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Community-Based Psychospiritual Support for Muslim Women: Integrating Positive Psychology and Spiritual Coping Through *Majelis Taklim* Ummahat in Bandung, Indonesia

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Abstrak

This article examines a culturally situated community-engagement programme that integrated positive psychology, Islamic spiritual coping and peer support within *Majelis Taklim* Ummahat in Bojongloa Kaler, Bandung, Indonesia. The Gerakan Self-Healing Muslimah was implemented from April to July 2026 through participatory problem identification, co-planning, four thematic learning sessions, observation and reflection. The community comprised approximately 120 active members; 87 participants had matchable pre- and post-program monitoring records, and 10 contributed interview accounts. Activities combined Qur'anic and Hadith study, Islamic history, *muhasabah*, *halaqah* discussion, gratitude practice, reflective dhikr and self-change journaling. Reported descriptive indicators changed from 45% to 82% for mental health literacy, from 62% to 34% for self-reported stress symptoms, and from 55% to 84% for daily righteous-deed practice. Participants' accounts portrayed small-group discussion as an accessible space for voluntary disclosure, listening and mutual encouragement. The programme also documented educational materials and initial commitments to peer-support continuation. Because the measures were adapted for programme monitoring, the documentation lacks sufficient item-level psychometric information, and no comparison group or long-term follow-up was available, these changes cannot establish clinical effectiveness or causal impact. The contribution is a context-sensitive, non-clinical model of community learning whose feasibility and limitations inform future evaluation and referral partnerships.

Kata Kunci:
Perempuan Muslim, Dukungan Psikospiritual, Literasi Kesehatan Mental, Koping Spiritual

Abstrak

Artikel ini mengkaji program pengabdian masyarakat yang mengintegrasikan psikologi positif, koping spiritual Islam, dan dukungan sebaya di Majelis Taklim Ummahat, Bojongloa Kaler, Kota Bandung. Program Gerakan Self-Healing Muslimah dilaksanakan pada April–Juli 2026 melalui identifikasi masalah secara partisipatif, perencanaan bersama, empat sesi pembelajaran tematis, observasi, dan refleksi. Komunitas memiliki sekitar 120 anggota aktif; sebanyak 87 peserta mempunyai catatan pemantauan praprogram dan pascaprogram yang dapat dipasangkan, sedangkan 10 peserta memberikan keterangan wawancara. Kegiatan mencakup kajian Al-Qur'an dan hadis, sejarah Islam, muhasabah, diskusi halaqah, praktik syukur, zikir reflektif, dan jurnal perubahan diri. Indikator deskriptif yang dilaporkan berubah dari 45% menjadi 82% untuk literasi kesehatan mental, dari 62% menjadi 34% untuk gejala stres yang dilaporkan sendiri, serta dari 55% menjadi 84% untuk praktik amal saleh harian. Wawancara menggambarkan halaqah sebagai ruang berbagi sukarela, mendengarkan, dan saling menguatkan. Mengingat instrumen digunakan untuk pemantauan program, dokumentasi psikometrik per butir belum memadai, dan tidak tersedia kelompok pembanding ataupun tindak lanjut jangka panjang, perubahan tersebut tidak dapat dianggap sebagai bukti efektivitas klinis atau dampak kausal. Kontribusi artikel terletak pada model pembelajaran komunitas nonklinis yang peka konteks, beserta batasan dan implikasinya bagi evaluasi lanjutan.

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INTRODUCTION

Mental health is shaped by the conditions in which people live, the resources available to them and their opportunities to obtain respectful support. The World Health Organization (World Health Organization, 2022) frames mental health promotion as a multisectoral responsibility that extends beyond specialist treatment to supportive environments, social inclusion and accessible forms of care. Community institutions can therefore contribute to health literacy and everyday coping even when they are not clinical providers. Such contributions require clear boundaries: educational activities may create opportunities for reflection and mutual assistance, but they should not be confused with diagnosis, psychotherapy or evidence of treatment efficacy. WHO guidance on community mental health services underscores the importance of person-centred, rights-based engagement and linkages to appropriate care (World Health Organization, 2021). These principles are particularly pertinent when discussing emotional distress in settings where individuals already seek social and spiritual guidance.

For Muslim communities, experiences of psychological difficulty are shaped by intersecting religious, relational and institutional factors. Tanhan and Young demonstrate that beliefs, stigma, perceived control, knowledge and social contexts influence engagement with mental health services (Tanhan & Young, 2022). A review of Muslim clients' support experiences further indicates that religious identity can facilitate meaning-making and trust while some interpretations and social pressures may delay formal help-seeking (Mahmood & McAloney-Kocaman, 2026). Faith should consequently be understood neither as a universal protective factor nor as an inherent barrier to care. A central challenge for community engagement is to identify culturally meaningful practices without suggesting that spiritual participation substitutes for evidence-based support when professional assessment is indicated.

Faith communities can operate as trusted sites for social connection and educational engagement. A scoping review of partnerships between faith communities and the mental health sector identified potential gains in literacy, stigma reduction and referral capacity, but it also highlighted weaknesses in evaluation and sustainability evidence (Perez et al., 2025). Evidence from systematic reviews of peer-support approaches similarly suggests that supportive relationships can be valued by participants while implementation conditions, boundaries and outcome measurement remain consequential (Cooper et al., 2024). These findings do not establish that an individual *majelis taklim* programme improves psychological symptoms. Rather, they provide a rationale for investigating whether a familiar religious-learning setting can host structured, psychologically informed and non-clinical forms of mutual support.

In Indonesia, the need to connect psychosocial concerns with accessible community education has prompted a growing set of initiatives. Yusvita et al., reported a programme addressing maternal mental-health knowledge (Yusvita et al., 2024), while Mulyani et al., described mental-

health education through Islamic values in a *majelis taklim* setting (Mulyani et al., 2025). Psychospiritual education involving *majelis taklim* members has also been applied to health-management activities (Asnaniar et al., 2025). More recently, Norman et al., discussed Islamic psychoeducation and mental-health literacy among *majelis taklim* members (Norman et al., 2026). These studies demonstrate that religious community settings are not a new intervention venue. The relevant contribution of the present programme must therefore be specified more precisely: a participatory sequence combining structured reflection, non-judgmental peer engagement, everyday spiritual coping and descriptive programme monitoring in an established Muslim women's community.

Majelis Taklim Ummahat, located in Bojongloa Kaler, Bandung City, provided the institutional setting for this programme. The programme description reports approximately 120 active women members aged 25–55 years. An assessment conducted in April 2026 through questionnaires, informal interviews and discussions with coordinators identified emotional fatigue, challenges in managing everyday stress and limited opportunities for structured self-reflection. The assessment also suggested a gap between familiar religious teaching and explicit discussion of mental-health literacy and practical coping. These are the locally reported needs that motivated the Gerakan Self-Healing Muslimah. They should not be interpreted as a clinical prevalence estimate, because the initial community assessment was not described as a diagnostic survey.

The intervention linked familiar Islamic concepts with educational practices that participants could use within their own social and spiritual vocabulary. *Muhasabah* supported reflection on experiences and responses; shukr was linked to gratitude journaling; dhikr was used as a reflective practice; and *tawakkal* and *sabar* offered language for discussing meaning, uncertainty and perseverance. Positive psychology supplied a complementary educational perspective focused on constructive attention, gratitude, self-compassion and intentional behaviour. A meta-analysis found that expressed gratitude interventions can yield modest benefits for psychological well-being across study settings (Kirca et al., 2023), but that evidence cannot be transferred directly to this four-session programme. Likewise, foundational work on positive education offers conceptual support for strengths-oriented learning, not clinical validation for the current intervention (Seligman et al., 2009). This distinction between a theoretical rationale and programme-specific evidence is central to the present analysis.

The programme additionally used the Ulul Ilmi concept as an interpretive Islamic educational framework connecting knowledge, faith, reflective responsibility and action. Its use here is conceptual rather than psychometric. Earlier scholarship developed the Ulul Ilmi model primarily in Islamic education and character formation (Abdussalam et al., 2020; Budiyanti et al., 2016); subsequent applications continue to concern student learning and character outcomes (Budiyanti et al., 2024). The present article does not infer a measured change in *Iman*, spiritual maturity or Ulul

Ilmi as a psychological variable. Instead, the concept offers a locally meaningful perspective for considering how learning, reflection and daily commitments are narrated by programme participants.

This article aims to document the implementation of a participatory, community-based psychospiritual support programme; describe its short-term monitoring indicators and participants' accounts; and examine what the experience suggests for culturally responsive, non-clinical mental-health promotion in Muslim women's learning communities. Its contribution is a bounded account of feasibility, implementation arrangements and preliminary monitoring-not proof of clinical improvement, sustained behaviour change or causal effectiveness. Explicit attention is given to the measurement, participation and referral questions that must be resolved before stronger conclusions can be drawn.

METHODS

Programme Setting, Participants, and Design

The Gerakan Self-Healing Muslimah was implemented between April and July 2026 at *Majelis Taklim* Ummahat, Masjid Qoshrul Muttaqin, Bojongloa Kaler, Bandung City, West Java, Indonesia. The reported membership base consisted of approximately 120 active women aged 25-55 years. The programme was organized as a community-engagement activity using a Participatory Action Research (PAR) orientation rather than as a controlled clinical trial. The analytic material comprised implementation records, session attendance, reflection documents, programme-monitoring questionnaires and accounts from participant interviews. The description in this article is restricted to information present in the retained activity documentation and the programme documentation; there has been no reconstruction of missing individual-level data.

Quantitative monitoring was described as having 87 matchable pre-program and post-program cases. Programme records indicate that participant codes were used to pair these records and that incomplete or unmatched records were excluded. The exact dates of assessment administration, numbers of initially approached and assessed members, and reasons for individual non-completion are not provided. Accordingly, the 87 cases are presented as a complete-case monitoring sample, not as a random or demonstrably representative sample of all active community members. Ten participants were purposively selected for interviews, with the source description citing differences in attendance, reflection involvement and willingness to describe their experiences. It is not established whether all interviewed participants belonged to the 87 complete monitoring cases.

Participatory Action Research Orientation

The programme articulated six connected activities: joint identification of problems, co-planning, action, observation, reflection and re-planning. Preliminary discussion with community

coordinators was used to establish the relevance of mental-health literacy, everyday emotional burdens and opportunities for peer support. Programme design then organized four sessions around spiritual orientation, emotional awareness, coping practice, gratitude, self-compassion and collective reflection. Observational and participant-feedback materials informed discussions about delivery. In PAR, however, participation is more than attendance or consultation; it involves community knowledge, shared decisions and iterative action (Cornish et al., 2023). The existing manuscript reports collaboration with coordinators and members, but does not preserve a decision-by-decision record showing exactly which suggested changes were adopted after each reflection. For this reason, the analysis describes a PAR-oriented implementation process without assuming that every claimed cycle of collective decision-making is fully traceable.

The work was therefore interpreted through two linked dimensions. The first concerns the practical sequence documented by the team: identifying needs, selecting a culturally accessible format, providing learning activities and reviewing responses. The second concerns the quality of participation: whether members experienced agency, confidentiality, voluntary disclosure and mutual encouragement. These dimensions are related but not interchangeable. A well-attended programme may still be facilitator-directed, whereas a smaller activity may afford stronger participant influence. The study thus treats evidence of participatory design as a process claim whose strength depends on the available documentation.

Intervention Content and Session Sequence

Seven interrelated activities formed the educational repertoire: Qur'anic study, Hadith study, Islamic history study, *muhasabah*, *halaqah muslimah*, personal reflection and self-change journaling. The four thematic meetings were designed as approximately two-hour sessions held once each month. Between sessions, participants were encouraged to use reflection worksheets, journaling or coping exercises. The intervention was not presented as a standardized psychotherapy manual; facilitators introduced concepts through familiar religious language and guided discussion. The labels "self-healing" and "psychospiritual support" refer to the programme's community-education identity, not to a clinically established treatment protocol.

Four sessions were reported with attendance counts of 77, 79, 82 and 85, respectively. These are session-level counts, not evidence that the same participants attended every session. Table 1 consolidates the schedule and intended outputs, avoiding duplicate presentation of similar material in separate agenda and replication tables. Each stated output identifies what a session was designed to elicit; it is not a claim that every participant completed the associated product.

Table 1. Programme Sessions, Core Activities, and Documented Attendance

Session	Focus	Core activities and inter-session work	Attendance
April	Healing Without	Qur'anic/Hadith study; *muhasabah*;	77

Session	Focus	Core activities and inter-session work	Attendance
	Losing Tawhid	personal reflection; reflection worksheet	
May	Integrating Psychology and Spirituality	Islamic history; emotional awareness; small-group *halaqah*; coping practice; journaling	79
June	Self-Love Through Faith and Righteous Deeds	Gratitude; self-compassion; self-change journaling; individual targets	82
July	Building a Sustainable Self-Healing Community	Peer reflection; review of journals; facilitator preparation; follow-up commitments	85

Monitoring Measures and Qualitative Documentation

Programme monitoring used three domains reported before and after implementation: mental-health literacy, a self-reported stress-symptom indicator and daily righteous-deed practice. The first was described as a short questionnaire concerning stress recognition, self-care and coping; the second as a checklist informed by, but not claimed to be equivalent to, DASS-21 concepts; and the third as a self-report of everyday religious and prosocial conduct. The available documentation does not provide item wording, response options, scoring algorithms, thresholds defining the reported percentages, or item-level distributions. It therefore cannot support independent calculation of scale scores, psychometric reliability, clinical cut-offs or comparisons with validated instruments. Indonesian validation research shows that measurement properties should be established for the population and instrument concerned (Hakim & Aristawati, 2023; Juniarni et al., 2025; Kaligis et al., 2022). These sources inform interpretation here but do not retroactively validate the programme checklists.

The monitoring analysis was restricted to the three programme-reported pairs of percentages across 87 matchable cases and their arithmetic difference in percentage points. No inferential significance testing, treatment effect, diagnosis or confidence interval was generated because the underlying individual responses were not provided for independent re-analysis. In addition to these three indicators, the programme documentation reports a baseline measure of familiarity with emotion-regulation techniques and a post-session demonstration of practical coping tasks. The latter used an operational criterion of completing at least three of four tasks independently and explaining their purpose. Because "awareness of a technique" and "independent demonstration of skills" are different constructs, they were not pooled into a common paired change score. The number of people assessed for the post-session practical task was not stated, so the reported 76% has an unresolved denominator.

Qualitative material consisted of interviews with ten purposively chosen participants, facilitation notes, reflections and documentation of *halaqah* activity. The programme documentation contains four illustrative interview excerpts attributed to coded speakers P1–P4 and groups the experiences around being heard, voluntary participation, emotional relief, perspective-taking and

encouragement. The documentation does not establish a full interview transcript corpus, translation protocol, saturation assessment, dual-coder process or formal thematic-analysis audit trail. Accordingly, quotations are treated as illustrative accounts that contextualize the described programme, rather than as evidence of prevalence, representativeness or generalized causal change.

Ethical Boundaries and Non-Clinical Referral

The source programme description reports that participants were informed about voluntary participation, confidentiality and the freedom not to disclose personal experiences. *Halaqah* facilitation emphasized non-judgmental listening and an option to remain silent. The activities were described as non-clinical; community facilitators did not diagnose psychiatric disorders or provide psychotherapy. Participants experiencing persistent or severe difficulties were reportedly encouraged to seek qualified health or mental-health assistance. This division of responsibility is consistent with the WHO (World Health Organization, 2021, 2023), emphasis on rights-based, accessible support and appropriate links with trained care providers. However, the documentation supplied for copyediting does not name a specific referral facility, provide the ethical-review status, or establish permission for publication of each identifiable photograph. These matters require author verification before production release and are not presumed resolved by editing.

RESULTS AND DISCUSSION

Cultural Adaptation and Contextual Mental Health Literacy

The programme was introduced within a familiar religious-learning environment rather than as an external mental-health clinic. Facilitators described emotional burdens through expressions such as kesehatan batin, kelelahan emosi, mengelola beban pikiran and menenangkan hati, then related these expressions to stress recognition, coping options and self-reflection. *Tawhid*, *sabr*, *shukr*, *muhasabah*, *tawakkul* and *dhikr* provided additional meaning-making language for the exercises. The programme's culturally situated vocabulary is a documented feature of implementation; whether it reduced stigma or improved help-seeking was not independently measured. This distinction matters because acceptability observed during sessions does not necessarily predict sustained engagement with services or the resolution of distress.



Figure 1. Home-Based *Halaqah* Learning Activity

The recurring delivery format combined guided study with personal reflection and small-group dialogue. Qur'anic and Hadith materials were discussed in relation to everyday experiences, while historical narratives were used to invite examples of perseverance and personal agency. The programme did not present its religious elements as diagnostic procedures. Instead, they operated as familiar starting points for discussing problems that might otherwise remain private. This practical translation between established religious practices and health-related language is a feature potentially transferable to other communities, provided local members participate in adapting the content and safeguards are retained.

The programme's principal contextual feature is its use of an existing Muslim women's learning community as the starting point for discussing psychological burdens. This choice may make mental-health promotion more accessible because members already recognize the venue, facilitators and vocabulary. Scholarship on Muslim mental-health service use cautions, however, that cultural proximity is not itself sufficient: relational trust, stigma, privacy and compatible service pathways shape whether individuals can translate supportive conversations into appropriate help-seeking (Mahmood & McAloney-Kocaman, 2026; Tanhan & Young, 2022). The language of *sabr* or *tawakkul* can provide meaning, but it can also be misunderstood if distress is interpreted exclusively as a failure of faith. Effective community education needs to support both spiritually meaningful coping and the legitimacy of seeking professional assistance.



Figure 2. Reflective Learning Session at the Mosque

Research on faith-community mental-health partnerships offers a productive comparison. Perez et al., found that mental-health education, leader preparation and referral arrangements are recurrent partnership components, but evidence on longer-term continuation remains limited (Perez et al., 2025). The Ummahat programme similarly combined education and peer engagement, yet no formal partnership with a named mental-health service was documented. The difference is substantive. A culturally sensitive learning session may increase perceived acceptability; an institutional referral relationship requires defined responsibilities, contact procedures and safeguarding arrangements. The current programme represents the former and can inform development of the latter.

National community-engagement studies reinforce the need to define novelty carefully. Mulyani et al., documented mental-health education through Islamic values in a *majelis taklim* setting (Mulyani et al., 2025), while Norman et al., reported Islamic psychoeducation directed toward mental-health literacy (Norman et al., 2026). Asnaniar et al., integrated psychospiritual education into community health-management activities (Asnaniar et al., 2025), and Yusvita et al., addressed maternal mental-health awareness (Yusvita et al., 2024). The Ummahat programme does not establish the first use of a religious gathering for mental-health education. Its distinctive configuration lies in combining participatory planning, sequenced reflection, small-group listening,

self-change records and descriptive monitoring within a single women's community. This is a contextual programme contribution, not a novel validated clinical treatment.

Participatory Action Research and Community Agency

PAR offers an important theoretical lens because it treats community members' experiential knowledge as part of identifying concerns and shaping responses. Cornish et al., emphasize that meaningful PAR involves relationships, power and practical action, not merely the use of surveys or participant discussions (Cornish et al., 2023). In this manuscript, the reported preliminary assessment and co-planning indicate some degree of local agenda setting, and participant quotations provide evidence that the *halaqah* format allowed voluntary contribution. The available material does not, however, show a sequence of documented community decisions, competing proposals, or adopted revisions over successive cycles. As a result, the article should not characterize the PAR process as fully evidenced simply because six conventional stage names appear in the methodology.

For future implementation, a light-touch decision log could capture the concern raised, participant suggestion, decision-maker, action taken and subsequent reflection. Such documentation would strengthen both analytical credibility and community accountability without placing unnecessary paperwork burdens on members. It would also distinguish a facilitator-led curriculum that consults participants from a process in which participants meaningfully determine the programme's design. The present account documents a PAR-oriented approach with reported collaborative elements; whether it constituted shared governance throughout all stages remains an open evaluation question.

Halaqah Peer Support and Psychological Safety

Halaqah activities were organized in groups described as containing five to eight participants. Group agreements included voluntary sharing, respect for different perspectives, confidentiality and an explicit right not to speak. Facilitators were reported to redirect judgmental responses and to encourage listening rather than unsolicited advice. These practices positioned the gathering as an informal setting for relational support, while remaining distinct from structured peer-support services delivered by trained mental-health personnel. Participant accounts suggest that being able to speak without immediate blame was particularly meaningful in this context.

> *"Usually, when I have a problem, I tend to keep it to myself. In the halaqah, I feel that I have a place where I can talk. The other women listen and do not immediately blame me. After sharing, I feel relieved and can see my problems from a different perspective." (P1, interview; quotation retained from the programme documentation)*
>
> *"What I like is that we are not forced to tell our stories. If we are not ready, we can remain silent. But when we are ready, the other women are willing to listen." (P2, interview; excerpt retained from the programme documentation)*

The excerpts convey three overlapping experiences: relief associated with being heard, a sense of psychological safety associated with the right to decline disclosure, and perspective-taking

through listening to others. The other two excerpts in the programme documentation describe greater connectedness and mutual encouragement (P3–P4). These accounts do not show how frequently such experiences occurred among all 120 members or among the 87 complete monitoring cases. They nonetheless provide concrete illustrations of what participants perceived as useful. The quoted wording follows the programme manuscript; whether the interviews were conducted in Indonesian or another language, and whether the published English represents author translation, remains to be confirmed.

The interview excerpts make the relational process tangible: participants described relief in speaking, a right to silence and appreciation for being listened to without blame. These observations are credible as accounts of those interviewed, but they are not equivalent to a measured reduction in distress for the community. The umbrella review by Cooper et al., also concerned organized peer-support approaches, many involving trained or paid supporters, and thus cannot be taken as direct evidence of efficacy for informal *majelis taklim* groups (Cooper et al., 2024). For replication, the Ummahat model would benefit from short training on active listening, privacy, boundaries, appropriate response to distress and safe signposting toward qualified services.

Safety is particularly important because journaling and reflection may invite disclosure of intimate family concerns. The right not to share, clear limits on what may be repeated outside the group and arrangements for private handling of worksheets are therefore substantive implementation features, not merely ethical formalities. WHO guidance provides useful orientation on person-centred supports, referral and the role of non-specialists within systems of care (World Health Organization, 2021, 2023). Facilitators should not be expected to diagnose or manage severe or persistent mental-health concerns. Instead, programmes should identify local professional contacts and an appropriate procedure for directing participants to them while protecting dignity and confidentiality.

Reflective Practices, Spiritual Coping, and the Ulul Ilmi Framework

Structured reflection used worksheets identified in the programme records as "Wounds That Become Light" and "A Love Letter to Myself." These worksheets invited participants to identify feelings, sources of burden, existing responses, gratitude and possible changes in everyday practice. Facilitators introduced four practical activities: gratitude journaling, *tadabbur*-based reframing, emotional self-observation through *muhasabah* and reflective dhikr. Their purpose was to connect discussion with an observable exercise rather than leave coping solely at the level of general advice. The manuscript does not provide completed worksheets or individual journal entries for independent analysis, so the content of participants' reflections cannot be quantified or inferred beyond the descriptions supplied.

At programme entry, 31% were described as aware of an emotion-regulation technique beyond du'a. At guided practice after the sessions, 76% of evaluated participants reportedly met the task-based criterion for independent performance. The percentages refer to different constructs and potentially different denominators. Thus, no 45-percentage-point skill gain is claimed. The stronger defensible interpretation is that the programme introduced structured activities and that a post-session exercise documented a proportion of observed independent demonstrations, subject to confirmation of the task assessor and the number evaluated.



Figure 3. Participants Completing Reflection and Monitoring Activities

The programme combined concepts from different traditions that should be analytically related rather than treated as identical. Gratitude practice and reflection are congruent with parts of strengths-oriented psychology, yet they arise here within an explicitly Islamic vocabulary of *shukr*, *muhasabah* and *dhikr*. Meta-analytic evidence concerning gratitude interventions suggests modest effects on well-being under particular experimental conditions (Kirca et al., 2023). Qualitative research on Sufi meditation in Indonesia likewise documents how participants interpret dhikr and muhasabah in relation to emotional life, although the social context and participants differ substantially from the present programme (Wahyudi et al., 2025). That broader evidence explains why gratitude exercises are plausible educational activities; it does not verify the programme's self-reported results. Likewise, participant descriptions of feeling heard may be consistent with the value of social support, but the processes and outcomes of trained peer-support services are not directly equivalent to lay *halaqah* discussion (Cooper et al., 2024).

The Ulul Ilmi framework further connects knowledge, spiritual meaning, self-accountability and morally informed action. In previous scholarship, it was developed and applied primarily in educational and character-formation contexts (Abdussalam et al., 2020; Budiyanti et al., 2016, 2024). Its contribution to this article is therefore interpretive: it offers a structured way to discuss why participants might relate mental-health learning to faith and daily practices. It should not be presented as a validated mental-health outcome, and the programme did not administer a recognized Ulul Ilmi measurement instrument. Treating the framework as an interpretive lens preserves its intellectual value without conflating theological constructs with psychological scores.

The experience also cautions against presenting religion only in affirmative terms. Religious beliefs may strengthen support and meaning-making yet may also interact with stigma, guilt or reluctance to seek formal care (Mahmood & McAloney-Kocaman, 2026; Weber & Pargament, 2014). A credible community-engagement model should therefore include language that differentiates spiritual encouragement from blame, acknowledges that serious distress can require professional attention, and respects individuals who choose not to disclose personal matters in a group. This is an important safeguard when self-help terminology is used in a setting where participants may associate healing with the resolution of illness.

Programme-Monitoring Outcomes and Evidence Boundaries

Table 2 presents the three principal descriptive indicators reported for the 87 matchable monitoring records. Mental-health literacy was reported at 45% before and 82% after programme implementation; the self-reported stress-symptom indicator at 62% and 34%; and daily righteous-deed practice at 55% and 84%. The resulting arithmetic differences are +37, −28 and +29 percentage points, respectively. Because the scoring rules and categorical thresholds are unavailable in the supplied documentation, each value is reproduced as a programme-defined percentage rather than reinterpreted as the percentage of clinically affected participants or an independently validated scale score. Figure 4 provides a visual comparison of these recorded indicators without introducing new measurements.

Table 2. Pre- and Post-Programme Monitoring Indicators as Reported (87 Matched Records)

Indicator	Pre (%)	Post (%)	Difference (pp)
Mental-health literacy (programme-defined)	45	82	+37
Self-reported stress-symptom indicator (programme-defined)	62	34	−28
Daily righteous-deed practice (programme-defined)	55	84	+29

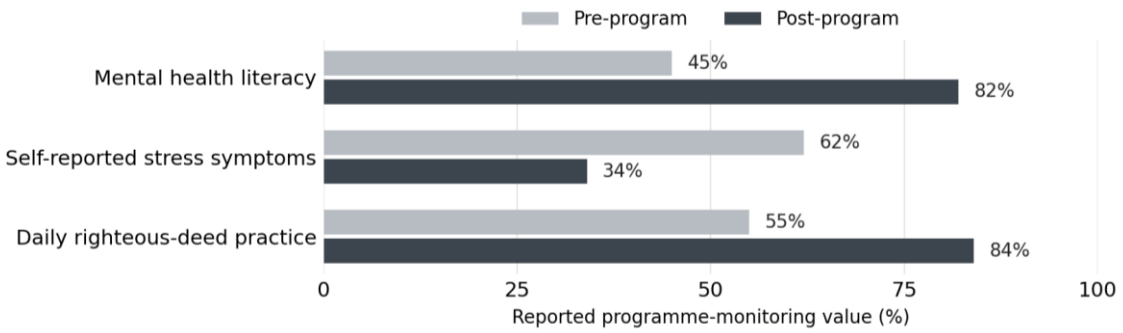


Figure 4. Visual Comparison of Programme-Reported Monitoring Percentages

The differences occurred within the same four-month period as the programme. They may reflect the educational activities, experiences outside the programme, continuing religious participation, social relationships, changes in self-reporting or other contextual factors. A one-group, short-term design cannot distinguish these explanations. The indicator described as stress is particularly sensitive to interpretation because an adapted checklist is not interchangeable with a validated depression, anxiety or stress measure. The results therefore justify a description of favourable reported changes in monitoring indicators, not a claim that the programme treated stress, reduced disorder prevalence or outperformed another intervention.

The reported changes of +37, −28 and +29 percentage points warrant attention because they indicate different directions of self-report over the programme period. They do not, however, all measure the same phenomenon. Literacy, symptom reporting and religious conduct have different conceptual meanings and different vulnerabilities to response bias. Without item wording, scale definitions, reliability information and raw matched data, it is not possible to determine whether the changes represent shifts in actual knowledge, changes in willingness to report, changes in item interpretation, or changes in everyday experience. The figures also cannot establish individual-level improvement from aggregated percentages alone. This is not a technicality: reliable interpretation depends on knowing what was measured and how.

Indonesian psychometric research provides useful comparators rather than post hoc certification. Kaligis et al., examined the translation and measurement properties of mental-health literacy and help-seeking questionnaires (Kaligis et al., 2022), while Hakim and Aristawati evaluated the Indonesian DASS-21 among early adults (Hakim & Aristawati, 2023). Juniarni et al., assessed a Bahasa Indonesia mental-health literacy scale in adolescents (Juniarni et al., 2025). The populations and measures in these studies differ from those of the Ummahat programme, but they illustrate the degree of specification required to make measurement claims replicable. Future versions of the programme should define each construct, document all items and response categories, establish appropriate validity evidence in adult community participants and report clear denominators. With complete paired data, prespecified analyses and uncertainty estimates could then be considered. A statistical test cannot repair an undefined measurement construct.

The data illustrate an additional point about communicating improvement responsibly. The stress-related percentage decreased while the literacy and daily-practice percentages increased; the same visual direction cannot be attached to all three variables. Figure 4 accordingly displays each indicator as reported, without aggregating them into a composite success score. Nor should the 31% awareness figure be compared numerically with 76% demonstrated performance as though they were repeated measures of the same skill. Keeping constructs distinct makes the paper more informative, not less persuasive, because it enables readers to assess precisely what the programme observed.

Programme Outputs, Sustainability, and Replicability

The programme records identify several tangible outputs: an 80-page Psychospiritual Self-Healing Muslimah module, five- to seven-minute microlearning materials disseminated through a community WhatsApp group, internal certificates for five community facilitators and expressions of commitment from 35 core members to meet fortnightly for peer support. These are reported implementation outputs and prospective continuation arrangements. They are more concrete than an unqualified assertion of sustainability, but their existence and subsequent use still require supporting files and records for independent verification. No verified post-programme attendance series or facilitator-performance dataset was supplied.

The proposed continuation mechanism was embedded in familiar community communication and gathering routines rather than a separate service institution. Such an arrangement may reduce logistical barriers and maintain social contact, but its value depends on whether commitments translate into regular activities and whether facilitators understand the limits of informal support. Table 3 condenses an operationally replicable structure from the session design and separates intended outputs from demonstrated longer-term outcomes.

Table 3. Reproducible Programme Components and Evidence Boundaries

Component	Implementation arrangement	Evidence available	Unverified follow-up
Learning sequence	Four monthly sessions, ~120 minutes each	Session themes and counts 77, 79, 82, 85	Individual retention across sessions
Reflection and coping	*Muhasabah*, journaling, gratitude, *dhikr*	Activities and worksheet titles described	Independent practice after programme
Peer discussion	*Halaqah* with voluntary disclosure rules	Four illustrative participant quotations	Systematic ongoing participation
Educational resources	80-page module and 5-7 minute microlearning	Outputs reported in manuscript	Distribution and use logs
Community facilitation	Five internally certified facilitators	Internal certification reported	Supervision and competence assessment
Continuation plan	35 members expressed commitment to bi-weekly meetings	Commitment reported	Attendance or outcomes of future meetings



Figure 5. Community Learning and Collective Reflection



Figure 6. Community Gathering Related to Follow-up Support Planning

LIMITATIONS AND IMPLICATIONS

This account has several limitations that determine the appropriate level of inference. First, the monitoring design had no comparison group and no long-term follow-up; favourable pre- to post-programme differences cannot be attributed exclusively to the intervention. Second, only summary percentages from 87 matched records were available in the available documentation. Question wording, score construction, missing-data patterns and participant-level responses were not supplied for independent checking. Third, the stress-symptom indicator was described as adapted from DASS-21 concepts but not documented as a validated diagnostic instrument. Fourth, awareness of a coping technique and independently demonstrated performance were assessed as different constructs with unclear denominators for the latter. Fifth, the ten interviews were purposively selected and the documented quotations were illustrative; the record does not establish a formal thematic-analysis or translation-validation protocol. Sixth, the programme took place in one community over four months, and continuation commitments have not yet been matched with longitudinal attendance or outcome evidence.

These limitations point toward practical improvements rather than invalidate the usefulness of all documented activities. A future assessment should retain item-level data and scoring rules,

distinguish session attendance from paired monitoring eligibility, document collaborative decisions after each reflection cycle and include the original interview language and translation procedure. An ethics and safeguarding checklist should explicitly cover informed consent, handling of identifiable photographs, private journals and named professional referral options. Longer follow-up would clarify whether the group's planned continuation actually occurred. Such steps would permit increasingly rigorous evaluation while preserving the cultural accessibility and voluntary nature of the intervention. Editorially, the current evidence supports feasibility and short-term descriptive programme monitoring; claims of clinical efficacy, tested causal mechanisms or durable community impact require additional study.

CONCLUSION

The Gerakan Self-Healing Muslimah illustrates how an established *majelis taklim* can host a culturally grounded, non-clinical programme combining positive-psychology concepts, Islamic spiritual coping, reflection and voluntary peer support. Across four sessions delivered between April and July 2026, the programme reported 87 matched monitoring records, ten qualitative interviews, and programme-reported changes in literacy, stress-related self-report and daily righteous-deed practice. Participants' accounts emphasized being heard, the freedom not to disclose personal concerns, and mutual encouragement.

The programme also described educational resources, facilitator preparation and commitments to continued meetings. Its contribution lies in documenting an accessible implementation pathway and identifying conditions for responsible adaptation. Because measurement definitions remain incomplete and the design lacks a comparator and longer follow-up, the findings should not be represented as clinical improvement or proven causal impact. Future work should combine clearer participatory decision records, validated context-appropriate measures, consent and referral safeguards, and follow-up evidence to assess whether this promising community learning arrangement yields durable, measurable benefits.

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Author Contributions (CRediT)

Nurti Budiyanti: Conceptualization, Methodology, Project administration, Supervision, and Writing-original draft; Indah Sari: Investigation, Data curation, Formal analysis, Visualization, and Writing-original draft; M. Rindu Fajar Islamy: Conceptualization, Investigation, Resources, and Writing-review & editing. All authors contributed to the critical review of the manuscript and approved the final version for publication.

Conflict of Interest

The authors declare no financial or non-financial competing interests that could have influenced the design, implementation, analysis, interpretation, or reporting of this community service programme.

Data Availability and AI Use

Data Availability: The findings presented in this article are supported by community needs assessments, attendance records, matched pre-test and post-test programme-monitoring data, participant interviews, reflective journals, facilitator observations, and programme documentation collected during the Gerakan Self-Healing Muslimah initiative. The underlying datasets have not been deposited in a public repository. Individual-level assessment records, interview transcripts, and personal reflections are not publicly available because they contain potentially sensitive information relating to participants' psychological experiences and personal circumstances. The findings are reported within the methodological and evidentiary limitations of the available records.

Declaration of Generative AI Use: ChatGPT (OpenAI) was used during manuscript preparation and revision to support academic language editing, structural refinement, literature identification, and bibliographic organization. The authors retain full responsibility for the scholarly content, originality, accuracy, and integrity of the manuscript, including the verification of references, interpretation of findings, and approval of the final published version.

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