



Integrating cognitive, narrative, and *taluba* into ALIVE counseling model for passive suicidal ideation: An NIH stage 1A study

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Article Information:

Received : May 11, 2026

Revised : May 17, 2026

Published : June 2, 2026

Keywords:

resilience, peer support,
gratitude, self-compassion

Abstract

Passive suicidal ideation among university students is increasingly associated with depression, hopelessness, loneliness, and elevated suicide risk. However, most suicide prevention interventions remain focused on active suicidality, while culturally responsive interventions specifically targeting passive suicidal ideation remain limited. This study aimed to develop and validate the ALIVE Counseling Model, integrating cognitive-behavioral counseling, narrative counseling, and Taluba local wisdom values. The study employed a Psychotherapy Research and Development design based on the NIH Stage 1A framework involving intervention development, expert validation, and prototype refinement. Four expert validators evaluated the model using a 36-item instrument assessing appropriateness, usefulness, convenience, and feasibility. Quantitative data were analyzed using Gregory's interrater agreement method, while qualitative feedback informed model revisions. The findings demonstrated very high interrater agreement, with all validator pairs obtaining agreement indices of 1.00. Validators consistently perceived the ALIVE Counseling Model as conceptually appropriate, practically useful, convenient, and feasible for reducing passive suicidal ideation among university students. Qualitative feedback strengthened the model through revisions related to conceptual clarity, implementation procedures, and cultural adaptability. The study contributes to culturally responsive psychotherapy development by integrating cognitive-behavioral, narrative, spiritual, and indigenous cultural dimensions into a structured counseling intervention and provides a foundation for future empirical implementation.

Introduction

Passive suicidal ideation (PSI) among university students has become an important mental health concern because it is associated with depression, hopelessness, loneliness, psychological distress, and elevated suicide risk (Hovey et al., 2023; Yao et al., 2023). PSI refers to generalized wishes for death without explicit suicidal planning and may function as an early precursor to more severe suicidal behavior (Liu et al., 2020). Among university students, passive suicidal ideation is strongly associated with depression, loneliness, hopelessness, anxiety, and uncertainty during emerging adulthood. Depression consistently predicts suicidal ideation severity (De la Cruz-Valdiviano et al., 2023), while loneliness contributes directly and indirectly through depressive processes (Tachikawa et al., 2023). These findings indicate that passive suicidal ideation involves not only maladaptive cognition but also disrupted meaning systems and emotional disconnection.

Cognitive-behavioral therapy (CBT) has demonstrated strong effectiveness in reducing suicidal ideation and suicide-related behaviors. Meta-analytic evidence shows that CBT and related approaches effectively reduce suicide attempts and suicidal symptoms (Hu et al., 2024; Jeong et al., 2023). Nevertheless, conventional CBT approaches are sometimes criticized for being overly structured and insufficiently responsive to cultural and spiritual meaning systems.

Narrative counseling offers a complementary perspective through storytelling, externalization, and reconstruction of personal meaning. Narrative approaches have shown promising outcomes in reducing emotional distress and suicidal behavior by helping individuals develop alternative life narratives (Mehl-Madrona & Mainguy, 2020; Taghipour et al., 2023). Integrating cognitive-behavioral and narrative approaches is beneficial because cognitive restructuring becomes more meaningful when individuals are encouraged to reinterpret and reconstruct the personal stories that shape their beliefs, emotions, and behaviors (Rhodes, 2014).

However, most suicide prevention interventions remain focused on active suicidal behavior and crisis intervention (Mann et al., 2021), while culturally responsive interventions specifically targeting passive suicidal ideation remain limited. On the other side, Banjar people tend to understand psychological suffering not only through cognitive and emotional perspectives but also through spiritual, relational, and cultural meaning systems (Abdurrahman & Abduh, 2019; Khadijah, 2019); therefore, conventional CBT and narrative approaches may be perceived as insufficiently relevant in practice when they are implemented without integrating local values, religious reflection, and culturally grounded communication patterns.

Within Banjar culture, *Taluba* values—*Baiman*, *Bauntung*, and *Batuah*—emphasize spirituality, meaningful living, and social usefulness (Sarbaini, 2022). Previous studies suggest that spiritual connectedness and meaning in life may function as protective factors against suicidal vulnerability (Costanza et al., 2019; Lew et al., 2020). These values may therefore provide culturally meaningful psychological resources that help individuals reinterpret distress, strengthen hope, and maintain social-spiritual connectedness during periods of emotional vulnerability.

Despite increasing evidence supporting CBT, narrative counseling, and culturally responsive psychotherapy independently, integrative counseling models specifically designed for passive suicidal ideation remain limited, particularly through psychotherapy-specific developmental frameworks such as the NIH Stage Model (Onken, 2019). This study addressed these gaps through the development and expert validation of the ALIVE Counseling Model, integrating cognitive-behavioral counseling, narrative counseling, and *Taluba* local wisdom values.

The present study aimed to develop and validate the ALIVE Counseling Model through the NIH Stage Model framework. The study examined whether the model

demonstrated strong expert agreement regarding its appropriateness, usefulness, convenience, and feasibility for reducing passive suicidal ideation among university students. The model was developed based on the assumption that passive suicidal ideation among emerging adults is closely associated with maladaptive cognitions, problem-saturated narratives, weakened meaning systems, and reduced social-spiritual connectedness, thereby requiring interventions that are both psychologically structured and culturally responsive.

Methods

Design

This study employed a Psychotherapy Research and Development design based on NIH Stage 1A to develop and validate the ALIVE Counseling Model, integrating cognitive-behavioral counseling, narrative counseling, and Taluba values for reducing passive suicidal ideation. The process involved conceptual development, manual preparation, expert validation, and model revision before empirical testing (Onken, 2019).

Participants

The participants consisted of four expert validators selected through purposive sampling based on their academic qualifications, professional expertise, and relevance to the ALIVE Counseling Model. Inclusion criteria included expertise in counseling or psychological interventions, at least associate professor status or equivalent professional experience, relevant expertise in cognitive-behavioral, narrative, indigenous, spiritual, or local wisdom-based counseling, experience in counseling research or model development, and willingness to provide quantitative and qualitative evaluations.

The validators included two associate professors and two professors from Indonesian universities with expertise related to the inclusion criteria. Their characteristics are presented in Table 1.

Table 1. Expert Validators Participating in the Interrater Agreement Analysis

Validator Code	Academic Qualification/Position	Area of Expertise	Institution
V1	Associate Professor	Post-modern counseling	Universitas Negeri Semarang
V2	Associate Professor	Cognitive-behavioral counseling	Universitas Negeri Malang
V3	Professor	Individual Counseling; Media in Counseling	Universitas Negeri Surabaya
V4	Professor	Guidance & Counseling; Banjar Local Wisdom	Universitas Lambung Mangkurat

Instruments

The primary instrument was an expert validation questionnaire developed to assess the ALIVE Counseling Model. It consisted of 36 items covering appropriateness (12 items), usefulness (5 items), convenience (13 items), and feasibility (6 items). Items were rated on a four-point Likert scale from 1 to 4 and categorized into Strong Agreement (3–4) and Weak Agreement (1–2) for interrater agreement analysis. The instrument also included open-ended sections for qualitative feedback regarding the model's conceptual, procedural, cultural, spiritual, visual, and practical aspects.

Procedure

The procedure of this study focused on the development and preliminary validation of the ALIVE Counseling Model within the NIH Stage Model Stage 1A framework (Onken, 2019). Figure 1 shows the overall procedure of this research.

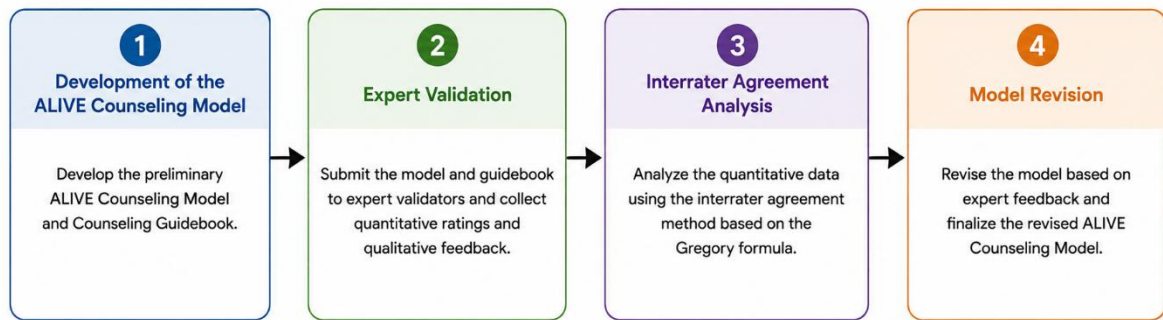


Figure 1. Development & Validation Procedure of the ALIVE Counseling Model

The procedure began with developing the ALIVE Counseling Model by integrating cognitive-behavioral counseling, narrative counseling, and *Taluba* values into a culturally responsive intervention for passive suicidal ideation. A counseling guidebook was then developed and evaluated by four expert validators using a 36-item instrument assessing appropriateness, usefulness, convenience, and feasibility. Quantitative data were analyzed using Gregory's (2015) interrater agreement method, followed by revisions to strengthen conceptual clarity, procedures, spiritual constructs, language, visual presentation, and cultural adaptability before finalizing the prototype.

Data Analysis

Quantitative data were analyzed using Gregory's (2015) interrater agreement method to determine expert agreement regarding the ALIVE Counseling Model. Ratings were categorized into Strong Agreement (3–4) and Weak Agreement (1–2). Agreement indices were calculated for each validator pair and for each assessment aspect: appropriateness, usefulness, convenience, and feasibility. As we can see in Table 2, agreement levels were interpreted as very high (0.80–1.00), high (0.60–0.79), moderate (0.40–0.59), low (0.20–0.39), and very low (0.00–0.19). Qualitative feedback was analyzed descriptively to identify conceptual and practical recommendations for model revision and refinement.

Table 2. Interpretation Criteria of Interrater Agreement

Agreement Index Range	Interpretation
0.80 – 1.00	Very High
0.60 – 0.79	High
0.40 – 0.59	Moderate
0.20 – 0.39	Low
0.00 – 0.19	Very Low

Results

Structure and Development of the ALIVE Counseling Model

The primary outcome of this study was the development of the ALIVE Counseling Model, a culturally integrated intervention designed to reduce PSI among university students by combining cognitive-behavioral counseling, narrative counseling, and *Taluba* values (*Baiman, Bauntung, Batuah*). As shown in Figure 2, the model consists of three phases: risk screening, ALIVE intervention sessions, and follow-up screening, supported by therapeutic alliance development, spiritual integration, and relapse prevention.

The screening stage assesses depression (BDI-II), self-harm (SHI), passive suicidal ideation (D-PSI), and active suicidal ideation (R-SIS). Students with severe self-harm or active suicidal ideation are referred to intensive mental health services, while students with PSI become the intervention targets.

The ALIVE intervention includes five components: Assess the problem-saturated stories (A), focusing on negative narratives and emotional patterns; Locate cognitive layers behind the narratives (L), identifying maladaptive cognitions through cognitive restructuring and reflective dialogue; Integrate religious practices with cognitive-narrative techniques (I), incorporating *Taluba* values and spiritual practices into meaning-making processes; View alternative meaning (V), facilitating narrative reconstruction and adaptive reinterpretation of experiences; and Evaluate the personal and social outcomes (E), emphasizing reflection, coping evaluation, and relapse prevention.

The intervention concludes with follow-up screening to monitor changes in depression and PSI. Overall, the ALIVE Counseling Model represents a culturally responsive counseling framework integrating cognitive, narrative, spiritual, and indigenous cultural dimensions within a structured intervention for PSI among university students.

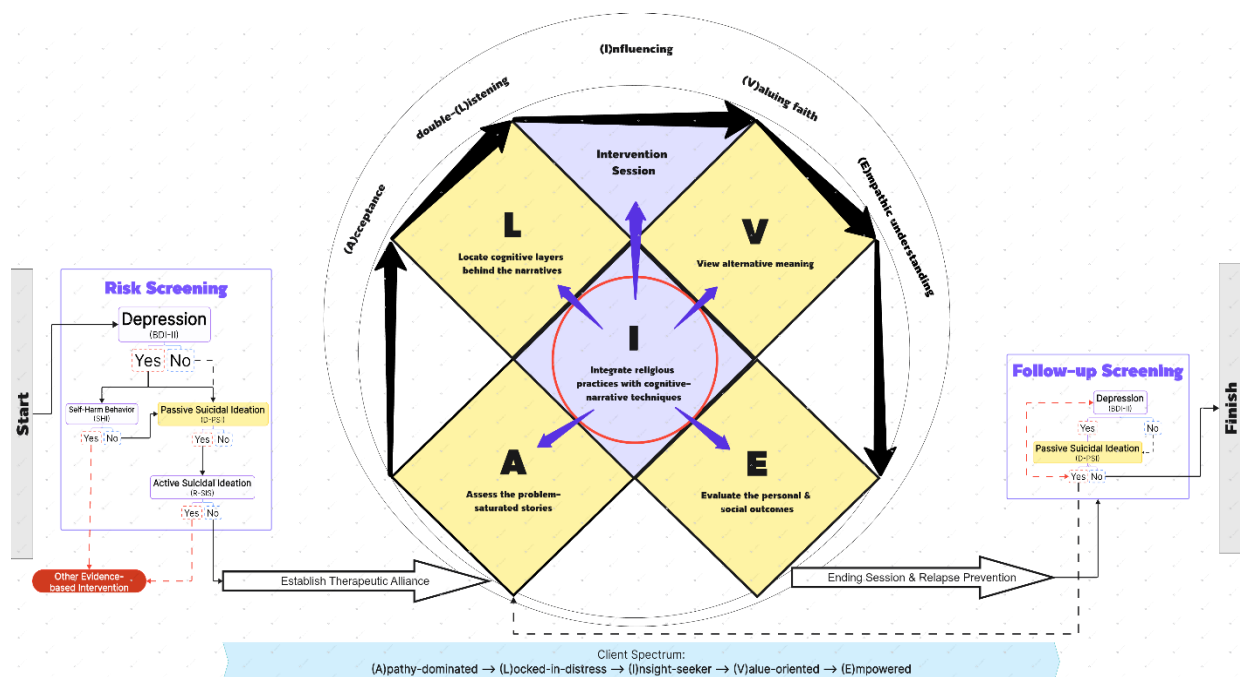


Figure 2. ALIVE Counseling Model

Interrater Agreement Analysis Results

Interrater agreement analysis involving four expert validators examined the validity and quality of the ALIVE Counseling Model across appropriateness, usefulness, convenience, and feasibility. All 36 assessment items received Strong Agreement ratings (see Table 3), indicating consistent expert consensus regarding the model’s conceptual validity and practical feasibility for reducing PSI among university students.

Table 3. Recapitulation of Expert Validation Results for ALIVE Counseling Model

No	V1		V2		V3		V4		
	Score	Interpret.	Score	Interpret.	Score	Interpret.	Score	Interpret.	
<i>Appropriateness</i>									
1	4	S	4	S	3	S	3	S	
2	4	S	4	S	4	S	4	S	
3	4	S	4	S	3	S	3	S	
4	4	S	3	S	3	S	3	S	
5	3	S	3	S	4	S	4	S	

No	V1		V2		V3		V4	
	Score	Interpret.	Score	Interpret.	Score	Interpret.	Score	Interpret.
6	4	S	4	S	3	S	4	S
7	3	S	4	S	3	S	3	S
8	3	S	3	S	3	S	3	S
9	3	S	4	S	4	S	3	S
10	3	S	3	S	3	S	4	S
11	4	S	3	S	3	S	4	S
12	4	S	3	S	3	S	3	S
<i>Usefulness</i>								
13	4	S	4	S	4	S	4	S
14	4	S	4	S	4	S	4	S
15	4	S	4	S	3	S	4	S
16	4	S	4	S	3	S	4	S
17	4	S	3	S	4	S	3	S
<i>Convenience</i>								
18	4	S	4	S	3	S	4	S
19	4	S	4	S	4	S	3	S
20	4	S	4	S	4	S	4	S
21	4	S	3	S	4	S	3	S
22	3	S	4	S	3	S	3	S
23	4	S	4	S	3	S	4	S
24	4	S	4	S	3	S	4	S
25	4	S	4	S	4	S	4	S
26	4	S	4	S	4	S	3	S
27	3	S	4	S	4	S	3	S
28	4	S	4	S	4	S	3	S
29	4	S	4	S	3	S	3	S
30	4	S	4	S	3	S	4	S
<i>Feasibility</i>								
31	4	S	4	S	4	S	4	S
32	4	S	4	S	3	S	4	S
33	4	S	4	S	4	S	4	S
34	4	S	3	S	3	S	4	S
35	4	S	4	S	3	S	4	S
36	4	S	3	S	3	S	3	S

S = Strong Agreement (Score 3 – 4); W = Weak Agreement (Score 1 – 2)

Pairwise interrater agreement analysis showed perfect consistency among validators. As presented in Table 4, all validator pairs obtained agreement indices of 1.00, categorized as “Very High.” The average agreement index was also 1.00, indicating perfect expert consensus regarding the validity and quality of the ALIVE Counseling Model.

Table 4. Interrater Agreement Results among Expert Validators

Validator Pair	Agreement Index	Category
Validator 1 × Validator 2	1.00	Very High
Validator 1 × Validator 3	1.00	Very High
Validator 1 × Validator 4	1.00	Very High
Validator 2 × Validator 3	1.00	Very High
Validator 2 × Validator 4	1.00	Very High

Validator Pair	Agreement Index	Category
Validator 3 × Validator 4	1.00	Very High
Average Agreement Index	1.00	Very High

The analysis by assessment aspect also demonstrated consistently high agreement levels (see Table 5). The appropriateness aspect, consisting of 12 items, obtained an agreement index of 1.00. This finding indicates that the validators strongly agreed on the conceptual suitability of the ALIVE Counseling Model, including its rationale, objectives, counseling stages, integration of Taluba values, and intervention procedures.

Table 4. Recapitulation of Interrater Agreement by Assessment Aspect

Assessment Aspect	N of Items	Agreement Index	Category
Appropriateness	12	1.00	Very High
Usefulness	5	1.00	Very High
Convenience	13	1.00	Very High
Feasibility	6	1.00	Very High
Overall Average	36	1.00	Very High

The usefulness, convenience, and feasibility aspects achieved agreement indices of 1.00, indicating very high expert consensus regarding the ALIVE Counseling Model's practical benefits, implementation clarity, and operational feasibility for reducing PSI among university students. Overall, the findings demonstrate excellent content validity, cultural relevance, and implementation readiness. Despite perfect quantitative agreement, validators provided qualitative recommendations regarding conceptual clarity, spiritual constructs, procedural elaboration, language simplification, practical examples, visual presentation, and cultural adaptability (see Table 6), which informed subsequent model revisions prior to future experimental implementation.

Table 6. Qualitative Feedback and Revision of the ALIVE Counseling Model

Aspect	Summary of Qualitative Feedback	Summary of Revisions
Indigenous and philosophical framework	Validators recommended a clearer explanation of the indigenous integration framework and philosophical consistency between cognitive, narrative, and spiritual dimensions.	The model was revised by strengthening conceptual clarity, indigenous integration explanations, and operational definitions of spiritual constructs.
Counseling procedures and techniques	Validators suggested clearer operational steps, reflective dialogue procedures, and externalization techniques.	Counseling procedures, techniques, implementation guidelines, and practical intervention steps were elaborated.
Practicality and readability	Feedback emphasized simplifying technical language, improving readability, and adding practical examples, counseling scripts, case illustrations, and flowcharts.	The manual was revised by simplifying language, improving readability, adding practical examples, and enhancing visual presentation and layout.
Cultural adaptability and implementation	Validators highlighted the importance of counselor competency, multicultural adaptation, and flexibility of spiritual components.	Revisions included counselor preparation guidelines, culturally adaptive implementation procedures, and recommendations for future empirical validation studies.

Discussion

PSI among university students is increasingly recognized as an important mental health concern because it is associated with depression, hopelessness, loneliness, psychological distress, and elevated suicide risk. Although suicide prevention research has expanded considerably, most interventions remain focused on active suicidality and crisis-oriented treatment (Haryadi et al., 2025). PSI, defined as generalized wishes for death without explicit suicidal planning, remains comparatively underexplored despite evidence suggesting it may precede more severe suicidal behaviors (Haryadi et al., 2026; Liu et al., 2020; Wastler et al., 2022). Existing interventions, particularly cognitive-behavioral therapy (CBT), have shown strong effectiveness in reducing suicidal ideation and self-harm, primarily by targeting maladaptive cognitions, hopelessness, and dysfunctional thinking patterns (Hu et al., 2024; Jeong et al., 2023; Wu et al., 2022). However, conventional CBT approaches are sometimes criticized for being overly structured and insufficiently responsive to cultural and spiritual contexts, especially within collectivistic societies (Corey, 2024).

Another important consideration is that emerging adulthood represents a developmental period characterized by identity instability, emotional vulnerability, and increasing existential concerns, all of which may intensify susceptibility to passive suicidal ideation. University students frequently encounter academic pressure, interpersonal difficulties, uncertainty regarding future careers, and weakened social connectedness, which may contribute to feelings of burdensomeness and hopelessness (Gull et al., 2026; Reji, 2025). Recent studies have emphasized that culturally responsive and meaning-centered interventions may be particularly effective during this developmental stage because they help emerging adults strengthen self-understanding, emotional resilience, and psychological connectedness within their sociocultural contexts (Arnett, 2015; O'Connor & Kirtley, 2018).

Furthermore, integrating cognitive-behavioral and narrative approaches may provide a more comprehensive therapeutic framework for addressing PSI because cognitive restructuring becomes more meaningful when individuals are encouraged to reinterpret the personal stories shaping their beliefs, emotions, and identities (Rhodes, 2014). Integrative approaches combining cognitive and narrative processes have increasingly been viewed as beneficial for promoting self-reflection, emotional processing, and adaptive meaning reconstruction within psychotherapy settings (Ibrahim & Allen, 2018). In collectivistic cultural contexts, such integration may also enhance therapeutic acceptance by allowing clients to express distress through relational, spiritual, and culturally meaningful narratives rather than focusing solely on dysfunctional cognitions (Abdullah, 2019).

The present study addressed these limitations through the development and expert validation of the ALIVE Counseling Model, integrating cognitive-behavioral counseling, narrative counseling, and Taluba local wisdom values. Narrative counseling contributed processes of storytelling, externalization, and reconstruction of meaning, which are particularly relevant because passive suicidal ideation is often embedded within hopeless self-narratives and existential distress. Previous studies demonstrated that narrative interventions may reduce emotional dysregulation and suicidal behavior by helping individuals construct alternative meanings and future-oriented identities (Mehl-Madrona & Mainguy, 2020; Taghipour et al., 2023). Within the ALIVE Counseling Model, these principles are reflected in the "Assess the problem-saturated stories" and "View alternative meaning" components.

A distinctive contribution of this study lies in the integration of Taluba values (Baiman, Bauntung, Batuah), which emphasize spirituality, meaningful living, and social usefulness within Banjar culture (Noortyani et al., 2023; Sarbaini, 2022; Safitri & Safitri, 2025). Rather than functioning merely as symbolic cultural elements, Taluba values were integrated into therapeutic processes through spiritual reflection, religious coping, and culturally grounded meaning-making. This finding aligns with literature suggesting that adaptive religious coping

and existential meaning systems may function as protective factors against suicidal ideation (Costanza et al., 2020; Goodwill, 2022; Lew et al., 2020). The study also contributes methodologically through the use of the NIH Stage Model, a psychotherapy-specific developmental framework emphasizing systematic intervention refinement before efficacy testing (Onken, 2019). To the best of the researcher's knowledge, this study represents one of the first counseling intervention studies in Indonesia explicitly applying the NIH Stage Model framework.

The findings demonstrated very high interrater agreement, with all validator pairs achieving agreement indices of 1.00 regarding the model's appropriateness, usefulness, convenience, and feasibility. Validators also provided recommendations concerning conceptual clarity, spiritual operationalization, procedural elaboration, language simplification, and multicultural adaptation, which informed subsequent revisions. Despite these contributions, the study remains limited to intervention development and expert validation within NIH Stage 1A and therefore cannot yet establish empirical effectiveness. Additionally, the Taluba framework may require adaptation before implementation within culturally diverse populations.

Implications

The findings carry important implications for counseling practice, suicide prevention, counselor education, and culturally responsive psychotherapy development. The ALIVE Counseling Model demonstrates that interventions for passive suicidal ideation may benefit from integrating cognitive-behavioral, narrative, spiritual, and indigenous cultural dimensions. The integration of Taluba values highlights how local wisdom can support meaning-making, emotional regulation, and spiritual resilience. The model also emphasizes preventive intervention before escalation into active suicidality and highlights the importance of counselor competencies in reflective dialogue, narrative exploration, multicultural counseling, and spiritually integrated practices within university counseling contexts.

Methodologically, this study contributes to Indonesian counseling research through the application of the NIH Stage Model—the first use reported in Indonesia, a psychotherapy-specific developmental framework emphasizing systematic intervention refinement before efficacy testing. Beyond Indonesian contexts, the findings contribute to broader discussions regarding culturally adaptive psychotherapy and the integration of non-Western cultural perspectives into evidence-informed counseling interventions.

Limitations and future directions

Several limitations should be considered when interpreting the findings of this study. The study was conducted within NIH Stage 1A and focused on intervention development, expert validation, and prototype refinement rather than empirical effectiveness testing. Thus, the findings provide preliminary evidence of conceptual and procedural validity rather than clinical efficacy. Although Taluba values strengthen cultural relevance within the Banjar context, their applicability across diverse cultural backgrounds remains uncertain and may require adaptation.

The validation process involved only four expert validators, although they represented diverse counseling expertise. Future studies should involve broader multidisciplinary panels and proceed to subsequent NIH stages through pilot implementation, feasibility testing, experimental evaluation, and longitudinal research (stages 1B – 5). Further investigation is also needed regarding therapeutic mechanisms such as religious coping, narrative reconstruction, emotional regulation, and therapeutic alliance. Additionally, digital adaptation of the ALIVE Counseling Model may increase accessibility and relevance within contemporary university mental health services.

Conclusion

Passive suicidal ideation among university students remains insufficiently addressed through culturally responsive counseling interventions. This study addressed this gap by developing and validating the ALIVE Counseling Model, integrating cognitive-behavioral counseling, narrative counseling, and Taluba values. The findings demonstrated very high interrater agreement regarding the model's appropriateness, usefulness, convenience, and feasibility. The model emphasizes cognitive restructuring, narrative reconstruction, spiritual reflection, and cultural meaning-making, suggesting that suicidal vulnerability in emerging adulthood is closely related to hopelessness, disrupted meaning systems, and weakened social-spiritual connectedness, while providing a foundation for future empirical implementation and culturally responsive psychotherapy development.

Acknowledgements

We would like to thank our fellow authors and institutions for their moral and intellectual support throughout the writing process. Especially to the Indonesian Education Scholarship (BPI), the Center for Higher Education Funding and Assessment (PPAPT), and the Indonesian Endowment Fund for Education (LPDP), for the financial support (funding ID: 202327092430). This financial support has played an important role in enabling the writing of this article to be carried out from the initial stages to the analysis.

Author Contribution Statement

RH conceived and designed the study, developed the ALIVE Counseling Model, collected and analyzed the data, interpreted the findings, and drafted the manuscript. MR contributed to the conceptual framework, research supervision, methodological refinement, and critical revision of the manuscript. NH contributed to the development of the counseling model, manuscript review, and research supervision. MM contributed to research supervision. HSLA contributed to the final manuscript evaluation. All authors reviewed and approved the final version of the manuscript.

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