

A New Perspective on Therapeutic Itineraries for Anxiety Management "A Single Case Formulation of the Effectiveness of Islamic Ruqyah in Reducing Panic Attacks"

منظور جديد في المسارات العلاجية لإدارة القلق "صياغة حالة مفردة لفاعلية الرقية الشرعية
في خفض نوبات الهلع"

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Abstract :

This study explored the efficacy of Ruqyah Shariah (Islamic spiritual healing) in reducing panic disorder symptoms. Using a single-case A-B-A' design, the study examined one participant (age 24) experiencing exam-related panic attacks. Assessment tools included the Bandelow Panic and Agoraphobia Scale and Chambless Agoraphobic Cognitions Questionnaire, administered before and after a 7-week Ruqyah intervention (5 sessions) that combined religious recitations with imaginal exposure.

Results demonstrated significant improvements: panic symptoms decreased from 66.66% to 16.66%, agoraphobic avoidance from 75% to 37.5%, anticipatory anxiety from 62.5% to 12.5%, work/family problems from 62.5% to 25%, health anxiety from 50% to 12.5%, and overall agoraphobic cognitions from 60% to 24.28%.

The study recommends further research with larger samples and suggests developing integrated protocols combining Ruqyah Shariah with evidence-based treatments like CBT, emphasizing collaboration between mental health and religious practitioners.

Keywords: Panic Disorder, Religious Therapy, Therapeutic Itinerary, Ruqyah.

ملخص

هدفت الدراسة إلى استكشاف إمكانات الرقية الشرعية (ممارسة علاجية روحية إسلامية) كنهج علاجي تكميلي لخفض اضطراب الهلع. استخدمت الدراسة تصميم الحالة الواحدة A-B-A' مع حالة واحدة (عمرها 24 عاما) تعاني من نوبات هلع أثناء الامتحانات. تم إجراء التقييمات باستخدام مقياس باندلو للهلوع وخواف الأماكن المفتوحة واستبيان شامبلز للأفكار الخوافية قبل وبعد التدخل بالرقية الشرعية، وذلك لمدة 7 أسابيع (5 جلسات). جمع التدخل بين الرقية الشرعية وتقنيات التعرض التخيلي. أظهرت النتائج بعد التدخل:

- انخفاض في أعراض الهلع من 66.66% إلى 16.66%.
 - انخفاض في التجنب الخوافي من 75% إلى 37.5%.
 - تحسن في القلق المتوقع من 62.5% إلى 12.5%.
 - انخفاض في المشاكل المتعلقة بالعمل/العائلة من 62.5% إلى 25%.
 - انخفاض في القلق الصحي من 50% إلى 12.5%.
 - انخفاض عام في الأفكار الخوافية من 60% إلى 24.28%.
- يوصى الباحثان بإجراء المزيد من الدراسات مع عينات أكبر، وتطوير نماذج علاجية تكاملية تدمج الرقية الشرعية مع العلاجات القائمة على الأدلة مثل العلاج المعرفي السلوكي، مع التأكيد على التعاون بين متخصصي الصحة النفسية والمعالجين الدينيين.

الكلمات المفتاحية: اضطراب نوبة الهلع، العلاج الديني، المسار العلاجي، الرقية الشرعية.

1. Introduction

Panic Disorder is a common mental illness that significantly affects an individual's life and ability to perform daily tasks. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), characterizes this disorder by recurrent and unexpected episodes of intense fear and distress, accompanied by severe physical and psychological symptoms (American Psychiatric Association, 2013). With increasing interest in integrative approaches to mental health, and consideration of the central role of Islam in Muslim society worldwide, alternative therapeutic approaches that acknowledge and provide for patients' spiritual and cultural contexts are being sought an approach that makes it so spiritually sensitive to psychotherapy that these demographic issues have become important. In this context, Ruqyah, a form of religious healing derived from Islamic heritage, is gaining popularity in some communities as a potential way to reduce anxiety symptoms and fear.

A review of the scientific literature reveals a notable knowledge gap in three key aspects of this technique. These aspects encompass its therapeutic efficacy, the underlying psychophysiological mechanisms through which it operates, and the feasibility of its integration into contemporary therapeutic approaches.

Despite these research gaps, preliminary findings from recent studies offer promising prospects. The available research indicates significant potential for this therapeutic modality, opening new horizons in the treatment field.

Razali et al. (2002), found in a study on a sample of Muslim patients with Generalized Anxiety Disorder, that religious and culturally sensitive psychotherapy led to rapid improvements in anxiety symptoms among Muslim patients, with strong religious beliefs.

Furthermore, existing research highlights the potential psychological and physiological benefits of Quranic recitation and Islamic spiritual practices. For instance, Nazir (2023) indicates that Quran recitation can alter physiological parameters within the cardiovascular and respiratory systems ,and the psychological function is enhanced by reducing stress levels,anxiety, depression, or other emotional disorders..

Araqsoui (1992) emphasizes the effect of relaxation and religious Ruqyah in treating hypertension, with a 60% improvement rate among individuals in the sample, reaching 87.11% when Ruqyah is combined with relaxation techniques.

Similarly, Hilsa's (2008) study, "The effect of psychotherapy by the Quran on reducing the level of depression among depressed patients," utilized the Beck Depression Inventory translated by Dr. Abdulkhaleq (1996). The researcher conducted pre and post-tests for each case, then applied six therapeutic sessions lasting one hour each, incorporating Quranic verses reading and Ruqyah. The study demonstrated a significant decrease in the arithmetic mean in the post-test compared to the pre-test. The difference between the arithmetic means of the pre and post-tests was statistically significant. The efficacy of this approach was also supported by the study of Nouredine Za'tar (2016), who developed a multidimensional behavioral therapy program with religious content to reduce depression.

Further supporting a potential link between Islamic practices and stress reduction, Aziz et al. (2019) suggest that listening to the Quran can be a complementary method for reducing stress responses in intensive care patients. Therefore, based on these aforementioned studies, this research aims to analyze the efficacy of Ruqyah and its impact on panic attacks, focusing on the theoretical underpinnings and available empirical evidence. We also aspire to explore how to integrate this approach into modern therapeutic pathways scientifically, methodically, and evidence-based.

2. Conceptual Framework :

2.1. Theoretical Framework of Panic Disorder: A Multidimensional Model

2.1.1 Concept and Diagnosis:

Panic disorder is defined according to globally recognized classifications through two main sources:

1) DSM-5-TR Criteria:

A panic attack is an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and during which time four (or more) of the following symptoms occur;

Note: The abrupt surge can occur from a calm state or an anxious state.

1. Palpitations, pounding heart, or accelerated heart rate.
2. Sweating.
3. Trembling or shaking.
4. Sensations of shortness of breath or smothering.
5. Feelings of choking.
6. Chest pain or discomfort.

7. Nausea or abdominal distress.
8. Feeling dizzy, unsteady, light-headed, or faint.
9. Chills or heat sensations.
10. Paresthesias (numbness or tingling sensations).
11. Derealization (feelings of unreality) or depersonalization (being detached from oneself).
12. Fear of losing control or "going crazy."
13. Fear of dying.

Diagnosis of Panic Disorder necessitates the presence of recurrent and unexpected panic attacks, along with at least one month of persistent worry or concern about having more panic attacks or their consequences, or a significant maladaptive change in behavior related to the attacks (American Psychiatric Association, 2013).

* Symptoms not attributable to physiological effects of substances or other medical conditions.

2) ICD-11 Criteria (WHO, 2022):

- Recurrent episodes of intense anxiety (panic)
- Occur in predictable or unpredictable situations
- Include four or more specified symptoms

2.1.2 Theoretical Explanatory Models:

a) Neurobiological Model:

Recent research by Liberzon and Abelson (2016), published in Nature Reviews Neuroscience, revealed that anxiety disorders stem from disruptions in neural networks that modulate fear and anxiety responses. These findings, supported by neuroimaging evidence from Shin and Liberzon's (2010) research, highlight the neurobiological basis of anxiety disorders.

1) Neurotransmitter Dysregulation: (Graeff & Del-Ben, 2023)

1. Serotonergic Mechanism:

5-HT enhances inhibitory avoidance in the forebrain

5-HT inhibits one-way escape in the midbrain PAG

2. Behavioral Correlations:

- Inhibitory avoidance and anticipatory anxiety are associated with GAD
- Escape behavior is associated with Panic Disorder (PD)

3. Endocrinological Findings:

- HPA axis is activated during anticipatory anxiety

- HPA axis is not activated during panic attacks

4. Functional Neuroimaging Results:

- During panic attacks:

- * Activation of the insula

- * Activation of upper brain stem (including PAG)

- * Deactivation of the anterior cingulate cortex (ACC)

5. Morphometric Analysis Results:

- Panic patients compared to healthy controls show:

- * Increased grey matter volume in the insula

- * Increased grey matter volume in upper brain stem

- * Decreased grey matter volume in ACC

6. Neural Substrates of Interoception:

- Insula and ACC translate interoceptive stimulation into feeling

- Panic patients demonstrate interoceptive supersensitivity

- These regions are potential sites of action for:

- * Drug therapy

- * Cognitive Behavioral Therapy (CBT)

7. Pharmacological Mechanism:

- Antidepressants prevent panic attacks by enhancing 5-HT inhibition in the PAG.

b) Cognitive-Behavioral Model:

Main components according to Clark & Beck's (2023) updated model:

1) Core Cognitive Beliefs:

- Danger beliefs (87% of patients)

- Catastrophic expectations (92% of patients)

2) Disorder Maintenance Cycle:

- Misinterpretation of bodily signals

- Avoidance behaviors

- Self-reinforcing anxiety

2.1.3. Recovery and Healing Criteria:

a) Quantitative Recovery Indicators:

According to Barlow et al.'s (2000) longitudinal study, core criteria include:

1. Reduction in Attack Frequency:

- Less than two attacks per month

- Attack duration less than 10 minutes

2. Functional Improvement:

- 70% improvement on PDSS scale
- 85% return to functional performance

b) Qualitative Recovery Indicators:

According to a qualitative study by Hofmann & Smits (2022):

1.Improvement Indicators:

- Ability to manage anxiety
- Restoration of self-confidence
- Improved quality of life

2.Stability Criteria:

- Sustained improvement for 6 months
- Ability to face anxiety-provoking situations
- Reduction in avoidance behaviors

2.1.4.Diagnostic and Assessment Criteria:

According to the American Psychiatric Association (2023):

- Use of objective assessment measures
- Documentation of physical and psychological symptoms
- Tracking improvement using standardized measurement tools.

2.2. Islamic Ruqyah:

2.2.1 Religious Concept:

Ruqyah is defined as the recitation of Quranic verses and prophetic supplications with the intention of healing and treatment. It is a form of Islamic religious therapy involving specific Quranic recitations and prayers aimed at healing physical and psychological ailments (Eneborg, 2013). The practice of Ruqyah is based on religious texts indicating the Quran's healing power, such as the verse: "And We send down of the Quran that which is healing and mercy for the believers" (Quran 17:82).

Al-Qarafi stated in Al-Furuq: "(The Ninth Truth) Ruqyah consists of specific phrases that result in healing from illnesses, diseases, and fatal causes" (Al-Qarafi, n.d.). Al-Bayhaqi reported from Talha bin Musarrif that it was said: when the Quran is recited near a sick person, they find relief (Al-Bayhaqi, 2003).

According to Keshavarzi & Haque (2013), Islamic Ruqyah relies on the concept of spiritual healing and aims to strengthen the connection between the individual and God, potentially contributing to improved mental and physical health.

2.2.2. Psychological and Physiological Effects of recitation of Quranic verses(Murottal): Peer-Reviewed Clinical Studies(Experimental Results):

Murottal represents a systematic methodology of Quranic recitation that adheres to precise phonological and prosodic principles. This form of sacred textual delivery incorporates meticulous attention to pronunciation (tajwid), rhythmic patterns, and melodic elements while maintaining the integrity of the Quranic text. Research indicates that engagement with such precisely rendered Quranic verses can facilitate psychological tranquility and emotional equilibrium in listeners. The therapeutic potential of murottal lies in its unique combination of linguistic precision, rhythmic consistency, and spiritual significance, which collectively contribute to its capacity to induce states of calmness and mental composure.

A systematic literature review revealed statistically significant disparities in anxiety and depression levels among coronary heart disease patients, comparing baseline and post-intervention measurements utilizing Murottal therapy. The analysis encompassed the intervention's effects on clinical outcomes and mortality rates, demonstrating meaningful statistical differences across multiple parameters.

As Wisuda et al. (2024) eloquently establish in their groundbreaking systematic review, "Islamic spiritual care with Murottal represents a significant advancement in holistic patient care approaches for cardiovascular conditions". This comprehensive analysis delves into the intersection of traditional Islamic practices and modern healthcare interventions, with particular emphasis on clinical settings where spiritual care integration has gained increasing attention in recent years. As noted by Wisuda et al. (2024), "The application of Murottal, the melodic recitation of Quranic verses, presents a unique therapeutic approach that bridges religious practice with clinical care". This innovative intervention addresses both the psychological and physiological dimensions of patient care, marking a significant development in holistic healthcare approaches.

The research demonstrates significant improvements in patient outcomes across multiple dimensions:

a) Anxiety Reduction

As Wisuda et al. (2024) report, "The implementation of Murottal therapy showed statistically significant reductions in anxiety levels among coronary heart disease patients" (p. 3). This finding supports the integration of spiritual care in cardiovascular treatment protocols.

b) Depression Management

"The systematic application of Islamic spiritual care demonstrated measurable improvements in depression scores" (Wisuda et al., 2024, p. 4), indicating the therapeutic value of this intervention in managing psychological comorbidities.

c) Physiological Response

The authors note that "patients receiving Murottal therapy showed improved vital signs and reduced stress markers" (Wisuda et al., 2024, p. 5), suggesting a direct physiological benefit from the intervention.

d) Discussion and Implications

This research contributes significantly to our understanding of integrative healthcare approaches. As highlighted by Wisuda et al. (2024), "The intersection of spiritual care and conventional medical treatment offers a promising pathway for enhanced patient outcomes" (p. 6).

e) Clinical Practice Recommendations

The study suggests several key implementation strategies:

- Structured integration of Murottal sessions
- Standardized delivery protocols
- Cultural competency training for healthcare providers
- Regular assessment of patient response

This comprehensive review establishes a strong foundation for the continued development and implementation of spiritually-informed healthcare interventions.

3. *Integration of Traditional and Modern Therapeutic Models: Theoretical and Empirical Evidence*

3.1. *Theoretical Basis for Therapeutic Integration*

Koenig (2009) presented an integrated theoretical framework explaining the relationship between religious practices and mental health, indicating:

- Psychological impact mechanisms of religious practices
- Role of beliefs in shaping therapeutic responses
- Importance of integrating psychological and religious therapy

3.2. *Cultural and Social Foundation*

Lewis-Fernández & Kleinman (1994) emphasized:

- Importance of understanding the cultural context of psychological disorders
- Role of beliefs in shaping illness experience
- Importance of adapting treatment to cultural context

Nortje et al. (2016) presented a systematic analysis showing the role of traditional therapy:

- Effectiveness of traditional and religious healers
- Importance of integrating traditional practices into healthcare systems
- Community role in supporting treatment

3.3. Clinical Empirical Evidence on Integration Effectiveness

- a) Razali et al. (2002) found that culturally and religiously compatible psychotherapy led to:
 - Rapid improvement in anxiety symptoms
 - Increased treatment compliance rates
 - Improved long-term therapeutic outcomes
- b) Faridah (2015) found that :

By listening to the noble verses of the Koran, the vibrations of the neurons will return to stability and even perform their principal functions well
- c) Based on Weber & Pargament's (2014) study, mechanisms were identified as:
 - 1. Integration of Religion/Spirituality in Psychiatric Treatment:
 - Must align with patients' values
 - Should enhance treatment outcomes
 - Already implemented in various programs
 - 2. Benefits Reported from Spiritual Programs:
 - Increased practice of:
 - * Forgiveness
 - * Gratitude
 - * Compassion
 - * Acceptance
 - Reduced:
 - * Negative thinking
 - * Ego-centricity
 - * Judgmental attitudes
 - Improved:
 - * Self-esteem
 - * Mood
 - * Mental clarity
 - * Relationships
 - * Anxiety and depression symptoms
 - 3. Evidence-Based Results:
 - Nondenominational spiritual interventions showed higher efficacy for GAD
 - Spiritual group treatment reduced PTSD symptoms in military trauma survivors

- Los Angeles County implementation (2012):
 - * 98% of wellness centers offered spiritual activities
 - * One-third provided spirituality focus groups
- 4. Religion-Specific Therapeutic Approaches:
 - Christian CBT proved superior to conventional CBT
 - Muslim-based psychotherapy showed better results when combined with:
 - * Prayer
 - * Quran reading
 - Bible use helpful for addressing religious doubts
- 5. Enhanced Therapeutic Methods:
 - Mindfulness interventions improved with spiritual components
 - Religious incorporation in treatment led to:
 - * Better stress and worry management
 - * Higher patient satisfaction rates
- d) Za'tar (2016) proposed implementation mechanisms through:
 - Integration of behavioral and cognitive elements
 - Integration of religious content
 - Application of multidimensional therapeutic techniques

So murattal Al-Quran therapy is more effective in reducing anxiety compared to other therapies so that it can be applied as a complementary therapy to reduce anxiety (Atmaja & Saputra, 2020)

4. Methodology:

4.1. Study Design:

This study employed a single-case design, known as A-B-A' design where;

- A: Baseline Phase (Pre-Intervention): Consistently measuring the target behavior (severity of panic attacks and related symptoms) without intervention.
- B: Intervention Phase: The Ruqyah intervention was introduced and implemented.
- A': Follow-Up Phase (Post-Intervention): Measuring the same behavior after the intervention to examine changes and treatment effects.

This method is one of single-subject research designs that offer a chance for establishing the consequences of an intervention on an individual. Through evaluating their behavior before, during and after intervention, individuals become their own control. A-B-A' designs are commonly used in clinical

practice, special education, and behavioral research to evaluate the effectiveness of interventions and treatments.

4.2. Study Limitations :

- **Spatial and Temporal Boundaries:** The study was done at the researcher's private center which is specialized in Ruqyah practice, it took place within a duration of seven weeks starting from March 31, 2022 to May 12, 2022 then followed by another session three weeks later.
- **Single-Case Design:** However useful for exploratory purposes these designs may not be applicable to larger populations without further research.

4.3. Study Instruments :

- a) ***Bandelow's Panic and Agoraphobia Scale (1995):*** This test was invented by B. Bandelow and it examines the severity of panic disorder and Agoraphobia through the use of 14 questions that each have a scale ranging from zero to four. The test measures five core domains relating to these disorders:
 - Panic attack symptoms (12 symptoms)
 - Phobic avoidance behavior (items 6, 7, and 8)
 - Anticipatory anxiety (items 9 and 10)
 - Work and family-related problems (items 11 and 12)
 - Health anxiety (items 13 and 14)
1. **Translation & Validation:** Belghalem Mohamed translated this scale from French into Arabic during the period of 2016-2017 adjusting it for Algerian population with strong psychometric properties presenting high validity rate =0.78 ,test-retest reliability=0.73,Cronbach's alpha =0.89,content validity=94%.
2. **Scoring:** Each item is rated on a scale of 0-4, reflecting the extent, severity, duration, frequency, anticipation, importance and difficulty of symptoms. The test continues with items 1 (panic symptoms) and 7 (agoraphobic situations), but they are not considered for the total score. The highest score attainable is 48 while the lowest possible score is zero.
- b) ***Chambless Phobic Thoughts Questionnaire (1984):*** This questionnaire was created by D.L. Chambless in order to evaluate the intensity of irrational negative thoughts associated with fear and anxiety. It consists

of fourteen items that are rated on a five-point scale ranging from one to five and measures two primary dimensions:

- Behavioral/social fears related phobic thoughts (items 6,8,9,11,12,13&14)
 - Physical sensations related phobic thoughts (items 1,2,3,,5,,7 &10)
1. Translation and Validation: The questionnaire was translated from Canadian French into Arabic by Belghalem Mohamed (2016-2017) and it has shown high levels of psychometrics measurements such as – high content validity, test-retest reliability = 0.86 after six days and 0.75 after 30 days, Cronbach's alpha = 0.80 and a strong correlation with panic/agoraphobia scales.
 2. Scoring: Each item uses a five-point rating scale ranging from "Never," "Rarely," "Sometimes," "Frequently," and "Always" to indicate the frequency of thoughts. Total scores for the scale range between 14 and 70, while behavioral/social fears score between 6 and 30, physical sensations fear between 8-40.

4.4. Study Procedures:

The intervention program included seven sessions held at an interval of five days each session took about forty-five to sixty minutes.

A. Baseline Phase (A) :

- a) Initial Interview: Information gathering and getting to know each other.
- b) Bandelow (1995) and Chambless (1984) questionnaires were administered at the close of the first interview.
- c) Second Interview: Information about Panic Disorder, Agoraphobia and Ruqyah

B. Intervention Phase (B) :

1. Ruqyah program was implemented for five sessions, at an interval of 5 days between each session and lasted for 45-60 minutes per session.
2. Imaginal Exposure: During every session, the patient is directed to imagine entering into an examination room while recording anxiety levels on a scale of one to ten. Imaginal exposure is combined with a recitation of "soothing verses" by the ruqyah practitioner as well as invocations.
3. Homework: Assigned activities included recording level of anxiety-provoking situations in a dedicated notebook and listening repeatedly to soothing verses recorded earlier during session six.

C. Follow-Up Phase (A'):

1. Post-Test Questionnaires: Administration of post-test questionnaires.

2. Follow-up Session : Conducted three weeks after the intervention phase.
3. Regular follow-up by a general practitioner, psychiatrist, and neurologist to verify the results

4.5. Case Presentation: Ms. R.

- Age : 24 years old
- Education Level: A student at a university
- Sibling Rank: Third born and last child
- Presenting Problem: Fearful feelings, Panic attacks during exams, characterized by abdominal pain, heart palpitations, trembling, sweating, intense fear of failure, feelings of emptiness, inability to recall information and nausea leading to exam avoidance.
- Interview Summary:

Ms. R. was accompanied by her mother who said that she had been experiencing panic attack since she was in middle school during examinations period. Ms.R appeared neat and composed though with an introverted personality. She narrated how she feels bodily sensations so strong as to make her leave examination room without completing it on several occasions despite being good academically. She also indicated having excellent academic performance apart from this situation. She mentioned good relations with family as well as a small circle of close friends. There is no family history of mental illness. Otherwise medical history is noncontributory

4.6. Pre-Test and Post-Test Results for Ms. R.:

4.6.1..Pre-Test Measures:

After the initial assessment through the first interview, Ms. R.'s responses to the Bandelow Panic and Agoraphobia Scale were as follows in **Table 1.**:

Table 1.

Dimension	Symptoms (Score)
Panic Attack Symptoms Axis	8/12 (66.66%)
Phobic Avoidance Behavior Axis	6/8 (75%)
Anticipatory Anxiety Axis	5/8 (62.5%)
Work and Family-Related Problems Axis	5/8 (62.5%)
Health Anxiety Axis	4/8 (50%)
Total Score	29/48 (60.41%)

- Notes: 14 out of 14 panic attack symptoms were reported. Avoidance of phobic situations: 6 out of 24 situations. Panic attack severity: 9/16 (56.25%).

Her scores on the Chambless Phobic Thoughts Questionnaire were as follows in

Table 2.

Dimension	Score
Behavioral and Social Fears	24/30 (80%)
Fears Related to Physical State	18/40 (45%)
Global Score	42/70 (60%)

4.6.2. *Post-Test Measures:*

After the Ruqyah intervention and at the end of the seventh session, Ms. R.'s responses on the Bandelow Panic and Agoraphobia Scale were as follows in **Table3:**

Table 3.

Dimension	Symptoms (Score)
Panic Attack Symptoms Axis	2/12 (16.66%)
Phobic Avoidance Behavior Axis	3/8 (37.5%)
Anticipatory Anxiety Axis	1/8 (12.5%)
Work and Family-Related Problems Axis	2/8 (25%)
Health Anxiety Axis	1/8 (12.5%)
Total Score	12/48 (25%)

- Notes: 10 out of 14 panic attack symptoms were reported. Avoidance of phobic situations: 2 out of 24 situations. Panic attack severity: 5/16 (31.25%).

Her scores on the Chambless Phobic Thoughts Questionnaire were as follows in **Table4:**

Table 4

Dimension	Score
Behavioral and Social Fears	9/30 (30%)
Fears Related to Physical State	8/40 (20%)
Global Score	17/70 (24.28%)

4.6.3. *Results:*

- a) Bandelow Panic and Agoraphobia Scale: The number of symptoms reported reduced from 14 to 10. The number of avoided phobic situations decreased from 6 to 2. This is clear improvement across all dimensions upon the scale which comprises:
- Symptoms of panic attack Axis decreased from 66.66% to 16.66%.
 - Phobic avoidance behavior Axis decreased from 75% to 37.5%.
 - Anticipatory anxiety Axis fell down from 62.5%to12.5%.
 - Family and work problem axis went down by more than half from 62.5% to 25%
 - Fears about health axis dropped by half, decreasing from 50% to12.5%.

- b) Chambless Phobic Thoughts Questionnaire: There was a significant reduction in phobic thoughts indicated by a decrease in the total score from 42 to 17.

Fig.1: A graph showing the comparison between the results of pre-test and post-test measurements on the Panic and Agoraphobia Scale by B. Bandelow 1995

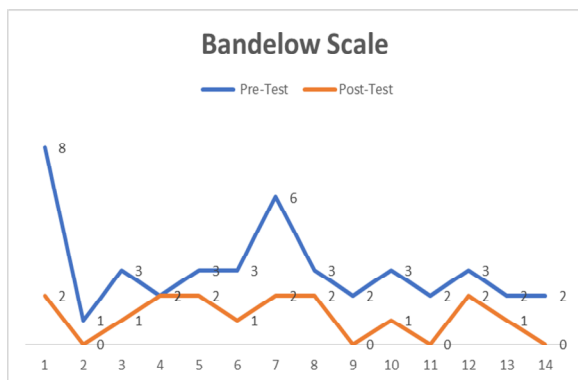
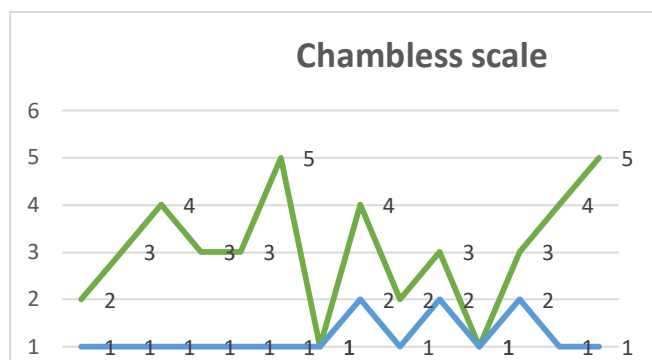


Fig.2: A graph showing the comparison between the results of pre-test and post-test measurements on the Agoraphobic Cognitions Questionnaire by Chambless, D.L. 1984



5.Initial Interview Analysis and Pre-Test Results:

The initial interview and pre-test results revealed that Ms. R. presented with severe panic disorder, demonstrating symptoms that align with current diagnostic criteria (American Psychiatric Association, 2022). Her score on the

Bandelow Panic and Agoraphobia Scale measured 29/48 (60.41%), with all characteristic symptoms present. This elevated score is particularly significant given the established reliability of standardized assessment tools in anxiety disorder diagnosis (Bandelow et al., 2017).

The Panic Attack Symptoms Axis score of 6/12 confirmed the presence of multiple panic symptoms necessary for diagnosis according to current clinical standards (World Health Organization, 2022). The interview findings demonstrated significant functional impairment across academic and social domains, with Ms. R. exhibiting marked difficulty in academic engagement due to anticipatory anxiety about potential panic episodes. This presentation aligns with the fear-conditioning model proposed by Bouton et al. (2001), wherein initial panic experiences establish robust associations between fear responses and internal sensations or environmental triggers.

The documented avoidance patterns (scoring 6 out of 24 on the avoidance subscale) represent a classic defensive mechanism in panic disorder. While this avoidance temporarily reduces anxiety, it ultimately reinforces the cycle of fear and avoidance behaviors. This phenomenon is well-explained by Clark's cognitive model (1986), which posits that panic attacks result from catastrophic misinterpretation of bodily sensations. The maintenance of these patterns through avoidance behavior has been thoroughly documented by Clark and Ehlers (1993), who demonstrated how avoidance prevents the disconfirmation of catastrophic beliefs.

Ms. R.'s pre-existing personality characteristics, notably shyness and introversion with limited social connections, suggest potential predisposition to anxiety disorders. The high anticipatory anxiety score (62.5% on the Bandelow scale) corroborates recent findings by Kim et al. (2021) regarding the significant impact of panic symptoms on daily functioning and quality of life. This is further evidenced by her elevated score (62.5%) on Work and Family-Related Problems, consistent with epidemiological studies showing widespread functional impairment in panic disorder patients (Kessler et al., 2006).

The assessment revealed substantial impact on both physical and mental health domains, aligning with current understanding of panic disorder's pervasive effects on overall functioning (Craske & Barlow, 2014). Moreover, the findings support the growing recognition of panic disorder as a condition with

significant implications for occupational and social functioning, extending beyond mere symptom presentation to affect multiple life domains (Clark & Beck, 2023).

The comprehensive nature of Ms. R.'s symptoms and their impact on daily functioning underscores the importance of considering both psychological and physiological aspects in assessment and treatment planning. This holistic approach is supported by current neurobiological research (Graeff & Del-Ben, 2008) and contemporary cognitive-behavioral conceptualizations of panic disorder (Hofmann & Smits, 2008).

6. Study Results Analysis and Connections to Prior Research and Theoretical Approaches:

Comparing the pre- and post-intervention surveys, along with the interview data, significant improvements were observed in Ms. R's condition following the Ruqyah intervention program. The analysis can be structured as follows:

a) Reduction in Panic Symptom Severity:

1. Measurement results:

- Decrease in Bandelow Panic and Agoraphobia Scale scores from 60.41% to 25%
- Reduction in reported symptoms from 14 to 10
- Panic symptoms decreased by 66.66% to 16.66%.

2. Interview Results Interpretation: Ms. R initially experienced severe physiological symptoms including abdominal pain, palpitations, and tremors. Post-Ruqyah intervention, a significant reduction in these physical manifestations was observed, indicating Ruqyah's positive impact on physiological anxiety responses. This aligns with recent findings by Nazir (2023) regarding the physiological benefits of Quranic recitation therapy.

3. Theoretical Framework and Research Connections:

- Cognitive interpretation: The symptom reduction aligns with Clark's cognitive model (1986), which emphasizes the role of cognitive reinterpretation of bodily sensations. Ms. R's shift in perceiving examinations as challenges rather than threats corresponds with the decrease in anticipatory anxiety from 62.5% to 12.5%.

- Physiological Basis: Recent research by Aziz et al. (2019) demonstrates that Quranic listening can positively influence physiological stress responses. This is supported by traditional findings on religious Ruqyah's effectiveness (Eneborg, 2013).

b) ***Reduction in Avoidance Behavior:***

1. Measurement results: Agoraphobic avoidance behavior decreased from 75% to 37.5%.
2. Interview Analysis: Ms. R reported significant reduction in situation avoidance, showing increased willingness to engage in previously anxiety-provoking scenarios. This improvement aligns with findings from Razali et al. (2002) on religious-cultural psychotherapy's effectiveness.
3. Theoretical and Research Integration:
 - Cognitive-Behavioral Framework: The results support Clark and Ehlers' (1993) model suggesting that reducing avoidance breaks the maintenance cycle of panic disorder.
 - Treatment Effectiveness: These outcomes align with Hofmann and Smits' (2008) meta-analysis on cognitive-behavioral interventions' efficacy in treating anxiety disorders..

c) ***Quality of Life Enhancement:***

1. Measurement Results:
 - Work/family-related problems reduced from 62.5% to 25%
 - Health anxiety decreased from 50% to 12.5%
2. Interview-Based Analysis: Ms. R demonstrated marked improvement in academic performance and social relationships, consistent with findings by Kim et al. (2021) on functional improvement in panic disorder patients..
3. Theoretical Framework Integration:
 - The improvements align with current understanding of panic disorder's impact on daily functioning (Craske & Barlow, 2014)
 - These outcomes support research by Telch et al. (1995) on treatment impact on quality of life in panic disorder patients
 - The results validate the effectiveness of culturally integrated approaches (Keshavarzi & Haque, 2013).

The overall improvement pattern demonstrates the effectiveness of integrating traditional Islamic healing practices with contemporary psychological approaches. This integration is supported by recent research on the benefits of

incorporating spiritual and religious elements in mental health treatment (Koenig, 2009). The significant reduction in both physiological and psychological symptoms suggests that Ruqyah intervention, when properly implemented, can contribute to comprehensive therapeutic outcomes in treating panic disorder. These findings are particularly relevant in cultural contexts where traditional healing practices are valued alongside modern psychological interventions (Lewis-Fernández & Kleinman, 1994).

Conclusion and Recommendations:

The results of this single-case study indicate promising potential for Islamic Ruqyah as a complementary approach in reducing panic attack symptoms, particularly for patients who place significant importance on spiritual and religious aspects in their lives. However, further experimental research is still needed to confirm the effectiveness of this approach and better understand its mechanisms.

Based on these findings, we present the following recommendations:

a) In-Depth Research

Future studies should focus on identifying specific factors determining the psychological and physiological effects of Ruqyah through:

- Ensuring standardized implementation of Ruqyah procedures
- Utilizing more precise measurement tools for objective assessment of changes in symptoms, thoughts, and behavior
- Conducting similar studies with larger case numbers to enhance result validity and generalizability
- Implementing Multiple Baseline Design to evaluate Ruqyah's effectiveness across diverse individuals with panic disorder

b) Medical Collaboration

It is essential to form therapeutic teams incorporating psychiatrists and qualified Ruqyah practitioners to:

- Conduct more complex studies
- Provide integrated treatment for patients who prefer religious therapeutic approaches

c) Intervention Diversity

Future studies should evaluate Ruqyah's effectiveness when integrated with other techniques such as:

- Meditation
- Relaxation techniques
- Cognitive Behavioral Therapy

This integration would help determine whether combined approaches contribute to enhanced outcomes.

in Summary This quasi-experimental study provides preliminary evidence for the effectiveness of Islamic Ruqyah in reducing panic attacks. Through the

single-case formulation design, we were able to document positive changes in panic symptoms and phobic cognitions in the case study.

Ultimately, this study emphasizes the importance of viewing mental health from a comprehensive perspective that considers the individual's biological, psychological, social, and spiritual aspects. It also opens the door for further research in the field of therapeutic interventions inspired by different cultures and traditions, potentially leading to the development of more effective and culturally appropriate therapeutic approaches for diverse cultural and social groups.

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