Muraqaba-Based Cognitive Restructuring for Anxiety Reduction in Muslim University Students: A Systematic Review and Integrative Conceptual Framework

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Abstract

Anxiety is among the most prevalent mental health problems in university students, and Muslim students in Indonesia and Southeast Asia report consistently high distress alongside limited access to culturally congruent care. Cognitive restructuring (CR), the core technique of cognitive behavioral therapy (CBT), has strong evidence for anxiety, yet its secular framing limits its resonance for religiously committed Muslim clients. *Muraqaba*, a contemplative discipline in Islamic Sufism grounded in the concept of *ihsan*, cultivates sustained metacognitive awareness of divine presence and shows structural parallels with mindfulness-based and metacognitive therapies. No systematic review has yet mapped the convergence between *Muraqaba* and CR or operationalized it into a clinical protocol. This study addresses that gap through a two-phase design: a systematic review followed by the development of a conceptual framework. Following PRISMA 2020 guidance, we searched Scopus, PsycINFO, ERIC, and Google Scholar in March 2024 for literature published from January 2000, with an update search in April 2026 extending coverage through March 2026. Forty-seven peer-reviewed studies and scholarly monographs met the inclusion criteria and were analyzed through thematic synthesis. The synthesis identified four convergence domains: attentional redeployment, metacognitive monitoring, cognitive defusion, and meaning reconstruction. From these domains, we propose the Muraqaba-Based Cognitive Restructuring Framework (MBCRF), a five-stage protocol comprising *Niyyah* Establishment, Muraqaba Induction, Islamo-Cognitive Identification, Divine Reframing, and *Muhasabah* Consolidation, along with five falsifiable propositions for empirical evaluation. MBCRF differs from

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Traditional Islamically Integrated Psychotherapy and Islamic Acceptance and Commitment Therapy by grounding integration in explicit mechanisms rather than content substitution, and by incorporating structural safeguards against spiritual bypass. Quasi-experimental and randomized trials are needed to test its efficacy.
Keywords: *Muraqaba*; cognitive restructuring; anxiety; Muslim university students; Islamic psychotherapy.

Introduction

Anxiety disorders are the most common mental health condition worldwide, affecting an estimated 301 million people in 2019.[1] The COVID-19 pandemic worsened this picture: global prevalence of anxiety and depression rose by about 25% in its first year, with young people hit hardest.[2] University students face particular risk. Across 21 countries, the WHO World Mental Health International College Student surveys found that about 31% of students met criteria for at least one common mental disorder, with anxiety disorders the most frequent at roughly 20%.[3]

Evidence from Southeast Asia sharpens this picture. Comparative studies during the pandemic documented elevated anxiety and suicidal ideation among Indonesian, Taiwanese, and Thai university students,[4] and similar psychological strain across Asian university students more broadly.[5] Within Indonesia, anxiety and depressive symptoms are common among medical students and are linked to maladaptive coping and low resilience;[6] elevated depression, anxiety, and stress have been recorded even at newly established remote campuses;[7] and coping strategies and social support shaped psychological distress among Jakarta students during the pandemic.[8] Evidence-based services remain scarce relative to need, the rationale for trials of internet-delivered

[1]GBD 2019 Mental Disorders Collaborators, "Global, Regional, and National Burden of 12 Mental Disorders in 204 Countries and Territories, 1990–2019: A Systematic Analysis for the Global Burden of Disease Study 2019," *The Lancet Psychiatry* 9, no. 2 (2022): 137–50, https://doi.org/10.1016/S2215-0366(21)00395-3.

[2]World Health Organization, "Mental Health and COVID-19: Early Evidence of the Pandemic's Impact" (Geneva: WHO, 2022).

[3]R. P. Auerbach et al., "WHO World Mental Health Surveys International College Student Project: Prevalence and Distribution of Mental Disorders," *Journal of Abnormal Psychology* 127, no. 7 (2018): 623–38, https://doi.org/10.1037/abn0000362.

[4]I. Pramukti et al., "Anxiety and Suicidal Thoughts during the COVID-19 Pandemic: Cross-Country Comparative Study among Indonesian, Taiwanese, and Thai University Students," *Journal of Medical Internet Research* 22, no. 12 (2020): e24487, https://doi.org/10.2196/24487.

[5]K. Chinna et al., "Psychological Impact of COVID-19 and Lockdown Measures: An Online Cross-Sectional Multicountry Study on Asian University Students," *PLoS ONE* 16, no. 8 (2021): e0253059, https://doi.org/10.1371/journal.pone.0253059.

[6]A. S. Ramadianto et al., "Symptoms of Depression and Anxiety in Indonesian Medical Students: Association with Coping Strategy and Resilience," *BMC Psychiatry* 22 (2022): 92, https://doi.org/10.1186/s12888-022-03745-1.

[7]E. Astutik et al., "Depression, Anxiety, and Stress among Students in Newly Established Remote University Campus in Indonesia," *Malaysian Journal of Medicine and Health Sciences* 16, no. 1 (2020): 270–77.

[8]Z. Akbar and M. S. Aisyawati, "Coping Strategy, Social Support, and Psychological Distress among University Students in Jakarta, Indonesia during the COVID-19 Pandemic," *Frontiers in Psychology* 12 (2021): 694122, https://doi.org/10.3389/fpsyg.2021.694122.

transdiagnostic interventions for Indonesian students.[9] This gap between the prevalence of anxiety and the availability of culturally appropriate care is the practical problem this study addresses.

Cognitive behavioral therapy (CBT), through its core technique of cognitive restructuring (CR), has the strongest evidence base among psychotherapies for anxiety across clinical populations.[10] CR identifies, challenges, and modifies the maladaptive automatic thoughts and cognitive distortions that maintain pathological anxiety, particularly catastrophizing, overgeneralization, and threat overestimation.[11] Yet CBT's secular framing limits its fit for religiously committed Muslim clients, for whom spiritual and religious meaning-making is inseparable from psychological well-being; this is a limitation of fit, not of efficacy.[12] Among Muslim university students, religiosity and religious coping are associated with lower psychological distress,[13] religiosity contributes to subjective well-being through resilience,[14] Islamic counseling has reduced anxiety and improved mindfulness during the pandemic.[15] These findings suggest that religious resources serve as an active therapeutic pathway not used by secular protocols.

Muraqaba draws on this pathway. Derived from the Arabic root *r-q-b* (to watch over, to observe, to guard), it is a contemplative discipline central to Islamic Sufism that cultivates continuous, attentive awareness of Allah's omniscience and presence.[16] Its theological foundation is the concept of *ihsan* articulated in the Hadith of Jibril: worshipping Allah "as though you see Him, for though you do not see Him, He surely

[9]M. Rahmadiana et al., "Transdiagnostic Internet Intervention for Indonesian University Students with Depression and Anxiety: Evaluation of Feasibility and Acceptability," *JMIR Mental Health* 8, no. 3 (2021): e20036, https://doi.org/10.2196/20036.
[10]Stefan G. Hofmann et al., "The Efficacy of Cognitive Behavioral Therapy: A Review of Meta-Analyses," *Cognitive Therapy and Research* 36, no. 5 (2012): 427–40, https://doi.org/10.1007/s10608-012-9476-1.
[11]Aaron T. Beck et al., *Cognitive Therapy of Depression* (New York: Guilford Press, 1979).
[12]Amber Haque, "Psychology from Islamic Perspective: Contributions of Early Muslim Scholars and Challenges to Contemporary Muslim Psychologists," *Journal of Religion and Health* 43, no. 4 (2004): 357–77, https://doi.org/10.1007/s10943-004-4302-z.
[13]M. H. A. Rashid et al., "Religiosity, Religious Coping and Psychological Distress among Muslim University Students in Malaysia," *International Journal of Evaluation and Research in Education* 10, no. 1 (2021): 150–60, https://doi.org/10.11591/ijere.v10i1.20870.
[14]B. Bukhori et al., "A Study on Muslim University Students in Indonesia: The Mediating Role of Resilience in the Effects of Religiosity, Social Support, Self-Efficacy on Subjective Well-Being," *Islamic Guidance and Counseling Journal* 5, no. 2 (2022): 152–71, https://doi.org/10.25217/igcj.v5i2.2972.
[15]A. Kadafi et al., "The Impact of Islamic Counseling Intervention towards Students' Mindfulness and Anxiety during the COVID-19 Pandemic," *Islamic Guidance and Counseling Journal* 4, no. 1 (2021): 55–66, https://doi.org/10.25217/igcj.v4i1.1018.
[16]Malik B. Badri, *Contemplation: An Islamic Psychospiritual Study* (Herndon, VA: International Institute of Islamic Thought and The International Association of Muslim Psychologists, 2000).

sees you" (Sahih Muslim, hadith no. 8), which Nurhakim and Rahman read as a theocentric mode of consciousness defined by sustained awareness of divine presence.[17] Contemporary Islamic psychotherapy has begun to translate this discipline into clinical form: Isgandarova proposed *Muraqaba* as a mindfulness-based therapy within Islamic psychotherapy and later developed a book-length treatment of its techniques,[18] while Aldbyani and Al-Harbi locate *Muraqaba* (self-monitoring) within a five-dimensional model of Islamic mindfulness with direct parallels to the five facets of secular mindfulness.[19] The self-observation *Muraqaba* cultivates resembles the mechanisms of change in interventions with demonstrated efficacy for anxiety, including mindfulness-based cognitive therapy, metacognitive therapy (MCT), and acceptance and commitment therapy (ACT).[20]

Few studies, however, have moved from this theoretical resonance to clinical integration, and work combining *Muraqaba* and CR into a single therapeutic protocol for anxiety remains fragmented. Some studies apply *Muraqaba* to specific problems, such as *Muraqaba* Intensification Therapy for social media addiction,[21] while others describe the mental health effects of Sufi meditation phenomenologically.[22] Adjacent integration programs have gone further: Traditional Islamically Integrated Psychotherapy (TIIP) has

[17]A. Nurhakim and A. Rahman, "The *Ihsan* Hadith as the Spiritual Foundation of *Muraqaba*: A Comparative Study with Contemporary Mindfulness," *Afkar* 27, no. 2 (2025): 427–56, https://doi.org/10.22452/afkar.vol27no2.13.

[18]N. Isgandarova, "*Muraqaba* as a Mindfulness-Based Therapy in Islamic Psychotherapy," *Journal of Religion and Health* 58, no. 4 (2019): 1146–60, https://doi.org/10.1007/s10943-018-0695-y; N. Isgandarova, *Mindfulness Techniques and Practices in Islamic Psychotherapy: The Power of Muraqaba* (London: Routledge, 2024), https://doi.org/10.4324/9781032631387.

[19]A. Aldbyani and M. F. O. Al-Harbi, "Five Dimensions of Islamic Mindfulness and Their Parallels with the Five Facets of Secular Mindfulness: A Narrative Theoretical Review," *Mindfulness* (2026), https://doi.org/10.1007/s12671-026-02837-3.

[20]Stefan G. Hofmann et al., "The Effect of Mindfulness-Based Therapy on Anxiety and Depression: A Meta-Analytic Review," *Journal of Consulting and Clinical Psychology* 78, no. 2 (2010): 169–83, https://doi.org/10.1037/a0018555; N. Normann and N. Morina, "The Efficacy of Metacognitive Therapy: A Systematic Review and Meta-Analysis," *Frontiers in Psychology* 9 (2018): 2211, https://doi.org/10.3389/fpsyg.2018.02211; S. C. Hayes et al., "Acceptance and Commitment Therapy: Model, Processes and Outcomes," *Behaviour Research and Therapy* 44, no. 1 (2006): 1–25, https://doi.org/10.1016/j.brat.2005.06.006.

[21]W. S. Harianti et al., "*Muraqaba* Intensification Therapy (MIT): An Alternative Islamic Therapy for Social Media Addiction," *International Journal of Public Health Science* 11, no. 1 (2022): 38–46, https://doi.org/10.11591/ijphs.v11i1.21137.

[22]M. A. Wahyudi et al., "Sufi Meditation and Mental Health: A Phenomenological Study of Spiritual Practices in the Naqshbandi Haqqani Order," *Indonesian Journal of Islam and Muslim Societies* 15, no. 2 (2025): 289–319, https://doi.org/10.18326/ijims.v15i2.289-319.

reported clinical outcomes among American Muslims,[23] Islamic values have been integrated into ACT,[24] and cognitive restructuring has been linked to Islamic concepts of spiritual purification within a stress-and-coping model.[25] None of these treats *Muraqaba* as the operative mechanism of cognitive change, and no systematic review has mapped where *Muraqaba* and CR converge or turned that convergence into a protocol ready for clinical use with Muslim students. That is the gap this study addresses.

This article pursues two aims. First, it systematically reviews the theoretical foundations, mechanisms of action, and empirical evidence for Muraqaba and cognitive restructuring, as well as their effects on anxiety. Second, building on this evidence, it proposes the *Muraqaba*-Based Cognitive Restructuring Framework (MBCRF), a five-stage protocol that operationalizes the convergence between *Muraqaba* and CR. Two research questions guide the review. RQ1: In what theoretical and functional domains do *Muraqaba* and cognitive restructuring converge as mechanisms of anxiety reduction? RQ2: How can these convergences be operationalized into a clinically implementable protocol that preserves both the theological integrity of *Muraqaba* and the scientific rigor of CR? Section 2 describes the review method. Section 3 presents the findings, including the four convergence domains (RQ1). Section 4 develops the MBCRF and its testable propositions (RQ2). Section 5 positions the framework in relation to existing faith-integrated psychotherapy models, addresses the risk of spiritual bypass, and outlines a staged evaluation roadmap.

Research Methodology

This study used a two-phase design: Phase 1, a systematic literature review (SLR) following the PRISMA 2020 reporting guidelines,[26] and Phase 2, development of an integrative conceptual framework based on the review's findings. An SLR suited Phase 1 for three reasons: the research question required synthesizing evidence across

[23]F. Khan et al., "Application of Traditional Islamically Integrated Psychotherapy (TIIP) and Its Clinical Outcome on Psychological Distress among American Muslims in Outpatient Therapy," *Spirituality in Clinical Practice* 12, no. 2 (2023): 147–60, https://doi.org/10.1037/scp0000350.
[24]A. Halik et al., "Integration of Islamic Values in Acceptance and Commitment Therapy: Exploring Psychological and Spiritual Outcomes in Muslim Populations," *Spiritual Psychology and Counseling* 11, no. 1 (2026): 37–69, https://doi.org/10.37898/spiritualpc.1733005.
[25]H. Hapsah et al., "From Cognitive Restructuring to Spiritual Purification: A Theoretical Synthesis of the Transactional Model and Islamic Psychology," *Journal of Psychiatric and Mental Health Nursing* (2026), https://doi.org/10.1111/jpm.70157.
[26]M. J. Page et al., "The PRISMA 2020 Statement: An Updated Guideline for Reporting Systematic Reviews," *BMJ* 372 (2021): n71, https://doi.org/10.1136/bmj.n71.

heterogeneous, interdisciplinary sources (psychology, Islamic studies, counseling, and neuroscience); the intended product is a conceptual framework, so primary data collection was unnecessary; and the PRISMA protocol enforces transparency and reproducibility standards that conventional narrative reviews do not.

We conducted the initial search of four electronic databases in March 2024: Scopus, PsycINFO (via APA PsycNet), ERIC (via EBSCO), and Google Scholar, covering publications from January 2000 onward. Because research on Islamic contemplative interventions has expanded rapidly, we conducted an updated search using identical terms in April 2026 to capture publications through March 2026, following PRISMA 2020 guidance on search currency.

Scopus, PsycINFO, and ERIC were the primary curated databases. Google Scholar served as a supplementary source to capture Indonesian-language and regionally indexed literature on Islamic counseling, which the curated databases underrepresent; its limited reproducibility is addressed in the limitations (Section 5.4). The search strategy combined Boolean operators and controlled vocabulary across four keyword clusters (Table 1). Searches combined Clusters 1+3, 2+3, 1+2, and the intersection of all four clusters. Additional articles were identified through backward citation chaining from included studies and forward citation tracking using Google Scholar's "cited by" function.

Table 1.
Search Clusters

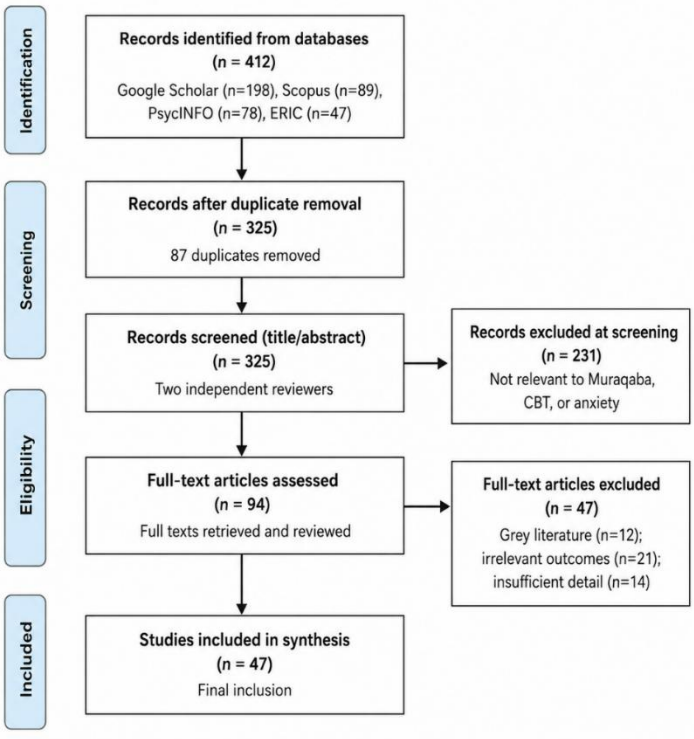
Cluster 1 (Contemplative practice)	**Cluster 2 (Cognitive intervention)**	**Cluster 3 (Target condition)**	**Cluster 4 (Population/context)**
"*Muraqaba*" OR "*Muraqaba*" OR "Islamic contemplation" OR "Islamic mindfulness" OR "tasawwuf AND psychology" OR "sufi contemplation"	"cognitive restructuring" OR "cognitive reappraisal" OR "cognitive-behavioral therapy" OR "CBT" OR "automatic thoughts"	"anxiety" OR "anxiety disorder" OR "worry" OR "anxious cognition" OR "psychological distress"	"muslim" OR "islamic counseling" OR "university students" OR "indonesia" OR "faith-based intervention"

To be included, an article had to meet three conditions: (a) publication in an indexed peer-reviewed journal or academic book between January 2000 and March 2026; (b) publication in English or Indonesian; and (c) substantive coverage of at least one of the review's focal domains (i) *Muraqaba*, Islamic contemplation, or faith-integrated therapy as a primary or significant topic; (ii) cognitive restructuring, CBT, metacognitive therapy,

or related cognitive approaches for anxiety or psychological distress; or (iii) theoretical frameworks integrating Islamic spiritual practices with evidence-based psychological interventions. We excluded articles that (a) were conference abstracts without full text; (b) addressed unrelated psychiatric conditions with no anxiety or distress component; (c) were grey literature without peer review; or (d) lacked sufficient methodological transparency for quality appraisal.

Database searches, including the update, yielded 412 records (Google Scholar: n = 198; Scopus: n = 89; PsycINFO: n = 78; ERIC: n = 47). After removing 87 duplicates, two reviewers independently screened the titles and abstracts of 325 records against the eligibility criteria; a third reviewer resolved disagreements that the discussion could not resolve. Screening excluded 231 records as not relevant to *Muraqaba*, CBT, or anxiety, leaving 94 full-text articles for eligibility assessment. Of these, 47 were excluded (grey literature, n = 12; irrelevant outcomes, n = 21; insufficient methodological detail, n = 14), and 47 studies were included in the final synthesis. For each included study, two reviewers extracted the author, year, country, design, population, focal construct(s), anxiety-related outcomes, and key findings onto a standardized extraction sheet. Figure 1 summarizes the PRISMA flow of the selection process.

Figure 1.
PRISMA 2020 flow summary



Two reviewers appraised the methodological quality of each included study using the Mixed Methods Appraisal Tool (MMAT, version 2018),[27] supplemented by meta-aggregation guidance for qualitative evidence,[28] and rated the certainty of each study's findings as high, moderate, or low. We excluded no studies on quality grounds alone; however, studies rated as low certainty were used descriptively and could not, on their own, support any convergence domain. Sensitivity analyses confirmed that the four reported convergence domains remained supported after excluding low-certainty studies.

We analyzed the included studies using thematic synthesis,[29] in three stages: line-by-line coding of findings, development of descriptive themes, and generation of analytical themes. Thematic synthesis was originally developed for qualitative primary studies. Still, it suits this corpus, which combines qualitative, quantitative, and theoretical work: coding was applied to each study's findings and conceptual claims rather than to raw participant data, and analytical themes had to be grounded in at least two independent sources from different disciplinary traditions. The four convergence domains reported in Section 3 constitute these analytical themes; the five MBCRF stages in Section 4 represent their translation into clinical form.

The authors hold dual educational backgrounds in psychology and Islamic studies and analyzed the corpus from a perspective favorable to faith-integrated interventions. To reduce confirmation bias, we documented coding decisions with supporting citations, actively sought contradictory evidence during theme development, and deliberately limited the framework's claims to falsifiable propositions.

Results

Characteristics of Included Studies

Of the 47 included studies, 18 directly addressed *Muraqaba* or closely related Islamic contemplative practices, 22 addressed cognitive restructuring and related CBT techniques in the context of anxiety, and 7 addressed faith-integrated therapeutic

[27]Quan Nha Hong et al., "The Mixed Methods Appraisal Tool (MMAT) Version 2018 for Information Professionals and Researchers," *Education for Information* 34, no. 4 (2018): 285–91, https://doi.org/10.3233/EFI-180221.

[28]C. Lockwood, Z. Munn, and K. Porritt, "Qualitative Research Synthesis: Methodological Guidance for Systematic Reviewers Utilizing Meta-Aggregation," *International Journal of Evidence-Based Healthcare* 13, no. 3 (2015): 179–87, https://doi.org/10.1097/XEB.0000000000000062.

[29]J. Thomas and A. Harden, "Methods for the Thematic Synthesis of Qualitative Research in Systematic Reviews," *BMC Medical Research Methodology* 8 (2008): 45, https://doi.org/10.1186/1471-2288-8-45.

frameworks or conceptualizations of anxiety from cognitive and Islamic perspectives. Table 2 summarizes the included studies.

Muraqaba: Theological Foundations and Psychological Mechanisms

Muraqaba is rooted in the Islamic concept of *ihsan*, defined in the Hadith of Jibril as worshipping Allah "as though you see Him, for though you do not see Him, He surely sees you" (Sahih Muslim, hadith no. 8). Nurhakim and Rahman read this hadith as the spiritual foundation of *Muraqaba*: a theocentric mode of consciousness marked by continuous awareness of divine presence, comparable to but distinct from contemporary secular mindfulness.[30] Al-Ghazali develops this awareness in the *Ihya' Ulum al-Din*, Book XXXVIII (*Kitab al-Muraqaba wa'l-Muhasaba*), situating *Muraqaba* among the stations of steadfast commitment (*murabata*) and defining it as a disciplined practice of inner observation that keeps the servant aware of Allah's witnessing of the heart, thoughts, and intentions.[31]

Badri, in a psychological analysis of Islamic contemplation, treated *Muraqaba* as the functional equivalent of what cognitive science calls metacognitive monitoring: the capacity to observe one's mental processes as objects of awareness rather than fuse with them.[32] Evidence-based modalities converge on this capacity as a core mechanism of therapeutic change in anxiety treatment.[33] Practitioners of *Muraqaba* develop what Haque calls theocentric attentional control: the deliberate, sustained shift of attention away from external anxiety triggers toward internal states, held within a theological frame of divine omniscience that recontextualizes perceived threat.[34]

Recent scholarship has moved this analysis from description to operationalization. Isgandarova argued that *Muraqaba* techniques can be adapted as a mindfulness-based therapy within Islamic psychotherapy, and later specified session-level practices for

[30]Nurhakim and Rahman, "*Ihsan* Hadith as the Spiritual Foundation of *Muraqaba*," 427–56.
[31]Abu Hamid Al-Ghazali, *Al-Ghazali on Vigilance and Self-Examination: Kitab al-Muraqaba wa'l-Muhasaba. Book XXXVIII of The Revival of the Religious Sciences (Ihya' 'Ulum al-Din)*, trans. A. H. M. Shaker (Cambridge: Islamic Texts Society, 2015).
[32]Badri, *Contemplation*.
[33]Adrian Wells, "Breaking the Cybernetic Code: Understanding and Treating the Human Metacognitive Control System to Enhance Mental Health," *Frontiers in Psychology* 10 (2019): 2621, https://doi.org/10.3389/fpsyg.2019.02621; Normann and Morina, "Efficacy of Metacognitive Therapy," 2211; P. M. McEvoy, "Metacognitive Therapy for Anxiety Disorders: A Review of Recent Advances and Future Research Directions," *Current Psychiatry Reports* 21, no. 5 (2019): 29, https://doi.org/10.1007/s11920-019-1014-3.
[34]Haque, "Psychology from Islamic Perspective," 357–77.

clinicians and spiritual care providers.[35] Aldbyani and Al-Harbi locate *Muraqaba* within a five-dimensional model of Islamic mindfulness alongside *dhikr*, *khushu'*, *Tafakkur*, and *tazkiyat al-nafs* and map its parallels to the observing and non-reactivity facets of secular mindfulness, strengthening the construct validity of *Muraqaba* as a distinct yet commensurable contemplative mechanism.[36]

Emerging empirical work supports this therapeutic operationalization. Harianti et al. developed *Muraqaba* Intensification Therapy as an Islamic intervention for social media addiction, showing that *Muraqaba* can be manualized into a discrete protocol.[37] In a phenomenological study of the Naqshbandi Haqqani order in Indonesia, Wahyudi et al. found that Sufi practices combining *Muraqaba*, *Muhasabah*, and *dhikr* shaped practitioners' mental health through processes the authors link to cognitive and emotional regulation.[38] Some scholars propose neuropsychological parallels between contemplative religious practice and mindfulness meditation, suggesting that both engage prefrontal regulatory circuits and attenuate threat reactivity;[39] however, this proposal rests on general and now-dated sources, and no neuroimaging study of *Muraqaba* has yet been published, so it stands as a plausible hypothesis rather than an established finding. Unlike secular mindfulness, *Muraqaba* also provides what Rosmarin et al. identify as divine attachment security, a psychological resource that secular interventions cannot replicate for religiously committed clients.[40]

Cognitive Restructuring: Mechanisms and Efficacy for Anxiety

Cognitive restructuring, developed by Beck as the cornerstone of cognitive therapy, rests on the premise that maladaptive emotional responses, including pathological anxiety, are maintained mainly by systematic cognitive distortions rather than by objective features of the situation.[41] The principal distortions in anxiety are catastrophizing (reading ambiguous situations as maximal threat), probability

[35]Isgandarova, *Mindfulness Techniques and Practices in Islamic Psychotherapy*.
[36]Aldbyani and Al-Harbi, "Five Dimensions of Islamic Mindfulness."
[37]Harianti et al., "*Muraqaba* Intensification Therapy," 38–46.
[38]Wahyudi et al., "Sufi Meditation and Mental Health," 289–319.
[39]Andrew B. Newberg and Mark Robert Waldman, *How God Changes Your Brain: Breakthrough Findings from a Leading Neuroscientist* (New York: Ballantine Books, 2009).
[40]D. H. Rosmarin et al., "A Randomized Controlled Evaluation of a Spiritually Integrated Treatment for Subclinical Anxiety in the Jewish Community, Delivered via the Internet," *Journal of Anxiety Disorders* 24, no. 7 (2010): 799–808, https://doi.org/10.1016/j.janxdis.2010.05.014.
[41]Beck et al., *Cognitive Therapy of Depression*.

overestimation (inflating the likelihood of negative outcomes), and magnification/minimization (amplifying threat while downplaying coping resources).[42]

CR comprises three core operations: (a) automatic thought identification, recognizing the specific thoughts triggered by anxiety-provoking stimuli; (b) cognitive evaluation, examining the logical, empirical, and functional validity of those thoughts through Socratic questioning; and (c) cognitive substitution, generating more balanced and adaptive alternatives that reduce anxiety without denying real risk.[43] Meta-analytic evidence supports the efficacy of CR-based CBT: a review of 106 meta-analyses across diagnostic categories reported moderate-to-large effects for anxiety disorders, with gains maintained at follow-up.[44] Process-based work continues to refine these mechanisms. Zettle et al. compared metacognitive restructuring with metacognitive defusion for managing meta-worry and found that the two operate as distinguishable but complementary change processes. This distinction informs the staging of MBCRF.[45]

From an Islamic psychological perspective, the Socratic method of CR resonates structurally with *Tafakkur* (systematic rational reflection) and with the recurring Quranic imperative to reflect (*afala ta'qilun*, *afala tatafakkarun*; e.g., QS Al-Baqarah 2:164; QS Al-Ra'd 13:3). Haque argues that Islamic epistemology has long privileged rational reflection and evidence-based examination of belief as a path to truth; on this reading, the empirical and rational methods of CR are not culturally alien but consonant with the Islamic intellectual tradition.[46] Hapsah et al. extend this line by synthesizing cognitive restructuring with Islamic concepts of spiritual purification within the transactional model of stress and coping.[47] Their synthesis does not specify a contemplative mechanism; MBCRF, by contrast, positions *Muraqaba* as that mechanism.

Anxiety: A Cognitive-Islamic Conceptual Analysis

From a cognitive-behavioral perspective, anxiety is a future-oriented emotional state marked by persistent anticipation of uncontrollable and unpredictable negative

[42]D. A. Clark and A. T. Beck, *Cognitive Therapy of Anxiety Disorders: Science and Practice* (New York: Guilford Press, 2010).
[43]Judith S. Beck, *Cognitive Behavior Therapy: Basics and Beyond*, 2nd ed. (New York: Guilford Press, 2011).
[44]Hofmann et al., "Efficacy of Cognitive Behavioral Therapy," 427–40.
[45]R. D. Zettle, H. Quan, and J. M. Larson, "Managing Worrying about Worrying with Metacognitive Restructuring versus Metacognitive Defusion," *Behavioral Sciences* 16, no. 4 (2026): 594, https://doi.org/10.3390/bs16040594.
[46]Haque, "Psychology from Islamic Perspective," 357–77.
[47]Hapsah et al., "From Cognitive Restructuring to Spiritual Purification."

events, together with a perceived deficit in coping resources.[48] The cognitive model holds that three interlocking mechanisms maintain anxiety: hypervigilance to threat cues, catastrophic misappraisal of ambiguous stimuli, and safety behaviors that prevent disconfirmation of threat beliefs.[49]

Four Domains of Convergence Between *Muraqaba* and Cognitive Restructuring

The thematic synthesis identified four domains of theoretical and functional convergence between *Muraqaba* and CR. These domains constitute the evidential foundation for MBCRF (RQ1).

Domain 1: Attentional redeployment**.** Both practices require deliberate attentional redeployment as a primary mechanism. In *Muraqaba*, the practitioner directs attention from external anxiety triggers toward the inner state of the heart (*qalb*), held within a frame of divine presence. In CR, attention shifts from the emotional content of anxiety to the cognitive structures that maintain it, the specific automatic thoughts driving the anxious response. Both train sustained, controlled focus: *Muraqaba* through spiritual discipline (*mujahada*), CR through structured exercise. Wells conceptualizes this mechanism as detached mindfulness, the capacity to observe thoughts without fusion, which parallels the inner witnessing cultivated in *Muraqaba*.[50]

Domain 2: Metacognitive monitoring**.** *Muraqaba* practice centers on developing an internal observer, a meta-level awareness that watches one's thoughts and heart-states without being swept up in them. This capacity is structurally comparable to the metacognitive monitoring that the self-regulatory executive function model identifies as a central mechanism of change in metacognitive therapy for anxiety.[51] The efficacy of MCT is well established: a systematic review and meta-analysis found large effects for anxiety and depression, with MCT performing at least as well as conventional CBT,[52] and reviews of MCT for anxiety disorders confirm that modifying metacognitive processes, rather than thought content alone, drives change.[53] The first CR operation, automatic thought identification, is itself a metacognitive act: the client steps back from cognitive

[48]D. H. Barlow, *Anxiety and Its Disorders: The Nature and Treatment of Anxiety and Panic*, 2nd ed. (New York: Guilford Press, 2002).
[49]Clark and Beck, *Cognitive Therapy of Anxiety Disorders*.
[50]Wells, "Breaking the Cybernetic Code," 2621.
[51]Wells, "Breaking the Cybernetic Code," 2621.
[52]Normann and Morina, "Efficacy of Metacognitive Therapy," 2211.
[53]McEvoy, "Metacognitive Therapy for Anxiety Disorders," 29.

experience far enough to observe it as a discrete object. *Muraqaba* training develops this stepping-back capacity through regular practice, which may improve clients' ability to engage with CR's identification techniques.

Domain 3: Cognitive defusion**.** The ACT concept of cognitive defusion creates psychological distance from thoughts by observing them as mental events rather than objective reality.[54] resonates with the *Muraqaba* understanding of thoughts as passing states of the *qalb* rather than fixed truths. The classical Sufi distinction between the whisperings of the *nafs* (passing thoughts, *khawatir*) and established belief mirrors ACT's fusion-defusion dimension.[55] This distinction matters clinically: Zettle et al. show that defusion and restructuring operate as separable processes,[56] and a systematic review of ACT integrated with Islamic values found that both standard and Islamically adapted ACT reduce anxiety in Muslim populations.[57] Related scholarship interprets *dhikr* as meditative remembrance that functions like mindfulness.[58] MBCRF proposes *Muraqaba* practice as the vehicle for establishing cognitive defusion before CR's evaluative phase, reducing rigidity and increasing openness to alternative cognitions.

Domain 4: Meaning reconstruction. The most clinically significant convergence lies in the shared focus on meaning reconstruction. The substitution phase of CR replaces maladaptive, threat-based meanings with more balanced appraisals. *Muraqaba* reconstructs meaning at a deeper level through its theocentric frame: by re-embedding anxiety-provoking events within a divine narrative of providence (*qadar*), purposeful trial (*ibtila'*), and redemptive meaning, it supplies a trans-situational framework unavailable to secular CR. Frankl's logotherapy converges here, holding that anxiety reduction is most durable when grounded in meaning reconstruction rather than in the mere correction of cognitive errors.[59] Empirical support for spiritually mediated meaning-making as a change process appears in Islamic counseling contexts[60] and in Shaik's religious-coping

[54]Hayes et al., "Acceptance and Commitment Therapy," 1–25.
[55]Al-Ghazali, *Kitab al-Muraqaba wa'l-Muhasaba*.
[56]Zettle, Quan, and Larson, "Managing Worrying about Worrying," 594.
[57]Halik et al., "Integration of Islamic Values," 37–69.
[58]M. Applebaum, "Dhikr as Mindfulness: Meditative Remembrance in Sufism," *Journal of Humanistic Psychology* 65, no. 2 (2025): 409–30, https://doi.org/10.1177/00221678231206901.
[59]Viktor E. Frankl, *Man's Search for Meaning: An Introduction to Logotherapy* (New York: Washington Square Press, 1963).
[60]R. Rosidi, S. Subandi, and M. Mubasit, "Moral and Spiritual Meaning-Making in Substance Use Recovery: An Interpretive Qualitative Study of Da'wah Counseling," *Islamic Guidance and Counseling Journal* 9, no. 1 (2026), https://doi.org/10.25217/0020269773200.

synthesis.[61] MBCRF integrates both levels: secular cognitive reappraisal for situational distortions, and *Muraqaba*-mediated divine reframing for the existential and spiritual dimensions of anxiety.

The *Muraqaba*-Based Cognitive Restructuring Framework (MBCRF)

Framework Overview

Drawing on the four convergence domains, we propose MBCRF as a five-stage integrative protocol to reduce anxiety among Muslim university students (RQ2). MBCRF rests on three theoretical pillars: (1) the cognitive model of anxiety;[62] (2) the Islamic spiritual psychology of *Muraqaba*;[63] and (3) metacognitive and mindfulness-based models of therapeutic change.[64] The framework is organized on three structural levels: a Theological Foundation (*tauhid* and *Tawakkul*), an Integration Bridge (the four convergence domains), and a Clinical Protocol (the five therapeutic stages).

The central proposition of MBCRF is that *Muraqaba* practice improves CR outcomes for Muslim clients through two mechanisms: (a) it develops the metacognitive monitoring capacity required for effective cognitive identification (Domain 2); and (b) it supplies a spiritually grounded source of meaning reconstruction that strengthens the cognitive reappraisal achieved through standard CR (Domain 4). MBCRF preserves the theological integrity of *Muraqaba*, treating it as a spiritual practice rather than a relaxation technique, while retaining the empirical rigor of evidence-based CR.

The Five Therapeutic Stages

Stage 1: *Niyyah* Establishment (intention alignment). Adapted from the Islamic principle of *Niyyah* (conscious intention-setting before meaningful action), the first stage sets the therapeutic frame. The counselor facilitates a structured *Niyyah* exercise in which the client aligns therapeutic intentions with Islamic values and divine purpose. This stage serves two functions: (a) activating the client's Islamic motivational resources, so that anxiety treatment becomes an act of worship with intrinsic spiritual reward rather than a secular self-improvement task; and (b) establishing the metacognitive frame of self-observation on which both *Muraqaba* practice and cognitive identification depend.

[61]D. N. Shaik, "Integrating Islamic Theology and Psychology: A Systematic Narrative Review of Religious Coping," *Pastoral Psychology* (2026), https://doi.org/10.1007/s11089-025-01298-0.
[62]Beck, *Cognitive Behavior Therapy*.
[63]Badri, *Contemplation*; Al-Ghazali, *Kitab al-Muraqaba wa'l-Muhasaba*; Nurhakim and Rahman, "*Ihsan* Hadith as the Spiritual Foundation of *Muraqaba*," 427–56.
[64]Wells, "Breaking the Cybernetic Code," 2621.

Research on implementation intentions supports the use of intention-setting as a predictor of engagement and outcomes.[65]

Stage 2: *Muraqaba* Induction. The second stage introduces structured *Muraqaba* practice as the foundation for subsequent cognitive work. Following the classical account of Al-Ghazali, interpreted psychologically by Badri and specified clinically by Isgandarova, the counselor guides the client through three steps: establishing physical stillness (*sukun*); cultivating awareness of divine presence through recitation of selected Quranic verses and *al-asma' al-husna*; and sustaining inward attention toward present thoughts, feelings, and heart-states.[66] The induction runs 10–15 minutes and targets two goals: establishing the metacognitive observer stance (Domain 2) and activating cognitive defusion from anxious thoughts (Domain 3). The precedent of Harianti et al. for manualization shows that *Muraqaba* can be protocolized in this form.[67]

Stage 3: Islamo-Cognitive Identification. With the observer stance established, the third stage applies the standard CR protocol to identify the automatic thoughts that maintain the client's anxiety, within an Islamic interpretive frame. The counselor uses modified Socratic questions that reference Islamic epistemological standards: "What evidence from the Quran or from your own experience supports this thought?"Is the certainty you feel consistent with the Islamic teaching that only Allah has definite knowledge of the future?" "What would a person with strong *Tawakkul* think in this situation?" Islamo-Cognitive Identification joins the empirical rigor of Beckian examination to the epistemology of Islamic reflection, producing an assessment of anxious cognitions that is both cognitively and spiritually grounded.

Stage 4: Divine Reframing (*Muraqaba*-mediated cognitive restructuring). The fourth stage operationalizes the meaning-reconstruction convergence (Domain 4). Having identified specific anxiety-provoking cognitions in Stage 3, the client returns to the observational stance of *Muraqaba* and examines those cognitions through Islamic theological concepts: *qadar* (divine providence), *Tawakkul* (trust in Allah's wisdom and mercy), *ibtila'* (trial as purposeful divine gift for growth), and *husn al-zann billah* (favorable assumption toward Allah). The counselor guides the client to generate

[65]P. M. Gollwitzer, "Implementation Intentions: Strong Effects of Simple Plans," *American Psychologist* 54, no. 7 (1999): 493–503, https://doi.org/10.1037/0003-066X.54.7.493.
[66]Al-Ghazali, *Kitab al-Muraqaba wa'l-Muhasaba*; Badri, *Contemplation*; Isgandarova, *Mindfulness Techniques and Practices in Islamic Psychotherapy*.
[67]Harianti et al., "*Muraqaba* Intensification Therapy," 38–46.

alternative appraisals that are at once more empirically accurate, as in standard CR, and more theologically grounded, drawing on Quranic wisdom and prophetic traditions relevant to anxiety. Divine Reframing differs from cognitive avoidance or denial: the client does not reject the reality of threatening situations but transforms the appraisal of their meaning, controllability, and ultimate implications within a frame of divine mercy.

Stage 5: *Muhasabah* Consolidation. The fifth stage draws on *Muhasabah* (self-accounting and reflection), as elaborated by Al-Ghazali alongside Muraqaba, to consolidate the gains of the preceding stages. The counselor facilitates a structured *Muhasabah* exercise with four components. The client (a) reviews the anxiety-provoking cognitions identified in Stage 3 alongside the Divine Reframings generated in Stage 4; (b) evaluates the experienced difference between the two cognitive stances, building metacognitive awareness that maladaptive cognitions are constructed mental events rather than fixed truths; (c) commits to behavioral experiments, consistent with standard CR protocols, to test alternative appraisals in daily life; and (d) identifies Quranic verses, hadiths, or supplications to serve as cognitive anchors during anxiety episodes between sessions. The phenomenological findings of Wahyudi et al., in which *Muhasabah* operates alongside *Muraqaba* and *dhikr* as a reflective consolidation practice, support placing *Muhasabah* at the close of the protocol.[68]

Table 3.
Summary of MBCRF Components

Stage	Islamic concept	CBT mechanism	Therapeutic outcome
1. *Niyyah* Establishment	*Niyyah* (intention)	Motivational activation; therapeutic alliance	Value-aligned therapeutic engagement
2. *Muraqaba* Induction	*Muraqaba* / *Ihsan*	Metacognitive monitoring; defusion	Observer stance: reduced cognitive fusion
3. Islamo-Cognitive Identification	*Tafakkur* / *taqwa*	Automatic thought identification	Maladaptive cognitions identified
4. Divine Reframing	*Tawakkul* / *qadar* / *ibtila'*	Cognitive restructuring/reappraisal	Balanced, Islamically grounded alternative thoughts
5. *Muhasabah* Consolidation	*Muhasabah* / do'a	Behavioral experiments; relapse prevention	Internalized adaptive cognition; spiritual coping resources

Testable Propositions and Evaluation Roadmap

To move MBCRF from a conceptual model to an empirical program, we state its central claim as a falsifiable proposition, P1 (additive efficacy). Among religiously

[68]Wahyudi et al., "Sufi Meditation and Mental Health," 289–319.

committed Muslim university students with elevated anxiety, MBCRF produces greater reductions in anxiety symptoms than standard CR of equivalent dose.

P2 (metacognitive mediation). The effect of MBCRF on anxiety is mediated by gains in metacognitive monitoring and decentering, as measured by decentering and cognitive fusion scales. These gains develop mainly during Stages 1–2 and index the Domain 2 and Domain 3 mechanisms. P3 (meaning mediation). MBCRF's durability at 3- and 6-month follow-up is mediated by change in spiritually grounded meaning-making and positive religious reappraisal (Domain 4 mechanism). Proposed measures: the Positive Religious Coping subscale of the Brief RCOPE;[69] the Meaning in Life Questionnaire–Presence subscale;[70] and, where available, the Psychological Measure of Islamic Religiousness or the Islamic Positive Religious Coping items.[71]

P4 (moderation by religiosity). The incremental benefit of MBCRF over standard CR increases with baseline intrinsic religiosity; MBCRF is not expected to outperform standard CR among clients with low intrinsic religiosity. P5 (bypass safeguard). Clients who complete the full staged MBCRF protocol show lower spiritual-bypass scores than clients receiving devotional practice alone (e.g., Quran-listening protocols). Proposed measure: the Spiritual Bypass Scale,[72] with the cognitive-emotional avoidance and premature transcendence subscales analyzed separately. This result would reflect the design requirement that reframing operates only on cognitions first identified and examined in Stage 3, and tested behaviorally in Stage 5.

A staged evaluation roadmap follows from these propositions: (1) protocol manualization and expert review by CBT clinicians and Islamic scholars to check fidelity to both traditions; (2) feasibility and acceptability piloting with Muslim university students, attentive to denominational variation in receptivity to Sufi-derived practice; (3) quasi-experimental comparison against a waitlist condition; and (4) randomized controlled trials against active comparators (standard CBT and generic Islamic

[69]K. Pargament, M. Feuille, and D. Burdzy, "The Brief RCOPE: Current Psychometric Status of a Short Measure of Religious Coping," *Religions* 2, no. 1 (2011): 51–76, https://doi.org/10.3390/rel2010051.
[70]M. F. Steger et al., "The Meaning in Life Questionnaire," *Journal of Counseling Psychology* 53, no. 1 (2006): 80–93, https://doi.org/10.1037/0022-0167.53.1.80.
[71]H. Abu-Raiya et al., "A Psychological Measure of Islamic Religiousness: Development and Evidence for Reliability and Validity," *International Journal for the Psychology of Religion* 18, no. 4 (2008): 291–315.
[72]J. Fox, C. S. Cashwell, and G. Picciotto, "The Opiate of the Masses: Measuring Spiritual Bypass and Its Relationship to Spirituality, Religion, Mindfulness, Psychological Distress, and Personality," *Spirituality in Clinical Practice* 4, no. 4 (2017): 274–87, https://doi.org/10.1037/scp0000141.

counseling), with mediation analyses testing P2 and P3. This trajectory parallels the staged program emerging in the Islamic ACT literature.[73]

Discussion

Theoretical Coherence and Position Among Faith-Integrated Models

MBCRF grounds its integration in identified structural and functional convergences between the two approaches, rather than in surface eclecticism that adds Islamic elements to a secular protocol. The four convergence domains, attentional redeployment, metacognitive monitoring, cognitive defusion, and meaning reconstruction, provide a mechanistic account of how *Muraqaba* can enhance CR efficacy for Muslim clients. This mechanistic grounding distinguishes MBCRF from earlier faith-integrated CBT models,[74] which tend to substitute religious content for secular content without specifying the psychological mechanisms of integration.

The same distinction applies to contemporary Islamic psychotherapy programs. TIIP has articulated an ontological model and reported clinical outcomes on psychological distress among American Muslims,[75] and grounded-theory work has mapped how practitioners understand Islamic psychotherapy.[76] Regional models offer further precedents: the *Shifaul Qalbi Perak formulation*,[77] Al-Ghazali-based counseling,[78] and the trajectory in Pakistan from Sufism toward culturally adapted CBT.[79] MBCRF differs from these programs on two axes. First, its scope is narrow by design. Rather than a comprehensive psychotherapy system, MBCRF operationalizes one contemplative practice (*Muraqaba*) as the enhancement mechanism for one evidence-

[73]Halik et al., "Integration of Islamic Values," 37–69.
[74]L. R. Propst, "Cognitive-Behavioral Therapy and the Religious Person," in *Religion and the Clinical Practice of Psychology*, ed. E. P. Shafranske (Washington, DC: American Psychological Association, 1996), 391–407; S. M. Razali et al., "Religious-Sociocultural Psychotherapy in Patients with Anxiety and Depression," *Australian and New Zealand Journal of Psychiatry* 32, no. 6 (1998): 867–72, https://doi.org/10.3109/00048679809073877.
[75]Khan et al., "Application of Traditional Islamically Integrated Psychotherapy," 147–60.
[76]A. Rothman and A. Coyle, "Conceptualizing an Islamic Psychotherapy: A Grounded Theory Study," *Spirituality in Clinical Practice* 7, no. 3 (2020): 197–213, https://doi.org/10.1037/scp0000219.
[77]K. Rajab and C. Z. Saari, "Islamic Psychotherapy Formulation: Considering the Shifaul Qalbi Perak Malaysia Psychotherapy Model," *Indonesian Journal of Islam and Muslim Societies* 7, no. 2 (2017): 175–200, https://doi.org/10.18326/ijims.v7i2.175-200.
[78]Y. Syukur et al., "Reassessing the Effectiveness of Al-Ghazali Based Counseling: A Spiritual Approach to Addressing Diverse Client Challenges," *Miqot: Jurnal Ilmu-Ilmu Keislaman* 50, no. 1 (2026): 56–84, https://doi.org/10.30821/miqot.v50i1.1518.
[79]M. Irfan et al., "Psychological Healing in Pakistan: From Sufism to Culturally Adapted Cognitive Behaviour Therapy," *Journal of Contemporary Psychotherapy* 47, no. 2 (2017): 119–24, https://doi.org/10.1007/s10879-016-9354-3.

based technique (CR) targeting one condition (anxiety), which makes its propositions directly testable. Second, whereas Islamic ACT integrates Islamic values into an acceptance-based change process,[80] MBCRF retains restructuring as the primary change process and positions defusion, cultivated through *Muraqaba*, as its preparatory condition, a staging consistent with evidence that defusion and restructuring are separable processes.[81] MBCRF is therefore complementary to, not duplicative of, Islamic ACT and Islamic mindfulness programs.

Preserving Theological Integrity and Avoiding Spiritual Bypass

The primary clinical innovation of MBCRF lies in preserving theological integrity within a scientifically rigorous protocol. A persistent critique of faith-integrated psychotherapy is that it instrumentalizes spiritual practice for secular therapeutic ends, reducing *Muraqaba* to an "Islamic mindfulness exercise" stripped of theological depth. MBCRF rejects this reduction: Divine Reframing (Stage 4) and *Muhasabah* Consolidation (Stage 5) are designed to deepen the client's relationship with Islamic theological understanding, not to borrow Islamic imagery for cognitive change. This design reflects Seligman's argument that the most durable positive interventions work through enhanced meaning and purpose, a function that theologically coherent integration can serve for devout clients.[82]

A related risk runs in the opposite direction. Spiritual bypass, the use of religious practice to avoid rather than engage psychological difficulty, moderates the relationship between religious coping and distress among Muslims, such that religious coping loses its protective function when it substitutes for psychological processing.[83] MBCRF contains structural safeguards against this risk: Stage 3 requires identification and examination of anxious cognitions before any reframing occurs, and Stage 5 requires behavioral experiments that test appraisals against lived experience. Divine Reframing, therefore, operates on cognitions that have first been confronted, not around them. This design choice distinguishes MBCRF from devotional interventions in which the spiritual

[80]Halik et al., "Integration of Islamic Values," 37–69.
[81]Zettle, Quan, and Larson, "Managing Worrying about Worrying," 594.
[82]Martin E. P. Seligman, *Flourish: A Visionary New Understanding of Happiness and Well-Being* (New York: Free Press, 2011).
[83]S. S. Ahmad, M. M. McLaughlin, and A. W. de Mamani, "Spiritual Bypass as a Moderator of the Relationships between Religious Coping and Psychological Distress in Muslims Living in the United States," *Psychology of Religion and Spirituality* 15, no. 1 (2023): 32–42, https://doi.org/10.1037/rel0000469.

practice itself constitutes the entire intervention (e.g., Quran-listening protocols[84]). It is stated as a falsifiable claim in Proposition P5 and responds to a criterion that reviewers of faith-integrated interventions increasingly apply.

Practical Implications

MBCRF has implications for counselor training and professional competence. Effective implementation requires counselors who are proficient in CBT techniques and knowledgeable about Islamic spirituality, a dual competence that remains rare and requires deliberate development. This underscores the need for curriculum reform in Islamic guidance and counseling (*Bimbingan dan Konseling Islam*, BKI) programs at Indonesian Islamic universities, incorporating evidence-based CBT training alongside structured training in Islamic spiritual practices as therapeutic modalities.[85] The TIIP training and outcome-monitoring model offers one implementable precedent.[86]

Implementation must also account for intra-Muslim diversity. *Muraqaba* is rooted in the Sufi tradition, and receptivity to Sufi-derived practice varies across Muslim communities and denominations. MBCRF is therefore presented in theologically generic terms, grounded in *ihsan* as an aspiration shared across Sunni traditions, and its acceptability across denominational contexts remains an empirical question built into the evaluation roadmap (Section 4.3). Beyond the counseling room, digital delivery is plausible: internet-based interventions are feasible and acceptable for Indonesian students,[87] Islamic spiritual-mindfulness applications have been piloted,[88] and MBCRF's staged, scripted structure suits guided digital adaptation.

Limitations

Five limitations qualify this review and framework. First, the empirical literature on *Muraqaba*, as distinct from salah, dhikr, or Islamic religiosity more broadly, remains sparse, constraining the evidence base for some framework propositions. Second, the

[84]A. Ghiasi and A. Keramat, "The Effect of Listening to Holy Quran Recitation on Anxiety: A Systematic Review," *Iranian Journal of Nursing and Midwifery Research* 23, no. 6 (2018): 411–20, https://doi.org/10.4103/ijnmr.IJNMR_173_17; K. Moulaei et al., "The Effect of the Holy Quran Recitation and Listening on Anxiety, Stress, and Depression: A Scoping Review on Outcomes," *Health Science Reports* 6, no. 12 (2023): e1751, https://doi.org/10.1002/hsr2.1751.
[85]A. R. Faqih, *Bimbingan dan Konseling dalam Islam* (Yogyakarta: UII Press, 2001); A. Sutoyo, *Bimbingan dan Konseling Islami: Teori dan Praktik* (Yogyakarta: Pustaka Pelajar, 2013).
[86]Khan et al., "Application of Traditional Islamically Integrated Psychotherapy," 147–60.
[87]Rahmadiana et al., "Transdiagnostic Internet Intervention," e20036.
[88]Z. U. A. Tariq et al., "Sukunn: Bridging Spiritual Heritage and Modern Digital Mental Health," *Studies in Health Technology and Informatics* 336 (2026): 1797–98, https://doi.org/10.3233/SHTI260539.

review covered only English- and Indonesian-language articles, which may have excluded relevant Arabic-language literature closer to the primary scholarly tradition of *Muraqaba*. Third, we did not prospectively register the review protocol, and we used Google Scholar as a supplementary source; both choices limit replicability compared with a registered protocol restricted to curated databases. Although two independent reviewers screened records with consensus resolution, we did not report an inter-rater reliability statistic. Fourth, the same team that conducted the review developed the framework, a design that risks confirmation bias despite the mitigation steps described in Section 2.7; independent replication of the convergence analysis would strengthen the framework's foundations. Fifth, MBCRF is a conceptual framework awaiting empirical validation: its propositions (Section 4.3) are testable hypotheses rather than established findings, and its generalizability across Muslim denominations and cultural contexts, including communities less receptive to Sufi-derived practice, remains to be demonstrated.

Conclusion

Through a systematic review of 47 empirical and theoretical studies on *Muraqaba*, cognitive restructuring, and anxiety, we developed the *Muraqaba*-Based Cognitive Restructuring Framework. The review identified four domains of convergence between *Muraqaba* and CR attentional redeployment, metacognitive monitoring, cognitive defusion, and meaning reconstruction that together justify their integration as a combined therapeutic protocol (RQ1). The five-stage MBCRF protocol (*Niyyah* Establishment, *Muraqaba* Induction, Islamo-Cognitive Identification, Divine Reframing, and *Muhasabah* Consolidation) translates this integration into a clinically implementable framework that preserves the theological integrity of *Muraqaba* while retaining the empirical rigor of CR. It formalizes its central claims as five falsifiable propositions (RQ2). The framework offers a culturally responsive, theologically grounded approach for treating anxiety among Muslim university students in Indonesia, a population underserved by existing secular therapeutic models.

MBCRF contributes to three fields. For Islamic guidance and counseling, Muraqaba is operationalized as a protocol-ready therapeutic technique rather than a diffuse spiritual resource. For CBT and clinical psychology, it shows how integrating a theocentric contemplative practice can extend the mechanisms of cognitive restructuring for religious populations. For the interdisciplinary study of religious and spiritual interventions in

mental health, it offers a mechanism-based integration methodology that distinguishes evidence-informed faith-integrated therapy from uncritical eclecticism and builds in explicit safeguards against spiritual bypass. Future research should prioritize quasi-experimental and randomized trials of the MBCRF protocol, process studies examining its hypothesized mechanisms (P1–P5), and cultural adaptation research testing its applicability across diverse Muslim communities.

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