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CULTURALLY-SENSITIVE NURSING INTERVENTION USING ISLAMIC CBT FOR AUDITORY HALLUCINATIONS IN A FINAL-YEAR UNIVERSITY STUDENT: A CASE REPORT

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ABSTRAK

Laporan kasus eksploratif ini menelaah feasibility (kelayakan penerapan) Islamic Cognitive Behavioral Therapy (ICBT) sebagai intervensi keperawatan berbasis budaya untuk seorang mahasiswa Muslim yang mengalami halusinasi auditorik. Seorang laki-laki berusia 22 tahun dengan diagnosis skizofrenia menjalani enam sesi terstruktur ICBT yang difasilitasi oleh perawat jiwa bersertifikat, bersamaan dengan pengobatan farmakologis standar (risperidone dan olanzapine). Intervensi mengintegrasikan tawakkul (percaya kepada Allah), dzikir (mengingat Allah), serta refleksi Al-Qur'an dalam kerangka CBT. Penilaian menggunakan PSYRATS-AH, Dysfunctional Attitude Scale, WHOQOL-BREF, dan Spiritual Well-Being Scale, dilengkapi pemantauan rutinitas harian dan jurnal reflektif. Setelah intervensi, pasien menunjukkan perbaikan yang tampak secara klinis: berkurangnya distres akibat halusinasi, menurunnya keyakinan disfungsional, meningkatnya refleksi diri, serta kembalinya keterlibatan dalam ibadah, interaksi sosial, dan perencanaan akademik. Namun, perubahan ini tidak dapat semata-mata dikaitkan dengan ICBT, mengingat adanya terapi antipsikotik bersamaan dan durasi intervensi yang singkat. Laporan ini menegaskan potensi ICBT sebagai pendekatan keperawatan berbasis budaya yang dapat meningkatkan keterlibatan terapeutik dan reframing spiritual pada pasien Muslim. Penelitian lebih lanjut dengan desain terkontrol diperlukan untuk menilai efektivitas, menjaga kesetiaan intervensi, serta memperjelas batas kompetensi praktik keperawatan dalam pemberian terapi berbasis CBT.

Kata Kunci : *Terapi Perilaku Kognitif Islami, Keperawatan sensitif budaya, Halusinasi pendengaran, Kesehatan jiwa Muslim.*

ABSTRACT

This exploratory case report examines the feasibility of Islamic Cognitive Behavioral Therapy (ICBT) as a culturally sensitive adjunctive nursing intervention for a Muslim university student experiencing auditory hallucinations. A 22-year-old male diagnosed with schizophrenia received six structured ICBT sessions facilitated by a licensed psychiatric nurse, alongside standard pharmacological treatment (risperidone and olanzapine). The intervention incorporated tawakkul (trust in God), dhikr (remembrance), and Qur'anic reflections within a CBT framework. Assessments included the PSYRATS-AH, Dysfunctional Attitude Scale, WHOQOL-BREF, and Spiritual Well-Being Scale, complemented by daily routine tracking and reflective journaling. Post-intervention, the patient demonstrated clinically observable improvements: reduced distress from hallucinations, fewer dysfunctional beliefs, increased self-reflection, and renewed engagement in prayer, social interaction, and academic planning. However, these changes cannot be attributed to ICBT alone, given the concurrent antipsychotic treatment and short intervention period. This report highlights ICBT's potential as a culturally grounded, nurse-facilitated approach that may enhance therapeutic engagement and spiritual reframing among Muslim patients. Further controlled studies are needed to evaluate its efficacy, ensure fidelity, and clarify the scope of nursing practice in delivering CBT-based interventions.

Keywords: Islamic Cognitive Behavioral Therapy, Culturally-sensitive nursing, Auditory hallucinations, Muslim mental health

A. INTRODUCTION

Hallucinations are core symptoms of psychiatric disorders, particularly schizophrenia, and are strongly associated with psychological distress, impaired functioning, and reduced quality of life (Chi et al., 2007; Kennedy & Xyrichis, 2017). Among these, auditory hallucinations are highly disruptive, often interfering with patients' emotional regulation, social participation, and academic performance. In clinical nursing practice, hallucinations represent a key focus of care due to their impact on safety, engagement, and recovery.

Management of hallucinations typically requires a combination of pharmacological and psychosocial interventions. Islamic Cognitive Behavioral Therapy (ICBT) has emerged as a culturally sensitive adaptation of conventional Cognitive Behavioral Therapy (CBT), embedding Islamic values, principles, and practices within the therapeutic framework (Cucchi, 2022; Munawar et al., 2025). ICBT seeks not only to modify dysfunctional thoughts and behaviors but also to strengthen the patient's spiritual framework—incorporating elements such as *'aql* (intellect), *qalb* (heart), *ruh* (spirit), and *nafs* (self)—in order to address psychotic experiences such as hallucinations (Husain & Hodge, 2016; Thomas & Ashraf, 2011a).

Evidence suggests that culturally adapted CBT (CaCBT) enhances therapeutic engagement and outcomes among ethnically diverse populations. Rathod et al. (2013) found CaCBT reduced psychotic symptoms in South Asian Muslim patients, while Subhas et al. (2021) reported improved engagement with Islamic-value-based CBT in Malaysia. Similarly, Sabry and Vohra (2013) emphasized that embedding Islamic values—including *ṣabr* (patience), *qadar* (belief in divine destiny), *ṣalāh* (prayer), *dhikr* (remembrance), and *du'ā* (supplication)—enhanced the acceptability and perceived relevance of psychotherapy.

Final-year university students represent a subgroup particularly vulnerable to psychological distress, with academic deadlines, thesis demands, and career uncertainty contributing to heightened risk of psychosis-like experiences (Barboza & Soares, 2012; Estrada Araoz, 2024). When effective coping strategies are absent, spiritual and psychological strain can exacerbate vulnerability (Anjum et al., 2021; Cheshure & Van Lith, 2024). In such contexts, ICBT may offer a valuable intervention, as it integrates spiritual meaning-making with evidence-based cognitive-behavioral methods (Fitriyana & Sarita Candra Merida, 2023; Husain & Hodge, 2016; Munawar et al., 2025; Thomas & Ashraf, 2011b). Compared to *murotal* therapy, which primarily provides comfort and spiritual support through passive listening Qur'anic recitation, ICBT engages patients more actively in cognitive restructuring, behavioral activation, and adaptive coping, (Rosmiarti et al., 2020; Sri Wahyuningsih et al., 2023; Yuniarti et al., 2019) though it requires trained facilitators and structured delivery.

From a nursing perspective, the application of ICBT presents a promising avenue for delivering culturally-sensitive and spiritually-integrated care. Nurses, as the frontline healthcare providers with frequent patient contact, play a strategic role in educating, guiding, and evaluating patients through cognitive-spiritual therapeutic interventions. However, despite its potential, the implementation of ICBT in psychiatric nursing remains limited across many mental health facilities. Training opportunities for nurses in delivering ICBT are still scarce, and institutional support for culturally relevant psychosocial therapies is often lacking (Kennedy & Xyrichis, 2017). This poses a critical challenge in actualizing patient-centered care that respects individual values, beliefs, and cultural backgrounds (Buccheri et al., 2013; England, 2006, 2007).

This case report presents the application of ICBT as a culturally grounded nursing intervention for managing persistent auditory hallucinations in an adult Muslim patient within a psychiatric

inpatient setting in Indonesia. The patient exhibited limited coping abilities and distress associated with hallucinations, highlighting the need for integrative approaches that address both psychological and spiritual dimensions. Despite the growing recognition of culturally adapted psychotherapeutic models like ICBT, their formal integration into routine psychiatric nursing care remains limited in many healthcare environments. This report underscores the role of mental health nurses in implementing spiritually sensitive cognitive-behavioral strategies, especially in settings where religious values significantly shape health perceptions and coping mechanisms. The findings aim to enrich the body of evidence supporting the incorporation of ICBT into clinical nursing practice, emphasizing its potential to enhance therapeutic outcomes, patient engagement, and culturally congruent care in mental health services.

B. MATERIAL AND METHODS

This report employed a single-case exploratory design, framed explicitly as a pilot feasibility case study rather than an evaluation of clinical efficacy. A mixed-methods approach was used, combining quantitative symptom monitoring with qualitative data from interviews, reflective journals, and nursing field notes. Quantitative measures provided descriptive indications of change, while qualitative data captured the patient's lived experience and the nursing process. Given the compressed timeline (seven days, six sessions) and single-case focus, findings are not generalizable but serve to explore feasibility and cultural relevance of Islamic cognitive behavioral therapy (ICBT) (see Table 1).

Table 1. the ICBT intervention mechanism

Stage	Core Component	ICBT Techniques Used	Measurement tool with adapted and revised to Islamic treatment	
			Quantitative Tools	**Qualitative Tools**
1.Assessment & Case Formulation	Identify negative thoughts, religious beliefs, and hallucination meaning	*Structured interview, psychoeducation, religious-based functional analysis*	PSYRATS-AH, DAS	CBT-1 Form: Hallucination & Irrational Belief Assessment
2.Islamic Cognitive Restructuring	Replace irrational thoughts with Islamic rational beliefs	*Cognitive Restructuring, Qur'anic Reflection, Script Replacement*	ATQ, BCIS	ICBT-2 Form: Negative Thoughts & Qur'anic Journal
3. Spiritual-Based Behavioral Activation	Rebuild routine and meaningful Islamic-based activities	*Behavioral Activation, Worship-Integrated Scheduling*	Brief RCOPE (Islamic version)	ICBT-3 Form: Daily Activities & Worship Log
4. Religious Coping & Emotional Management	Strengthen religious coping and emotional control	*Dhikr, spiritual journaling, coping skills*	Brief RCOPE (Islamic version)	ICBT-4 Form: Religious Coping &

				Dhikr Relaxation
5. Role of Psychiatric Nurse	Facilitate, monitor, educate patient & family	*Psychoeducation, Guided Discovery, Family Involvement*	Therapeutic Alliance Scale, Adherence Scale	ICBT-5 Form: Nurse Role & Therapeutic Alliance Notes
6. Termination and Evaluation	Assess psychosocial-spiritual function and meaning-making	*Qur'anic Meaning-Making, Spiritual Reflection*	WHOQOL-BREF, SWBS	ICBT-6 Form: Life Quality & Spiritual Reflection

Note: PSYRATS-AH (*Psychotic Symptom Rating Scales – Auditory Hallucinations*); DAS (*Dysfunctional Attitude Scale*); ATQ (*Automatic Thoughts Questionnaire*); BCIS (*Beck Cognitive Insight Scale*); WHOQOL-BREF (*World Health Organization Quality of Life – BREF*); SWBS (*Spiritual Well-being Scale*)
Source: Adaptation of ICBT from (Aldahadha & Al Dwakat, 2025; Husain & Hodge, 2016; Munawar et al., 2025; Qasqas, 2024).

Setting and Participants

The intervention was conducted in the psychiatric ward of Dr. Saiful Anwar General Hospital, Malang, Indonesia, a tertiary facility specializing in acute and sub-acute psychiatric care. At the time of study, seven inpatients carried a schizophrenia diagnosis (ICD-10 F20–F29). However, only one patient met inclusion criteria: (a) inpatient status with a primary nursing diagnosis of auditory hallucinations, (b) Muslim final-year university student, (c) able to communicate and cognitively engage in therapy, (d) willing to participate in spiritual-based intervention, and (e) not in an acute psychotic or aggressive state. Exclusion criteria included severe cognitive deficits or inability to attend sessions.
The selected participant was a 22-year-old male with ICD-10 diagnosis F20.0 (paranoid schizophrenia) in a sub-acute stabilization phase, presenting with persistent auditory hallucinations but no visual hallucinations. This case was chosen purposively as it fulfilled criteria most relevant to the study's focus on integrating spiritual and cognitive nursing care.

Intervention Procedure

The program was conducted over seven consecutive days (July 15–21, 2025) with three phases:

1. Days 1–2 (Preparation & Baseline): informed consent, structured clinical interview, and baseline assessments.
2. Days 3–6 (Intervention): six structured ICBT sessions (30–45 minutes each; two shorter sessions on Days 4–5). Sessions targeted psychoeducation, cognitive restructuring, behavioral activation, Qur'anic reflection (*tadabbur*), *dhikr* (remembrance), and *du'ā* (supplication). Sessions were co-facilitated by a psychiatric nurse with formal ICBT training and supervised by a senior psychiatric nursing specialist.
3. Day 7 (Termination & Post-assessment): final evaluation, reflective discussion, and feedback.

This intensive short-term protocol was a pragmatic adaptation due to inpatient length-of-stay constraints and should be interpreted as exploratory.

Pharmacological Context

At admission, the patient was prescribed risperidone (2 × 1 mg/day) and olanzapine (10 mg/day). These medications were continued throughout the admission, without dose changes or cross-tapering. ICBT was introduced as an adjunctive intervention rather than a replacement for pharmacological therapy. Because antipsychotic treatment likely contributed substantially to improvement, disentangling medication effects from psychotherapy effects is not possible. This is acknowledged as a major limitation.

Cultural Adaptation of ICBT

The ICBT protocol preserved the active mechanisms of CBT—cognitive restructuring, behavioral activation, and coping skills training—while embedding Islamic elements to enhance cultural resonance.

1. *Cognitive restructuring* followed standard steps (identifying irrational beliefs, guided discovery, reframing) but anchored new cognitions in Qur'anic reflections (e.g., QS Al-Baqarah: 286) to promote meaning-making.
2. *Behavioral activation* applied activity scheduling but emphasized daily prayers, Qur'an recitation, and acts of kindness as spiritually meaningful tasks.
3. *Coping skills* (e.g., relaxation and breathing) were reinforced with rhythmic *dhikr*. Islamic content thus *contextualized* rather than replaced CBT mechanisms, maintaining fidelity while increasing cultural acceptability.

Instruments

Quantitative monitoring used the following tools included:

1. Psychotic Symptom Rating Scales – Auditory Hallucinations (PSYRATS-AH): severity and distress of hallucinations.
2. Dysfunctional Attitude Scale (DAS): maladaptive cognitive beliefs.
3. WHOQOL-BREF: quality of life domains.
4. Spiritual Well-Being Scale (SWBS): spiritual health and connectedness.
5. Brief RCOPE (Islamic version): religious coping strategies. This tool was adapted from the original Brief RCOPE with culturally relevant Islamic items. While previously used in Indonesian Muslim populations, full psychometric validation remains limited; this is acknowledged as a methodological limitation.

For pragmatic reasons, abbreviated bedside forms were used, which had not undergone full psychometric validation in Indonesian Muslim populations. Accordingly, pre- and post-scores are presented descriptively as clinical tracking data, not standardized outcomes. The main weight of interpretation relies on qualitative findings.

Qualitative data were gathered through semi-structured interviews, daily reflective journals, and nursing field notes. Thematic analysis identified cognitive, emotional, and spiritual themes, triangulated with quantitative data to enhance credibility.

Ethical Considerations

This study adhered to international ethical standards for research involving human participants and complied with the principles outlined in the Declaration of Helsinki. Ethical approval was obtained from the Health Research Ethics Committee, Universitas Muhammadiyah Malang (Approval No. E.4.d/143/KEPK/FIKES-UMM/IX/2025) and was acknowledged by the Psychiatry Department of Dr. Saiful Anwar General Hospital, Malang. Informed consent was obtained in writing from the patient and his legal guardian after a full explanation of the study's objectives, procedures, potential risks, and benefits. Explicit

permission was also granted for the publication of this case report, including the use of anonymized clinical data, assessment results, and selected patient quotations. All personal identifiers have been removed, and potentially sensitive family psychiatric history has been blurred to safeguard confidentiality.

To minimize researcher bias, the intervention was not conducted solely by the co-author. Instead, the sessions were facilitated by general nurses under the direct supervision and guidance of a licensed psychiatric nurse with formal certification in Cognitive Behavioral Therapy and Islamic Cognitive Behavioral Therapy (ICBT) (author: M. Ari Arfianto, S.Kep., Ns., M.Kep., S.Kep.J). Mr. Arfianto provided structured supervision, reviewed session content, and ensured fidelity to the ICBT framework, while documentation was cross-checked by other members of the research team not involved in therapy delivery.

The ICBT intervention was implemented as a complementary, short-term nursing approach within the approved scope of nursing practice. It was conducted under the oversight of the hospital's psychiatric team and did not replace pharmacological management or specialist-led psychotherapy. The feasibility and ethical soundness of nurse-led ICBT were ensured through structured training, ongoing supervision, and clinical oversight.

C. CASE REPORT

Medical History and Background

Mr. F is a 22-year-old single Muslim male and Final-year university students at a public university in East Java. He was referred by a psychiatrist and admitted to a psychiatric inpatient unit on July 15, 2025, with a diagnosis of acute psychosis, presenting with persistent auditory and visual hallucinations. He reported hearing threatening whispers and seeing shadowy figures, which were often accompanied by irritability, emotional withdrawal, and disorganized speech. According to his mother, he had become increasingly agitated, frequently talking back to unseen entities and displaying paranoid behavior. These symptoms emerged acutely on July 14, 2025, while he was alone in his rented room, shortly after experiencing intense pressure from academic obligations, particularly the completion of his undergraduate thesis. Although early signs—such as social withdrawal, poor sleep, and low mood—had previously been managed through spiritual practices and positive thinking, his coping strategies gradually failed as the condition worsened. At the time of admission, the patient was prescribed oral risperidone (2 × 1 mg/day) and olanzapine (10 mg/day), with no changes in dosage, cross-tapering, or reported side effects during the study period. While these antipsychotics likely played a central role in symptom stabilization, clinical response remained incomplete, particularly regarding persistent auditory hallucinations and limited insight. Therefore, adjunctive Islamic Cognitive Behavioral Therapy (ICBT) was introduced as a complementary nursing intervention to support coping, meaning-making, and engagement with treatment.

A psychosocial assessment revealed relevant stressors across psychological, social, spiritual, and familial domains. Psychologically, Mr. F disclosed long-standing feelings of social exclusion and emotional trauma, stemming from bullying and interpersonal conflict during his final year of high school. Socially, he had been living alone in Malang for four years, having moved away from his family, who resides in Aceh. He reported feeling isolated and unsupported, particularly during periods of academic pressure. Spiritually, he interpreted the hallucinated voices as divine messages or spiritual tests, contributing to his internal conflict and confusion about the nature of his experiences. The patient is the second of four siblings, raised in a democratic and affectionate family environment. However, the physical distance from his parents and infrequent contact over recent years were perceived as contributing factors to his current psychological vulnerability. A maternal family history of psychosis was noted, with

both his grandfather and maternal aunt previously diagnosed with similar hallucinatory symptoms and treated by psychiatric services.

Table 2. ICBT process chart for Mr. F

Day of Intervention	Application/ Stage	Follow up/Assessment
Day 1	*Initial assessment & building therapeutic rapport* Mr. F was welcomed into the ward with warmth and respect. The therapist and nurse established rapport through empathic listening, avoiding any stigmatizing language. Together with his mother, who traveled from Aceh to support him, they explored his experiences of hearing voices and seeing shadowy figures. Spiritual beliefs were integrated, allowing Mr. F to safely express that he perceived the voices as divine tests or possible spiritual disturbances. A structured clinical-spiritual interview was conducted using Form ICBT-1.	Mr. F reported relief after being understood without judgment. He identified his most distressing hallucinations and the times they typically appeared. He shared that he had been feeling abandoned by friends and "*punished by God.*" Assessment revealed significant dysfunctional thoughts and religious misinterpretations.
Day 2	*Islamic cognitive restructuring* The therapist facilitated a safe space for Mr. F to explore his recurring belief that his hallucinations were divine punishment. He disclosed frequent urges to escape the hospital after hearing threatening voices that said he deserved to suffer. He often heard	Mr. F began writing down his automatic thoughts and labeling them as *"bisikan yang melemahkan iman"* (whispers that weaken faith). He reflected: *"Mungkin ini ujian, bukan hukuman"* ("Maybe this is a test, not a punishment"). Form ICBT-2 indicated early improvement in cognitive insight. He showed reduced guilt-based interpretations of his hallucinations and began

	voices mocking and bullying him, reinforcing his conviction: "*Saya pantas menderita karena ini hukuman dari Allah*" ("I deserve this suffering because it's a punishment from Allah"). Using Islamic Cognitive Restructuring techniques, the therapist gently challenged this belief by introducing Qur'anic verses that emphasize divine mercy and human dignity, such as *QS Al-Baqarah: 286* ("Allah does not burden a soul beyond that it can bear") and *QS Az-Zumar: 53* ("Do not despair of the mercy of Allah"). Mr. F's mother was present during the session and emotionally reminded him of his strengths as a student and how he once supported his family through hardship. Together, they worked on reframing his thoughts using reflective journaling and Qur'anic contemplation.	identifying internal spiritual resources to cope. He was more open to continue therapy without expressing a desire to run away.
Days 2–6	*Spiritual behavioral activation* The nurse-facilitator worked collaboratively with Mr. F and his mother to design a personalized daily routine integrating	Mr. F performed morning prayer (*sholat subuh*) for the first time in weeks and began initiating group interactions. He stated, *"Membantu orang lain bikin saya lupa suara-suara itu"* ("Helping

	Islamic values and meaningful structure. The routine included regular prayer (*sholat*), short Qur'anic recitations, hygiene self-care, and light physical activities to encourage self-discipline and positive engagement. To nurture social interaction and purpose, Mr. F was gently encouraged to perform small acts of kindness—such as assisting another patient in preparing for prayer—framed as *"amal jariyah"* (ongoing charity). These behaviors were introduced as spiritually rewarding and psychologically grounding, helping to reduce passivity, loneliness, and spiritual disconnection.	others helps me forget the voices"). He was also observed taking greater care in his appearance and showed increased willingness to follow daily routines. Form ICBT-3 indicated improved engagement in meaningful spiritual-behavioral activities and reduced social withdrawal. His mother noted, "He seems lighter, more present." Behavioral activation became a bridge between faith, function, and recovery.
Days 4–6	*Religious coping and emotional regulation* The nurse introduced Mr. F to simple *dzikir* (remembrance of Allah) as a grounding technique during emotional distress. Breathing exercises were synchronized with Qur'anic affirmations, designed to anchor Mr. F in the present and help him regulate overwhelming emotions. His mother joined the session and lovingly modeled the practice, creating a	During an episode of auditory hallucinations, Mr. F consciously applied the breathing-*dzikir* techniques. He reported feeling *"lebih tenang dan tidak langsung panik"* (calmer and not immediately panicke). He began to reinterpret the voices not as divine punishment, but as trials meant to be met with spiritual endurance. He wrote in his journal: "*Saya mencoba tenang, ini mungkin ujian untuk memperkuat hati saya"* ("I tried to

	supportive spiritual environment. Mr. F was also guided to keep a spiritual journal, where he recorded his hallucinations, emotional reactions, and the spiritual strategies he used to cope. The therapeutic focus was to help Mr. F accept emotional pain as part of the human experience while embracing faith as a source of peace and resilience. He was taught to breathe slowly while reciting phrases like "*Allah*" (4 seconds), "*La hawla wa la quwwata illa billah*" (7 seconds), and "*Hasbunallahu wa ni'mal wakeel*" (8 seconds), in a rhythmic and mindful manner.	stay calm, maybe this is a test to strengthen my heart"). Form ICBT-4 showed significant progress in emotional regulation and adaptive use of religious coping, with a decrease in avoidance and fear-based reactions.
Day 5	*Family and nurse-facilitated psychoeducation* A reflective dialogue was conducted with Mr. F and his mother on Islamic views of mental illness, reframing illness as *rahmah* (mercy), *ṣabr* (patience), and *shifā'* (healing). Guided discovery questions were used (e.g., *"What have you learned about patience through this experience?"*). A culturally adapted logbook was provided to reinforce lessons.	Mr. F expressed gratitude for his mother's role: *"Allah masih kasih saya kesempatan untuk sembuh lewat ibu saya dan perawat yang sabar"* ("Allah still gives me a chance to heal through my mother and this patient nurse"). ICBT-5 reflected stronger therapeutic alliance and adherence. His mother also gained confidence in providing supportive care.

Day 6	*Reflection on spiritual meaning and life purpose* In the final ICBT session, the nurse facilitated a reflective dialogue with Mr. F and his mother, focusing on his therapeutic journey, spiritual transformation, and future hopes. They explored the concept of *"hikmah"*—the divine wisdom behind suffering—and reframed his experience not as punishment, but as an opportunity for inner growth and reconnection with Allah. Mr. F was encouraged to express his reflections through personal prayer writing and to set small, meaningful goals, such as gradually returning to campus and continuing his thesis work. The session concluded with shared *du'ā* and words of affirmation from his mother and therapist.	Mr. F expressed, *"Maybe I had to go through this to become closer to Allah,"* indicating a shift in spiritual narrative from guilt to growth. He shared a self-written prayer asking for *sabr* (patience) and *istiqomah* (steadfastness). He showed renewed motivation to resume academic responsibilities, including completing his thesis, and actively participated in discharge planning. Form ICBT-6 (WHOQOL-BREF & Spiritual Well-Being Scale) revealed enhanced spiritual insight, psychological resilience, and quality of life. Mr. F was discharged with strong family support and an outpatient follow-up plan, with the nurse reinforcing relapse prevention strategies rooted in faith and self-awareness.

Source: Author own work

Table 3. Patient's assessment scale scores

	Assessment Tools	Indicator / Format	Pre-Score	Post-Score
1	**PSYRATS–Auditory Hallucinations (PSYRATS–AH)**	Standard 11-item scale (here adapted into 8 key items, 0–4 scale) measuring frequency, duration, loudness, and distress of hallucinations.	26	12
2	**Dysfunctional Attitudes Scale (DAS)**	Standard long form (40 items); in this case, an **abbreviated 8-item tracking version (0–3 scale)** was used to monitor irrational beliefs.	20	8
3	**Automatic Thoughts Questionnaire (ATQ)**	Original 30-item ATQ; in this case, a **2-statement ad hoc version (0–10 scale)** was used to track frequency and believability of core negative thoughts.	8.5	3.0
4	**Beck Cognitive Insight Scale (BCIS)**	Original 15-item BCIS; in this case, a **2-statement clinical adaptation (0–10 scale)** was	3.5	7.5

		used to track self-reflection and certainty.		
5	**WHOQOL–BREF**	Original 26-item WHOQOL-BREF; here, an **8-item spiritual-emotional subset (0–3 scale)** was used for routine clinical monitoring.	1.2	2.6
6	**Spiritual Well-Being Scale (SWBS)**	Original 20-item SWBS; in this case, an **8-item adaptation (1–5 scale)** focused on peace, meaning, and connectedness.	2.1	4.3

Note: *a. The abbreviated forms used in this study were developed as clinical tracking tools for this case, not standardized substitutes for the full scales; b. They were translated and culturally adapted into Indonesian with integration of Islamic-religious context (e.g., wording adapted to align with Qur'anic concepts of peace, patience, and meaning); c. No formal psychometric testing (e.g., Cronbach's a, construct validity) was conducted for these short versions. Therefore, results should be interpreted as indicative of individual progress, not comparable to standardized population norms; d. The full validated versions of PSYRATS–AH, DAS, ATQ, BCIS, WHOQOL-BREF, and SWBS remain the gold standard; the shortened forms here served as ad hoc adjuncts for clinical feasibility in a busy inpatient ward.*

Source: Author own work

Therapy process

Mr. F, a final-year university student experiencing distressing auditory hallucinations with strong religious themes, engaged in a six-day ICBT program tailored to his cultural and spiritual context. The therapy was co-facilitated by a psychiatric nurse, Mr. Ari Arfianto, S.Kep., Ns., M.Kep., S.Kep.J, who holds a nationally recognized license in psychiatric nursing (STR Sp1 No.0041/Sp-FIK/2/2016). His role as co-facilitator is reported transparently, and he is included as a co-author in this article to reflect his contribution. All sessions were conducted under a supervision protocol, with oversight from a senior psychiatric nursing specialist experienced in CBT and transcultural therapy, ensuring that the intervention adhered to both ethical and competence standards.

The process began with building a therapeutic alliance grounded in empathy and cultural sensitivity (see Table 2). In initial sessions, Mr. F disclosed hearing threatening voices that he interpreted as divine punishment, which triggered overwhelming guilt and repeated urges to flee the ward. This theme of "divine retribution" became a critical therapeutic target. Using Islamic cognitive restructuring, the therapist collaboratively challenged Mr. F's beliefs with compassionate reframing and Qur'anic verses (e.g., QS Al-Baqarah: 286). This approach followed the ICBT framework of cognitive restructuring through culturally congruent rational beliefs, helping Mr. F shift from fatalistic interpretations toward spiritual growth.

Mr. F began journaling his intrusive thoughts, labeling them as "*whispers that weaken faith*," and reframed his suffering as a divine test, not a curse. This reframing coincided with a clinically meaningful reduction in dysfunctional beliefs, as tracked by the ad hoc abbreviated DAS (from 20 to 8; see Table 3).

To reinforce this cognitive shift, spiritual behavioral activation was introduced. Mr. F co-designed a daily structure with the nurse and his mother, integrating prayers, Qur'anic recitation, personal hygiene, and acts of kindness—each framed as worship and healing. His active participation in helping others appeared to mitigate social withdrawal and hallucination salience, expressed in his words: "*Helping others helps me forget the voices.*" This period was marked by a clinically observed reduction in PSYRATS-AH scores (from 26 to 12), suggesting decreased frequency and distress of hallucinations.

Religious coping and emotional regulation were emphasized through dzikir and breathing exercises. Mr. F practiced synchronized breathing with spiritual phrases (e.g., *La hawla wa la quwwata illa billah*), which he successfully applied during a hallucination episode. He later journaled: "*Maybe this is a test to strengthen my heart.*" This self-awareness was supported by improvements in ATQ (from 8.5 to 3.0) and BCIS (from 3.5 to 7.5), indicating enhanced insight and reduced automatic negative thinking.

Midway, a psychoeducational session was conducted with Mr. F and his mother. Islamic perspectives on mental illness were discussed, emphasizing rahmah (divine mercy) and shifa (healing). The mother was guided to provide supportive responses without reinforcing hallucinations. Mr. F reflected positively: "*Allah still gives me a chance to heal through my mother and this patient nurse.*" This reinforced therapeutic alliance and family engagement, tracked with Form ICBT-5.

The final session focused on meaning-making and life purpose. Mr. F reflected on his journey and wrote a personal *du'a* asking for patience and strength, reframing his experience as growth: "*Maybe I had to go through this to become closer to Allah.*" Quantitatively, his WHOQOL-BREF score increased from 1.2 to 2.6, and SWBS from 2.1 to 4.3. However, these scales were used in abbreviated, ad hoc forms and administered in a timeframe shorter than the original two-week reference period recommended by WHO. Thus, the results should be interpreted as clinical indicators of progress, not standardized outcomes.

Across six days, Mr. F demonstrated clinically meaningful and spiritually relevant improvement, reflected in both structured assessments and narrative transformation. His hallucinations became less distressing, his belief system more adaptive, and his spiritual functioning re-engaged. At discharge, he expressed readiness to resume academic pursuits, framing his recovery journey as both therapeutic and spiritual awakening.

D. DISCUSSION

This case report presents a culturally-adapted nursing intervention using ICBT for managing auditory hallucinations in a Muslim university student. The intervention incorporated Islamic principles into the core framework of CBT, aligned with the patient's values, spiritual worldview, and social context. The case illustrates how religiously-sensitive therapy can enhance engagement, insight, and emotional regulation, contributing to improved clinical outcomes and patient recovery.

Effectiveness of culturally-adapted CBT for auditory hallucinations

Auditory hallucinations are complex phenomena often intertwined with individual belief systems, especially in religious populations. Standard CBT has demonstrated efficacy in reducing distress associated with voice-hearing by addressing dysfunctional appraisals and promoting adaptive coping (England, 2006; Zanello et al., 2023). However, cultural and religious adaptations can further enhance therapeutic relevance. As highlighted in a recent review, psychological interventions in low- and middle-income countries are more effective when tailored to the patient's spiritual and linguistic background (Sivaji et al., 2025).

In this case, the application of ICBT provided a spiritually congruent framework that allowed Mr. F to reframe his hallucinations not as divine punishment, but as a spiritual trial—a belief that was both theologically grounded and psychologically adaptive. This aligns with findings from Sivaji et al. (2025), who emphasize that cultural congruence reduces attrition and enhances therapeutic alliance in psychiatric care. Quantitatively, Mr. F showed significant improvements in hallucination severity (PSYRATS-AH), dysfunctional beliefs (DAS), and quality of life (WHOQOL-BREF, SWBS), supporting prior evidence that CBT can reduce auditory hallucination distress (England, 2007; McLeod et al., 2007). The religious integration appeared to increase Mr. F's commitment to therapy and deepen emotional reflection.

Role of Nurses in Delivering ICBT

The therapeutic process in this case underscores the unique role of psychiatric nurses as both caregivers and culturally sensitive therapists. Nurses are often the most consistent point of contact for patients, placing them in a strong position to deliver brief psychotherapeutic interventions. In alignment with McCluskey et al. (2024), this case shows that nurses, when trained appropriately, can successfully integrate CBT techniques with culturally sensitive care (McCluskey et al., 2024). Using the ICBT approach, the nurse guided Mr. F through cognitive restructuring, emotional regulation, and behavioral activation, all framed within Islamic teachings. For example, the replacement of negative automatic thoughts with dzikir-based affirmations allowed Mr. F to regulate his emotional arousal and feel spiritually supported. The collaborative involvement of his mother further aligns with literature stressing the value of family-inclusive care in collectivist cultures (Kotowski, 2012; Sivaji et al., 2025).

However, the implementation of ICBT requires more than basic training. According to Munawar et al. (2025), culturally tailored CBT demands not only psychological competence but also theological sensitivity. In the Indonesian context, this is particularly relevant. While general nurses may receive some exposure to basic therapeutic communication and psychosocial care,

the delivery of structured psychotherapeutic interventions such as CBT—including its culturally adapted forms like ICBT—falls under the scope of psychiatric nursing specialists (*perawat spesialis keperawatan jiwa*). These specialists undergo advanced clinical education and are formally trained in psychotherapeutic modalities. Therefore, to ensure ethical and effective practice, the administration of ICBT should ideally be carried out by or under the supervision of psychiatric nurse specialists who possess both the clinical and cultural competencies required. This presents a practical challenge in healthcare settings where access to such specialized professionals may be limited, thus highlighting the need for systemic capacity building in mental health nursing education and practice in Indonesia.

Mechanism of Change and Spiritual Integration

The ICBT model functions by restructuring cognitive distortions through an Islamic lens—integrating principles such as *sabr* (patience), *tawakkul* (trust in God), and *hikmah* (spiritual wisdom behind hardship). These theological constructs serve a similar function as traditional CBT cognitive reframes, but with deeper personal meaning for Muslim patients (de Abreu Costa & Moreira-Almeida, 2022; Husain & Hodge, 2016).

In this case, Mr. F's reframing of his hallucinations as part of a divine test rather than punishment shifted his emotional response from fear to hope, reflecting a key therapeutic transformation. The mechanism aligns with prior findings by Qasqas (2024), who suggests that spiritual meaning-making enhances therapy adherence and reduces the risk of relapse in Muslim populations (Qasqas, 2024). Additionally, spiritual behavioral activation—including daily prayer, Qur'anic recitation, and acts of kindness—promoted engagement in meaningful, non-pathological activities. This directly contributed to Mr. F's social re-engagement and psychological stabilization, as supported by the work of Kannan et.al (2022) on the effectiveness of structured, value-based interventions in severe psychiatric cases (Kannan et al., 2022).

Debating the Integration of Islamic Principles in CBT

The integration of Islamic theology into CBT presents both clinical advantages and ethical considerations. On one hand, such integration improves cultural congruence, enhances rapport, and provides spiritually meaningful coping strategies (Kotowski, 2012; Sivaji et al., 2025). On the other hand, it raises challenges regarding therapist competence in religious matters and potential tension between religious content and evidence-based CBT protocols.

In this case, the nurse effectively navigated these tensions by using Islamic content to support—rather than replace—CBT principles. For example, reframing cognitive distortions was done with Qur'anic guidance that promoted self-compassion, not magical thinking or fatalism (Aldahadha & Al Dwakat, 2025; Cucchi, 2022). This approach preserved the structure of CBT while increasing its accessibility.

Limitations and Future Directions

While the outcome in this case is promising, several limitations must be acknowledged. This report describes a single case with a short intervention duration and no long-term follow-up,

thereby limiting the generalizability of the findings. In addition, maternal involvement during sessions may have introduced potential bias, which should be considered in interpreting the results. The role of the psychiatric nurse in delivering ICBT in this case was focused on supportive guidance, psychoeducation, and facilitation of therapeutic exercises—complementary to, but not replacing, the diagnostic and pharmacological responsibilities of psychiatrists or the specialized psychotherapeutic expertise of psychologists. Broader generalization requires larger, controlled studies evaluating both the efficacy and fidelity of ICBT protocols in clinical practice. Moreover, institutional capacity for training psychiatric nurses in ICBT must be expanded to ensure sustainable implementation. Future research may explore hybrid models involving collaboration between mental health professionals and religious leaders to deliver ICBT with greater authenticity and acceptance, as well as assess the long-term effects of such interventions on relapse rates and functional recovery.

E. CONCLUSION

This case report highlights the feasibility of implementing Islamic Cognitive Behavioral Therapy (ICBT) as a culturally sensitive nursing intervention for a Muslim patient experiencing auditory hallucinations. Integrating Islamic values with structured CBT techniques appeared to support spiritual reframing, emotional regulation, and engagement in the therapeutic process, particularly when combined with family involvement.

Nevertheless, the observed improvements cannot be attributed to ICBT alone, as the patient was concurrently treated with antipsychotic medication, which likely played a major role in symptom reduction. The findings should therefore be interpreted as exploratory and illustrative, rather than evidence of effectiveness.

Several limitations must be acknowledged: the single-case design, the short and intensive intervention period, absence of long-term follow-up, the use of abbreviated and non-validated assessment tools, and the potential bias associated with the therapist–researcher dual role. Moreover, the delivery of CBT-based interventions by nurses requires clear recognition of professional scope; in this study, feasibility was ensured under the supervision of a licensed psychiatric nurse trained in ICBT, within a multidisciplinary psychiatric care team.

In conclusion, ICBT may serve as a promising adjunctive and culturally grounded approach for Muslim patients with psychosis. Further studies employing validated instruments, rigorous designs, and extended follow-up are needed to establish its efficacy, clarify mechanisms of change, and define the appropriate role of nurses in its delivery.

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