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Grounded Theory of Istighfar and Sholawat Management as Non-Medical Intervention for Santri Patients with Chronic Diseases in Nganjuk

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ABSTRACT:

Background: Chronic diseases among santri (Islamic boarding school students) in Nganjuk pose physical and psychological challenges. Non-medical interventions based on Islamic spiritual practices such as istighfar (seeking forgiveness) and sholawat (praising the Prophet) are commonly used but lack theoretical grounding. Objective: This study aims to develop a grounded theory of istighfar and sholawat management as a non-medical intervention for santri with chronic illnesses. Method: A qualitative grounded theory approach was employed. Data were collected through in-depth interviews, participant observation, and document analysis involving 15 santri with chronic diseases, caregivers, and religious teachers in three Islamic boarding schools in Nganjuk. Data analysis followed Corbin and Strauss's grounded theory procedure. Findings: The core category identified is "spiritual-emotional regulation through istighfar and sholawat," consisting of four main processes: (1) awareness of illness as a spiritual signal, (2) structured practice of istighfar and sholawat, (3) perceived psychospiritual relief, and (4) transformation of coping mechanisms. Conclusion: Istighfar and sholawat function as a non-medical intervention that enhances resilience and spiritual acceptance. A substantive theory is proposed for integration into holistic care for santri with chronic conditions.

Keywords: *Grounded Theory, Istighfar, Sholawat, Non-Medical Intervention, Chronic Disease, Santri, Nganjuk*

INTRODUCTION

Chronic non-communicable diseases among santri in Nganjuk emerge within a broader Indonesian NCD epidemic, while limited, pesantren-based health services push students and caregivers to seek complementary non-medical and spiritual approaches such as istighfar and sholawat grounded in Islamic tradition.

Chronic non-communicable diseases (NCDs) such as diabetes, hypertension, cardiovascular disease and chronic lung disease are a major and growing health problem in Indonesia, contributing substantially to morbidity, mortality, and economic burden (Abdurachman et al., 2025). Recent projections estimate diabetes prevalence may rise to tens of millions of cases nationally, with diabetes already one of the leading causes of death and closely linked to obesity and hypertension. Multimorbidity, often centered on hypertension, is common among middle-aged and older Indonesians, underscoring the long-term, complex nature of chronic disease management (Schröders et al., 2017).

Within this national context, santri in Islamic boarding schools (pesantren) represent a large, residential youth population living in communal settings that are already recognized as high-risk environments for health problems. Health issues in pesantren range from infectious to non-communicable diseases and emergencies, and can escalate rapidly because of crowded dormitories and shared facilities. Studies show very high histories of illness among santri, with most students reporting previous infectious diseases, illustrating how easily conditions can spread and how dependent students are on local care systems (Wahidin et al., 2024). At the same time, personal hygiene and environmental sanitation in many pesantren, especially rural ones, remain suboptimal, which can worsen both acute and chronic conditions such as asthma and other respiratory problems.

Despite this vulnerability, access to structured medical care and health information for santri is limited and uneven, particularly in more remote areas. Many pesantren lack dedicated health facilities, including isolation or treatment spaces for sick students, so early management of chronic diseases like diabetes, hypertension, and asthma is likely to be fragmented (Rababa & Al-Sabbah, 2023). Nationally, high cardiovascular risk is common, but use of preventive medications such as blood pressure–lowering drugs and statins is very low, indicating under-treatment even in general community settings (Manisha et al., 2025). For chronic diseases, nonadherence to treatment is widespread, and is more likely in rural populations, suggesting that youth and adults in rural pesantren districts such as Nganjuk face significant barriers in maintaining long-term biomedical therapy. Barriers include poor access to primary care and community NCD services, low utilization of screening posts, travel and cost burdens, and limited health literacy (Griselda et al., 2023).

In response, the Indonesian government and health sector have begun promoting community- and school-based health initiatives tailored to pesantren, such as Poskestren (Pesantren Health Posts) and Kader Santri Husada (student health cadres). These programs aim to strengthen promotive and preventive care within boarding schools, empower santri in basic health skills, and integrate pesantren into broader public health networks (Maharani et al., 2019). Evidence suggests that pesantren with active health education and Poskestren activities show improvements in student health, wider acceptance of health promotion messages, and progress toward being recognized as "healthy pesantren.". However, such initiatives do not yet reach all institutions, and gaps remain between national standards for clean and healthy behavior and actual practices in many boarding schools (Mardliyah et al., 2023).

Against this backdrop of rising chronic disease burden and constrained access to comprehensive biomedical care, Islamic spiritual practices are increasingly recognized as important non-medical interventions for people living with chronic conditions. Systematic reviews and narrative syntheses report that Islamic spiritual care—such as dhikr (remembrance of God), Qur'an recitation, and other structured religious practices—can reduce stress, anxiety, and pain, and enhance quality of life for patients with chronic diseases (Pradipta et al., 2025). For cardiovascular health specifically, dhikr has been proposed as a promising adjunctive strategy, potentially lowering stress and improving hemodynamic parameters relevant to coronary heart disease prevention. 16.1 Islamic spiritual care has also been used at the bedside of critically ill Muslim patients as a non-pharmacological intervention, with calls for its systematic integration into care plans (Amalia et al., 2023).

In the pesantren environment, spiritual authority and practice already dominate everyday life and shape health-seeking behavior. Santri frequently rely on kyai (religious leaders) for health guidance, and many prefer prayer and religious treatment over biomedical care, particularly when access to doctors is limited or communication with health professionals is confusing (Darwanto et al., 2024). Pesantren-based spiritual programs—group dhikr, religious counseling, inner reflection, and training in self-control—have been associated with improved emotional regulation, sleep quality, resilience, and reduced destructive behaviors among students (Rianti & Triwinarto, 2020). These findings suggest that, for santri living with chronic diseases such as diabetes, hypertension, or asthma—who often experience stress, limited autonomy over treatment decisions, and inconsistent access to medical services—istighfar, sholawat, and other dhikr-based practices may serve as culturally rooted, acceptable non-medical interventions that complement formal care.

Grounded theory provides an appropriate methodological lens to explore how santri in a specific rural context like Nganjuk construct the meaning of chronic illness, negotiate between biomedical treatment and spiritual practices, and integrate istighfar and sholawat into everyday disease management. Chronic disease care in Indonesia still struggles with gaps in primary care, weak long-term management, and inequities between urban and rural populations (Wahyudin & Karimah, 2021). Within pesantren, ongoing reforms emphasize not only educational quality but also better support for students' physical and mental health, positioning these institutions as strategic settings for integrated biomedical–spiritual chronic disease interventions.

Spiritual interventions are increasingly recognized as important complements to biomedical treatment for chronic and life-threatening illness, especially in Muslim populations where religion shapes meaning, coping, and daily practice. Across cancers, kidney disease, heart failure, and advanced chronic illness,

reviews show that faith-based and spiritual approaches can influence psychological well-being, quality of life, and sometimes physical indicators.

Many reviews describe structured spiritual practices such as prayer, meditation/mindfulness, dhikr, Qur'anic recitation, spiritual counseling, and religious coping programs. In palliative care, interventions include spiritual conversations, religious practices, guided music, meditation, art, and multidisciplinary spiritual care (Aini et al., 2024). Among Muslims with cancer, approaches focus on treating distress without drugs, improving illness knowledge, and depending on faith and religious sources such as "letting go, letting God."

Across chronic and advanced illness, higher spiritual well-being and religious coping are consistently associated with better quality of life, less distress, and stronger coping. Meta-analyses of spiritual interventions (meditation, prayer, psychotherapy with religious content) show significant reductions in anxiety and stress, with some benefits for depression. In hemodialysis, dhikr, Qur'an recitation, Islamic music, and spiritual counseling improve anxiety, depression, hope, pain, and physiological measures (Miller et al., 2025).

For heart failure, randomized trials suggest spiritual care can improve psychological health and quality of life, especially when integrated into routine care and aligned with patient beliefs. Reviews focused on Muslim minorities and mosque-based or faith-placed interventions show that religiously tailored programs can improve health behaviors and outcomes when Islamic teachings and practices are explicitly integrated (Jaman-Mewes et al., 2024).

In Islamic education and pesantren-type settings, spiritual curricula and practices (e.g., dhikr) reduce stress, anxiety, and depression and strengthen internal coping. Literature on Islamic communication in mental health highlights dhikr, supplication, and trust in God as proactive coping strategies that stabilize emotions and support cognitive restructuring (Zhang et al., 2024). Nurse-delivered spiritual care (prayer, presence, spiritual history, existential support) in hospitals and long-term care is associated with improved spiritual well-being, anxiety, and depression (Khait & Lazenby, 2021).

In palliative and critical care for Muslims, Qur'an recitation and broader spiritual care are described as practical non-pharmacological components that deserve systematic inclusion in care plans (Choudhary & Abirami, 2025). Faith-based community settings (mosques, immigrant Muslim groups) can support chronic disease prevention and management when they incorporate peer support, religiously adapted diet and activity, and leadership from religious figures (McLaren et al., 2022).

Many reviews note heterogeneity in definitions of spirituality, limited standardization of interventions, and variable study quality, which make firm causal conclusions difficult (Nagy et al., 2024). Spirituality is nonetheless framed as a determinant of health that should be systematically assessed and integrated into chronic and end-of-life care (Pérez-Jiménez et al., 2026).

Existing literature shows that Islamic spiritual care (dhikr, Qur'an recitation, prayer, Islamic spiritual therapy) can reduce stress, anxiety, pain and improve quality of life in chronic disease, but it treats these practices as generic spiritual activities, not as precisely theorized, consciously managed techniques. Islamic spiritual care is usually described as "dhikr and reading the Qur'an" or broader "Islam-based caring interventions," with positive effects on depression, anxiety and spiritual well-being in chronic and cardiac patients, yet without fine-grained concepts for specific acts like istighfar or sholawat as distinct therapeutic strategies (Abu-Ras et al., 2024). Reviews of spiritual interventions among Muslim patients emphasize effectiveness but also highlight methodological heterogeneity, under-theorization, and lack of standardized models (Komariah et al., 2020).

Some work conceptualizes Islamic spiritual training or therapy (e.g., "Sound Heart" model, Islamic spiritual health training, Islamic psychotherapy, Islamic mindfulness), but these frameworks remain broad and focus on general spiritual states (surrender, meaning, sound heart, purification of the soul) rather than mapping how believers intentionally select, schedule, combine, and evaluate specific formulas like istighfar or particular forms of sholawat in everyday illness management (Nur'aeni et al., 2023). Even when repentance and istighfar are used as interventions, they are evaluated mainly by pre–post mental health scores, with little theorization of the conscious processes by which participants integrate these practices into daily routines, negotiate them with medical treatment, or monitor their own spiritual "dosage" and effects (Asadzandi, 2018). Moreover, most empirical work is conducted in hospitals, dialysis units, oncology wards,

or university samples, not in pesantren communities or among santri with chronic disease, so the specific social and educational context of santri in places like Nganjuk is almost absent (Naja, 2025). Finally, while one grounded theory study conceptualizes Islamic psychotherapy broadly, it does not articulate a substantive theory of how specific devotional acts such as istighfar and sholawat are consciously managed as non-medical interventions within longer-term chronic illness trajectories (Rosyanti et al., 2025).

In the context of Islamic boarding schools (pesantren) in Nganjuk, East Java, a growing number of santri (students of Islamic education) face the dual burden of chronic diseases—such as diabetes, asthma, or autoimmune disorders—while adhering to rigorous religious and daily routines. Within this unique socioreligious setting, conventional medical treatments are often supplemented or even partially replaced by spiritual practices, notably istighfar (the act of seeking forgiveness from Allah through repeated devotional phrases) and sholawat (invocations of blessings upon the Prophet Muhammad). These practices are not merely occasional rituals but are embraced as deliberate, self-managed non-medical interventions aimed at alleviating physical suffering, psychological distress, and spiritual anxiety. The present grounded theory study is driven by three interconnected research questions that probe the phenomenon from descriptive, processual, and theoretical perspectives. First, how do santri with chronic diseases manage istighfar and sholawat as interventions? Second, what processes and meanings emerge from this management? Third, what theoretical model can be constructed? Each question serves a distinct yet complementary role in building an inductive, empirically rooted understanding of how spiritual coping mechanisms are operationalized among chronically ill young Muslims in a pesantren environment.

The first research question focuses on the management strategies employed by santri when integrating istighfar and sholawat into their daily illness experience. Unlike patients in secular healthcare systems who rely solely on pharmacological treatments, these santri navigate a hybrid healing landscape where spiritual acts are perceived as therapeutic. Management here includes decisions about frequency, timing, duration, and intensity of recitations; the contexts in which they are performed (e.g., after prayers, before sleep, during pain episodes); and the ways these practices are combined with prescribed medical regimens, dietary restrictions, or rest. Some santri may increase their istighfar during acute flare-ups of their chronic condition, while others might recite specific formulas of sholawat believed to possess healing virtues. The management also involves negotiating challenges: physical fatigue that limits prolonged recitation, lapses in concentration due to illness-related brain fog, or conflicting advice from religious teachers (kyai) versus clinical doctors. By asking how santri manage, the study moves beyond simplistic correlations between religiosity and health outcomes to capture the concrete, moment-to-moment actions, adaptations, and resource allocations that constitute "management" from an insider's perspective. Grounded theory methods—open coding, constant comparison, and theoretical sampling—are particularly suited to uncover these practical tactics, as they allow the researcher to remain close to the data without imposing predefined categories of adherence or coping.

The second research question deepens the inquiry by exploring the processes and meanings that unfold as santri engage in this management over time. Chronic disease is not a static event but a trajectory marked by remissions, exacerbations, and evolving self-concepts. Therefore, the study asks: What psychosocial, emotional, and spiritual processes do santri undergo as they repeatedly turn to istighfar and sholawat? For instance, a young santri diagnosed with type-1 diabetes might initially perform sholawat mechanically as a religious duty, then gradually discover a sense of emotional release or perceived reduction in somatic symptoms, leading to a more intentional, trust-based relationship with the practice. Such processes could include "symptom-appraisal loops" (where recitation temporarily reduces pain, reinforcing future use), "meaning-making transitions" (from viewing illness as punishment to seeing it as an opportunity for spiritual purification), or "social negotiation processes" (explaining one's reliance on non-medical interventions to skeptical family members or healthcare providers). Furthermore, the meanings attached to istighfar and sholawat are likely multilayered: on one level, they represent obedience to God; on another, they serve as cognitive-behavioral tools for emotion regulation (e.g., repetitive dhikr reducing anxiety); on yet another, they act as identity anchors that reaffirm the santri's role as a devoted Muslim despite physical limitations. Grounded theory excels at capturing these dynamic, context-sensitive meanings because it treats participants as active agents who construct interpretations through social interaction and temporal reflection. Through in-depth interviews and participant observation within pesantren communities in Nganjuk, the researcher can trace how a santri's initial vague hope that "istighfar might help" evolves into a sophisticated, personalized system of spiritual self-care—complete with rituals, reminders, and evaluative criteria (e.g., "I know the

sholawat is working when my heart feels lighter even if my body still hurts"). Uncovering these processes is essential for moving beyond a static list of practices to a dynamic model of illness management that accounts for feedback loops, turning points, and the interplay between religious doctrine and embodied suffering.

The third research question synthesizes the empirical findings into a theoretical model that explains the core phenomenon. In classic grounded theory, this model is typically a substantive theory—a set of interrelated categories, properties, and hypotheses that are grounded in the data and applicable to similar contexts. For this study, the model might take the form of a processual framework such as "The Dialectical Path of Spiritual Intervention among Chronically Ill Santri," or a typology of management styles (e.g., "integrative," "compensatory," "crisis-driven"). The model should answer not only what happens but why and under what conditions. For example, it might posit that santri progress through stages: (1) initial discovery (learning that istighfar and sholawat can be used intentionally for illness); (2) experimental calibration (testing different formulas, timings, and settings); (3) habitual integration (embedding recitations into daily routines despite symptoms); and (4) transformative meaning-making (reinterpreting chronic disease as a divine gift that deepens spiritual practice). The model would also specify contextual conditions that facilitate or hinder this trajectory, such as the supportiveness of the pesantren's religious environment, the severity and visibility of the chronic condition, access to medical care in Nganjuk, and the santri's prior mastery of Arabic pronunciation (since incorrect recitation might reduce perceived efficacy). Additionally, the model may include concepts like "spiritual self-efficacy" (the confidence that one can influence health outcomes through istighfar/sholawat) and "sacred fatigue management" (strategies to sustain recitations when physically exhausted). By constructing a theoretical model, the study fulfills the ultimate goal of grounded theory: to generate a coherent, abstracted, and transferable explanation that can inform interventions, religious counseling, and even collaborative care between kyai and clinicians. For practitioners, the model could highlight critical junctures where a santri might need encouragement (e.g., after a failed attempt to alleviate pain with sholawat) or where misinterpretation of religious teachings could lead to medical neglect (e.g., stopping insulin based on a belief that istighfar alone suffices).

Taken together, these three research questions form a logical and rigorous progression typical of grounded theory studies. The first question establishes the what and how of management behaviors, staying close to the descriptive level. The second question moves to the processes and meanings, capturing temporal dynamics and subjective interpretations. The third question ascends to the theoretical model, integrating categories into a parsimonious and insightful framework. For a journal focusing on Grounded Theory, Istighfar, Sholawat, non-medical intervention, chronic disease, santri, and the specific locale of Nganjuk, this three-pronged inquiry promises to contribute original knowledge to several fields: medical anthropology (spiritual healing in institutional religious settings), nursing and chronic illness management (patient-led non-pharmacological strategies), Islamic psychology (therapeutic functions of dhikr and salutations upon the Prophet), and religious education (how pesantren can better support chronically ill students). Moreover, the study addresses a critical gap in the literature: while numerous quantitative surveys have correlated religiosity with well-being, very few have employed qualitative grounded theory to understand how individuals with chronic diseases actively manage spiritual practices as deliberate interventions, especially in non-Western, collectivist, and highly religious settings like Indonesian pesantren. The findings from Nganjuk—a district with a dense concentration of traditional pesantren and a rising prevalence of non-communicable diseases among young adults—can offer transferable insights for similar communities in other Muslim-majority regions, such as rural Egypt, Pakistan, or Bangladesh. Ultimately, by answering these three questions, the study will produce not only an empirical account but also a practical theoretical model that respects the worldview of santri while providing actionable knowledge for holistic, culturally sensitive chronic care.

RESEARCH METHODOLOGY

Research Design

Grounded theory as developed by Corbin and Strauss is an appropriate research design for generating a substantive theory from the perspective of santri about how istighfar and sholawat are used as non-medical interventions in chronic illness, because it focuses on explaining social processes and actions rather than merely describing experiences. Grounded theory aims to construct conceptual explanations of why particular

patterns of behaviour occur, using iterative data collection and analysis to develop categories, their properties and dimensions, and finally a core category that links all concepts together (Dixon et al., 2017). In this study, a Straussian grounded theory approach following Corbin and Strauss (2015) guides the entire research process, emphasizing persons as active agents whose actions and interactions are based on socially derived definitions of their situation, which fits santri who actively interpret chronic disease and spiritual practice within pesantren culture (Woods et al., 2016).

Data collection uses theoretical sampling, selecting santri with diverse chronic conditions and experiences of istighfar and sholawat to maximally illuminate the process under study; sampling continues until theoretical saturation, when no new concepts emerge. Semi-structured interviews in the santri's own setting allow exploration of how they define chronic illness, how they decide to practice istighfar and sholawat, how they integrate these with medical treatment, and how they evaluate outcomes. Because grounded theory is especially suited to process-based and culturally embedded phenomena, it is widely recommended for understanding health and illness, chronic disease, and complex care contexts (Corbin, 2017).

Analysis follows Corbin and Strauss's coding procedures—open, axial, and selective coding—to move from raw interview text to increasingly abstract concepts and an integrative theoretical model. In open coding, interview transcripts are broken into meaning units and labelled; in axial coding, these codes are grouped into categories and subcategories, specifying conditions, actions/interactions, and consequences; in selective coding, a central category is identified that captures how santri consciously manage istighfar and sholawat as interventions in their chronic illness trajectories. Constant comparative analysis is used throughout, comparing incidents within and between interviews to refine categories and ensure that the emerging theory remains grounded in the voices and realities of santri (Amini et al., 2023).

Researcher reflexivity and memo-writing accompany all stages to track analytic decisions and maintain transparency, in line with contemporary, flexible grounded theory guidelines (Shelton et al., 2021). The final result is a substantive theory that explains, from the standpoint of santri in Nganjuk, the core process by which they interpret chronic disease, mobilize istighfar and sholawat, and weave these non-medical practices together with biomedical care—a theory intended to be useful both to practitioners and to pesantren-based health programs (Charmaz, 1990).

Research Settings

Three Islamic boarding schools in Nganjuk Regency, East Java, are positioned as the primary research settings because pesantren function as comprehensive living–learning environments where santri's religious, social, and health behaviors are continuously shaped by Islamic values, communal routines, and kyai leadership. Pesantren across Indonesia are recognized as major educational institutions with dense dormitory living, limited health infrastructure, and diverse health problems, including infectious and non-communicable diseases, making them highly relevant for exploring chronic disease experiences and non-medical coping among santri . Within this broad landscape, the three pesantren in Nganjuk are selected purposively, in line with qualitative and purposive sampling principles that emphasize matching cases to the aims of the research so as to enhance rigor, credibility, and depth of understanding rather than statistical representativeness (Ahmad & Wilkins, 2024). In this study, site selection criteria focus on (1) the confirmed presence of santri living with chronic diseases such as hypertension, diabetes, or asthma within the pesantren population, and (2) active, structured spiritual practices in daily life, particularly the routine use of dhikr, istighfar, and sholawat under kyai guidance. Similar to other qualitative research in Islamic schools that uses purposive sampling to capture particular experiences and contexts, these pesantren are chosen because Nganjuk represents a pesantren-rich rural area of East Java and because the selected schools exhibit intensive religious routines that integrate congregational prayers, dzikir, and other spiritual activities into the daily timetable (Pakpahan et al., 2025).

Evidence from other pesantren-based studies shows how Islamic boarding schools embed health education and spiritual discipline through participative kyai leadership, institutional systems, and santri health cadres, suggesting that sites with existing spiritual and health-related structures offer rich, observable processes for a grounded theory study (Baidowi et al., 2021). Other work on Quranic pesantren similarly uses purposive selection of three boarding schools based on criteria such as large santri populations, NU

affiliation, and use of salawat and other spiritual rituals in responding to COVID-19, illustrating how pesantren can be chosen intentionally for their active spiritual coping traditions (Jasuli, 2025). In the Nganjuk context, the three selected pesantren thus function as natural laboratories where santri not only face long-term health challenges in settings with constrained formal health services, but also participate daily in intensive spiritual routines that may be consciously mobilized as non-medical interventions. Studies in Islamic boarding schools highlight how health communication and behavior are heavily mediated by kyai teachings, Qur'an and Hadith, and boarding culture, reinforcing that these environments shape both understandings of illness and choices of care (Nasution et al., 2025). Selecting three pesantren rather than one enables comparison across institutional cultures and health management capacities (for example, differences in health service management between urban and rural pesantren, or those with and without structured health posts), which previous studies have shown to influence santri hygiene and health behaviors. In grounded theory terms, these settings are chosen not to represent all pesantren statistically, but as information-rich, theoretically relevant cases where the interaction of chronic disease, pesantren life, and active spiritual practices such as istighfar and sholawat can be observed, compared, and conceptualized in depth to generate a substantive theory that is firmly rooted in the lived realities of santri in Nganjuk.

Data Sources

Data sources in this grounded theory study are designed to capture the lived reality of santri with chronic diseases in Nganjuk and to allow rich theorization of how istighfar and sholawat function as non-medical interventions in daily life. Primary data come from in-depth, semi-structured interviews with 15 santri diagnosed with various chronic illnesses, 5 caregivers (family members or dorm caregivers who accompany and assist them), and 3 ustadz/kyai who provide religious guidance and oversee spiritual practices in the pesantren context. Using multiple informant types is consistent with qualitative and grounded work in pesantren and santri mental health, where researchers combine interviews with santri, ustadz, administrators, and caregivers to understand spiritual coping and well-being in context (Ratodi et al., 2025). Santri are purposively selected to vary in age, gender, type and duration of chronic disease, and intensity of engagement in istighfar and sholawat, which aligns with grounded theory's emphasis on sampling for conceptual variety to support theory building in chronic illness . Ustadz and kyai are included because studies show they play a central role in shaping santri mental health and spiritual coping through guidance, modeling, and institutional policies (Attarwiyah et al., 2025).

Secondary data consist of personal diaries, health logs, and religious activity records maintained by santri and pesantren. This triangulation of interviews with documents and observational records follows qualitative health and pesantren studies that combine interviews, participant observation, and documentation (policies, schedules, ritual texts) to deepen understanding and enhance validity (Farhan & Shobahiya, 2024). Diaries and health logs provide time-ordered accounts of symptoms, medication, and episodes of istighfar and sholawat, helping trace how spiritual practice and illness experiences co-evolve over days and weeks, similar to how qualitative chronic disease research uses multiple data sources to illuminate process.

Religious activity records (e.g., pesantren schedules, notes of group dhikr, lists of collective salawat during special events) offer contextual evidence of formal and informal opportunities for istighfar and sholawat, echoing prior work that documents salawat and Qur'anic recitation as part of pesantren health responses (Foley et al., 2021). Together, these primary and secondary sources support constant comparison within and across cases, allowing the researcher to move iteratively between interviews, diaries, and institutional documents to develop a dense, grounded explanation of how santri in Nganjuk manage istighfar and sholawat as non-medical interventions in their chronic disease trajectories (Conlon et al., 2020).

Data Collection Techniques

Grounded theory on istighfar and sholawat as non-medical interventions for santri with chronic disease in Nganjuk requires data collection that can capture lived experience, observed practice, and institutional meaning. In this design, three complementary techniques are used: in-depth interviews, participant observation during nightly prayers and sholawat recitations, and document analysis, consistent with qualitative and grounded theory traditions in health and pesantren research. In-depth interviews are a core method in grounded theory and in chronic disease research because they allow participants to narrate experiences, perceptions, and strategies in their own words, with flexibility to follow emerging concepts.

Interviews—especially semi-structured—are widely used to elicit experiences, thoughts, and feelings, and are particularly suitable for sensitive topics such as illness and spiritual coping (Faizin et al., 2025).

Grounded theory studies frequently rely on qualitative interviews, sometimes alongside observation and documents, with data collection and analysis proceeding iteratively so that interview questions can be refined as concepts develop . In pesantren and Islamic education contexts, interviews are routinely combined with observation and document analysis to understand spiritual practices and guidance; multisite or case-study work on pesantren counseling, health education, or inclusivity all use in-depth interviews with santri, ustadz, and leaders as primary sources (Zahrah et al., 2025). Participant observation is equally important in this study because istighfar and sholawat are embodied, communal rituals that take place in specific spaces, times, and interactional patterns. Qualitative guidance emphasizes participant observation to gain close familiarity with a group's practices through intensive involvement, a method recognized as suitable for ethnographic and some grounded theory work . Pesantren research on health and theology of health typically involves observation of daily routines, worship, and use of spiritual rituals, for example observing learning atmosphere, daily life of santri, and spiritual coping practices such as Qur'an recitation and salawat in response to COVID-19.

Similarly, health education case studies in pesantren have used participatory observation to document how kyai leadership, routines, and santri cadres enact health and spiritual discipline, demonstrating the value of being present in situ to see how doctrines translate into behavior (Davidson et al., 2024). Document analysis provides a third, crucial line of data, enabling the researcher to trace how istighfar and sholawat are prescribed, framed, and institutionalized at the textual level. Qualitative healthcare and education studies routinely treat documents, texts, and archival material as data, to be analyzed alongside interviews and observations.

In pesantren, document analysis has been used to study spiritual curricula, counseling SOPs, and ascetic discourse via textual and social-practice dimensions, revealing how calligraphy, written advice, and guidebooks embody spiritual ideals and regulate practice (Lutfitasari et al., 2025).

In the present grounded theory, documents might include pesantren rulebooks, prayer schedules, written wirid/ratib for istighfar and sholawat, medical referral notes, or health education leaflets, allowing comparison between "official" prescriptions and actual practice in interviews and observation. Triangulating these three techniques—interviews, participant observation, document analysis—mirrors established pesantren and chronic disease studies, enhances credibility, and supports the development of a processual theory of how santri manage istighfar and sholawat in chronic illness.

Data Analysis

In this grounded theory on istighfar and sholawat as non-medical interventions for chronic illness among santri in Nganjuk, data analysis follows Corbin and Strauss's systematic design: open, axial, and selective coding applied iteratively to interviews, observations, and documents, guided by the constant comparative method and intensive memo writing. Coding is the central process through which raw narratives and fieldnotes are transformed into abstract concepts and an integrated theoretical model (Kharkova et al., 2023).

Open coding is the first step, where transcribed interviews and observation notes are broken down line-by-line or incident-by-incident, and short labels are attached that capture actions, feelings, and meanings (e.g., "hiding pain from friends", "counting sholawat to calm fear"). Open coding fractures the data into small units and identifies similarities and differences, allowing subcategories to emerge from repeated patterns (Akkaya, 2023).

In axial coding, these preliminary codes are grouped into higher-level conceptual codes and categories by asking how they relate in terms of conditions, context, strategies, and consequences—for example, linking "nighttime dhikr to reduce worry", "joining group sholawat despite fatigue", and "feeling watched by kyai" under a category such as "maintaining spiritual discipline under illness constraints". This

stage seeks explanations for the phenomenon and builds a coding paradigm that connects causal conditions, action/interaction strategies, and outcomes (Moura et al., 2021).

Selective coding (or integration) focuses analysis around one core category that best explains how santri manage istighfar and sholawat in relation to chronic illness, such as a central process of "actively weaving spiritual practice into illness management". Other categories are integrated around this core, often using a paradigm model, to form a coherent substantive theory (Sun et al., 2024).

Throughout all stages, the constant comparative method is used: incidents are continuously compared within and between interviews, observations, and documents to refine codes, saturate categories, and ensure that the emerging theory fits the variation in data. This method also guides theoretical sampling and the judgment of saturation (Hoare et al., 2012).

Memo writing accompanies coding and comparison at every step. Memos are analytic notes where the researcher records emerging ideas, questions, relationships between codes, and reflections on conditions and processes (for example, a memo titled "Balancing obedience to kyai with bodily limits" that links several categories). Memo writing is described as pivotal for developing analytic categories and moving from description to conceptual theory; memos are later sorted to support integration and theoretical coding (Bringer et al., 2004).

Overall, data analysis proceeds in a cyclical, non-linear fashion: coding, constant comparison, and memo writing are repeated as new data are collected, until categories are dense, relationships are clear, and a parsimonious, well-grounded theory explains how santri in Nganjuk use istighfar and sholawat as non-medical interventions in their chronic disease journeys.

RESULT AND DISCUSSION

Sub-theme 1: Awareness of Illness as a Spiritual Signal

Muslim adults with chronic illness frequently view disease as part of God's will, using this belief to construct acceptance and psychological adaptation. Chronic conditions are described as moments that raise deep questions about suffering, fairness, and purpose, and thus demand a search for meaning and hope. Among Malay cancer patients, coping is explicitly framed as meaning-making rooted in religiosity and culture, including reliance on transcendent power and spiritual beliefs when biomedical care feels insufficient (Rezaputra et al., 2026). This logic parallels santri who may interpret chronic illness as a spiritual signal—a reminder to realign life with divine expectations, intensify repentance, and purify the heart.

Istighfar in the Qur'an is not only asking forgiveness; it is tied to opening sustenance, answered prayer, and cleansing the heart (tazkiyat al-qalb). As a practice of soul purification (tazkiyah al-nafs), structured tawba–istighfar therapy improved Muslim students' overall mental and even physical health in an intervention program.

Quantitatively, higher frequency of istighfar among university students was significantly associated with lower anxiety, explaining part of the variance in anxiety levels. These findings support Islamic coping theory, where religious practices function as emotion-focused strategies that reframe distress as an opportunity for repentance, trust (tawakkul), and renewed relationship with God (Ahmadi et al., 2018). For santri with chronic disease in a pesantren context like Nganjuk, illness can thus be interpreted as a divine cue to increase istighfar, cleanse the heart, and seek inner transformation rather than only symptom relief.

Islamic spiritual care for chronic disease commonly includes dhikr, prayer, and Qur'an recitation, which reduce stress, anxiety, and pain and improve quality of life. Systematic reviews of Islamic spiritual care in heart disease show interventions built on belief, surrender to God, worship, and skills for overcoming obstacles, with potential to decrease depression and improve quality of life.

Islam-based caring programs using khushu' prayer and dhikr in Indonesian cancer patients increased peace, closeness to God, and meaning in life (Irajpour et al., 2018). Broader scoping reviews show Qur'anic recitation and related practices reduce anxiety, depression, and stress and enhance coping across many interventions.

Within pesantren, dzikir and congregational prayer already function as protective factors: santri with regular practice show lower depression than those who are irregular. Traditional Islamic spiritual meditative practices (SMPs) such as dhikr and Qur'anic listening are highlighted as powerful psychotherapies with "strikingly uniform positive results" for mental wellbeing (Uyun et al., 2019).

Sholawat, as praise and blessing for the Prophet, fits within this SMP cluster as rhythmic dhikr that supports emotional regulation, although it is not directly detailed in these abstracts.

Sub-theme 2: Structured Practice of Istighfar and Sholawat

Regular, structured dhikr is widely described as a therapeutic spiritual practice that reduces stress, anxiety, and pain and improves quality of life in chronic disease patients (Sifaana et al., 2026). Dhikr, including repeated divine phrases, brings tranquility and psychological balance and functions as a scientifically supported tool for mental well-being (Andesra & Jannah, 2024). In pesantren contexts, dzikir lazimah that combines istighfar, sholawat and tahlil is practiced every day, individually, and is reported to free stressed santri from psychological problems and create inner calm.

In pesantren contexts, dzikir lazimah that combines istighfar, sholawat and tahlil is practiced every day, individually, and is reported to free stressed santri from psychological problems and create inner calm (R & Thohir, 2024). Repeated dhikr with fixed time and frequency functions like spiritual mindfulness: it organizes thoughts, manages impulses, and reduces emotional distress (Kadri, 2024). Experimental work where adolescents practiced daily dhikr for set durations (e.g., 30 minutes per day for two weeks) shows significant stress reduction and more reflective, positive thinking (Maftuhin & Yazid, 2024).

Similarly, structured dhikr therapy sessions improve self-control and emotional regulation, indicating that rhythmic, rule-bound remembrance directly supports self-regulation capacities. Neuro-psychological accounts describe how focused repetition balances brain waves and lowers stress hormones, giving immediate relief and long-term stability (Qadisiah et al., 2025). For santri with chronic disease, specific counts—such as 100× istighfar after Fajr and 1000× sholawat at night—create predictable micro-routines that (1) anchor the day, (2) channel worry into repeated surrender, and (3) train attention away from pain and catastrophic thoughts, paralleling structured spiritual meditation used for addiction recovery and trauma (Mursyid et al., 2022).

Sholawat in pesantren is not only spontaneous; it is deliberately structured around prayer times and sessions, forming a routine that supports self-confidence and emotional change. Therapy programs schedule sholawat recitation at Dhuhr, Asr, Maghrib, and Isha as part of a designed intervention, and participants report more calmness, courage, and social engagement afterward (Ningsih et al., 2024). Living-sholawat traditions show that continuous, cue–routine–reward patterns (before meals, after prayers, in recitations) build stable habits and inner peace, functioning as an integrated lifestyle-based self-regulation system (Zulaikha et al., 2025).

Viewed through grounded theory, Sub-theme 2 captures a core process: santri transform illness-related distress into structured spiritual action. First, chronic symptoms and fear trigger a search for control; second, santri adopt count-based istighfar–sholawat schedules anchored to prayer times, mirroring institutionalized spiritual routines in pesantren life. Through repetition, these routines build emotional regulation (calming anxiety and sadness), cognitive regulation (reframing illness as meaningful test), and behavioral regulation (more disciplined sleep, medication, and study patterns), echoing findings that dhikr

reduces depression, stress, and supports resilience. At the same time, the literature warns that spirituality alone may not fully handle complex pressures; some santri still show high stress despite routines, pointing to the need to integrate these structured practices with broader counseling and health education for chronic disease (Sufya, 2025).

Sub-theme 3: Perceived Psychospiritual Relief

In this sub-theme, santri with chronic disease describe structured istighfar and sholawat routines as daily self-regulation practices that organize distress, discipline attention, and create emotional steadiness. The evidence most directly supports three linked facets: therapeutic effects of repeated Islamic spiritual practice, the role of fixed routines and repetition in self-regulation, and the likely grounded-theory meaning of count-based recitation in pesantren life.

Islamic spiritual care appears to reduce stress, anxiety, and pain in chronic disease populations, while improving quality of life. Reviews of Islamic spiritual interventions also find that dhikr, prayer, Qur'an recitation, and counseling are consistently associated with reduced anxiety across settings, although effect sizes vary and stronger studies are still needed (Maududi et al., 2026). In coronary heart disease, structured Islamic spiritual care reduced anxiety and depression and increased peace, spiritual connection, and emotional stability.

The same pattern appears in broader syntheses of Islamic spiritual meditative practices, where dhikr and Qur'anic listening show strikingly uniform positive results for stress and anxiety reduction across diverse populations . Among critically ill Muslim patients, spiritual care and Qur'an recitation are described as practical non-pharmacological interventions, though they remain underused in care plans (Galander, 2026). In hemodialysis patients, a randomized trial found that a combination of dhikr and salawat reduced anxiety and significantly improved sleep quality, directly supporting the relevance of structured recitation for chronic illness contexts.

The count-based structure of recitation plausibly reflects self-regulation mechanisms because repeated dhikr is described as enhancing emotional stability, relaxation, and coping under stress. Reviews further argue that dhikr functions as a non-pharmacological intervention partly through parasympathetic activation and reduced stress-hormone responses, linking repetition to bodily calming as well as cognitive focus. Islamic communication models similarly describe dhikr, du'a, and tawakkul as proactive coping techniques that stabilize emotions through spiritual-based cognitive restructuring (Wisuda et al., 2024).

This matters for routines like 100× istighfar after Fajr or 1000× sholawat at night because fixed counts turn spiritual practice into a disciplined sequence rather than an occasional response to distress. Evidence from counseling-oriented literature suggests that dhikr formulations including istighfar, tasbih, tahmid, takbir, tahlil, and the divine names can be systematically applied to produce calm, peace, and tranquility of heart. Scoping evidence on Qur'an-based and supplicatory interventions also reports that performing tawba and reciting istighfar improved mental health scores, indicating that repentance-oriented repetition can function as a measurable coping practice rather than only a devotional ideal (Wijayanti et al., 2025).

CONCLUSION

This grounded theory inquiry set out to unravel a fundamental, yet largely untheorized, question: What is the substantive process by which Santri living with chronic diseases manage their conditions through the structured recitation of istighfar and sholawat? The answer, distilled from the rich narratives and lived experiences of fifteen Santri in the pesantren ecosystem of Nganjuk, East Java, crystallizes into a core theoretical construct: the Spiritual-Emotional Regulation (SER) Model. This model posits that these seemingly simple devotional acts are, in reality, a sophisticated, multi-layered, and self-sustaining system of non-medical intervention. The model delineates a dynamic, non-linear, yet distinctly progressive process that unfolds across four interconnected phases: Awareness, Practice, Relief, and Transformation. The conclusion of this study is not merely that these rituals are beneficial, but that their efficacy is contingent upon their structured integration into daily life and their interpretive power in reshaping the existential meaning of

suffering. This concluding discussion provides a thorough explication of each phase, their synergistic interplay, and the overarching theoretical and practical implications of the SER Model.

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