAL TO ONE FULL
MONTH) FOR THE NEXT FOLLOWING
QUESTIONS

In this period of time (2 Weeks
period)...

... have experienced weight loss or
weight gain? (How much?) (Have you
been in the process of losing your
weight?)

IF NOT: How about your appetite? (If
compared to your usual appetite)
(Have you been in need to push
yourself to eat?) (Eat [less/more] than
usual?) (Has that happened almost
every day?)

... how about your sleep? (Have you
been feeling difficult to sleep, often
wake up during sleep, wake up early
OR oversleep? How many hours per
night if compared to your usual
sleeping? Has that happen every
night?)

... Have you been feeling agitated or
always wanting to move so that you
could not sit still? (Has that happened
so obvious to the point other people
notice it? What have they noticed?
Has that happened every day?)

IF NOT: How about being the other
side – less talk or slower movement
than usual? (Has that happened so
obvious to the point other people
notice it? What have they noticed?
Has that happened every day?)

... How has your energy like?
(continuous fatigue? Almost every
day?)

(3) significant weight loss when ? 1 2 3
not dieting or weight gain (e.g., a
change of more than 5% of body
weight in a month), or decrease
or increase in appetite nearly
every day.
Note: In children, consider failure
to make expected weight gains.

Check whether:
___ weight loss or decrease in
appetite
___ weight gain or increase in
appetite

(4) insomnia or hypersomnia ? 1 2 3
nearly every day.

Check whether:
___ insomnia
___ hypersomnia

(5) psychomotor agitation or ? 1 2 3
retardation nearly every day
(observable by others,
not merely subjective feelings of
restlessness or being slowed
down)

NOTE: ALSO CONSIDER THE
BEHAVIOR DURING INTERVIEW

Check whether:
___ psychomotor retardation
___ psychomotor agitation

(6) fatigue or loss of energy ? 1 2 3
nearly every day

SCID – I (DSM IV) Version - 2.0 (Final - February 1996)

In this period of time...

...How has you been feeling about yourself? (worthlessness?) (Almost every day?)

IF NOT: How about guilt about the things you had or had not done? (Almost every day?)

(7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)

NOTE: GIVE CODE "1" OR "2" IF ONLY LOW SELF ESTEEM

Check whether:

___ feeling of worthlessness
___ feeling of inappropriate guilt

...Have you been experiencing difficulties to concentrate? What made it happen? (Almost every day?)

IF NOT: Has it been difficult for you to make routine decision? (Almost every day?)

(8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

Check whether:

___ diminished ability to think
___ indecisiveness

(4) insomnia or hypersomnia ? 1 2 3
nearly every day.

Check whether:

___ insomnia
___ hypersomnia

...has everything so bad to the point you have a recurring thoughts of death or better of death? Have you ever thought about harming yourself?

IF YES: Have you done something to harm yourself?

(9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide ? 1 2 3

NOTE: GIVE CODE "1" FOR SELF HARM WITH/OR PLAN TO COMMIT SUICIDE

Check whether:

___ thoughts of death
___ suicidal ideation
___ specific plan
___ suicide attempt

AT LEAST FIVE FROM GIVEN SYMPTOMS ABOVE GIVEN CODE "3" AND AT LEAST ONE OF THESE TOTAL SYMPTOM IS ITEM (1) OR (2)

NOTE: Criteria B DSM IV (which is do not meet criteria of Mixed Episode) has been erased from SCID

1 3

Continue to "PAST MAJOR DEPRESSIVE EPISODE" A.12

SCID – I (DSM IV) Version - 2.0 (Final - February 1996)

IF NOT CLEAR: Has the (depression episode / own words) created difficulties for you to do work, house chores, or socializing with other people?

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

NOTE: Criteria B DSM IV (which is do not meet criteria of Mixed Episode) has been erased from SCID

? 1 2 3

Continue to "PAST MAJOR DEPRESSIVE EPISODE" A.12

Exactly before this was all started, did you experience any physical illness?

IF YES: What did the doctor said?

Exactly before this was all started, did you consume any medication?

IF YES: Was there any difference in the amount of medication that you consumed?

C. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

IF THERE IS AN INDICATION OF SECONDARY DEPRESSION (DUE TO GENERAL MEDICAL CONDITION OR SUBSTANCE INDUCED, GO TO GENERAL MEDICAL CONDITION /SUBSTANCE INDUCED, A.43 AND GO BACK HERE TO OBTAIN RATING "1" OR "3".

? 1 2 3

SUBSTANCE INDUCED OR DUE TO GENERAL MEDICAL CONDITION CONTINUE to "PAST MAJOR DEPRESSIVE EPISODE" A.12

Exactly before this was all started, did you drink any alcohol or consume any narcotics?

Included in General Medical Condition are: degenerative neurological conditions (e.g., Parkinson's disease, Huntington's disease), cerebrovascular disease (e.g., stroke), metabolic conditions (e.g., vitamin B12 deficiency), endocrine conditions (e.g., hyper- and hypothyroidism, hyper- and hypoparathyroidism, hyper- and hypoadrenocorticism), autoimmune conditions (e.g., systemic lupus erythematosus), viral or other infections (e.g., hepatitis, mononucleosis, human immunodeficiency virus [HIV]), and certain cancers (e.g., carcinoma of the pancreas).

Included in substance induced are: alcohol; amphetamine and related substances; cocaine; hallucinogens; inhalants; opioids; phencyclidine and related substances; sedatives, hypnotics, and anxiolytics. Medication includes: antihypertensive, oral contraceptives, corticosteroids, anabolic steroids, cancer medication, analgesics, anticholinergics, cardiac medications

MAIN MOOD EPISODE

CONTINUE BELOW

? = Insufficient Information 1 = Not exist / False 2 = Almost True / Indecisive 3 = True / Sufficient

Did this start after you have lost someone close?

D. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

1	3
SIMPLE BEREAVEMENT CONTINUE to "PAST MAJOR DEPRESSIVE EPISODE" A.12	
NOT SIMPLE BEREAVEMENT CONTINUE BELOW	

CODE "3" GIVEN TO CRITERIA A, B, C AND D OF MAJOR DEPRESSION EPISODE.

1	3
CONTINUE to "PAST MAJOR DEPRESSIVE EPISODE" A.12	PRESENCE MAJOR DEPRESSIVE EPISODE

In your life, how many times (in different episode) you feel (depress / own words) almost every day with the minimum of 2 weeks period and experience many symptoms that you have mentioned such as (...)

The amount presence Major Depression Episode (GIVE CODE 99 IF THE AMOUNT IS TOO MANY OR TOO DIFFICULT TO DIFFERENTIATE)

NOTE: DETAILS RECORD ABOUT PAST EPISODE AVAILABLE IN J.9 (OPTIONAL)

MINOR DEPRESSION DISORDER

CRITERIA OF MINOR DEPRESSION DISORDER

? 1 2 3

A. Mood disorder is defined as:

(1) at least two (but less than five) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (a) depressed mood or (b) diminished interest or pleasure.

RETURN TO
MODUL D

IF NOT CLEAR:

Has the (depression episode / own words) created difficulties for you to do work, house chores, or socializing with other people?

Exactly before this was all started, did you experience any physical illness?

Exactly before this was all started, have you been consuming any medication?

IF YES: Was there any difference in the amount of medication that you consumed?

Exactly before this was all started, have you been drinking or consuming street medicine

(2) the symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

(3) the symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism)

IF GENERAL MEDICAL CONDITION OR SUBSTANCE POSSIBLY LINKED TO THE DEPRESSION, GO TO GENERAL MEDICAL CONDITION /SUBSTANCE INDUCED, A.43 AND GO BACK HERE TO OBTAIN RATING "1" OR "3".

Included in General Medical Condition are: degenerative neurological conditions (e.g., Parkinson's disease, Huntington's disease), cerebrovascular disease (e.g., stroke), metabolic conditions (e.g., vitamin B12 deficiency), endocrine conditions (e.g., hyper- and hypothyroidism, hyper- and hypoparathyroidism, hyper- and hypoadrenocorticism), autoimmune conditions (e.g., systemic lupus erythematosus), viral or other infections (e.g., hepatitis, mononucleosis, human immunodeficiency virus [HIV]), and certain cancers (e.g., carcinoma of the pancreas).

Included in substance induced are: alcohol; amphetamine and related substances; cocaine; hallucinogens; inhalants; opioids; phencyclidine and related substances; sedatives, hypnotics, and anxiolytics. Medication includes: antihypertensive, oral contraceptives, corticosteroids, anabolic steroids, cancer medication, analgesics, anticholinergics, cardiac medications

? 1 2 3

RETURN TO
MODUL D

? 1 3

DUE TO
GENERAL
MEDICAL
CONDITION
OR
SUBSTANCE

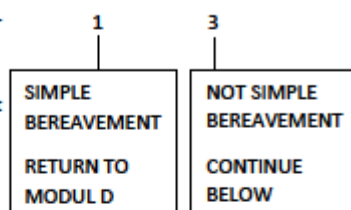
RETURN TO
MODUL D

PRIMER
MOOD
EPISODE

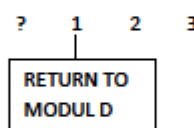
CONTINUE TO THE
NEXT PAGE

Did this start after you have lost someone close?

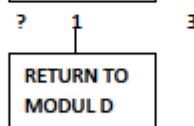
(4) The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation



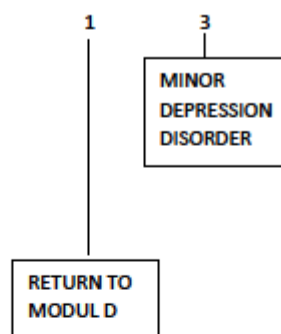
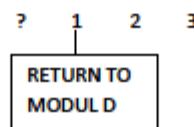
B. There has never been a Major Depressive Episode (see p. 356), and criteria are not met for Dysthymic Disorder.



C. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode, and criteria are not met for Cyclothymic Disorder. Note: This exclusion does not apply if all of the manic, mixed, or hypomanic-like episodes are substance or treatment induced.



D. The mood disturbance does not occur exclusively during Schizophrenia, Schizophreniform Disorder, Schizoaffective Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.
CODE "3" GIVEN TO CRITERIA A, B, C AND D OF MAJOR DEPRESSION EPISODE.



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The Co-Design of a Chat Telepsychotherapy Manual for Indonesians with Minor Depression – A Research Protocol

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Clifford van OMMEN⁴**

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Abstract

The development of technology is affecting the way psychological treatment is being conducted. It is now more common to have psychological treatment from a distance. In Indonesia, where the prevalence of depression has reached 6.1% or approximately 16 million of the population, a psychological treatment using a medium of synchronous texting or "chatting" is favoured. This research protocol presents the collaborative design of Chat-Telepsychotherapy Manual for Indonesians with minor depression. A six stage Collaborative Design with two groups of participants will be conducted via online focus group discussions. One group will consist of Indonesian Clinical Psychologists while the other will consist of Indonesians who are currently experiencing a minor depression episode. As per the researchers' knowledge, this research will be the first attempt to create a manual that guides Indonesian Clinical Psychologists' execution of Chat-Telepsychotherapy to help Indonesians with minor depression.

Key words: Co-design; chat telepsychotherapy; Indonesians; manual; minor depression

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1. Introduction

In response to the dramatic rise in information technology and internet usage, it is now possible to conduct psychological treatment with the help of digital technology (Weitz, 2018). There are several approaches to conducting digital based psychological treatment. This study will focus on one specific approach, Chat-Telepsychotherapy (CT). Chatting in this research is defined as real-time text-based online communications using the Internet (Derrig-Palumbo, 2016). CT started to gain attention due to its practical and modern approach. As the younger generation, particularly Millennials and Generation Z, are more used to communicating with each other by chatting, it allows the clients to have a familiar chatting experience by being able to exchange messages in real time with the psychologists (Chicca & Shellenbarger, 2018; Fang, et al., 2018; Gatti, et al., 2016; Nitzburg, & Farber, 2019). A similar pattern is also found in Indonesia, the biggest archipelago country in South East Asia with 16 million of its population dealing with depression (The Ministry of Health of Republic of Indonesia; or Kementerian Kesehatan Republik Indonesia, 2019). Indonesians tend to be reluctant to engage in face-to-face psychological treatment (Duniawati et al., 2020) and are more open to use an internet based psychological intervention for depression (Arjadi et al., 2018a).

To the researchers' knowledge, there are no Indonesian studies or documents that provide guidance on how to conduct CT for Clinical Psychologists in Indonesia in helping Indonesians who suffer from minor depression. This is a large gap in our guidance and knowledge since CT is what Indonesian people appear to be currently seeking. Thus, this study will focus on designing a manual for CT specifically to assist Indonesians with minor depression.

2. Theoretical background

2.1. The Term Chat-Telepsychotherapy

Currently, there is no literature that specifically discusses CT as the term "Chat Telepsychotherapy" might only be established in this very research. However, there are many terms for synchronous text based online communications psychological treatment in the literature. Therefore, we will discuss findings regarding similar topics such as: Online Counselling, Online Therapy, Chat Psychotherapy/Counselling, e-Counselling, Text Based Therapy/Counselling and any other forms that could align with CT.

We utilise the term CT to emphasise that the focus of this research is on psychotherapy and not counselling in relation to chatting communication. Jones-Smith (2019) indicates that while counselling is more focussed on problem solving and is short term based aim to help normally functioning people to achieve their goals, psychotherapy tends to have a longer term of intense treatment that aims to reconstruct or to repair the mind and behaviour of a person with serious coping issue in their life.

2.2. The use and the effectiveness of Chat-Telepsychotherapy

Telepsychotherapy in any kind provides an alternative for dealing with practical issues emerging in traditional face-to-face psychotherapy such as time constraints, transportation concerns, caregiving responsibilities, stigma concerns, disability, or living in a rural area that lacks adequate mental health services (Alvares and Azocar, 1999, as cited in Mohr et al., 2008). Clients with specific types of mental disorder could also benefit from Telepsychotherapy. Van Ballegooijen, et al. (2016) describe that Internet Delivered Cognitive Behavioural Therapy (ICBT) could be beneficial for a person who is suffering from panic disorder that is comorbid with agoraphobia. A person who suffers from this type of mental disorder would avoid situations and places with no available escape when the panic attacks occurred. This situation would make the sufferer having a hard time to even leave their house to seek treatment. Thus, having an

option where psychotherapy can be delivered to them without the need to leave their house would be beneficial.

Dowling and Rickwood (2013) included six studies of online chat counselling under their systematic review study and found that all six studies revealed a significant positive outcome. Their study also asserted that online chat counselling could be equally effective to face-to-face counselling and also better than telephone delivered counselling. Ersahin and Hanley (2017) conducted a systematic review of 19 studies of text-based synchronous chat therapeutic support that included 11-25 years old participants. The result of their study showed reasonably positive results, including an increased level in well-being, self-esteem, quality of life and hope.

These reviews provide not only promising findings but also references for future studies. The researchers of the current study found that from all the researches that are reviewed, none of them are focusing on creating a synchronous text based therapeutic program that is based on evidence but rather researching on the existing program. Thus, the current study where the researchers are aiming to co-design a CT manual to help Millennials and Generation Z of Indonesians that experiencing minor depression with the involvement of the stakeholder parties (i.e. The Clinical Psychologists and The Indonesians who experience minor depression) would have an additional value for the literature of synchronous text based therapeutic program.

2.3. CT in Indonesian Setting

Several reasons may be identified for the current popularity of CT in Indonesia. Firstly, exchanging messages using chatting application has become a comfortable way of communicating for Indonesian society. As the fourth most populated country in the world with the total population of 264 million (Whalley, 2020; Indonesian Internet Provider Association or Asosiasi Penyelenggara Jasa Internet Indonesia, 2019), data from 2018 suggests that 64.8% (171.17 million) of the population were actively engaged with the internet with the number one purpose of them accessing the internet was to communicate with other using chatting application (Indonesian Internet Provider Association, 2019).

Another strong reason is the geographical state of Indonesia. As a country comprised of thousands of islands, most psychologists are located on one of the five main islands, Java Island. The official website of Indonesian Clinical Psychologist Association (ICPA; or Ikatan Psikologi Klinis Indonesia, 2021) indicates that of the 2,974 registered Clinical Psychologist in Indonesia, 2,157 or 72.5% are located on Java Island. Finally, Indonesians are still facing the challenge of negative stigma regarding mental health issues. People are reluctant to seek direct face-to-face therapy as the society tends to think that having mental health issues is a sign of weakness or that those with such issues need to be cast out (Asti et al., 2016).

One of the latest major developments of CT in Indonesia happened during COVID-19 pandemic, – an infectious respiratory disease caused by the SARS-CoV-2 virus (World Health Organization, 2021a). As per data of April 7, 2021, the COVID-19 pandemic has affected 132,046,206 people and become the cause of death of 2,867,242 people around the world (World Health Organization, 2021b). As one of the countries affected by COVID-19 with 1,542,516 cases and 41,977 deaths (as per April 7, 2021), Indonesia has emphasized social distancing rules and, as a result, the Indonesian Psychological Association (IPA; or Himpunan Psikologi Indonesia [HIMPSI]) started to utilize Telepsychotherapy to help those in need (Kawal COVID 19, 2020). Hundreds of Indonesian Psychologists started to join this approach and most of them prefer to conduct CT to Phone Telepsychotherapy.

2.4. Depression in Indonesian setting and it's cultural consideration

The Ministry of Health of Republic of Indonesia (or Kementerian Kesehatan Republik Indonesia, 2019) indicated that 6.1% or approximately 16 million of Indonesians are estimated to

be depressed. To this date, Indonesia's Clinical Psychologists based their depression symptom classification on a particular mental health classification system; the Manual of Classification and Diagnosis of Mental Disorder in Indonesia III (or Pedoman Penggolongan dan Diagnosis Gangguan Jiwa di Indonesia III [PPDGJ III], Department of Health of Republic of Indonesia [or Departemen Kesehatan Republik Indonesia], 1993). PPDGJ III based its diagnostic features and criteria on two sources; the International Classification of Disease 10 (ICD 10, World Health Organization, 1993) and the Diagnostic and Statistical Manual of Mental Disorders IV (DSM IV, American Psychiatric Association, 1988). The code and diagnostic criteria for each mental disorder in the PPDGJ III is based on the ICD, whilst it also uses a multiaxial diagnostic system based on the DSM IV (Maramis & Maramis, 2009).

However, both the ICD and DSM diagnostic features and criteria derive from a western psychopathological approach. Consequently, we need to consider culturally specific individualism and collectivism. Individualism is where the society would have a loose tie between the individual while collectivism is where the society is integrated and cohesive. (Hofstede et al., 2010). Western countries such as Australia and the United States are usually regarded as countries with a high level of individualism, where they prioritize the autonomy of the individual. Asian countries on the other hand, are often seen as collectivist cultures that prioritize interrelatedness (Hofstede et al., 2010).

Hofstede (n.d) categorises Indonesia as a collectivist country with a low individualism score of 14. Hofstede postulated that Indonesians tend to conform to the ideal of the groups where they belong. Even though this claim was criticized by a couple of Indonesian researches (Perdhana, 2014; Suharnomo and Syahruramdhan, 2018) for the low variety of sample and disregarding the cultural variation of Indonesia, newer research from Suharnomo and Syahruramdhan (2018) found that Hofstede's finding is still valid. Indonesia in general is still a collectivist country.

Given the above, using a western approach to diagnose Indonesians may therefore be unsuitable. Jacob (2013) argues that imposing a Euro-American paradigm on non-western cultures could become problematic. The standard of abnormality could be different between the two cultural types and could lead to misdiagnosis (Canino & Alegria, 2008). Furthermore, there is evidence that depression shows cultural variation, especially in eastern societies. For example, Chang et al. (2017) argue that depression for Chinese people tends to take the predominant form of somatic symptoms such as lack of sleep, poor appetite and headache, rather than psychological symptoms such as feeling sad and worthless.

In the Indonesian setting, there have been no specific studies that focus on culturally specific expressions of depression. As stated before, Indonesia tends to use the western individualist approach in conceptualizing depression even though the country itself tend to be more collectivist. Several Indonesian studies have used western measurement tools for conceptualising depression, such as the Beck Depression Inventory and the Patient Health Questionnaire (Arjadi et al., 2018b; Ningrum & Kartinah, 2020; Ramdhani et al., 2020). Given this, the proposed project also aims to address the potential variation in the expression of depression in Indonesia.

2.5. Culturally Sensitive Psychotherapy

Culture not only affects the symptoms of mental disorders, but also the nature of psychotherapy intervention. According to Bernstein et al. (2018), psychotherapy emerged in the western culture and thus is essentially individualistic. Applying psychotherapy that originated from one culture to a client from another culture could be ineffective and even harmful (Moleiro et al., 2018).

Therefore, the researchers of this study will use two theories as the conceptual backbone for this project. The first theory is Eight Cultural Elements which was introduced by Bernal et al.

(1995). In this study, the team developed a framework that could help them adapt existing treatment to better suit the Hispanic community. The framework itself consists of eight dimensions: 1) language; 2) persons; 3) metaphors; 4) content; 5) concepts; 6) goals; 7) methods, and 8) context. They later asserted that these dimensions may be valuable for developing culturally sensitive treatments for other ethnic and minority groups.

The second theory is common factor psychotherapy (Rosenweig, 1936), which implies that all psychotherapies share common factors. Cuijpers et al. (2019) state that the therapeutic relationship has been consistently proposed as the most important common factor. In line with this, the current study will also focus on investigating the therapeutic relationship as a central factor. Norcross and Lambert (2018) explored which factors in the therapeutic relationship are effective. The result of the study yielded six domains that are evidently effective in individual psychotherapy. This study also showed the effect size of each aspect. Aspects with significant effect are: (a) collaboration ($d = 0.61$); (b) empathy ($d = 0.58$); and (c) alliance ($d = 0.57$). The other two aspects, goal consensus (medium effect size) and positive regard and affirmation (small effect size), did not show a large effect size but were still found to be effective. The last aspect, collecting and delivering client feedback which is effective, has a varying effect size ($d = 0.14 - 0.49$) depending on comparison group and feedback method.

2.6. Epistemological Orientation

Adopting an epistemological orientation indicates that a research topic has clear stand on the nature of knowledge that the research is trying to find and also how to actually unveil that knowledge. Willig (2013) stated that Epistemology could also determine what is the most appropriate general approach (methodology) and the specific research techniques (method) to conduct research. For this study, we are adopting Neo Empiricism as our epistemological orientation. Neo Empiricism comes from an older epistemological orientation which is empiricism. Empiricists believe that knowledge of the world must be derived from the facts of experience and grounded from data (Willig 2013).

However, empiricism faced one major criticism which was the problem of induction (Goldsmith, 2007). It had been doubted on how empiricists could make a general theory to explain infinite number of inferences based on a finite number of sources. This criticism led to a new wave of empiricism which is often called New Empiricism or Neo Empiricism. Unlike empiricism, neo empiricism takes a more loose stand on the claim of the theory. Neo empiricism asserts that every theory made is justifiable, however, the implication of the theory is in the range of probability. Neo Empiricist argues it is impossible to test every outcome of a theory, however every outcome should be close to the justifiable claim that has been made (Goldsmith, 2007). As this study holds on to neo empiricism, the methodology and the methods of this study will emphasize on finding and interpreting the fact of the participants' experiences.

3. Methodology

3.1. Design

This study will proceed using a Collaborative Design method called Co-Design. This involves a process of collective creativity between involved stakeholders in the entire design process (Thabrew et al., 2018). In Co-Design, the end user (i.e. the customer of the product) acts as an "expert of their experiences" actively collaborating with researcher, product experts, designer and developers to design a product that would meet their needs and expectation. Furthermore, a Co-Design stages framework proposed by Bowen et al. (2013) will be used in this

study. Table 1 provides the description of the adapted Bowen et al. Co-Design stages that will be implemented in this study.

Table 1. Co-Design Stages

No	Stages	Description
1	<i>Understanding and Sharing Experiences</i>	In the first stage of Co-Design the aim of the discussion is to share experiences and needs in relation to CT in both the psychologist and client groups.
2	<i>Exploring BlueSky Ideas</i>	Here the output from stage one is used as guidance for further discussion. Both groups discuss broad concepts regarding CT.
3	<i>Selecting and Developing a BlueSky Concept</i>	This includes more practical matters such the design of the sessions, goals and activities per session and potential material to be used in every CT session.
4	<i>Compiling a Practical Proposal</i>	After the psychologist group re-evaluates the BlueSky concept provided by both groups in the previous stage, the psychologist and client groups start to compile a concrete proposal.
5	<i>Prototyping</i>	At this stage, no new design data will be collected. Instead, the researcher starts to create the intervention manual from the data gathered using qualitative thematic analysis.

An additional feedback stage is added to the above framework. In the feedback stage, the manual prototype that has been produced will be given to both the client and psychologist groups to be thoroughly evaluated. Each of the groups will then be able to give final feedback regarding the prototype before it is finally revised and becomes the final version of the manual.

3.2. Setting

This study will use online focus group discussion (FGD) for the designing stages, in which the researcher and the participants hold video conference sessions. Stewart and Shamdasani (2017) indicate that online FGD can be used to reach consumers with a distance barrier. Tutas (2015) states that a web conference is able to create real-time communication among participants across various geographical locations. A web conference provides a service where participants and moderator are able to see and hear each in real time. Thus, a similar environment to face-to-face FGD is reached. In this particular research, it has to be noted that the participants in both Clinical Psychologist and client group might be located in any part of Indonesia. Having an online FGD is more suitable in terms of time and effort compared to gathering all the participants into one place.

However, Tutas (2015) states that online FGD also have limitations. Firstly, given the nature of a possible time region differences, it is challenging to gather a group of people to actually meet online. Economic barriers and technological requirements can also come to the surface. It is also important to make sure all the participants are familiar with the platform used for the online group discussions. Some participants might have a good quality connection while others may not. In order to minimize this limitation, the researchers include technology literacy as one of the requirements to become participant in this study. The researcher will also discuss the scheduling of the sessions with all participants to ensure that all participants can meet up at the same time.

FGD might also be beneficial for the client group participants who are experiencing minor depression. Peek and Fothergill (2009) share their experience of completing two research projects

with sensitive participants. In one study, the participants were second generation Muslim Americans, following the events of 9/11 attack. Another study aimed to gather experiences of children that were affected by Hurricane Katrina. They found that during the FGD, these participants are able to show their vulnerabilities to the group. The FGD also became a place where they could find people that listened and empathized with them. Thus, the FGD could have a therapeutic effect for these particular participants. Although the FGD in the said research involved face-to-face sessions, the researchers of current study believe that online FGD would lead to similar positive result.

Another consideration for the researchers to use online FGD is because the data gathering process will take place during the ongoing COVID-19 pandemic. During this period of time, it is obviously important for all people to limit their contact with another people and having an online FGD will therefore be more suitable. To sum up, with the consideration of spread locations of the participants, supporting previous researches, calculated possible risk and the current pandemic situation, the researchers believe that using online FGD will be the most suitable data gathering method for this study

3.3. Population and Sampling

There are a total of two groups of participants. The first group will consist of Clinical Psychologists (Clinical Psychologists Group) and the second group will consist of Indonesians who currently experience minor depression (Clients Group). Literature suggest that the ideal size for an FGD would be 5 – 8 participants as numbers that exceed this may hinder active participation and could lead to chaotic and hard to manage flow of the discussion (Krueger, 2014; Mishra, 2016). Drawing from this, we aim to recruit eight participants per group for this study. The highest number from the literature is chosen given the possibility of participants dropping out of the study during the data gathering process.

We also have taken into consideration the fact that this FGD will be conducted via online video conferencing platform which is Zoom. There is no definite guideline on what is the ideal size for conducting online video FGD, however we do found other studies that has done the same method with the same number of participant or even bigger (Islam, et al., 2021; Morrison, et al., 2020; Murfianti, et al., 2020; Rahiem, 2020; Sawarkar, et al., 2020; Verbytska & Syzonenko, 2020; Wirtz, et al., 2019; Zaman, et al., 2020). None of the studies actually commented on the group size and came out with an ideal number. Comments and discussion that are found that related to the online focus group are more into technical matter (Wirtz, et al., 2019) preparation (Morrison, et al., 2020) and managing the flow of the FGD in online setting (Murfianti, et al., 2020; Wirtz, et al., 2019; Zaman, et al., 2020). Thus we have high confidence that eight participants per group will be do able and give us a rich finding. Below are the criteria for each group:

Clinical Psychologists Group

- Identify as belonging to the Indonesian culture
- Identify as having grown up under Indonesian customs and lifestyle
- Able to speak Bahasa Indonesia
- A registered Clinical Psychologist
- Technology literate
- Have experience in Chat/Text Counselling/Psychotherapy for at least 6 months.

Clients Group

- Aged between 19-40
- Identify as belonging to the Indonesian culture
- Identify as having grown up under Indonesian customs and lifestyle
- Able to speak Bahasa Indonesia

- Technology literate
- Have at least one experience as a client where Chat/Text Counselling/ Psychotherapy was utilised.
- Currently has symptoms of minor depression

The exclusion criteria of the clients group participants are based on SCID IV (1) Indonesian Version:

- Substance abuse
- Illness or disease caused by neurological, cerebrovascular, metabolic, endocrine, virus, infection or cancer
- Current or previous psychotic disorder
- Current of previous manic or hypomanic disorder
- Premenstrual Dysphoric Disorder

These exclusion criteria would be asked during interview using SCID IV (1). Participants who present as acutely suicidal, characterized by having suicide plan with preparatory behaviour (Arjadi, et al., 2018b), will also be excluded from this study. Should any participant have any exclusion criteria, the participant will be carefully directed to seek professional help through either a medical or mental health professional.

3.4. Research Instrument

A total of three instruments will be used to assess the level of depression and the overall well-being of the participants in the clients' group.

The Inventory of Depressive Symptomatology Self Report (IDS-SR- Indonesian Version)

The IDS – SR is a freely available depression self-report assessment, that has good psychometric properties (Rush et al., 1996). IDS-SR is chosen in this study due to its ability to detect somatic symptoms. This is important since this study also considers the somatic symptoms of depression in the Indonesian context. The Indonesian Version of IDS-SR was developed by Arjadi et al. (2017) using confirmatory factor analysis of a sample of 1622 Indonesian, ages 16 years old and above.

Structured Clinical Interview for DSM IV – 1 (SCID IV-1) – Indonesian Version

SCID is a widely used semi-structured interview intended to determine whether individual meets criteria for any DSM disorder (Glasofer et al., 2017). The SCID IV is based on DSM IV and used to diagnose Axis I disorders including mood disorders, psychotic disorders, substance use disorders, anxiety disorders, somatoform disorders, eating disorders, and current adjustment disorder. The Indonesian Version of SCID IV – 1 was produced and validated by the Psychiatry Department of University of Indonesia in 2000 (Primasari & Hidayat, 2016). The Indonesian Version of SCID IV – 1 provides descriptions of the severity and exclusion criteria for people with depression. According to SCID IV – 1 Indonesian Version, a minor depression would be indicated by having less than five symptoms for a minimum period of two weeks. Should a person have five symptoms of depression continuously for two weeks, this would result in a diagnosis of major depression.

The World Health Organization Quality of Life BREF Version (WHOQoL-BREF) – Indonesian Version

The WHOQoL-BREF is a 26-item questionnaire that was developed by the World Health Organization (World Health Organization, 1995). It measures four domains of life: (1) Physical Health; (2) Psychological Health; (3) Social Relationships; and (4) Environment (World Health Organization, 1996). This study will use the Indonesian version of WHOQoL BREF. This measurement tools is used in this study due to its ability to detect the multidimensional correlation between depression and other domains. Depression itself has been showed to correlate with poorer quality of life (Cho et al., 2019).

3.5. Recruitment

To recruit psychologist participants, the researcher will be assisted by the ICPA by endorsing this research via association's social media. The researcher will also use snowball sampling if necessary. The researcher will contact several of his colleagues in Indonesia who fit the criteria of the psychologist participant. The contacted participants could also recommend some of their colleagues to the researcher. Psychologist group participants who are eligible to be in the study will be asked to provide an e-consent.

To recruit the participants in the clients' group, the researcher will use social media to advertise the project. In the advertisement, the researcher will provide a brief explanation about the study. Participants who are then interested in the study will be asked for consent before being administered the IDS-SR-Indonesian Version. All consent forms and screening tools will be transformed into electronic versions and uploaded into Qualtrics, a website for private and secure online surveys where a link can be generated and given to the participants. Should the potential participant meet the cut off score for depression, the potential participant will be invited to be interviewed using SCID IV (1) – Indonesian version to ensure that they meet the minor depression criteria. Participants who experience much severe depression or having suicide plan with preparatory behaviour will be led to a helpline. Client group participants who are eligible to be in the study will again be asked to give e-consent. Before starting the Co-Design process, the participant will again be administered the WHOQOL. The purpose of this measurement is to assess the overall quality of life of the participants.

3.6. Study Procedure

A schedule will be arranged for all the participants to proceed with the Co-design session. Each stage of Co-Design will be in a form of online focused group discussion (online FGD). To proceed with the online FGD, the researcher will use Zoom (<https://zoom.us/>). This software has a feature where online video conference can be recorded and saved directly to a local computer with encryption. Furthermore, Zoom ensures that no data or recording will be stored on their system. A consultation with Zoom Customer Support was completed on 6 May 2020 in relation to a recent hacking incident suffered by Zoom (Matthews, 2020). Yuan (2020), the CEO of Zoom, has published a statement in regard to the incident and made sure that his company is aware of the issue and has also made several improvements to deal with the incident.

The total duration of the data gathering process is expected to be between six to nine months. However, the participants will only actively engage in the data gathering for between two to four months of the total duration. There will be time during this period where participants will be engaged each week. There will also be a time in this period where the participants will have to wait for the prototype of the manual. During the data gathering stage, they are expected to commit between three to five hours a week. The full data gathering will include the main Co-Design process, the prototyping process and the feedback process. All participants will be compensated for their time. The final outcome of this data gathering will be a full working Chat Telepsychotherapy Manual. Figure one shows the Co-Design process for the two groups

3.7. Data Analysis

Qualitative Data

It is important to acknowledge that the nature of the data collection in this study is a series of continuous evolving multiple online FGDs. Therefore, the researchers of this study will adapt an analysis strategy postulated by Krueger (2014). Krueger (2014) asserts that it is possible to do continuous data analysis for multiple FGDs. This is because the separation is unclear between data collection, entry stops and the beginning of data analysis. In FGD, the first analysis could begin in the first session and data analysis is concurrent. Moreover, in doing so the researcher

could write a field note and record the session to be later review when the session ends. It is also recommended to create summaries after every session (Krueger, 2014). By doing this, researchers can be more alert to identifying more questions that need to be followed up and further discussed in the next session (Krueger, 2014). Finally, Krueger (2014) argues that doing analysis along the way can result in better data collection compared to waiting until all FGD sessions are finished. Another strategy planned by the researchers of this study is to also conduct a second data analysis when all the online FGD sessions are finished. Thematic analysis will be used for this second analysis. Braun and Clarke (2006) provide a six-step process for thematic analysis which are 1) familiarising oneself with the data 2) generating initial codes 3) searching for themes 4) reviewing themes 5) defining and naming themes, and, 6) producing the report. By implementing this strategy, the researchers hope that all the data will be analysed thoroughly during and after the data gathering process.

Quantitative Data

A basic descriptive data analysis will be used to analyse the quantitative data. The quantitative data from this study will be obtained from the measurement tools which are The Inventory of Depressive Symptomatology Self Report (IDS-SR- Indonesian Version) and The World Health Organization Quality of Life BREF Version (WHOQoL-BREF) – Indonesian Version. The basic descriptive data analysis would provide insight regarding the depression level of the client participants and whether or not they experience physical manifestations of depression.

Demographic Data

A basic descriptive data analysis will also be used to analyse the demographic data. Demographic data such as age, gender, ethnicity, domicile and previous experience with Chat/Text Counselling/ Psychotherapy will be obtained from the participants. Analysing the demographic data provides details regarding the overall characteristics of the participants. Furthermore, understanding the characteristics of the participants provides relevant information for other researchers to replicate our study (Hammer, 2011).

3.8. Expected Outcomes

This study is expected to have a primary and secondary outcome. The primary outcome would be a full working manual of Chat Telepsychotherapy that is culturally sensitive for Indonesians. The backbone theories of this study which are Aspects of Culturally Sensitive Psychotherapy by Bernal (1995) and Therapeutic Relationship as the most important Common Factor of Psychotherapy (Rosenweig, 1936; Cuijpers et al., 2019), will guide the discussion of the online FGDs. The secondary outcome from this study is an evidence based preliminary concept of the Indonesian version of depression. The discussion of the secondary outcome will focus on how minor depression manifests in an Indonesian setting.

3.9. Ethics Approval and Permits

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application NOR 20/53. Permissions to use all research instruments have been obtained. To use The Inventory of Depressive Symptomatology Self Report (IDS-SR- Indonesian Version), the researcher has been in contact with the author and informed that IDS-SR-Indonesian Version is free to use with acknowledgment. To use the Structured Clinical Interview for DSM IV – 1 (SCID IV-1) – Indonesian Version, the researcher has been given training and a permit by the Ministry of Health of Indonesia – Directorate General of Health Services – Central General Hospital, Dr Cipto Mangunkusomo, with the letter number UM.01.05/VII.1/0234/2020. Permission to use The World Health Organization Quality of Life BREF Version (WHOQoL-BREF) – Indonesian Version has been given by World Health

Organization with request number 364228. Finally, a permit to recruit Indonesian Clinical Psychologists as participants in this research has been granted by the Clinical Psychologist Association of Indonesia with a letter number 36/EKT/IPK-Indonesia/P-II.2021.

4. Discussion

This is the first study that focuses on developing a CT manual for Indonesians with minor depression. It acknowledges the contextual nature of knowledge. Predictive context-independent theories cannot exist in social science (Flyvbjerg, 2006). Therefore, in order for social science (in this case psychology) to develop, context-dependent knowledge is needed (Flyvbjerg, 2006). The result of this study may or may not be able to be generalized and applied to the whole population of Indonesia. However, findings yielded from this study will contribute to the development of both practical and theoretical psychology in Indonesia. More specifically, this study aims to contribute to the therapeutic effectiveness of the Clinical Psychologist community in Indonesia. The manual as the primary outcome of this study will provide guidance to Clinical Psychologists who use CT to help their Indonesian clients who are experiencing minor depression. This study could also contribute to the development of CT in general, with the manual potentially providing the foundation for CT manuals for other mental health issues. The preliminary information of an Indonesian conceptualisation of depression from this study may contribute to both clinical and theoretical psychology. This study will open renewed discussion as to how the depression manifests in the Indonesian community.

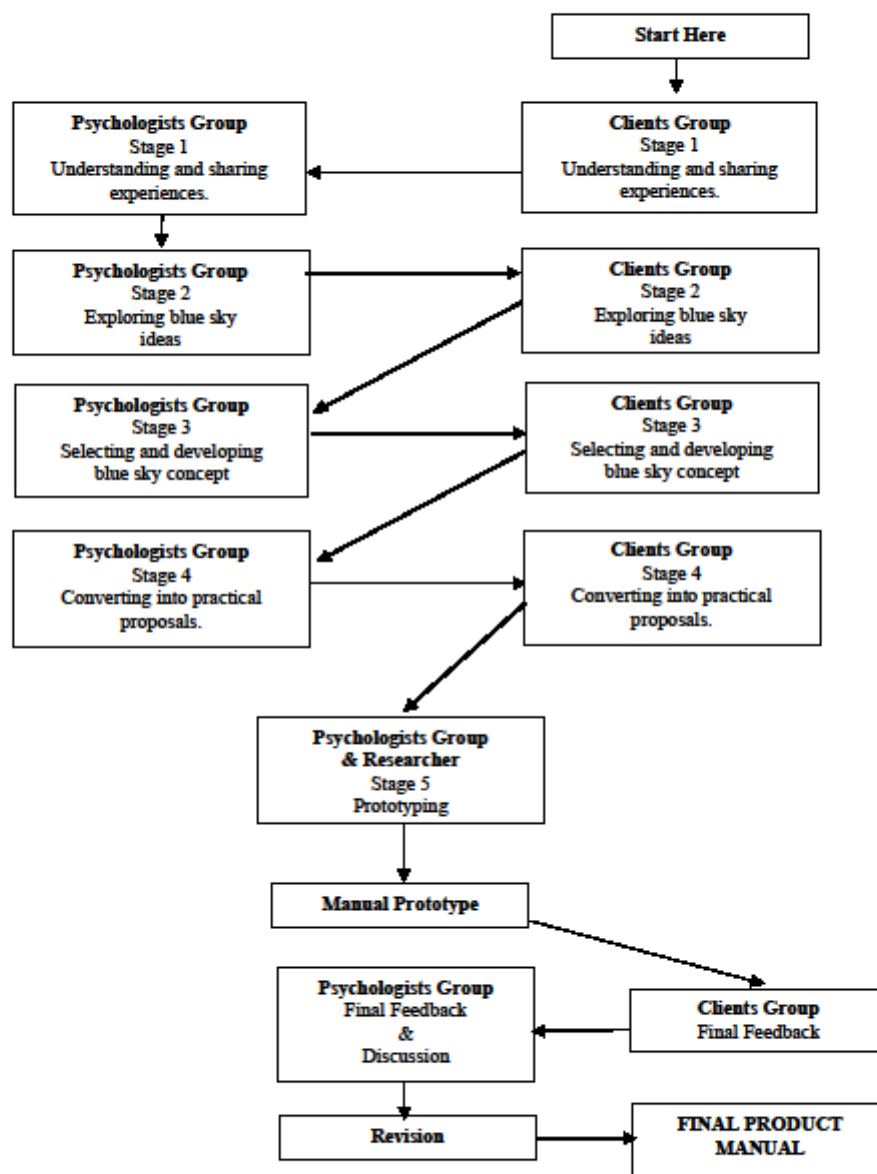
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Figure 1: Study procedure flow diagram



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Appendix M – Participant Information Sheet and Consent Form for Screening Stage in English and *Bahasa Indonesia*



PARTICIPANT INFORMATION SHEET
Screening Process for Participants Recruitment

Title of the Research

The Co-design of a Chat Telepsychotherapy Manual for Indonesians with Minor Depression

Research Team

Main Researcher : Wisnu Tri Widodo Endro, S.Psi., M.A.
Main Supervisor : Dr. Matthew Shepherd
Co-Supervisor : Dr. Clifford van Ommen; Dr. Heather Kempton

Dear Potential Participants

My name is Wisnu Tri Widodo Endro and I am a Doctorate student from Massey University, New Zealand. First of all, thank you for your interest towards this study. I am inviting you to be a part of the first stage from a total two stages of recruitment process. The aim of this recruitment process is to find suitable participants for my ongoing doctorate research titled The Co-design of a Chat Telepsychotherapy Manual for Indonesians with Minor Depression.

In the nutshell, the main objective of my doctorate research is to design a Chat Telepsychotherapy (or some of you might called it "Chat Psychotherapy or Online Counseling") manual specialized in helping Indonesian who experiencing minor depression.

Furthermore, we are currently looking for participants that could contribute to this research. If you are an Indonesian with the age of 17 – 40 and currently feeling a little bit blue, you might be eligible for this research. This screening test will take around 10 – 15 minutes to complete. Once you have finished with the screening test an email will be sent to you as a respond to your result within 48 hours. Should you are eligible, you will be invited for the second stage which will be an interview. The interview itself would take between 15 to 45 minutes depending on how you respond to the interview. Once the interview is finish and you are still eligible, you will be invited fully to contribute to the study and will be given a full information about the study.

During this recruitment process, there will be a chance that you might experience uncomfortable feelings. Should this uncomfortable feeling become intense, please call 119 extension 9 immediately. If you decide not to participate, then you do not need to provide any reason, just simply close this webpage. If you decide to participate but change your mind halfway, then you can withdraw from the study at any time.

Any identifiable data obtained in this recruitment process will be kept private and will only be used for this research related matter only. If you have any questions regarding this recruitment process or this study, you are welcome to contact me at +628562215888 via WhatsApp or email me at wisnu.tw.endro@gmail.com

I therefore convey my gratitude for your time and interest.

With warm Regards
Wisnu T.W. Endro, S.Psi., M.A.

CONSENT AND DECLARATION TO PARTICIPATE IN THE SCREENING TEST

I have read, or have had read to me in my first language, and I understand the Participant Information given above. I agree to participate in the screening test under the conditions set out in the Information Sheet

Start the screening test >



LEMBAR INFORMASI PARTISIPAN

Tahapan Penyaringan Untuk Proses Rekrutment Partisipan

Judul Penelitian:

Rancang Kolaborasi dari Panduan Telepsikoterapi Teks untuk Orang Indonesia dengan Gangguan Depresi Minor

Tim Peneliti

Peneliti Utama : Wisnu Tri Widodo Endro, S.Psi., M.A.

Pembimbing Utama : Dr. Matthew Shepherd

Pembimbing Pendamping : Dr. Clifford van Ommen; Dr. Heather Kempton

Kepada Partisipan Potensial

Nama saya adalah Wisnu Tri Widodo Endro, saya adalah mahasiswa yang sedang menempuh pendidikan doktoral di Universitas Massey yang berlokasi di Selandia Baru. Pertama-tama terimakasih atas ketertarikan anda kepada studi ini. Saya mengundang anda untuk menjadi bagian dari tahap pertama dari total dua tahap proses rekrutmen. Tujuan dari proses rekrutmen ini adalah untuk mencari partisipan yang sesuai untuk menjadi bagian penelitian doktoral saya yang berjudul Rancang Kolaborasi dari Panduan Telepsikoterapi Teks untuk Orang Indonesia dengan Gangguan Depresi Minor.

Ide dasar dari penelitian saya adalah untuk merancang panduan dari Telepsikoterapi Teks (atau mungkin lebih dikenal dengan "Konseling Chat" atau "Psikoterapi Chat" yang dirancang khusus untuk orang Indonesia dengan gangguan minor.

Lebih jauh, kita sekarang sedang mencari partisipan yang dapat berkontribusi di dalam penelitian ini. Apabila anda berumur 17-40 dan sekarang mungkin sedang merasa sedikit sedih, anda mungkin dapat menjadi bagian dari penelitian ini. Setelah anda menyelesaikan tes saringan, anda akan menerima *email* dalam jangka waktu 48 jam. Apabila anda sesuai, anda akan diundang kepada tahap dua dari proses rekrutment yaitu wawancara. Wawancara sendiri akan memakan waktu antara 15-45 menit tergantung bagaimana anda menjawab pertanyaan wawancara tersebut. Apabila wawancara telah selesai dan anda tetap sesuai menjadi partisipan penelitian ini, anda akan diundang secara penuh untuk berkontribusi di dalam penelitian ini dan akan diberikan informasi penuh mengenai penelitian ini.

Di dalam tahap rekrutmen, anda mungkin merasakan perasaan tidak nyaman. Apabila perasaan tidak nyaman ini semakin sulit dikendalikan, harap segera menghubungi nomor 119 *extension* 9. Apabila anda memutuskan untuk tidak berpartisipasi, maka anda tidak perlu memberikan alasan apapun, silahkan menutup halaman *website* ini. Apabila anda bersedia berpartisipasi dan kemudian berubah di tengah jalan, anda dapat mengundurkan diri kapanpun.

Te Kura
Hiraka
Tangata

School of Psychology – Te Kura Hiraka Tangata
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www.massey.ac.nz

Segala data yang dapat diidentifikasi di dalam proses rekrutmen ini akan disimpan secara rahasia dan hanya digunakan untuk kepentingan penelitian ini. Apabila anda memiliki pertanyaan tentang penelitian ini, anda dipersilahkan untuk mengontak saya di +628562215888 atau *email* saya di wisnu.tw.endro@gmail.com

Demikian hal diatas saya sampaikan.

Dengan salam hangat,
Wisnu T.W. Endro, S.Psi., M.A.

DEKLARSI KEBERSEDIAAN UNTUK BERPARTISIPASI DI DALAM TEST PENYARINGAN.

Saya telah membaca atau dibacakan kepada saya di dalam bahasa saya, dan saya memahami informasi yang diberikan diatas. Saya setuju untuk berpartisipasi di dalam test penyaringan yang akan dilakukan dibawah kondisi-kondisi yang telah disebutkan diatas.

Mulai Tes Penyaringan >

**Appendix N – Depression Symtomatic and Demographic Questions for Screening Stage
in English and *Bahasa Indonesia***

Depression Symptomatic Question

1. Have you ever been treated for substance abuse?
Yes No
2. Have you ever been treated or under treatment (other than Chat/SMS
Counseling/Psychotherapy) for any Psychological Disorders?
Yes No

What was / is the concern?

3. Have you ever been treated or under treatment for serious physical illness?
(Examples of this would be: Neurological, Cerebrovascular, Endocrine, Virus Infection and
Cancer)
Yes No
4. Have you ever had any thoughts, ideation, plan or even attempted suicide?
Yes No
5. Are you recently had or currently having your menstrual cycle?
Yes No

Demographic Questions

1. Name:
2. Age:
3. Current Domicile:
4. Are you able to speak Bahasa Indonesia fluently?
Yes No
5. Do you consider yourself belong to the Indonesian Culture?
Yes No
6. Do you grow up under Indonesian custom and lifestyle?
(Examples of this would be: think about what you eat, how your parent/s raise you, how you relate to your surrounding people)
Yes No
7. Do you consider yourself technology literate?
(Example of this would be: Currently have a smart phone with access to email and chatting application; understand how to upload and download files; understanding about online data storage such as Google Drive or Cloud)
Yes No
8. Have you ever used Online/Distant Psychological Services based on chat/message/text before?
(Example of this would be: Chat/SMS Counseling/Psychotherapy)
Yes No
9. What was your concern at the time?

Pertanyaan Simptom Depresi

1. Apakah anda pernah dirawat karena substansi terlarang?
Ya Tidak
2. Apakah anda pernah dirawat atau sedang dalam perawatan (selain Chat/SMS
Konseling/Psikoteerapi) gangguan Psikologis apapun?
Ya Tidak

Apa gangguan yang anda alami?
3. Apakah anda pernah dirawat atau sedang dalam perawatan atas gangguan fisik yang
serius?
(Contohnya: Gangguan Saraf, Serebrovaskular, Endokrin, Infeksi Virus atau Kanker) Have
Ya Tidak
4. Apakah anda pernah memiliki pemikiran/beride/merencanakan atau bahkan mencoba
bahkan bunuh diri?
Ya Tidak
5. Apakah anda sedang mengalami siklus menstruasi?
Ya Tidak

Pertanyaan Demografi

1. Nama:
2. Umur:
3. Domisili Sekarang:
4. Apakah anda dapat Berbahasa Indonesia secara lancar?
Ya Tidak
5. Apakah anda merasa diri anda memiliki Budaya Indonesia?
Ya Tidak
6. Apakah anda bertumbuh dewasa dibawah kebiasaan anda gaya hidup Indonesia?
(Contohnya adalah: Renungkan apa yang anda makan, bagaimana orang tua membesarkan anda, bagaimana anda berelasi dengan orang-orang di sekitar anda)
Ya Tidak
7. Apakah anda menilai diri anda melek akan teknologi?
(Contohnya adalah: Memiliki *smart-phone* dengan akses terhadap email dan aplikasi chatting; memahami *download* dan *upload*, memahami tentang penyimpanan data online seperti *Google Drive* atau *Cloud*)
Ya Tidak
8. Apakah anda pernah menggunakan Jasa Psikologi *Online/ Jarak jauh* berbasis *chat* atau *SMS* sebelumnya?
(Contohnya adalah: *Konseling/Psikoterapi SMS/ Chatting*)
Ya Tidak
9. Apakah keluhan yang anda alami?

**Appendix O - Participant Information Sheet – Data Gathering Stage – Psychologists
Group in English and Bahasa Indonesia**

English



PARTICIPANT INFORMATION SHEET CLINICAL PSYCHOLOGIST GROUP

Title of the Research

The Co-design of a Chat Telepsychotherapy Manual for Indonesians with Minor Depression.

Subtitle of the Research

The development of a Chat Telepsychotherapy manual for Millennial and Generation Z Indonesians who experience Minor Depression.

Research Team

Main Researcher : Wisnu Tri Widodo Endro, S.Psi., M.A.
Primary Supervisor : Dr Matthew Shepherd
Co-Supervisor : Dr Clifford van Ommen; Dr Heather Kempton

Contact

Cellphone Number
+628562215888 / +64272089080

Email

wisnu.tw.endro@gmail.com

My name is Wisnu Tri Widodo Endro and I am a Doctorate student from Massey University, New Zealand. Currently I am undertaking research with the aim of creating a Chat Telepsychotherapy (CT) Manual. Chat Telepsychotherapy is also known as Chat Therapy / Chat Counseling.

I am inviting you to be a part of this study. If you are not able to contribute, you do not need to provide any reason, just simply close this webpage. If you are willing to contribute but change your mind halfway, you are able to withdraw at any time. This participant sheet aims to help you in making your decision. Below you will find the rationale of this study, what is involved in participation, and the advantages and risks that you might experience during this study.

Should you decided to be a part of this research, you will then be asked to sign the consent form in the last part of the document.

Rationale

CT has started to gain attention due to its practical and modern approach. As the younger generation specifically Millennial and Generation Z is more used to communicating through text, it allows the client to have a familiar texting experience by being able to exchange messages in real time with a psychologist. To date, there are no studies that could provide guidance for the practitioner of CT in Indonesia to help people with depression. This is significant considering that depression is one of the most common mental health issues in Indonesia. Thus, this study will focus on creating a manual for CT specifically to assist Indonesian people with depression.

Aim of the Study

To collaboratively design a Chat Telepsychotherapy manual for Indonesian People (particularly the Millennial and Z Generation) with minor depression. Theoretically, this study will contribute to the knowledge and literature of Psychology in Indonesia especially in Clinical Psychology. Practically, this study provides a foundation and guidance for conducting CT for Indonesian Clinical Psychologists.

Methods

This study will use a collaborative design (co-design) method where the researcher and participants will together design a manual for CT. The data gathering process will be done using Focused Group Discussion (FGD) that will minimally consist of six sessions.

Who will become the participant in this study?

The first group is comprised of Clinical Psychologists (Psychologist Group). The second group is comprised of Indonesian Millennial and Generation Z participants who are experiencing minor depression (Clients Group). Below are the criteria for the Psychologist Group participants:

Psychologists Group

- Identify themselves as people who belong to the Indonesian culture
- Identify themselves as people who grown up under Indonesian customs and lifestyle
- Able to speak Bahasa Indonesia
- Are a registered Clinical Psychologist
- Technology literate (i.e., Familiar with internet technology, online data management and chatting application)
- Have experience in Chat Telepsychoterapy for at least 6 months.

How will I participate in this study?

The research activity consists a minimum of six sessions of focus group discussions in which the goal is to design a CT manual. During these activities you and other participants will be asked to discuss topics, and provide testimonies and opinions. The topic of the discussion will around your experience practising CT. This study will also include a clients group who will also participate in the same type of discussions. Together we will work together to design a working CT Manual. You also have the chance to comment on the ideas proposed by the clients group. The table below will give you an idea about how the study will run.

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Activity	Description
Stage 1	You will be asked to discuss your prior practice experiences with CT. You will also have the chance to comment on the experience that has been gathered from the clients group.
Stage 2	You will be asked to give an idea on how CT should be conducted. Questions will revolve around culture, your relationship with the therapist, and the therapeutic material. You will also have the chance to comment on ideas that has been proposed by the clients group.
Stage 3	You will be asked to choose relevant ideas from the previous stage and develop a broad concept of CT based on these ideas. You will also have the chance to comment on the core concept that has been proposed by the clients group.
Stage 4	You will be asked to continue developing the CT manual by proposing a practical and technical aspects derived from the core concept developed in the previous stage. You will also have the chance to comment on the practical concepts that has been proposed by the clients group.
Stage 5	You will work together with the researcher to create the prototype of the CT manual.
Feedback	You will be asked to give feedback on the manual prototype.

How is the schedule arrangement for data gathering?

The total duration of the data gathering is expected to be between six to nine months with a minimum of 6 Focus Group Discussion (FGD) sessions. However, you will only actively engage in the data gathering for between two to four months of the total duration. During the first five to ten weeks you will be having weekly FGD Sessions. Each session would last between 1½ to 2 hours. After these sessions, there will be a period where the proposal of the manual is completed. This proposal preparation might take two to four months. Once the proposal is ready, you will again invited to have another FGD that focuses on giving feedback regarding the manual proposal. The feedback session will also take between 1½ to 2 hours. All in all, the total duration of the data gathering is expected to be 12 – 18 hours of FGD sessions that will be completed between six to nine months. All FGD sessions will involve the Zoom platform. The schedule of each session will be discussed beforehand to ensure everyone is able to attend. The table below will give you an idea about how the study will run.

What are the advantages and risks from this study?

This study offers advantages which you could feel directly or indirectly. The design proses could give you a fruitful discussion with new knowledge and insights generated for your practice especially in a CT. This study has also a potential to be an important contribution towards the discipline of Psychology in Indonesia.

This study would expect to be minimal to no risk involved. There might be uncomfortable feeling during the discussion resulting from having different opinions to other fellow psychologists. Other than that, you will not be given questions that have negative impact to your personal life.

Compensation

You will be compensated for your time, effort and internet credit. This compensation will be given to you via a Bank Transfer. Below is the illustration of the compensation given.

No	Activities	Time & Effort Compensation	Internet Usage Compensation	Total
1	FGD Online Sessions	IDR 75,000 / Hour	IDR 30,000 / Hour	IDR 105,000 / Hour

Voluntary Procedure and Rights

Your participation of this study is totally voluntary. You have the right to withdraw from the study at any time without consequences. Should you decide to withdraw from the study, you will be given a withdrawal form to be completed. However, given the nature of the FGD, all the data that you give during your participation will still be included in the research and cannot be removed. You are also free to re-enter the study if you want to. You also have the right to see all the transcripts from your sessions.

Confidentiality and Data Security

All information that could identify you will be kept confidential or anonymised. Every document that will be produced under this study such as thesis, proceedings, journals and seminars will maintain your identity as confidential. Video recordings and transcripts will be safely stored in the researcher drive that is password protected. Only the primary researcher and the supervisory teams are allowed to see the original identifiable data of the research. Transcripts and any information that could lead to your identity will be destroyed two years after final Doctoral Thesis submission.

Contact

Should you have any question regarding this study, you are invited to contact the main researcher, the primary supervisor and/or one of the co-supervisors using their email addresses that can be found in the beginning of the document.

Ethic

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application NOR 20/53. If you have any concerns about the conduct of this research, please contact Dr Fiona Te Momo, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800, x 43347, email humanethicsnorth@massey.ac.nz

Bahasa Indonesia



LEMBAR INFORMASI PARTISIPAN KELOMPOK PSIKOLOG KLINIS

Judul Penelitian:

Rancang Kolaborasi dari Panduan Telepsikoterapi Teks untuk Orang Indonesia dengan Gangguan Minor.

Sub Judul Penelitian

Pengembangan Panduan Telepsikoterapi Teks untuk Generasi Milenial dan Generasi Z Indonesia dengan Gangguan Depresi Minor

Tim Peneliti

Peneliti Utama : Wisnu Tri Widodo Endro, S.Psi., M.A.
Pembimbing Utama : Dr. Matthew Shepherd
Pembimbing Pendamping : Dr. Clifford van Ommen; Dr. Heather Kempton

Kontak

Nomor Telepon Genggam
+628562215888 / +64272089080

Surat Elektronik

wisnu.tw.endro@gmail.com

Nama saya adalah Wisnu Tri Widodo Endro, saya adalah mahasiswa yang sedang menempuh pendidikan doktoral di Universitas Massey yang berlokasi di Selandia Baru. Saya sedang melakukan penelitian yang bertujuan untuk membuat sebuah panduan untuk melakukan Telepsikoterapi Teks atau yang mungkin lebih familiar dengan nama Psikoterapi *Chat* / Konseling *Chat*.

Dengan ini saya mengundang Anda untuk menjadi bagian dari penelitian ini. Apabila Anda tidak berkenan untuk berkontribusi, maka Anda tidak perlu memberikan alasan apapun dan cukup menutup halaman ini. Apabila Anda ingin berkontribusi namun berubah pikiran di kemudian hari, Anda dapat mundur dari penelitian ini kapan-pun. Lembar informasi partisipan ini akan membantu Anda dalam membuat keputusan. Anda akan menemukan alasan mengapa penelitian ini dilakukan, bagaimana Anda berpartisipasi dalam penelitian ini, serta keuntungan serta faktor resiko yang mungkin Anda alami selama berpartisipasi di dalam penelitian ini.

Apabila Anda memutuskan untuk bergabung di dalam penelitian ini, maka Anda akan diminta untuk menandatangani lembar persetujuan di bagian akhir dari dokumen ini.

Pendahuluan

Te Kūnenga
ki Pūrehuroa

School of Psychology – Te Kura Hinengaro Tangata

Private Bag 102904, North Shore Mail Centre, Auckland 0745, New Zealand T +64 9 414 0800 extn 41244 F +64 9 414 0831
www.massey.ac.nz

Telepsikoterapi berbasis percakapan teks telah menyita perhatian khayalak Indoensia karena kemudahan dan juga sifatnya yang moderen. Ketika generasi yang lebih muda, lebih spesifiknya generasi Millennial dan Generasi Z lebih terbiasa berkomunikasi melalui *chatting*, Telepsikoterapi Teks membuat klien merasakan pengalaman yang familiar dengan dapat bertukar pesan secara langsung dengan Psikolog. Hingga saat ini, belum ada penelitian yang benar-benar dapat membimbing praktisi Telepsikoterapi Teks di Indonesia untuk mengatasi orang dengan gangguan depresi. Hal ini menjadi celah yang disayangkan mengingat bahwa Telepsikoterapi Teks adalah jenis terapi yang tampaknya sedang dicari oleh masyarakat Indonesia. Oleh karena itu, penelitian ini akan fokus pada pembuatan panduan untuk melakukan Telepsikoterapi Teks untuk Generasi Milenial dan Generasi Z Indonesia dengan gangguan depresi tingkat ringan hingga menengah

Tujuan dan Manfaat Penelitian

Penelitian ini bertujuan untuk merancang secara kolaboratif, panduan untuk melakukan Telepsikoterapi Teks yang dikhususkan untuk Generasi Milenial dan Generasi Z Indonesia dengan gangguan depresi minor. Secara teori, penelitian dapat menambah pengetahuan dan literatur Psikologi di Indonesia khususnya di bidang Psikologi Klinis. Secara praktis, penelitian ini dapat menjadi dasar atau panduan dalam melakukan Telepsikoterapi Teks bagi para Psikolog Klinis yang mempraktekannya.

Metodologi

Studi ini akan menggunakan metode rancang kolaborasi dimana peneliti dan para partisipan secara bersama-sama merancang panduan untuk Telepsikoterapi Teks. Proses pengambilan data akan dilakukan menggunakan Diskusi Kelompok Terarah yang akan terdiri dari minimal enam sesi.

Siapa yang akan menjadi partisipan dalam penelitian ini?

Kelompok pertama adalah kelompok Psikolog Klinis, sedangkan kelompok kedua adalah Generasi Milenial dan Generasi Z Indonesia dengan Gangguan Depresi Minor Berikut adalah kriteria kelompok Psikolog Klinis:

Kelompok Psikologi

- Mengidentifikasi dirinya sebagai seseorang yang memiliki budaya Indonesia.
- Mengidentifikasi dirinya sebagai seseorang yang tumbuh di dalam pengaruh budaya dan gaya hidup Indonesia.
- Mampu berbahasa Indonesia
- Merupakan Psikolog Klinis terdaftar
- Memiliki literasi teknologi (yaitu memahami teknologi internet, pengelolaan data secara daring serta juga memahami aplikasi *chatting*)
- Memiliki pengalaman Telepsikoterapi Teks Psikoterapi *Chat* / Konseling *Chat*. selama sekurang-kurangnya 6 bulan.

Bagaimanakah Partisipasi Saya dalam peneltitian ini?

Aktivitas penelitian diskusi kelompok terarah yang terdiri dari minimal enam sesi yang dimana tujuannya adalah untuk merancang panduan Telepsikoterapi Teks. Selama aktivitas-aktivitas ini anda dan partisipan lainnya akan diajak untuk mendiskusikan, memberi testimoni dan opini akan topik-topik yang akan diangkat. Topik-topik yang diangkat akan seputar pengalaman

anda mempraktekkan telepsikoterapi teks. Penelitian ini juga akan terdiri dari kelompok klien yang juga akan berpartisipasi di dalam tipe diskusi yang sama. Bersama-sama, kita kan bekerja bersama untuk merancang panduan Telepsikoterapi Teks. Anda juga akan diberikan kesempatan untuk memberikan komentar akan ide-ide yang diajukan oleh kelompok klien. Tabel dibawah ini akan memberikan anda gambaran akan bagaimana penelitian ini dijalankan.

Aktivitas	Deskripsi
Tahap 1	Anda akan diminta untuk mendiskusikan mengenai pengalaman anda seputar Telepsikoterapi Teks sebelumnya Anda juga akan diberikan kesempatan untuk memberikan komentar terhadap pengalaman-pengalaman yang berhasil dikumpulkan dari kelompok klien.
Tahap 2	Anda diminta untuk memberikan ide atau pendapat tentang bagaimana sebaiknya Telepsikoterapi Teks dilakukan. Pertanyaan akan terfokus pada budaya, relasi anda dengan terapis dan materi terapeutik. Anda juga diberi kesempatan untuk berpendapat terhadap ide dan pendapat yang iberikan oleh Kelompok Klien.
Tahap 3	Anda diminta untuk memilih ide-ide yang paling relevan dari semua ide yang telah tercetus dan membawa ide-ide tersebut menjadi sebuah konsep Telepsikoterapi Teks Anda juga diberi kesempatan untuk berpendapat terhadap konsep yang sudah dicetuskan oleh Kelompok Klien.
Tahap 4	Anda akan diminta untuk melanjutkan pengembangan panduan Telepsikoterapi Teks dengan mengajukan aspek praktikal dan tenis yang diambil dari konsep-konsep yang telah didapatkan dari tahap-tahap sebelumnya. praktis Anda juga diberi kesempatan untuk berpendapat terhadap proposal yang sudah dicetuskan oleh Kelompok Klien.
Tahap 5	Pada tahap ini anda akan diminta bekerja sama untuk membuat purwarupa dari panduan Telepsikoterapi Teks.
Evaluasi	Anda akan diminta untuk memberikan evaluasi atas purwarupa panduan.

Bagaimana pengaturan jadwal dari pengambilan data ini?

Total durasi dari pengambilan data diharapkan antara enam hingga Sembilan bulan dengan minimum lima sesi diskusi kelompok terarah. Meskipun begitu anda akan hanya aktif berpartisipasi di dalam proses pengambilan data antara dua hingga empat bulan dari durasi total. Di dalam lima hingga sepuluh minggu pertama, anda akan memiliki sesi diskusi mingguan. Setiap sesi akan memakan waktu 1.5 hingga 2 jam. Setelah sesi-sesi ini, akan ada periode dimana purwarupa dari panduan akan diselesaikan dan anda akan diminta untuk berdiskusi dengan peneliti untuk membantu penyelesaian ini. Proses penyelesaian purwarupa ini mungkin akan memakan waktu dua hingga empat bulan. Setelah purwarupa selesai, anda akan kembali diminta untuk memiliki sesi diskusi yang fokus dalam memberikan evaluasi kepada purwarupa manual tersebut. Sesi diskusi evaluasi akan juga memakan waktu antara 1.5 hingga 2 jam. Secara total, total durasi dari pengambilan data adalah 12 – 18 jam diskusi kelompok yang akan diselesaikan dalam waktu enam hingga sembilan bulan. Semua sesi diskusi akan menggunakan platform *Zoom*. Jadwal dari setiap sesi akan didiskusikan sebelumnya untuk memastikan semua dapat hadir.

Apa sajakah potensi keuntungan dan resiko dari studi ini?

Terdapat beberapa manfaat dari penelitian ini yang dapat Anda rasakan secara langsung maupun dalam jangka panjang. Proses rancang berpotensi memberikan anda terdapat banyak pengetahuan baru yang relevan dengan kegiatan praktek Psikologi Anda, terutama di bidang hubungan teurapeutik jarak jauh. Hasil dari studi ini-pun memiliki potensi kontribusi yang besar terhadap literatur Psikologi maupun Psikologi terapan di Indonesia.

Penelitian ini diharapkan memiliki resiko yang sangat kecil atau tidak ada resiko sama sekali. Terdapat kemungkinan perasaan tidak nyaman di dalam diskusi yang disebabkan oleh perbedaan pendapat dari sesama Psikolog. Selain itu, Anda tidak akan diberikan pertanyaan yang memberikan efek negatif kepada kehidupan pribadi Anda.

Kompensasi

Anda akan mendapatkan kompensasi atas waktu, usaha dan kuota internet yang anda berikan. Kompensasi akan diberikan kepada anda melalui transfer Bank. Tabel dibawah mengilustrasikan skema pemberian kompensasi

No	Aktivitas	Kompensasi Waktu & Usaha	Kompensasi Kuota Internet	Total
1	Sesi Daring Diskusi Kelompok Terarah	Rp. 75.000,00 / Jam	Rp. 30.000,00 / Jam	Rp. 105.000,00 / Jam

Hak dan Prosedur Kesukarelaan

Partisipasi anda di dalam studi ini adalah sepenuhnya sukarela. Anda memiliki hal untuk mengundurkan diri dari penelitian kapan-pun dan tanpa konsekuensi. Apabila anda memutuskan untuk mengundurkan diri dari penelitian ini anda akan diberikan lembar pengunduran diri yang harus diisi. Meskipun begitu, karena sifat dasar dari diskusi kelompok, semua data yang telah anda berikan selama partisipasi anda akan tetap ada didalam penelitian dan tidak dapat dihapuskan. Anda juga dapat secara bebas untuk kembali bergabung di dalam penelitian apabila anda menginginkannya. Anda juga berhak untuk melihat transkrip dari sesi-sesi anda.

Kerahasiaan dan Keamanan Data

Segala informasi yang dapat menghubungkan dengan identitas anda akan disimpan secara rahasia atau tanpa nama, Semua dokumen yang akan diproduksi dibawah penelitian ini seperti tesis, prosiding, jurnal dan seminar tidak akan menampilkan data identitas anda. Rekaman video dan transkrip akan disimpan secara aman oleh penlit di *drive* peneliti dan akan diberikan kode. Hanya peneliti utama dan tim pembimbing yang akan diperbolehkan untuk melihat data yang dapat dihubungkan dengan identitas anda. Transkrip dan informasi yang dapat dihubungkan kepada identitas anda akan dihancurkan dua tahun setelah peneyerahan tesis doctoral.

Kontak

Apabila Anda memiliki pertanyaan, kekhawatiran, dan keluhan tentang studi ini Anda dapat mengontak peneliti utama serta para pembimbing yang mensupervisi peneliti utama

Etika

Proyek ini telah dievaluasi dan disetujui oleh Komite Etika Manusia dari Universitas Massey: Aplikasi Utara NOR 20/53. Apabila anda memiliki kekhawatiran tentang perlakuan penelitian ini. Silahkan kontak Dr. Fiona Te Momo, Pimpinan, Komite Etika Manusia Universitas Massey: Utara, Telepon +64094140800 *extension* 43347, email humanethicsnorth@massey.ac.nz

Appendix P - Participant Information Sheet – Data Gathering Stage – Clients Group in English and Bahasa Indonesia

English



PARTICIPANT INFORMATION SHEET CLIENT GROUP

Title of the Research

The Co-design of a Chat Telepsychotherapy Manual for Indonesians with Minor Depression.

Subtitle of the Research

The development of a Chat Telepsychotherapy manual for Millennial and Generation Z Indonesians who experience Minor Depression.

Research Team

Main Researcher : Wisnu Tri Widodo Endro, S.Psi., M.A.
Main Supervisor : Dr. Matthew Shepherd
Co-Supervisor : Dr. Clifford van Ommen; Dr. Heather Kempton

Contact

Cellphone Number
+628562215888 / +64272089080

Email

wisnu.tw.endro@gmail.com

My name is Wisnu Tri Widodo Endro and I am a Doctorate student from Massey University, New Zealand. I am currently doing research with the aim to create a Chat Telepsychotherapy manual or also known as Chat Therapy / Chat Counseling.

I am inviting you to be a part of this study. If you should decide not to participate, then you do not need to provide any reason, just simply close this webpage. If you decide to participate but change your mind halfway, then you can withdraw from the study at any time. The participant sheet will help in making your decision. You will find the rationale of this study, how you would participate, and advantages and risks that you might experience during this study.

Should you decide to be a part of this research, you will then be asked to sign the consent form in the last part of the document.

Aim of the Study

The aim of this study is to design a Chat Telepsychotherapy (CT) manual. CT is becoming more popular in Indonesian society especially amongst the Millennial and Generation Z generations. This is due to the fact that they are more used to communicate using text. However, up until now, there has been no official guideline as to how to conduct CT for people who suffer from depression. Therefore, this study will focus on designing a CT manual for Indonesian Millennial and Generation Z persons who are experiencing minor depression.

Voluntary Procedure and Rights

Your participation of this study is totally voluntary. You have the right to withdraw from the study at any time without consequence. Should you decide to withdraw from the study, you will be given a withdrawal form to be completed. However, given the nature of FGD all the data that you give during your participation will still be part of the research and cannot be removed. You are also free to re-enter the study later if you decide to do so. You also have the right to see all your data such as your transcript from this research.

How will I participate in this study?

The research activity consists a minimum of five sessions of focus group discussions in which the goal is to design a CT manual. During these activities you and other participants will be asked to discuss topics, and provide testimonies and opinions. The topic of the discussion will around your experience with CT. This study will also include Clinical Psychologists who will be invited to participate in the same type of discussions. Together we will work together to design a working CT Manual. You also have the chance to comment on the ideas proposed by the psychologist group. The table below will give you an idea about how the study will run.

Activity	Description
Stage 1	You will be asked to discuss your prior experiences with CT.
Stage 2	You will be asked to give an idea on how CT should be conducted. Questions will revolve around culture, your relationship with the therapist, and the therapeutic material. You will also have the chance to comment on ideas that has been proposed by the Psychologist group.
Stage 3	You will be asked to choose relevant ideas from the previous stage and develop a broad concept of CT based on these ideas. You will also have the chance to comment on the core concept that has been proposed by the Psychologist group.
Stage 4	You will be asked to continue developing the CT manual by proposing a practical and technical aspects derived from the core concept developed in the previous stage. You will also have the chance to comment on the practical concepts that has been proposed by the Psychologist group
Feedback	You will be asked to give feedback on the manual prototype.

How is the schedule arrangement for data gathering?

The total duration of the data gathering is expected to be between six to nine months with a minimum of five Focused Group Discussion (FGD) sessions. However, you will only actively engage in the data gathering for between two to four months of the total duration. During the first five to ten weeks you will be having weekly FGD Sessions. Each session would last form 1.5-2 hours. After that, you will need to wait until the proposal of the manual is finished. This proposal preparation might take two to four months. Once the proposal is finished you

be again invited to have another FGD Session that focused on giving feedback towards the proposal of the manual. The feedback session will also take between 1.5-2 hours. All in all, the total duration of the data gathering is expected to be 10 – 18 hours of FGD sessions that will be completed between six to nine months. Each FGD sessions would be done using the Zoom platform. The schedule of each sessions will be discussed beforehand to ensure everyone could attend.

What are the advantages and risks from this study?

This study offers advantages that you might directly or indirectly experience during the study. Research has shown that involvement in a discussion group can create positive and comfortable feelings. Furthermore, you will become a part of a study that has a potential to make a substantial contribution to the Psychology discipline and therapeutic practice in Indonesia.

When you are participating in this study and the discussions, there will be a chance that you might experience uncomfortable feelings during the process. Furthermore, this uncomfortable feeling might become intense. If you are finding it difficult to deal with these feelings, please call 119 extension 9 as this number is the helpline for mental health provide by the Indonesian Government.

Confidentiality and Data Security

Information that could link to your identity will be kept confidential. This is also applicable in other data such as transcripts of the discussion. Every document produced and written reports such as thesis, proceedings, journals and seminars that is related to this study will maintain your confidentiality. Video recording and transcript will safely be stored in the researcher drive that is protected with password. Only the main researcher and the supervisory teams are allowed to see the original identifiable data of the research. Video recording, Transcripts and any information that could lead to your identity will be destroyed two years after final Doctoral Thesis submission.

Compensation

The researcher understands that taking a part of a research that is largely done by Video Conference will drain your internet credit. Therefore, the researcher will provide compensation in the form of cellphone voucher with the nominal of IDR 25,000 to IDR 30,000 that will be given during every session/hour. The nominal depends on your cellphone provider. This compensation will be given to you via Bank Transfer

Contact

Should you have any questions regarding this study, you may contact the researcher, primary supervisor, and/or the co-supervisors.

Ethic

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application NOR 20/53. If you have any concerns about the conduct of this research, please contact Dr Fiona Te Momo, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800, x 43347, email humanethicsnorth@massey.ac.nz

Bahasa Indonesia



LEMBAR INFORMASI PARTISIPAN

KELOMPOK KLIEN

Judul Penelitian:

Rancang Kolaborasi dari Panduan Telepsikoterapi Teks untuk Orang Indonesia dengan Gangguan Depresi Minor

Sub Judul Penelitian

Pengembangan Panduan Telepsikoterapi Teks untuk Generasi Milenial dan Generasi Z Indonesia dengan Gangguan Depresi Minor.

Tim Peneliti

Peneliti Utama : Wisnu Tri Widodo Endro, S.Psi., M.A.
Pembimbing Utama : Dr. Matthew Shepherd
Pembimbing Pendamping : Dr. Clifford van Ommen; Dr. Heather Kempton

Kontak

Nomor Telepon Genggam
+628562215888 / +64272089080

Surel

wisnu.tw.endro@gmail.com

Nama saya adalah Wisnu Tri Widodo Endro, saya adalah mahasiswa yang sedang menempuh pendidikan doktoral di Universitas Massey yang berlokasi di Selandia Baru. Saya sedang melakukan penelitian yang bertujuan untuk membuat sebuah panduan untuk melakukan Telepsikoterapi Teks atau yang mungkin lebih familiar dengan nama Psikoterapi *Chat* / Konseling *Chat*.

Dengan ini saya mengundang Anda untuk menjadi bagian dari penelitian ini. Apabila Anda tidak berkenan untuk berkontribusi, maka Anda tidak perlu memberikan alasan apapun dan cukup menutup halaman ini. Apabila Anda ingin berkontribusi namun berubah pikiran di kemudian hari, Anda dapat mundur dari penelitian ini kapan-pun. Lembar informasi partisipan ini akan membantu Anda dalam membuat keputusan. Anda akan menemukan alasan mengapa penelitian ini dilakukan, bagaimana Anda berpartisipasi dalam penelitian ini, serta keuntungan serta faktor resiko yang mungkin Anda alami selama berpartisipasi di dalam penelitian ini.

Apabila Anda memutuskan untuk bergabung di dalam penelitian ini, maka Anda akan diminta untuk menandatangani lembar persetujuan di bagian akhir dari dokumen ini.

Tujuan dan Manfaat Penelitian

Penelitian ini bertujuan untuk merancang secara kolaboratif, panduan untuk melakukan Telepsikoterapi Teks yang dikhususkan untuk Generasi Milenial dan Generasi Z Indonesia dengan gangguan depresi minor. Secara teori, penelitian dapat menambah pengetahuan dan literatur Psikologi di Indonesia khususnya di bidang Psikologi Klinis. Secara praktis, penelitian ini dapat menjadi dasar atau panduan dalam melakukan Telepsikoterapi Teks bagi para Psikolog Klinis yang mempraktekannya.

Prosedur Kesukarelaan

Jika Anda berminat untuk menjadi bagian dari studi ini. Maka pertama-tama Anda akan diminta mengisi kuesioner *online* dan apabila Anda sesuai dengan kriteria awal partisipan penelitian, Anda akan dikontak oleh peneliti untuk melakukan wawancara lanjutan. Selanjutnya, apabila hasil wawancara menunjukkan bahwa Anda masuk di dalam kriteria penuh penelitian ini, Anda akan diundang untuk menjadi bagian dalam penelitian ini.

Keikut-sertaan Anda di dalam penelitian ini bersifat sukarela. Anda memiliki hak untuk mundur dari studi ini kapanpun. Akan tetapi, data yang saya dapat dari Anda selama penelitian berjalan, tidak akan dapat ditarik kembali. Anda juga diperbolehkan untuk masuk kembali ke dalam studi ini apabila anda ingin melakukannya. Anda juga memiliki hak untuk melihat data anda seperti transkrip dari penelitian ini.

Bagaimanakah Partisipasi Saya dalam peneltitian ini?

Aktivitas penelitian diskusi kelompok terarah yang terdiri dari minimal lima sesi yang dimana tujuannya adalah untuk merancang panduan Telepsikoterapi Teks. Selama aktivitas-aktivitas ini anda dan partisipan lainnya akan diajak untuk mendiskusikan, memberi testimoni dan opini akan topik-topik yang akan diangkat. Topik-topik yang diangkat akan seputar pengalaman anda dengan Telepsikoterapi Teks. Penelitian ini juga akan terdiri dari kelompok psikolog klinis yang juga akan berpartisipasi di dalam tipe diskusi yang sama. Bersama-sama, kita kan bekerja bersama untuk merancang panduan Telepsikoterapi Teks. Anda juga akan diberikan kesempatan untuk memberikan komentar akan ide-ide yang diajukan oleh kelompok Psikolog. Tabel dibawah ini akan memberikan anda gambaran akan bagaimana penelitian ini dijalankan

Kegiatan	Deskripsi
Tahap 1	Anda akan diminta untuk berbagai pengalaman Anda mengenai layanan telepsikoterapi yang pernah Anda lakukan.
Tahap 2	Anda diminta untuk memberikan ide atau pendapat tentang bagaimana sebaiknya Telepsikoterapi Teks dilakukan. Pertanyaan akan terfokus pada budaya, relasi anda dengan terapis dan materi terapeutik. Anda juga diberi kesempatan untuk berpendapat terhadap ide dan pendapat yang iberikan oleh Psikolog
Tahap 3	Anda diminta untuk memilih ide-ide yang paling relevan dari semua ide yang telah tercetus dan membawa ide-ide tersebut menjadi sebuah konsep Telepsikoterapi Teks Anda juga diberi kesempatan untuk berpendapat terhadap konsep yang sudah

	dicetuskan oleh Psikolog
Tahap 4	Anda akan diminta untuk mengubah konsep yang sudah disetujui menjadi sebuah proposal panduan Telepsikoterapi Teks yang lebih rinci dan praktis Anda juga diberi kesempatan untuk berpendapat terhadap proposal yang sudah dicetuskan oleh Psikolog
Evaluasi	Pada tahap ini anda akan diminta untuk memberikan evaluasi pada purwarupa dari panduan.

Bagaimana pengaturan jadwal dari pengambilan data ini?

Total durasi dari pengambilan data diharapkan antara enam hingga Sembilan bulan dengan minimum lima sesi diskusi kelompok terarah. Meskipun begitu anda akan hanya aktif berpartisipasi di dalam proses pengambilan data antara dua hingga empat bulan dari durasi total. Di dalam lima hingga sepuluh minggu pertama, anda akan memiliki sesi diskusi mingguan. Setiap sesi akan memakan waktu 1.5 hingga 2 jam. Setelah sesi-sesi ini, akan ada periode dimana purwarupa dari panduan akan diselesaikan dan anda akan diminta untuk menunggu hingga proses ini selesai. Proses penyelesaian purwarupa ini mungkin akan memakan waktu dua hingga empat bulan. Setelah purwarupa selesai, anda akan kembali diminta untuk memiliki sesi diskusi yang fokus dalam memberikan evaluasi kepada purwarupa manual tersebut. Sesi diskusi evaluasi akan juga memakan waktu antara 1.5 hingga 2 jam. Secara total, total durasi dari pengambilan data adalah 12 – 18 jam diskusi kelompok yang akan diselesaikan dalam waktu enam hingga sembilan bulan. Semua sesi diskusi akan menggunakan platform *Zoom*. Jadwal dari setiap sesi akan didiskusikan sebelumnya untuk memastikan semua dapat hadir.

Apa sajakah potensi keuntungan dan resiko dari studi ini?

Penelitian ini menawarkan kemungkinan keuntungan bagi diri Anda yang mungkin dapat Anda rasakan secara langsung atau dalam jangka panjang. Hasil penelitian menunjukkan bahwa berbagi cerita di dalam sebuah kelompok diskusi dapat menimbulkan perasaan nyaman. Lebih jauh hasil anda akan menjadi bagian dari studi yang berpotensi memiliki pengaruh besar di dalam Disiplin Ilmu Psikologi di Indonesia.

Ketika Anda berpartisipasi dalam studi ini, terdapat kemungkinan bahwa Anda akan mengalami perasaan tidak nyaman. Lebih jauh, perasaan tidak nyaman ini dapat menjadi sangat mengganggu. Apabila anda menemukan kesulitan untuk mengelola perasaan ini, segera hubungi nomor 119 *extension* 9 karena nomor ini adalah *helpline* kesehatan mental yang disediakan oleh pemerintah Indonesia.

Kerahasiaan dan Keamanan data

Segala informasi yang dapat menghubungkan dengan identitas anda akan disimpan secara rahasia atau tanpa nama, Semua dokumen yang akan diproduksi dibawah penelitian ini seperti tesis, prosiding, jurnal dan seminar tidak akan menampilkan data identitas anda. Rekaman video dan transkrip akan disimpan secara aman oleh peneliti di *drive* peneliti dan akan diberikan kode. Hanya peneliti utama dan tim pembimbing yang akan diperbolehkan untuk melihat data yang dapat dihubungkan dengan identitas anda. Transkrip dan informasi yang dapat dihubungkan kepada identitas anda akan dihancurkan dua tahun setelah penyerahan tesis doctoral

Kompensasi

Peneliti paham bahwa melakukan video call akan membebani kuota internet Anda. Oleh karena itu peneliti akan menyediakan kompensasi berupa voucher pulsa sebesar Rp. 25.000 – Rp. 30.000 per satu jam sesi diskusi. Kompensasi ini akan diberikan melalui Transfer Bank,

Kontak

Apabila Anda memiliki pertanyaan, kekhawatiran, dan keluhan tentang studi ini Anda dapat mengontak peneliti utama serta para pembimbing yang mensupervisi peneliti utama

Etika

Proyek ini telah dievaluasi dan disetujui oleh Komite Etika Manusia dari Universitas Massey: Aplikasi Utara NOR 20/53. Apabila anda memiliki kekhawatiran tentang perlakuan penelitian ini. Silahkan kontak Dr. Fiona Te Momo, Pimpinan, Komite Etika Manusia Universitas Massey: Utara, Telepon +64094140800 *extension* 43347, *email* humanethicsnorth@massey.ac.nz

**Appendix Q – Consent Form – Data Gathering Stage – Psychologists Group in English
and Bahasa Indonesia**



**FOCUS GROUP PARTICIPANT CONSENT FORM
CLINICAL PSYCHOLOGIST GROUP**

I have read, or have had read to me in my first language, and I understand the Participant Information Sheet given to me. I have had the details of the study explained to me, any questions I had have been answered to my satisfaction, and I understand that I may ask further questions at any time. I have been given sufficient time to consider whether to participate in this study and I understand participation is voluntary and that I may withdraw from the study at any time

1. I understand the Focused Group Discussion is being image and sound recorded.
2. I understand that I have an obligation to respect the privacy of the other members of the group by not disclosing any personal information that they share during our discussion.
3. I understand that all the information I provide will be kept confidential to the extent permitted by law, and the names of all people in the study will be kept confidential by the researcher.

Note: There are limits on confidentiality as there are no formal sanctions on other group participants from disclosing your involvement, identity or what you say to others in the focus group. There are risks in taking part in focus group research and taking part assumes that you are willing to assume those risks.

4. I agree to participate in the focus group under the conditions set out in the Participant Information Sheet

Declaration of Participation:

I agree to participate in the focus group under the conditions set out in the Information Sheet

Signature : _____

Full Name : _____

Date : _____

Te Kōwhiri
ki Pūwhiri

School of Psychology – Te Kura Hīrangia Tangata
Private Bag 10230, North Shore Mail Centre, Auckland 0745, New Zealand T +64 9 414 0000 ext: 81244 F +64 9 414 0031
www.massey.ac.nz



**LEMBAR PERSETUJUAN PARTISIPASI DISKUSI KELOMPOK TERARAH
KELOMPOK PSIKOLOG KLINIS**

Saya telah membaca di dalam bahasa saya sendiri dan memahami lembar informasi yang telah diberikan kepada saya. Saya telah dijelaskan mengenai rincian penelitian ini, semua pertanyaan yang saya miliki telah dijawab secara memuaskan oleh peneliti dan saya memahami bahwa saya dapat kembali bertanya kapanpun. Saya telah diberikan waktu yang cukup untuk memikirkan partisipasi saya di dalam studi ini dan memahami bahwa partisipasi saya di dalam studi ini adalah sukarela dan saya dapat mengundurkan diri kapan-pun dari studi ini.

1. Saya memahami bahwa diskusi kelompok terarah ini akan direkam secara gambar dan suara.
2. Saya memahami bahwa saya memiliki kewajiban untuk menghormati privasi dari partisipan lain di dalam kelompok dengan tidak membuka segala data pribadi yang mereka bagikan di dalam diskusi.
3. Saya memahami bahwa semua informasi yang saya sediakan akan disimpan secara rahasia sampai sejauh hukum yang berlaku, dan nama-nama partisipan di dalam studi ini akan disimpan secara rahasia oleh peneliti.
Catatan: Terdapat batasan di dalam kerahasiaan karena tidak adanya hukuman formal kepada partisipan kelompok lainnya membuka keterlibatan anda dan semua yang anda katakan di dalam diskusi. Ada resiko ketika menjadi bagian dari penelitian diskusi kelompok dan ketika anda menjadi bagian dari penelitian ini anda diasumsikan mau mengambil resiko itu.
4. Saya setuju untuk berpartisipasi di dalam diskusi kelompok yang akan dilakukan dibawa kondisi-kondisi yang telah disampaikan di dalam lembar informasi.

Deklarsi Berpartisipasi:

Saya setuju untuk berpartisipasi di dalam diskusi kelompok terarah dibawah kondisi-kondisi yang telah disampaikan di lembar informasi.

Tanda Tangan : _____

Nama Lengkap : _____

Tanggal : _____

Te Kōhanga
ki Pōwhiri

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www.massey.ac.nz

Appendix R – Consent Form – Data Gathering Stage – Clients Group in English and Bahasa Indonesia



**FOCUS GROUP PARTICIPANT CONSENT FORM
CLIENT GROUP**

I have read, or have had read to me in my first language, and I understand the Participant Information Sheet given to me. I have had the details of the study explained to me, any questions I had have been answered to my satisfaction, and I understand that I may ask further questions at any time. I have been given sufficient time to consider whether to participate in this study and I understand participation is voluntary and that I may withdraw from the study at any time

1. I understand the Focused Group Discussion is being image and sound recorded.
2. I understand that I have an obligation to respect the privacy of the other members of the group by not disclosing any personal information that they share during our discussion.
3. I understand that all the information I provide will be kept confidential to the extent permitted by law, and the names of all people in the study will be kept confidential by the researcher.

Note: There are limits on confidentiality as there are no formal sanctions on other group participants from disclosing your involvement, identity or what you say to others in the focus group. There are risks in taking part in focus group research and taking part assumes that you are willing to assume those risks.

4. I agree to participate in the focus group under the conditions set out in the Participant Information Sheet

Declaration of Participation:

I agree to participate in the focus group under the conditions set out in the Information Sheet

Signature : _____

Full Name : _____

Date : _____



**LEMBAR PERSETUJUAN PARTISIPASI DISKUSI KELOMPOK TERARAH
KELOMPOK KLIEN**

Saya telah membaca di dalam bahasa saya sendiri dan memahami lembar informasi yang telah diberikan kepada saya. Saya telah dijelaskan mengenai rincian penelitian ini, semua pertanyaan yang saya miliki telah dijawab secara memuaskan oleh peneliti dan saya memahami bahwa saya dapat kembali bertanya kapanpun. Saya telah diberikan waktu yang cukup untuk memikirkan partisipasi saya di dalam studi ini dan memahami bahwa partisipasi saya di dalam studi ini adalah sukarela dan saya dapat mengundurkan diri kapan-pun dari studi ini.

1. Saya memahami bahwa diskusi kelompok terarah ini akan direkam secara gambar dan suara.
2. Saya memahami bahwa saya memiliki kewajiban untuk menghormati privasi dari partisipan lain di dalam kelompok dengan tidak membuka segala data pribadi yang mereka bagikan di dalam diskusi.
3. Saya memahami bahwa semua informasi yang saya sediakan akan disimpan secara rahasia sampai sejauh hukum yang berlaku, dan nama-nama partisipan di dalam studi ini akan disimpan secara rahasia oleh peneliti.
Catatan: Terdapat batasan di dalam kerahasiaan karena tidak adanya hukuman formal kepada partisipan kelompok lainnya membuka keterlibatan anda dan semua yang anda katakan di dalam diskusi. Ada resiko ketika menjadi bagian dari penelitian diskusi kelompok dan ketika anda menjadi bagian dari penelitian ini anda diasumsikan mau mengambil resiko itu.
4. Saya setuju untuk berpartisipasi di dalam diskusi kelompok yang akan dilakukan dibawa kondisi-kondisi yang telah disampaikan di dalam lembar informasi.

Deklarsi Berpartisipasi:

Saya setuju untuk berpartisipasi di dalam diskusi kelompok terarah dibawah kondisi-kondisi yang telah disampaikan di lembar informasi.

Tanda Tangan : _____

Nama Lengkap : _____

Tanggal : _____

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Appendix S – Withdrawal from Research Form in English and Bahasa Indonesia



LETTER OF WITHDRAWAL FROM A RESEARCH STUDY

Name of the Primary Researcher:

Wisnu Tri Widodo Endro, S.Psi., M.A.

Title of the study:

The Co-design of a Chat Telepsychotherapy Manual for Indonesians with Minor Depression

I, _____ want to end my participation in this study.

Please find below as other options in regards to my withdrawal.

Options	Agree	Disagree
The researcher is still allowed to make direct quotation from my data when the study is reported.		
The researcher still need my authorization when directly quoted my data when the study is reported.		

Other than direct quotation, I understand that any data collected as part of my participation in the study will remain as part of the study records and cannot be removed.

Signature : _____

Date : _____



SURAT PENGUNDURAN DIRI DARI PENELITIAN

Name Peneliti Utama

Wisnu Tri Widodo Endro, S.Psi., M.A.

Judul Penelitian

Rancang Kolaborasi dari Panduan Telepsikoterapi Teks untuk Orang Indonesia dengan Gangguan Depresi Minor.

Saya, _____ mengakhiri partisipasi saya di dalam penelitian ini.

Berikut pilihan yang saya pilih sehubungan dengan pengunduran diri saya.

Pilihan	Setuju	Tidak Setuju
Peneliti masih diperbolehkan untuk mengutip langsung data-data saya saat studi ini dilaporkan.		
Peneliti masih membutuhkan izin saya ketika ingin mengutip langsung data-data saya ketika studi ini dilaporkan.		

Selain dari kutipan langsung, saya memahami bahwa data-data lain yang dikumpulkan sehubungan dengan partisipasi saya di dalam studi ini akan tetap menjadi bagian dari penelitian ini dan tidak dapat dihapuskan.

Tanda Tangan : _____

Tanggal : _____

Appendix T – Authority for Release of Transcripts in English and Bahasa Indonesia



**The Co-design of a Chat Telepsychotherapy Manual for Indonesian People
with *Mild to Moderate Depression***

AUTHORITY FOR THE RELEASE OF TRANSCRIPTS

I confirm that I have had the opportunity to read and amend the transcript of the Focus Group Discussion sessions conducted with me.

I agree that the edited transcript and extracts from this may be used in reports and publications arising from the research.

Name : _____
Date : _____



Rancang Kolaborasi dari Panduan Telepsikoterapi Teks untuk Orang Indonesia dengan Gangguan Depresi Tingkat Ringan hingga Menengah.

KEWENANGAN MENERBITKAN TRANSKRIP

Saya mengkonfirmasi bahwa saya telah diberikan kesempatan untuk membaca dan mengubah transkrip dari diskusi kelompok terarah yang telah dilakukan bersama dengan saya.

Saya setuju bahwa transkrip yang telah diedit dan ekstrak dari transkrip ini akan digunakan didalam laporan dan publikasi yang didasarkan pada penelitian ini.

Nama : _____

Tanggal : _____

Appendix U - List of Questions in the CoDesign Process

Please be advised that the original document is in Indonesian Language

Psychologists Group

Stage 1 - Understanding and Sharing Experiences.

1. What comes to your mind when handling depressed client with online therapy?
2. What comes to your mind when handling depressed client with Live-Chat therapy?
3. Please make a list of the advantages and disadvantages of handling depressed clients with live-chat therapy
4. How do you find the effectiveness on handling depressed clients with live-chat therapy?
5. What do you think the uniqueness of Depressed People in Indonesia?
6. How do you think culture are affecting the treatment of Indonesian depressed clients?
7. What do you think is the best therapy for Indonesian Depressed people?
8. What kind of feelings arises when you are handling depressed clients with CT?
9. What would be the technical difficulties that you experience during CT?
10. Tell us the most unique cases you have ever encountered during CT.
11. What would be the challenges and advantages of handling clients with different stage of development (ie Teenage and early adulthood)

Stage 2 – Exploring Blue-sky Ideas

1. Please make a list of the most important factor to make a successful therapy for depressed people?
2. What is the best way to deliver these important factors in a Live-Chat Therapy?
3. What are the functions in chat application that might useful for live-chat therapy?
4. How do you think we build therapeutic alliance in Live-chat therapy?
5. How do we show empathy in CT?
6. How do we show appraisal in CT?
7. How do you think we addressed the culture aspect in chat psychotherapy?
8. How do we deal with language differences in CT?
9. What are the things that might be consider offensive that could happen in CT?
10. What can we do if we do not understand a culturally based concept that the client might brought up during the session?
11. What do you think are the values that we need to uphold during our therapeutic relationship with the clients?
12. How do you think culture affect goal setting in the CT session?
13. In your experience is there a solid empirical psychotherapy paradigm that suit best with Indonesian depressed clients?
14. What do you think would be the best template of therapy would suit best with Indonesian depressed clients?
15. What kind of material should we share with the clients?
16. How do we share materials CT?
17. How do we address confidentiality in live telepsychotherapy?
18. How do we assess the level of issues on a client?

Stage 3 – Selecting and Developing Blue Sky Concept

1. What is the treatment plan for Indonesian depressed people?
2. How many sessions should a CT be?
3. What kind of goals should we established in every sessions?
4. How do you think each session should be structured?
5. How to make sure each goal is achieved in every session?
6. What functions need to be existing in the communication platform with the clients?

Stage 4 – Converging to Practical Proposals

1. How many sessions are allocated for the chat telepsyhothotherapy?
2. What is the goal of every session?
3. How to form an effective message to the client?
4. What would be the sentence to show empathy towards clients?
5. What would be the sentence to show appraisal towards clients?
6. How would a client be handled in the first contact?
7. What would be the sentence to firstly greet the clients?
8. What are the measurement tools will be used to measure the issue that the client have?
9. How long after therapy should we follow up the clients?
10. What are the platforms that would be used to communicate with the clients?

Clients Group

Stage 1 - Understanding and Sharing Experiences.`

1. What do you feel and think at the moment?
2. Do you mind to share in the group what had you been through that led you to this situation?
3. What some sort of feeling and thoughts that come across you when this "sad period" hit you the most?
4. What would be triggering factor that lead you to that particular stage?
5. How do you find out about CT?
6. What comes to your mind when you notice such a service?
7. What attract you or maybe hesitate you for doing such a service?
8. What would be the preliminary assumption that you had when you notice such a service? Were those assumptions happen to be true?
9. What kind of feelings and thoughts arises when you are having CT?
10. Please make a list of the advantages and disadvantages of having chat telepsychotherapy
11. Do you have preference in terms of the psychotherapist?
12. What would be the technical difficulties that you experience during CT?
13. Tell us the most unique cases you have ever encountered during CT.
14. Do you think culture affecting you therapy?

Stage 2 – Exploring Blue-sky Ideas

1. Please kindly share what do you think a CT should be like?
2. Please let me know what do you seek from CT?
3. How do you want to be helped when you opt for a CT?
4. What kind of feature do you want to experience using CT?

5. What do you think is the best flow of CT? What do you want to get in the first contact? What do you want the middle and the last part of the therapy would be?
6. What would be the type of messages would you prefer to receive from the psychotherapist?
7. Should the psychotherapist give some sort of material to you, what do you think is the best way to receive it?
8. What do you think of receiving homework in a therapy?
9. What are the functions in chat application that might useful for live-chat therapy?
10. What would be the best way to established a productive and warm atmosphere with the psychotherapist?
11. How should we addressed this in a CT?
12. How do we address confidentiality in a telepsychotherapy?
13. How do you think culture affecting the CT session?
14. Indonesia consist a lot of language, how do you think lamgiage affecting CT sessions?
15. What are the things that might be consider offensive that could happen in CT?
16. What do you think are the values that we need to uphold during CT session?

Stage 3 – Selecting and Developing Blue Sky Concept

1. What do you think about the treatment plan proposed by the psychotherapist? How should we improve it?
2. What do you think about the session goals proposed by the psychotherapist? How should we improve it?
3. What do you think about the session structured proposed by the psychotherapist? How should we improve it?
4. What functions need to be existing in the communication platform with the psychotherapist?

Stage 4 – Converging to Practical Proposals

1. What do you think about the final proposal of the chat teletherapy by the psychotherapist? Do you like on the number of sessions, goals and structure of it?
2. What do you think about the wording proposed by the psychotherapist? Do you feel that the massages serve it purposes?
3. What do you think about the first contact procedure made the psychotherapist? How can we improve it?
4. What are the platforms that would be used to communicate with the clients?

Appendix V – Example of the Transcription

Please be advised that the original document is in Indonesian Language

Researcher:

From the researcher team, we would like to know whether you experience any physical related complain during depression episode. There are many literatures that suggest Depression cause physical symptoms, but the current diagnosis system does not really look into it. So we want to know whether you all shared the same experience.

Participant	Data	Coded For
P8	When I feel depressed, I feel lack of sleep, headache, stomach cramping, tactical numbness, dizziness, muscle stiffness and aching, passing out, heart palpitation. I thought I had cardiac arrest, but it turned out to be normal. Then I went to neurologist and found out that my neural system was also okay. The doctor referred me to a Psychiatrist and the psychiatrist refer me to a psychologist. Finally, after I realized what happen, I don't feel disable anymore. Only stiff in the shoulder, neck, stomach cramping, shortness of breath and unenergetic.	• Lack of Sleep • Headache • Stomachache • Tactical Numbness • Dizziness • Passing out • Muscle Stiffness • Muscle Aching • Heart Palpitation • Shortness of breath • Unenergetic

Appendix W - Example of Theme Searching

Please be advised that the original document is in Indonesian Language

Researcher: What comes to your mind when I say Chat Telepsychotherapy?

Participants	Coded For	Themes
C1	• Make depression even worse • Need to type despite the lack of energy • Prefer to be spontaneous as writing chat hinder real intention to be fully conveyed • Did not get the feel, something implicit that can be unsaid.	Disadvantage <u>(Theme)</u> • Make depression even worse • Need to type despite the lack of energy • Prefer to be spontaneous as writing chat hinder real intention to be fully conveyed • Did not get the feel, something implicit that can be unsaid. Preference <u>(Theme)</u> • Spontaneous communication
C3	• Helpful • Typing need so much of energy • No expresession • Prefer voice • Prefer video call.	Advantage <u>(Theme)</u> • Helpful Disadvantage <u>(Theme)</u> • Typing need so much of energy • No expresession Preference <u>(Theme)</u> • Prefer voice • Prefer video call.
C4	• Relieved • Calming, somebody is there to help us • No intonation • Use voice note	Advantage <u>(Theme)</u> • Relieved • Calming, somebody is there to help us Disadvantage <u>(Theme)</u> • No intonation Suggestion <u>(Theme)</u> • Use voice note

Appendix X – Example of Summaries of Sessions

Please be advised that the original document is in Indonesian Language

SUMMARY OF DATA GATHERING STAGE 1 – PSYCHOLOGIST GROUP

Held on Monday and Wednesday (19 and 21 July 2022) 07.30 PM – Western Indonesia Time

Research Data of Wisnu T.W. Endro – Massey University – Please keep it confidential.

DEFINING CHAT TELEPSYCHOTHERAPY

Points suggested appearing on the definition.

- Is a therapeutic relationship that is also curative in nature.
- Aim to provide aid to the clients or to make clients have more self-awareness.
- Aid was given in the form of solutions or attempts to gain insights
- That it is done by the media of chatting/text
- Not necessarily through text but also through other features such as emojis or stickers.

Research Data of Wisnu T.W. Endro – Massey University – Please keep it confidential.

Appendix Y – Before and After Routine (Stage 1 – Stage 4) Data Gathering Mental Health Level Statistical Analysis

The Inventory of Depression Symptomatology – Self Report – Indonesian Version

Client Group Participants	Score Prior Data Gathering	Score After Data Gathering
1	33	42
2	27	Missing
3	33	29
4	24	16
5	36	46
6	48	39
7	37	38
8	48	33
Mean	35.75	34.71
Median	34.5	38
SD	8.71	9.96

Statistical Analysis using Wilcoxon Signed Rank Test

Wilcoxon Signed Ranks Test

Ranks

		N	Mean Rank	Sum of Ranks
IDS_SR_After - IDS_SR_Before	Negative Ranks	4 ^a	4.13	16.50
	Positive Ranks	3 ^b	3.83	11.50
	Ties	0 ^c		
	Total	7		

a. IDS_SR_After < IDS_SR_Before
b. IDS_SR_After > IDS_SR_Before
c. IDS_SR_After = IDS_SR_Before

Test Statistics^a

	IDS_SR_After - IDS_SR_Before
Z	-.423 ^b
Asymp. Sig. (2-tailed)	.672

a. Wilcoxon Signed Ranks Test
b. Based on positive ranks.

World Health Organisation – Quality of Life – Bref - Indonesian Version

Client Group Participants	Physical Prior	Physical After	Psychological Prior	Psychological After	Social Interaction Before	Social Interaction After	Environment Before	Environment After
1	81	38	63	44	75	69	56	50
2	<i>Missing</i>							
3	63	75	56	44	50	56	56	50
4	56	75	50	69	56	75	56	69
5	63	44	56	44	69	94	50	63
6	44	63	31	50	50	50	50	63
7	63	44	44	25	25	44	50	50
8	44	63	56	63	81	94	75	94
Mean	59.14	57.43	50.86	48.43	58.00	68.86	56.14	62.71
Median	63.00	63.00	56.00	44.00	56.00	69.00	56.00	63.00
SD	12.85	15.37	10.56	14.41	18.97	20.17	8.84	15.83

Statistical Analysis of Physical Aspect using Wilcoxon Signed Rank Test

Wilcoxon Signed Ranks Test

Ranks				
		N	Mean Rank	Sum of Ranks
r - WHO_QoL_Physical_Before	Negative Ranks	3 ^a	5.00	15.00
	Positive Ranks	4 ^b	3.25	13.00
	Ties	0 ^c		
	Total	7		

a. WHO_QoL_Physical_After < WHO_QoL_Physical_Before
b. WHO_QoL_Physical_After > WHO_QoL_Physical_Before
c. WHO_QoL_Physical_After = WHO_QoL_Physical_Before

Test Statistics^a

	WHO_QoL_Physical_After - WHO_QoL_Physical_Before
Z	-.175 ^b
Asymp. Sig. (2-tailed)	.861

a. Wilcoxon Signed Ranks Test
b. Based on positive ranks.

Statistical Analysis of Psychological Aspect using Wilcoxon Signed Rank Test

Wilcoxon Signed Ranks Test

Ranks				
		N	Mean Rank	Sum of Ranks
WHO_QoL_Psychological_After - WHO_QoL_Psychological_Before	Negative Ranks	4 ^a	4.00	16.00
	Positive Ranks	3 ^b	4.00	12.00
	Ties	0 ^c		
	Total	7		

a. WHO_QoL_Psychological_After < WHO_QoL_Psychological_Before
b. WHO_QoL_Psychological_After > WHO_QoL_Psychological_Before
c. WHO_QoL_Psychological_After = WHO_QoL_Psychological_Before

Test Statistics^a

	WHO_QoL_Psychological_After - WHO_QoL_Psychological_Before
Z	-.345 ^b
Asymp. Sig. (2-tailed)	.730

a. Wilcoxon Signed Ranks Test
b. Based on positive ranks.

Statistical Analysis of Social Interaction Aspect using Wilcoxon Signed Rank Test

Wilcoxon Signed Ranks Test

Ranks		N	Mean Rank	Sum of Ranks
WHO_QoL_Sos_Interaction_After - WHO_QoL_Sos_Interaction_Before	Negative Ranks	1 ^a	1.50	1.50
WHO_QoL_Sos_Interaction_After - WHO_QoL_Sos_Interaction_Before	Positive Ranks	5 ^b	3.90	19.50
	Ties	1 ^c		
	Total	7		

- a. WHO_QoL_Sos_Interaction_After < WHO_QoL_Sos_Interaction_Before
b. WHO_QoL_Sos_Interaction_After > WHO_QoL_Sos_Interaction_Before
c. WHO_QoL_Sos_Interaction_After = WHO_QoL_Sos_Interaction_Before

Test Statistics^a

	WHO_QoL_Sos_Interaction_After - WHO_QoL_Sos_Interaction_Before
Z	-1.897 ^b
Asymp. Sig. (2-tailed)	.058

- a. Wilcoxon Signed Ranks Test
b. Based on negative ranks.

Statistical Analysis of Environment Aspect using Wilcoxon Signed Rank Test

Wilcoxon Signed Ranks Test

Ranks		N	Mean Rank	Sum of Ranks
WHO_QoL_Sos_Environment_After - WHO_QoL_Sos_Environment_Before	Negative Ranks	2 ^a	1.50	3.00
WHO_QoL_Sos_Environment_After - WHO_QoL_Sos_Environment_Before	Positive Ranks	4 ^b	4.50	18.00
	Ties	1 ^c		
	Total	7		

- a. WHO_QoL_Sos_Environment_After < WHO_QoL_Sos_Environment_Before
b. WHO_QoL_Sos_Environment_After > WHO_QoL_Sos_Environment_Before
c. WHO_QoL_Sos_Environment_After = WHO_QoL_Sos_Environment_Before

Test Statistics^a

	WHO_QoL_Sos_Environment_After - WHO_QoL_Sos_Environment_Before
Z	-1.594 ^b
Asymp. Sig. (2-tailed)	.111

- a. Wilcoxon Signed Ranks Test
b. Based on negative ranks.

**Appendix Z – Permission from Beck Institute to use Testing Your Thoughts Worksheet
in the Manual**



Wisnu Endro <wisnu.tw.endro@gmail.com>

Formal Letter from Massey University - Permission for Testing Your Thoughts Worksheet

Beck Institute Help <help@beckinstitute.org>

28 July 2022 at 08:18

To: "Wisnu T. W. Endro" <wisnu.tw.endro@gmail.com>

Cc: Diamond Hackley <dhackley@beckinstitute.org>, Ivy McDaniels <imcdaniels@beckinstitute.org>, Tommy Neilson <tnilson@beckinstitute.org>, "Shepherd, Matt" <M.Shepherd1@massey.ac.nz>, "Kempton, Heather" <H.Kempton@massey.ac.nz>, "Van Ommen, Clifford" <C.VanOmmen@massey.ac.nz>

Hello Wisnu,

Thank you very much for this letter.

I am pleased to confirm you have our permission to use the Testing Your Thoughts Worksheet in your manual. Thank you for your thorough communications and we wish you the very best on your thesis!

If you find yourself with any questions, please feel welcomed to reach out.

Warm Regards,

Diamond Hackley

Customer Service Representative

Pronouns: she/her

Beck Institute for Cognitive Behavior Therapy
One Belmont Avenue, Suite 700

Bala Cynwyd, PA 19004

Email: dhackley@beckinstitute.org

phone: 610.664.3020 x245



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From: Wisnu T. W. Endro <wisnu.tw.endro@gmail.com>
Sent: Tuesday, July 26, 2022 8:00 AM
To: Beck Institute Help <help@Beckinstitute.org>
Cc: Diamond Hackley <dhackley@beckinstitute.org>; Ivy McDanielis <imcdanielis@beckinstitute.org>; Tommy Neilson <tneilson@beckinstitute.org>; Shepherd, Matt <M.Shepherd1@massey.ac.nz>; Kempton, Heather <H.Kempton@massey.ac.nz>; Van Ommen, Clifford <C.VanOmmen@massey.ac.nz>
Subject: Formal Letter from Massey University - Permission for Testing Your Thoughts Worksheet

Dear Beck Institute
Hope this email finds you well.

My name is Wisnu Endro. I am a PhD student from Massey University - New Zealand, who has been querying about using one of Beck's worksheets in my thesis. We have had correspondence dated back to February 2022. This correspondence has been documented, and you might find our interaction in the PDF attached titled Correspondence History. In one of our correspondence, on February 22nd, 2022, you mentioned that I should write a formal letter under my university name to delineate my request regarding the permission request.

In this email, I attached a formal letter under my University containing all the details about my request. You will see on the second page of the letter that I have four points that reflect the nature of my request. On the same page, I also emphasised that Beck Institute will retain the intellectual property of the worksheet as per requested.

Finally, it would be an honour for me to be able to include the Testing Your Thoughts Worksheet in my thesis. I look forward to your response to this formal request.

Kind Regards

—

Wisnu T.W. Endro, S.Psi., M.A.

PhD Candidate
School of Psychology
Massey University
Auckland Campus
Email: wisnu.tw.endro@gmail.com / wisnu.endro.1@uni.massey.ac.nz



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Appendix ZA – Permission from Guilford to use Thinking Error in the Manual

Permission Inquiry

permissions@guilford.com <permissions@guilford.com>
To: "Wisnu T. W. Endro" <wisnu.tw.endro@gmail.com>

24 March 2022 at 09:28

Dear Wisnu Endro,

Thank you for your request. We can grant permission to include the table in your dissertation at no charge. However, if the university wishes to publish the manual and make it for sale to the public, additional permission will be required. A reprint fee will be assessed at that time. The university should complete our online request form for permission to include the table in a published book.

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Best wishes,

Angela Whalen

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