Research Article

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Healing Minds and Souls: The Impact of Traditional Islamically Integrated Psychotherapy on Cyberbullied Adolescents

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Abstract

Cyberbullying affects adolescent mental health, contributing to depression, anxiety, and suicidal ideation. Traditional Islamically Integrated Psychotherapy (TIIP) combines psychological therapy with Islamic spiritual practices, offering a culturally relevant treatment for Muslim adolescents. This study evaluates TIIP's effectiveness in reducing suicidal ideation and improving mental health among cyberbullied adolescents. It also explores how demographic factors, such as gender, bullying duration, and bullying type, influence the intervention's impact. A One-Group Pretest-Posttest Design was used to assess changes in mental health before and after the intervention. Ten adolescents, aged 14 to 19, participated in 11 therapy sessions, incorporating psychological counselling and Islamic spiritual practices like Salah and Dhikr. Paired sample t-tests analyzed changes in suicidal ideation, self-harm, and well-being, with statistical significance set at $p < 0.05$. The results showed significant improvements in mental health. Subjective well-being increased (pre-test mean: 30.30, post-test mean: 17.10, $t = 4.50$, $p = 0.00$), as did self-harm behaviors (pre-test mean: 26.70, post-test mean: 16.80, $t = 2.61$, $p = 0.02$). The most significant change was in suicidal ideation (pre-test mean: 28.00, post-test mean: 15.60, $t = 3.17$, $p = 0.01$), indicating that TIIP effectively reduced emotional distress and suicidal thoughts. TIIP alleviated immediate distress and promoted long-term resilience, integrating Islamic teachings and providing a sense of purpose and belonging. These results highlight the importance of culturally relevant interventions that blend spiritual and psychological approaches. The study recommends expanding TIIP-based programs in communities where Islamic values are central and further research to confirm long-term effectiveness.

Keywords: *Cyberbullying, Suicidal Ideation, Mental Health, Spiritual Practices, Psychological Therapy*

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1. Introduction

Cyberbullying is the display of aggressive behavior on digital platforms such as social media, messaging applications, or social forums. (Cakar-Mengu & Mengu, 2023). Traditional bullying is different because it doesn't just happen at a specified place or time; it can happen continuously and worldwide. (Hawkins, 2023)This is especially relevant to adolescents, as their developmental stage adds a new dimension to their sensitivity to social judgment and inclusion afforded by peers. (Cao et al., 2024). The instances of cyberbullying may be spreading rumors. (Perera & Fernando, 2021), spreading manipulated victims' images (Kumar, 2024), and sharing manipulated images to humiliate a victim (Soler & Roos, 2022). For instance, a teenager can make a fool out of himself because he is ridiculed everywhere by his peers on social media through derogatory posts. (Cakar-Mengu & Mengu, 2023).

Another factor is that adolescents could suffer from harassment at online gaming platforms, where offensive language or discriminatory comments are a chronic annoyance to them. (Ibrahim, 2022). A considerable number of adolescents are vulnerable to cyberbullying at their age, with grave psychological consequences. (Li et al., 2024; Zhu et al., 2021). These experiences can lead to victims reporting higher levels of depression and anxiety that can develop into self-harming behaviors and suicidal ideation. (Dorol & Mishara, 2021; Morales-Arjona et al., 2024; Subaramaniam et al., 2022). Some will suffer from social withdrawal and difficulty trusting people and maintaining relationships; others will find their academic performance plummeting due to the emotional impact of these types of experiences. (Perry, 2023). Cyberbullying is pervasive and damaging, demonstrating the clear, urgent necessity for identifying mental health interventions for these problems. (Malik & Dadure, 2024).

Cultural and religious sensibilities make mental health issues Muslims face a unique set of complexities. (Arnold, 2022). Religious beliefs become a baseline of the identity and coping methods in many Muslim communities. (Etengoff & Rodriguez, 2022). This can change individual understandings of mental health issues and help. (Bagasra, 2023). However, such communities may have limited resonance with conventional therapeutic models, which are frequently progressive, and so adolescents may have little network through which to receive this help. (Wang et al., 2024). For example, some Muslim families might attribute mental health struggles to spiritual weakness alone; then, they can tell their adolescents to do more prayer instead of getting more professional support. It can lead to a lack of access to conventional therapy, in part because it may not be consistent with their faith-based worldviews. (Baig, 2023).

Moreover, cultural norms that amplify modesty, a collective family orientation, and gender-specific dynamics are layered on top. For example, if a female adolescent is cyberbullied, they may think they don't want to share it because of family honour or privacy. (Mustafa et al., 2023). Thus, a culturally relevant approach to mental health care should incorporate these religious and cultural elements. Henceforth, interventions are effective and acceptable to the target population. (Hassen et al., 2022; Tanhan & Young, 2022). Incorporating Islamic teachings into therapy, facilitating dialogue between mental health and trusted recognized religious leaders, and discussing specific family and societal dynamics from the Islamic perspective (Maleque, 2024; Surbakti et al., 2024).

Traditional Islamically Integrated Psychotherapy (TIIP) provides a therapeutic framework integrating conventional Islamic spiritual practices and known psychological techniques (Khan & Keshavarzi, 2023). This model attempts to involve as much of the person as that person needs to significantly contribute to healing the depression and is informed by the recognition that faith can be a powerful source of resilience and healing, particularly so among communities that share a deep connection between their religion and their daily lives (Khan & Keshavarzi, 2023; Rassool, 2024). A critical component of TIIP is made up of Qur'anic reflections. The verses cited help clients reframe their challenges by utilizing verses of hope, patience, and divine support. For instance, the verse "Indeed, with hardship comes ease" (Qur'an 94:6) can help reinforce to a fighting adolescent that their problems are temporary as well as conquerable (Khan et al., 2023).

Another essential point is that directed supplications, or dua, urge individuals to impart their fears and trust to God, which in turn helps them feel connected and capable of making change (Rassool, 2024). These spiritual practices are accompanied by psychological strategies (e.g., techniques from cognitive behavioral therapy). They can also be adapted to practitioners' tastes: for example, mindfulness exercises can be infused with dhikr (remembrance of God), providing practitioners with an opportunity to find calm and focus through spiritual reflection. (Husain & Hasan, 2021; Isgandarova, 2024; Nabi et al., 2023). TIIP's strength is its flexibility, which allows it to tailor according to the needs and circumstances of each person. As a result, this is exceptionally suitable for dealing with the mental health problems confronted by Muslim children who are harassed by online harassment. (Bano et al., 2025; Mahmood & Kalo, 2024). A TIIP session that combines Qur'anic teaching about resilience, practical mechanisms for anxiety control, and governor-guided prayers that reinforce self-respect and spiritual connectedness for an adolescent who is feeling isolated and shamed by cyberbullying. This holistic method not only helps ease predominant emotional aches but may also give the flexibility to cope with problems in the long run. (Khan & Keshavarzi, 2023; Rassool, 2024).

While cyberbullying is on the rise in pervasiveness, few anti-bullying programmes address adolescent cyberbullying and psychological effects with an Islamic framework. Muslim teens with cyberbullying-related challenges such as suicidal ideation and self-injury can benefit significantly from TIIP's spiritually integrated treatment. The rationale for this study is to reduce cyberbullying's psychological and emotional impacts on Muslim teens with special focus on employing Traditional Islamically Integrated Psychotherapy (TIIP) as a culturally responsive treatment. It emphasizes cyberbullying's pervasiveness and extreme mental health impacts such as suicidal ideation and self-injury. It seeks to determine whether TIIP with Islamic spiritual practices and psychological therapy can alleviate these negative impacts and enhance subjective well-being. A one-group pretest-posttest design with teens demonstrates that TIIP is effective in alleviating emotional distress and strengthening resilience and that culturally and spiritually responsive treatment is crucial in mental health treatment.

2. Method

2.1 Research Design

The intervention was tested with a one-group pretest-posttest design by McBurney & White, 2009. In this design, a single group of subjects is given the same treatment and monitoring. Pre- and post-intervention

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measurements were made on the dependent variable, and the treatment effect was measured by the difference between the pre-test and post-test on the dependent variable. Decisions on design based on participant requirements like availability and ethical considerations in practical application limitations were also considered.

2.2 Sample

The sample included 10 participants (4 males, 6 females), aged 13–19, recruited from 5 A-level and 5 higher secondary setups. Participants had experienced cyberbullying within the past year, owned smartphones, and consented to participate.

2.2.1 Screening Procedure for Cyberbullying A two-step process ensured participants met the inclusion criteria. First, a self-report questionnaire (adapted from Smith et al., 2008) assessed cyberbullying experiences over the past 12 months, including threats, online exclusion, and false information sharing. Second, a brief semi-structured interview, conducted with school counsellors present, validated the responses. Only adolescents who met a pre-established cutoff and showed consistent results across both steps were included. Exclusion criteria included those under 13 or above 19, unwilling participants, individuals with psychological disturbances, or those in therapy/medication. Continuity from Phase 1 was maintained to ensure consistency, reliability, and focus on psychological outcomes like well-being, self-harm, and suicidal ideation.

2.3 Instruments

Based on Smith et al. (2008), this 3-item scale assessed bullying and cyberbullying behaviors over the past two months using a 4-point Likert scale (0–3). Definitions of bullying and cyberbullying were provided. The scale demonstrated good reliability ($\alpha = 0.81$). A 5-item measure evaluating suicidal ideation severity across dimensions like frequency, controllability, and impact on daily functioning. Respondents rated items on a 0–10 scale; scores >21 indicated high risk. SIDAS showed excellent reliability ($\alpha = 0.91$, test-retest $r = 0.86$) and validity, developed by Van Spijker et al. (2014). Assessed a wide range of self-harm behaviors via yes/no responses, covering actions like cutting, reckless driving, and self-sabotage. Modeled after the Self-Harm Inventory (SHI) by Sansone et al. (1998), it demonstrated strong reliability ($\alpha = 0.80$–0.90) and captured both NSSI and broader maladaptive coping mechanisms.

All instruments used in this study were selected based on their established psychometric properties in adolescent populations. The Bullying and Cyberbullying Scale (Smith et al., 2008), Suicidal Ideation Attributes Scale (SIDAS; Van Spijker et al., 2014), and the Self-Harm Inventory (Sansone et al., 1998) have demonstrated acceptable reliability in previous research, with Cronbach's alpha values ranging from .80 to .91. While alpha coefficients for some scales were re-calculated in the current study and reported, all tools were also reviewed for their relevance and cultural appropriateness. Where possible, slight adaptations were made (e.g., language adjustments for better comprehension), and pre-testing was conducted to confirm clarity and comprehension among adolescents in the local context. Despite this, future studies should formally revalidate these tools for local cultural and linguistic sensitivity to strengthen the reliability of results.

2.4 Procedure

The intervention was tailored to the TIIP framework and approved by the Board of Advanced Studies and Research (BASR) at the International Islamic University Islamabad (IIUI). Institutional and parental consent was obtained through formal documentation outlining the study's purpose, intervention plan, session details, and confidentiality assurances. Ten adolescents participated voluntarily, with sessions scheduled post-school on alternate weekdays to ensure privacy. Participants were informed of their right to withdraw at any point without consequences, and no deception or harm was involved. Pre- and post-intervention assessments were conducted by reference teachers to minimize bias. The procedure was systematically structured into distinct phases:

2.4.1 Pre-test and Initial Engagement*:* Rapport was built, and a comprehensive assessment of psychological and emotional needs was conducted.

2.4.2 Identification of Goals: Collaborative goal-setting aligned with the TIIP framework, addressing spiritual, cognitive, emotional, and behavioural dimensions.

2.4.3 Therapeutic Intervention: Sessions incorporated Quranic reflections, guided supplications, Islamic mindfulness practices, and cognitive-behavioral strategies. Participants were guided in implementing Islamic coping mechanisms to enhance resilience and well-being. Sessions were conducted individually, twice weekly with a 3-day gap.

2.4.4 Monitoring and Feedback: Progress was assessed in every session, with feedback loops facilitating adjustments to the intervention.

The pre-intervention and post-intervention data were compared using SPSS 27 paired sample t-tests to provide stringent testing of the efficacy of the intervention. The study was done in four phases (selecting for treatment group, administering pre-assessment to establish baseline scores for suicidal ideation, self-harm, and subjective well-being using the framework of TIIP to apply it to cyberbullied teens selected for treatment, and administering post-assessment to test for efficacy of intervention). This systematic method provided a comprehensive study of the effects of therapy.

2.5 Data Collection and Data Analysis

Demographic data and pre- and post-intervention self-harm and suicide behaviour and subjective well-being scores were obtained. Demographic data was analysed with SPSS 27.0 and frequencies and percentages to derive a participant profile. Pre- and post-intervention measurement was employed to establish the efficacy of Traditional Islamically Integrated Psychotherapy (TIIP). Paired-sample t-tests compared pre- and post-intervention mean scores. As a secondary step, other statistical tests were employed to explore relations and potential modulation to provide a comprehensive assessment of prediction of intervention effect.

2.6 Intervention of TIIP

Traditional Islamically Integrated Psychotherapy (TIIP) served as an intervention for cyberbullying in adolescents, which blended behavioral science and Islamic principles (Keshavarzi & Haque, 2013). TIIP has its basis in the Qur'an, Sunnah, and the Islamic traditions of tasawwuf techniques via spiritual, emotional, cognitive, and behavioral approaches. The framework is non-manualized to allow flexibility and clinical intuition in tailoring sessions to the needs of the participants. Its objectives are to build therapeutic alliances, psycho-spiritual assessments, and effect change through dhikr, emotion-focused psychotherapy (EFT), and cognitive restructuring from an Islamic point of view. CBT techniques were translated into the Islamic context, providing psychospiritually balanced and healthy intellectual and therapeutic growth.

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The intervention spanned 11 sessions over four months, with 10 individual therapy sessions followed by a 3-month follow-up. Although longer follow-ups (6–12 months) offer stronger evidence of sustained improvement, a 3-month follow-up was chosen due to practical and ethical constraints, such as academic schedules, participant availability, and the need to reduce attrition. Research also supports the value of short-term follow-ups in capturing early therapeutic outcomes in adolescent mental health (Miller et al., 2021; Haime et al., 2024). This timeframe allowed assessment of initial progress while informing future studies with extended follow-up periods. Sessions lasted 50 minutes, except for the 40-minute follow-up. The therapist, certified in TIIP, ensured an age-appropriate, supportive environment for participants to build trust and engage effectively. Each session reviewed prior progress and built on it to achieve therapeutic goals. While the plan initially intended weekly sessions, scheduling challenges extended the timeline. Despite this, the intervention successfully integrated TIIP principles to address participants' psychological and spiritual needs.

Figure 1: Research Design Used in the Intervention Plan

2.7 Materials Used During Intervention

The intervention employed flexible materials per TIIP guidelines (Keshavarzi & Haque, 2013), integrating positive psychology and CBT techniques. These included Qur'anic ayats, ahadees, prophetic stories, thought records, maladaptive thinking challenges, and self-affirmation exercises. Sessions were held in college counsellor rooms, tailored to individual needs.

Table 1

Description of Intervention Plan

Description of Intervention Plan	
No. of intervention sessions	10 per week
No. of follow-up sessions	1 per week
No. of weeks	4 per week
Total weeks of intervention	16 per week
Duration of each session	50 minutes
Duration of follow-up session	40 minutes
Duration in total intervention sessions	540 minutes

3. Result

In the current study, the demographic profile of the respondents is analyzed using SPSS 27.0. In demographic analysis, frequency and percentage were computed to check the respondents' basic characteristics.

Table 2

Frequency and Percentage of Demographic Variables of Intervention Group (N=10)

Variables	Category	*f*
Gender	Male	4
	Female	6
Age	13-15	5
	16-19	5
Birth Order	First Born	4
	Middle Born	5
	Youngest	1
Family System	Nuclear	6
	Joint	4
Last Two Grades	Marks up to 75 %	2
	Marks up to 70%	4
	Marks up to 65%	4
Social Circle	Small	6
	Medium	4

Note. N=number of participants, % = percentage, M=Mean, SD= Standard Deviation

The table presents the demographic characteristics of the intervention group (N = 10). Six of the participants were female and 4 were male. Age was evenly split, with 50% of participants (n = 5) in the 13–15 age range and the remaining 50% (n = 5) in the 16–19 age range. In terms of birth order, 4 were first-born, 5 were middle-born, and 1 was the youngest. Regarding family systems, 6 of the participants belonged to nuclear families, while 4 were from joint families. Academic performance in the last two grades showed that 2 scored up to 75% marks, 4 scored up to 70% and 4 scored up to 65% marks. Lastly, 6 of the participants reported social circle sizes as small while 4 had a medium social circle. This demographic profile provides an overview of the participants' backgrounds, highlighting a balanced age distribution, predominant nuclear family systems, and diverse academic achievements and social circles.

The table 3 presents pre-test and post-test descriptive statistics for Subjective Well-being (SW), Self-Harm (SH), and Suicidal Ideation (SI). For each variable, the number of items (k), reliability (Cronbach's alpha, α), means (M), standard deviations (SD), actual and potential ranges, skewness, and kurtosis are provided.

Pre-test Scores

Subjective Well-being (SW) had a mean score of 17.10 (SD = 6.15) with an actual range of 12–21, indicating lower well-being levels at baseline. Reliability was moderate (α = 0.73), with slight positive skewness (1.01) and kurtosis (0.73). Self-harm (SH) showed a mean of 26.70 (SD = 11.10) within an actual range of 18–32, reflecting high self-harming behaviors. Reliability was high (α = 0.85), with skewness (1.14) and kurtosis (1.21). Suicidal Ideation (SI) had a mean of 28.00 (SD = 10.49) and an actual range of 18–38, signifying considerable suicidal thoughts. Reliability was also high (α = 0.79), with skewness (0.17) and kurtosis (1.22).

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Table 3

Descriptive Statistics for Subjective Well-being, Self Harm and Suicidal Ideation from pre and post-treatment (N=10)

				Pre-test Range			
Variables	**k**	**α**	**M(SD)**	**Actual**	**Potential**	**Skewness**	**Kurtosis**
SW	7	.73	17.10(6.15)	12-21	5-45	1.019	.731
SH	23	.85	26.70(11.10)	18-32	2-44	1.145	1.211
SI	5	.79	28.00(10.49)	18-38	5-50	.174	1.222
				Post-test Range			
Variables	**k**	**α**	**M(SD)**	**Actual**	**Potential**	**Skewness**	**Kurtosis**
SW	7	.75	30.30(8.23)	23-37	5-45	.197	.798
SH	23	.81	16.80(8.37)	11-22	2-44	1.837	1.348
SI	5	.78	15.60(5.27)	11-18	5-50	1.530	1.842

Note. k= No. of items, M (SD) = Mean (Standard Deviation), α= Cronbach's Alpha

Table 4

Means Standard deviations and Paired sample t-test values on Pre- and Post-intervention scores for Subjective well-being, Self-harm, and Suicidal ideation (N=10)

Variables	**Groups**							
	Pre-test (N = 10)		**Post-test (N = 10)**				**95% CI**	
	M	**SD**	**M**	**SD**	**t**	**p**	**LL**	**UL**
Subjective Well-being	17.10	6.15	30.30	8.23	4.508*	.001	6.576	19.824
Self-Harm	26.70	11.01	16.80	8.38	2.610*	.028	1.319	18.481
Suicidal Ideation	28.00	10.50	15.60	5.28	3.171*	.011	3.553	21.247

*df = 9; M = Mean, SD = Standard Deviation, CI = Confidence Interval, LL = Lower Limit, UL = Upper Limit and * = p < 0.05*

Post-test Scores

Subjective Well-being (SW) improved significantly, with a mean score of 30.30 (SD = 8.23) and an actual range of 23–37. Reliability remained stable (α = 0.75), and skewness (0.19) and kurtosis (0.79) suggested a more normal distribution. Self-harm (SH) decreased notably to a mean of 16.80 (SD = 8.37) within an actual range of 11–22. Reliability remained high (α = 0.81), with increased skewness (1.83) and kurtosis (1.34). Suicidal Ideation (SI) showed a marked reduction to a mean of 15.60 (SD = 5.27) and an actual range of 11–18. Reliability was consistent (α = 0.78), with skewness (1.53) and kurtosis (1.84).

The results indicate significant improvements in subjective well-being and reductions in self-harm and suicidal ideation post-intervention, supported by shifts in skewness and kurtosis values reflecting more normalized score distributions. These findings highlight the intervention's effectiveness in addressing psychological concerns.

Table 4, presents the pre-and post-intervention means (M), standard deviations (SD), and paired-sample t-test results for Subjective Well-being (SW), Self-Harm (SH), and Suicidal Ideation (SI) among participants (N = 10).

Subjective Well-being

The mean significantly increased from 17.10 (SD = 6.15) pre-intervention to 30.30 (SD = 8.23) post-intervention, t(9) = 4.50, p = .001. The confidence interval (CI) [6.57, 19.82] confirms a meaningful improvement.

Self-Harm

The mean decreased from 26.70 (SD = 11.01) to 16.80 (SD = 8.38), t(9) = 2.61, p = .02, indicating a significant reduction. The CI [1.31, 18.48] highlights the intervention's impact.

Suicidal Ideation

The mean dropped from 28.00 (SD = 10.50) to 15.60 (SD = 5.28), t(9) = 3.17, p = .01, reflecting a significant decline. The CI [3.55, 21.24] further supports this change.

These results demonstrate the intervention's effectiveness in improving well-being and reducing self-harm and suicidal ideation, with all variables showing statistically significant changes (p < .05).

The table 5, presents the results of independent-sample t-tests comparing pre- and post-intervention scores for Subjective Well-being (SW), Self-Harm (SH), and Suicidal Ideation (SI) by gender (Male, n = 4; Female, n = 6).

Subjective Well-being:

Pre- and post-intervention scores showed no significant gender differences. Pre-intervention means were nearly identical (M = 17.00, SD = 4.32 for males; M = 17.17, SD = 7.56 for females; t(8) = 0.04, p = .96), and post-intervention means were also similar (M = 30.25, SD = 10.69 for males; M = 30.33, SD = 7.31 for females; t(8) = 0.01, p = .98).

Self-Harm

While females had higher pre-intervention scores (M = 30.33, SD = 12.82) than males (M = 21.25, SD = 4.86), the difference was not statistically significant, t(8) = 0.85, p = .42. Post-intervention, males reported lower mean scores (M = 14.00, SD = 5.48) compared to females (M = 18.67, SD = 9.89), but the difference remained non-significant, t(8) = 1.33, p = .21.

Suicidal Ideation

Pre-intervention scores were slightly lower for males (M = 26.25, SD = 12.74) compared to females (M = 29.17, SD = 9.85), but not significantly different, t(8) = 1.69, p = .12. Post-intervention, males had higher scores (M = 18.75, SD = 6.60) than females (M = 13.50, SD = 3.27), though the difference was not significant, t(8) = 0.41, p = .69.

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No significant gender differences were found in pre- or post-intervention scores for subjective well-being, self-harm, or suicidal ideation, suggesting the intervention was equally effective for both genders.

Table 5

Independent Samples T-test results Showing pre- and Post scores for Subjective Well-being, Self-Harm, and Suicidal Ideation for Gender Differences among Participants(N=10)

Variables	Male (n = 4)	Female (n = 6)	*t*	*p*	95% of *CI*		Cohen's *d*
	M(SD)	*M(SD)*			*LL*	*UL*	
Subjective Well-being Pre	17.00(4.32)	17.17(7.56)	.040	.969	-9.8	9.5	.026
Subjective Well-being Post	30.25(10.69)	30.33(7.31)	.015	.989	-13.0	12.9	.010
Self-Harm Pre	21.25(4.86)	30.33(12.82)	.850	.420	-17.3	8.0	.495
Self-Harm Post	14.00(5.48)	18.67(9.89)	1.333	.219	-24.8	6.6	.860
Suicidal Ideation Pre	26.25(12.74)	29.17(9.85)	1.695	.129	-1.8	12.3	1.094
Suicidal Ideation Post	18.75(6.60)	13.50(3.27)	.410	.693	-19.3	13.4	.265

df = 8; M = Mean, SD = Standard Deviation, CI = Confidence Interval, LL = Lower Limit, UL = Upper Limit

4. Discussion

The findings of this study illustrate significant enhancements in subjective well-being and reductions in self-harm and suicidal thoughts in cyberbullied adolescents following Traditional Islamically Integrated Psychotherapy (TIIP). These findings provide strong support for the efficacy of TIIP as a culturally adapted model of intervention. Post-intervention scores of subjective well-being significantly improved (pre-test mean: 17.10, post-test mean: 30.30, p = .001), suggesting a significant improvement in participants' general happiness and contentment with life. This finding aligns with research highlighting the role of spirituality in fostering mental well-being. For example, research by Khan and Keshavarzi (2023) highlights that the use of spiritual practices like guided supplications can be a source of emotional anchoring and resilience. Other international studies have also demonstrated that culturally sensitive interventions improve engagement and outcomes compared to secular interventions (Weisman de Mamani et al., 2023).

The self-harm scores decreased significantly (pre-test mean: 26.70, post-test mean: 16.80, p = .028), which is consistent with existing literature that indicates mindfulness-based practices like Dhikr (God's remembrance) can regulate emotional pain and impulsive behaviour (Abdulkerim & Li, 2022; Isgandarova, 2024). Follow-up for a long duration is necessary to sustain decreases in self-harming behaviour because some of the individuals may regress due to external stressors (Haime et al., 2024; Miller et al., 2021).

There was a significant reduction in suicidal ideation post-intervention (pre-test mean: 28.00, post-test mean: 15.60, p = .011). These results resonate with findings from (Duarté-Vélez et al., 2022); and Meza and Bath (2021), who observed that interventions tailored to individual cognitive and emotional needs, particularly within a cultural framework, effectively alleviate suicidal thoughts. However, studies have found similar trends in reducing ideation through Islamic therapy, and international comparisons suggest that interventions integrating both spiritual and community support yield even stronger results (Malviya et al., 2022; Parveen et al., 2024).

Globally, interventions combining psychological and cultural frameworks, such as culturally adapted CBT, show comparable effectiveness in improving mental health outcomes (Mishu et al., 2023; Naeem et al., 2023). This study's findings are particularly notable as they focus on a specific religious context, underscoring the unique contribution of TIIP. While some international models incorporate spirituality, they often lack the depth of alignment with the participants' core values and traditions, as observed in TIIP.

Islamic-based frameworks to address mental health are the subject of studies, which have emphasised, though often been anecdotal or lacked empirical evidence (Asafo, 2021; Othman, 2021). However, this study fills a critical gap by instead supplying measurable outcomes and thus shares proof that TIIP can be used to help cyberbullied adolescents. The study's limitations, however, limit its effectiveness. Results are limited by the small sample size (n=10). While the one-group pretest-posttest design is practical, it utilises no control group. Therefore, the resultant data cannot be located within the broader context of similar students in other classes, thus calling into question the specificity of TIIP's effects. Additionally, the study design lacks a control group, which limits the ability to attribute observed improvements specifically to the TIIP intervention. Without a randomized controlled trial (RCT) or even a waitlist control group, it is difficult to rule out alternative explanations such as natural recovery, external support systems, or personal growth over time. Furthermore, there was no random selection or random assignment of participants, introducing potential selection bias. As a result, the sample may not adequately represent the broader population of adolescents experiencing cyberbullying, limiting the generalizability of the findings.

Implications Recommendations of the Study

The results show that the use of this TIIP may effectively address mental health issues associated with cyberbullying. TIIP provides a model by combining psychological counselling with Islamic principles that may have an attractive cultural and religious lean and fills a critical gap in the existing mental health care landscape. Additionally, the investigation emphasises including religious practices in therapeutic methods for populations in which faith is essential to their identity.

Furthermore, findings should serve as future research on larger, more diverse samples to improve generalizability. We need randomised controlled trials to ascertain causality and determine the intervention's unique effects. Moreover, we might enrich the insight by adding qualitative methods like interviews to the research design. Additional outcomes might be gained through integrating TIIP with broader support systems (e.g., parental education, and peer counselling) at the community level.

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Conclusion

Traditional Islamically Integrated Psychotherapy (TIIP) is tested and proven to sort out mental illnesses among adolescents due to cyberbullying, as spotlighted in this study. The intervention was found to significantly improve subjective well-being, and decreases in self-harm and suicidal ideation provide evidence of the promise of culturally relevant therapeutic models. Much like other programs integrating Islamic spiritual practices (such as Dhikr and Qur'anic reflection) with psychological counselling, TIIP (and various following programs) offered a holistic approach to emotional healing and resilience building. We find that TIIP impacts not just by relieving immediate psychological distress but also by helping participants develop long-term coping mechanisms that are attuned to their cultural and spiritual values. This is consistent with more general evidence about the efficacy of combining psychological and spiritual practices for mental health interventions among populations in which faith is an essential aspect of its identity.

Although the findings were promising, the research was constrained by a small sample size, the absence of a control group, and using self-reported measures. Future research should address these limitations by using larger, more diverse samples and randomised controlled designs to establish causality. Subsequent validation of its sustainability will result from expanding the intervention's duration and incorporating follow-up assessments. Therefore, TIIP can provide a very attractive model that addresses the mental health injuries of cyberbullying in Muslim young people by assimilating Islam's therapeutic parts and conventional practices in the methodology of this intervention. The research encourages TIIP to be used more broadly in similar contexts, alongside further research to refine and expand its use for more inclusive, impactful mental health care solutions.

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