Changes in Symptom Severity and Quality of Life Following Adjunctive Ruqyah Therapy in Patients with Schizophrenia: A Quasi-Experimental Pre–Post Study

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ABSTRACT

Schizophrenia is a chronic psychiatric disorder that impairs thought, perception, emotion, behavior, and quality of life. Spiritually relevant supportive approaches, including ruqyah syar'iyyah, are increasingly used in rehabilitation settings, but evidence in schizophrenia remains limited. This study examined pre–post changes in symptom severity and quality of life among schizophrenia patients receiving adjunctive ruqyah syar'iyyah at the Jalma Sehat Rehabilitation Center. A quasi-experimental one-group pre–post design was used. Thirty-five eligible patients with psychiatrist-confirmed DSM-5 schizophrenia were recruited by convenience sampling. Participants received ruqyah syar'iyyah twice weekly for six months as part of the rehabilitation program. Symptom severity was assessed using the Positive and Negative Syndrome Scale (PANSS), and quality of life was assessed using the World Health Organization Quality of Life-BREF (WHOQoL-BREF). Pre–post differences were analyzed with the Wilcoxon signed-rank test, and associations between symptom severity and quality of life were examined using Spearman's rank correlation test. Significant pre–post differences were found in PANSS positive, negative, and general psychopathology subscales, as well as in all WHOQoL-BREF domains. Lower PANSS scores were significantly associated with greater improvements in WHOQoL-BREF scores. Adjunctive ruqyah syar'iyyah was associated with favorable within-group changes in symptom severity and quality of life, although the findings should be interpreted cautiously because the study lacked a control group, randomization, and blinded assessment.

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1. INTRODUCTION

Schizophrenia is a chronic and severe mental disorder that imposes a substantial burden on affected individuals, families, and health systems. The disorder is characterized by disturbances in thought, perception, emotion, and behavior, often accompanied by functional decline and reduced quality of life (Darni et al., 2022). In Indonesia, schizophrenia remains an important public health concern, with national survey data indicating a considerable household burden. Its management is further complicated by limited access to mental health services, persistent stigma, and restrictive practices that may delay appropriate care (Badan Penelitian dan Pengembangan Kesehatan, 2018; Laila et al., 2018). These factors can worsen social exclusion, reduce continuity of treatment, and increase the long-term psychosocial burden experienced by patients and families (Degnan et al., 2018; Shafie et al., 2021).

Conventional treatment for schizophrenia primarily relies on antipsychotic medication and routine psychiatric follow-up. Pharmacological treatment remains essential for symptom control, relapse prevention, and stabilization of acute psychopathology. However, this approach may not fully address broader dimensions of recovery, including subjective well-being, social reintegration, and culturally meaningful experiences of care (Shafie et al., 2021). Interest in adjunctive and culturally responsive approaches has therefore increased, particularly in settings where religious and spiritual beliefs shape help-seeking behavior and treatment acceptance (Irawati et al., 2023; Turner & Hodge, 2020).

One such approach is *ruqyah syar'iyyah*, an Islamic spiritual healing practice based on the recitation of Qur'anic verses and supplications. Ruqyah is familiar in many Muslim communities in Indonesia and is sometimes used alongside medical care (Faisal et al., 2024). However, ruqyah should not be treated as a single uniform psychiatric intervention because its implementation may vary across practitioners, institutions, and therapeutic settings. The available literature has not yet established a standardized operational protocol regarding content, session structure, fidelity, or practitioner qualifications in psychiatric populations.

Previous studies suggest that spiritually informed or religiously adapted interventions may be associated with improvement in coping, emotional adjustment, and selected psychiatric outcomes among people with psychotic disorders (Habib et al., 2015; Nolan et al., 2012). However, this evidence remains limited and methodologically heterogeneous. Many studies involve small samples, use varied intervention formats, and remain vulnerable to confounding from religiosity, expectancy effects, concurrent treatment, and rehabilitation context (Turner & Hodge, 2020). As a result, the available literature does not justify strong causal claims regarding the clinical efficacy of ruqyah syar'iyyah for schizophrenia, particularly in real-world rehabilitation settings.

Taken together, these gaps indicate that limited evidence is available on changes in symptom severity and quality of life among patients with schizophrenia receiving adjunctive ruqyah syar'iyyah in rehabilitation settings. This issue is particularly relevant in Indonesia, where cultural and spiritual frameworks often influence how mental illness is understood and how treatment is received (Faisal et al., 2024; Irawati et al., 2023). Therefore, the present study was conducted at the Jalma Sehat Rehabilitation Center to examine pre–post changes in schizophrenia symptom severity and quality of life during a six-month period of adjunctive ruqyah therapy in a real-world rehabilitation context.

The present study aimed to examine pre–post changes in symptom severity and quality of life among schizophrenia patients receiving adjunctive ruqyah therapy at the Jalma Sehat Rehabilitation Center. Symptom severity was assessed using the Positive and Negative Syndrome Scale (PANSS), while quality of life was measured using the WHO Quality of Life-BREF (WHOQoL-BREF). Specifically, this study addressed three research questions: (1) whether symptom severity changed between pre-intervention and post-intervention assessment, (2) whether quality of life changed over the same period, and (3) whether changes in symptom severity were associated with changes in quality of life. This study was designed as an exploratory evaluation of changes observed during the intervention period in a naturalistic rehabilitation setting. It was hypothesized that PANSS scores would decrease and WHOQoL-BREF scores would improve following the intervention period.

This study was informed by Engel's Biopsychosocial Model, which conceptualizes health as the dynamic interaction of biological, psychological, and social factors (Engel, 1977). In this study, spiritual and cultural context was considered part of the patient's psychosocial experience rather than a separate formal domain. The study also drew on a transcultural psychiatric perspective, which recognizes that cultural and religious meanings can influence illness interpretation, help-seeking behavior, and engagement in care (Irawati et al., 2023; Turner & Hodge, 2020). Within this perspective, ruqyah was approached as a culturally relevant adjunctive practice, while any specific clinical mechanism was considered beyond the scope of the present study.

This study provides a preliminary contribution by documenting within-group changes in symptom severity and quality of life among schizophrenia patients receiving adjunctive ruqyah syar'iyyah in a real-world rehabilitation setting. Its novelty lies in evaluating a culturally relevant spiritual practice using standardized psychiatric and quality-of-life instruments within an exploratory pre–post design. Rather than establishing definitive efficacy, this study aims to provide an initial empirical basis for future controlled research on spiritually relevant adjunctive care in schizophrenia.

2. METHODS

This study used a **quasi-experimental one-group pre–post design** to examine changes in symptom severity and quality of life among patients with schizophrenia who received adjunctive *ruqyah syar'iyyah* during rehabilitation. The design was intended to document within-group changes over time in a naturalistic institutional setting. Because the study did not include a control group, randomization, or blinding, the findings should be interpreted as exploratory and do not permit causal inference.

The study population consisted of residents of the Jalma Sehat Rehabilitation Center with a diagnosis of schizophrenia confirmed by a licensed psychiatrist according to DSM-5 criteria. Participants were recruited using a convenience sampling approach from patients undergoing routine rehabilitation during the study period. A total of 35 participants fulfilled the eligibility criteria and were included in the study. No formal sample size or power calculation

was performed. The final sample reflected the number of eligible and available participants during the study period rather than a statistically predetermined recruitment target.

The inclusion criteria were: (1) age between 18 and 60 years; (2) schizophrenia diagnosis confirmed by a licensed psychiatrist based on DSM-5 criteria; (3) ability to communicate verbally and follow instructions, with assistance when necessary; (4) willingness to participate in the intervention schedule during the study period; (5) provision of written informed consent by the participant or legal guardian; and (6) adherence to the Islamic faith, given that *ruqyah syar'iyyah* is a religiously specific intervention. This final criterion was necessary for compatibility with the intervention, although it may limit the generalizability of the findings and introduce selection and expectancy-related influences. Exclusion criteria included severe neurological or psychiatric comorbidities, inability to cooperate with the assessment process, or withdrawal during the intervention period.

Data collection was conducted in three phases: pre-intervention, intervention, and post-intervention. The pre-intervention phase was carried out in October 2024, during which baseline PANSS and WHOQoL-BREF scores were obtained. The intervention phase was conducted over six months, from October 2024 to March 2025. During this period, participants received adjunctive *ruqyah syar'iyyah* twice weekly, with each session lasting approximately 30–45 minutes. The six-month intervention period was selected to allow repeated exposure to the adjunctive intervention within the routine rehabilitation schedule and to permit observation of within-group change over time in a naturalistic setting. The post-intervention phase was completed in March 2025, when PANSS and WHOQoL-BREF were re-administered using the same schedule as at baseline.

The *ruqyah syar'iyyah* intervention consisted of recitation of selected Qur'anic verses and supplications commonly used in Islamic spiritual healing, including Surah Al-Fatihah, Ayat Kursi (Surah Al-Baqarah: 255), Surah Al-Ikhlas, Surah Al-Falaq, and Surah An-Nas. These recitations were selected in accordance with routine practice at the rehabilitation center rather than according to a universally standardized psychiatric protocol. Sessions were delivered by practitioners recognized by the center as qualified to

provide Islamic spiritual healing. However, detailed external verification of practitioner certification was not performed in this study. Attendance logs and participation checklists were used to monitor adherence and participation throughout the intervention period. However, no formal fidelity audit, audio-video recording, or independent protocol verification was undertaken.

Symptom severity was assessed using the Positive and Negative Syndrome Scale (PANSS), while quality of life was assessed using the World Health Organization Quality of Life-BREF (WHOQoL-BREF). Both instruments were administered at baseline and post-intervention using the same assessment schedule for all participants. The present study did not employ blinded raters or formal inter-rater reliability testing, and this methodological limitation should be considered when interpreting the findings.

All collected data were analyzed using statistical procedures appropriate to the type and distribution of the variables. Descriptive statistics were used to summarize participant characteristics and pre–post outcome scores. Normality of data distribution was assessed using the Shapiro–Wilk test. Because the data were not normally distributed, pre–post comparisons of PANSS and WHOQoL-BREF scores were analyzed using the Wilcoxon signed-rank test rather than the paired sample t-test. The association between changes in schizophrenia symptom severity, as reflected by PANSS scores, and changes in quality of life, as measured by WHOQoL-BREF, was examined using Spearman's rank correlation test. Given the exploratory nature of the study, no adjustment for multiple comparisons was performed, and effect size estimation was not included in the present analysis. Findings should therefore be interpreted cautiously.

Written informed consent was obtained from participants or their legal guardians prior to inclusion in the study. Participation was voluntary, and confidentiality, anonymity, and privacy were maintained throughout the study. All data were de-identified before analysis and reporting, and participants were informed that they could withdraw from the study at any time without affecting their routine care.

The overall research process is illustrated in Figure 1 to provide a clear overview of each stage of the study, from participant

selection and baseline assessment to the intervention period, post-intervention assessment, and statistical analysis.

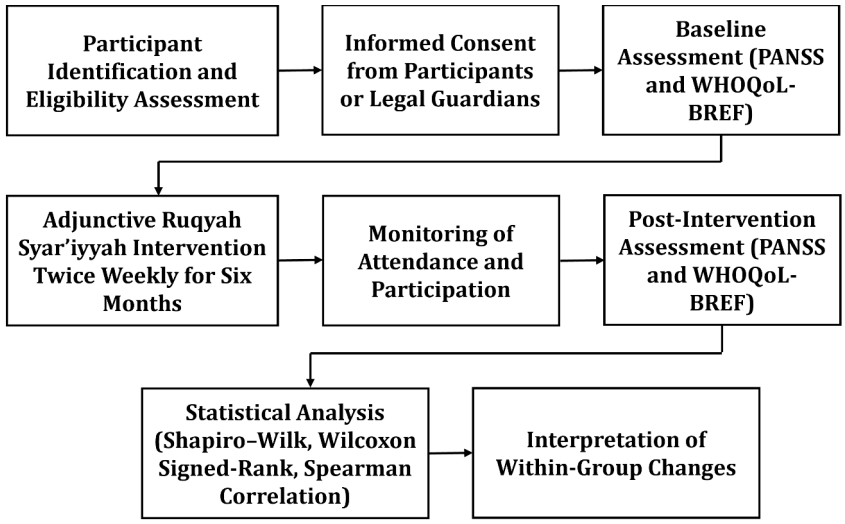


Figure 1. Research Flow Diagram of the Study

3. RESULTS

A total of 35 patients with schizophrenia undergoing rehabilitation at the Jalma Sehat Rehabilitation Center were included in the study. The sample was predominantly male (82.86%), with a mean age of 37.4 years (SD = 6.8) and a mean length of stay of 3.8 years (SD = 1.9). The mean attendance rate during the intervention period was 86.3% (SD = 6.2), and 91.4% of participants attended more than 80% of sessions. The descriptive participant profile is summarized in Table 1.

Table 1. Participant Characteristics

Variable	Mean	SD	Median	Mode	Range
Age (year)	37.4	6.8	38	38	26–50
Length of Stay (year)	3.8	1.9	4	5	1–7
Attendance Frequency (%)	86.3	6.2	87	87	72–96

To address the first research question, symptom severity was assessed using the Positive and Negative Syndrome Scale (PANSS). Lower symptom scores were observed at post-intervention across all reported subscales. As presented in Table 2, the mean score for positive symptoms changed from 18.7 to 15.2, the mean score for

negative symptoms changed from 20.5 to 16.8, and the mean score for general psychopathology changed from 36.1 to 28.7. Based on the subscale means, the summed PANSS score changed from 75.3 before the intervention to 60.7 after the intervention. Figure 2 illustrates the lower post-intervention values across all PANSS subscales. These findings indicate that symptom severity was lower at post-intervention than at baseline.

Table 2. PANSS Score Before and After the Intervention

PANSS subscale	Pre-intervention Mean	Pre SD	Pre Median	Pre Range	Post-intervention Mean	Post SD	Post Median	Post Range
Positive	18.7	4.5	18	10–28	15.2	4.1	15	7–24
Negative	20.5	5.0	20	12–29	16.8	4.3	20	9–25
General psychopathology	36.1	3.8	36	30–43	28.7	3.5	29	23–35

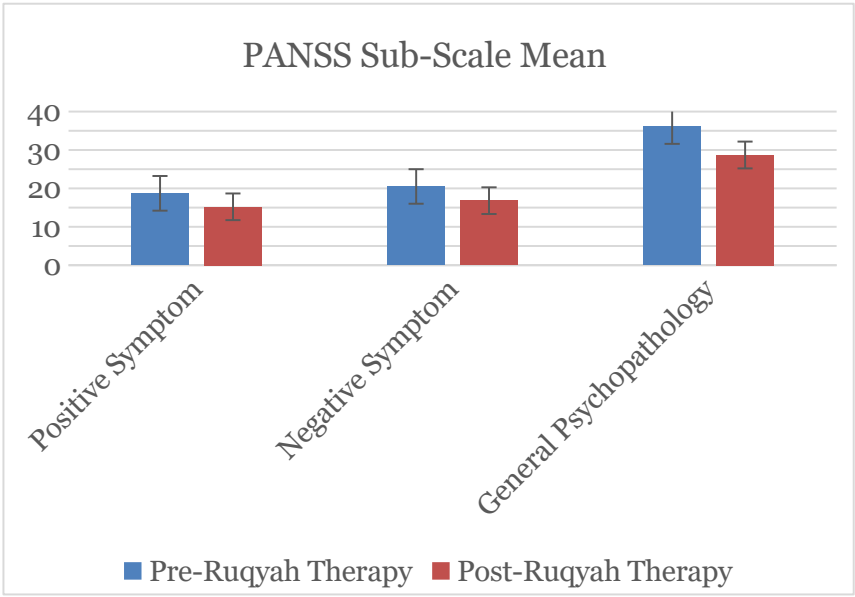


Figure 2. PANSS Sub-Scale Mean

The statistical comparison of PANSS scores is presented in Table 3. The largest mean change was observed in the general psychopathology subscale (–7.4), followed by the negative symptom subscale (–3.7) and the positive symptom subscale (–3.5). All reported p-values were below 0.001, indicating statistically

significant pre–post differences during the study period. These findings suggest a consistent reduction in PANSS scores across domains.

Table 3. Wilcoxon Signed-Rank Test for PANSS Score Changes

Subscale	Mean Difference	*p-value*
General Psychopathology	-7.4	< 0.001
Negative Symptom	-3.7	< 0.001
Positive Symptom	-3.5	< 0.001

To address the second research question, quality of life was assessed using the WHOQoL-BREF instrument. As shown in Table 4, higher post-intervention mean scores were observed across all WHOQoL-BREF domains. The mean physical domain score changed from 12.1 to 16.4, the psychological domain from 10.3 to 18.5, the social domain from 13.2 to 17.9, and the environmental domain from 12.9 to 15.0. The total WHOQoL-BREF score increased from 48.6 at baseline to 63.8 at post-intervention. Figure 3 illustrates the higher post-intervention values across the four WHOQoL-BREF domains. These findings indicate better perceived quality of life during the post-intervention period, particularly in the psychological and social domains.

Table 4. WHOQoL-BREF Scores Before and After the Intervention

WHOQoL-BREF domain	Pre-intervention Mean	Pre SD	Pre Median	Pre Range	Post-intervention Mean	Post SD	Post Median	Post Range
Physical	12.1	2.1	12	8–15	16.4	2.5	16	12–20
Psychological	10.3	1.8	10	7–13	18.5	3.0	18	14–22
Social	13.2	2.4	13	9–16	17.9	2.7	17	14–21
Environmental	12.9	2.3	13	8–15	15.0	2.1	15	12–18

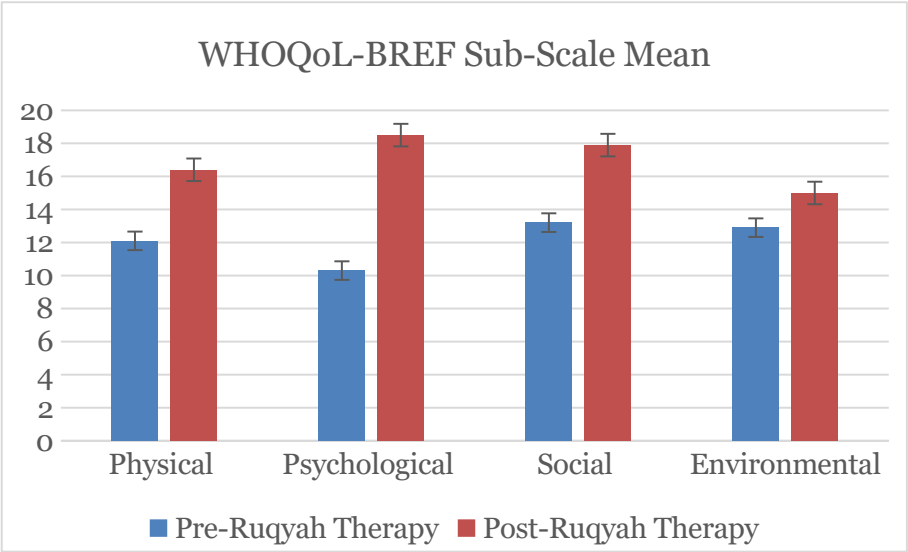


Figure 3. WHOQoL-BREF Sub-Scale Mean

The statistical comparison of WHOQoL-BREF scores is presented in Table 5. The largest mean difference was observed in the psychological domain (+8.2, $p < 0.001$), followed by the social domain (+4.7, $p = 0.002$), physical domain (+4.3, $p = 0.001$), and environmental domain (+2.1, $p = 0.028$). All WHOQoL-BREF domains showed statistically significant pre–post differences during the study period.

Table 5. Wilcoxon Signed-Rank Test for WHOQoL-BREF Score Changes

Domain	Mean Difference	p-value
Physical	4.3	0.001
Psychological	8.2	< 0.001
Social	4.7	0.002
Environmental	2.1	0.028

To address the third research question, a Spearman correlation test was performed using the delta scores of PANSS and WHOQoL-BREF to assess the association between changes in symptom severity and changes in quality of life. As shown in Table 6, the analysis demonstrated a statistically significant negative correlation ($r = –0.667$, $p < 0.001$), indicating that greater reductions in PANSS scores were associated with greater improvements in WHOQoL-BREF scores. This finding indicates an

association between changes in symptom severity and changes in quality of life during the study period.

Table 6. Spearman Correlation Between Change in PANSS and Change in WHOQoL-BREF

Variable	Delta WHOQOL	Delta PANSS
Delta WHOQOL	1.000	-0.667
Sig. (2-tailed)	–	< 0.001
N	35	35
Delta PANSS	-0.667	1.000
Sig. (2-tailed)	< 0.001	–
N	35	35

4. DISCUSSION

Interpretation of changes in symptom severity

Regarding the first research question, the present study showed lower PANSS scores at post-intervention than at baseline across the positive, negative, and general psychopathology domains. These findings should be interpreted cautiously because the study design did not include a control group, randomization, or blinding, and therefore does not permit causal attribution. However, it cannot be determined from the present design whether these changes were attributable to *ruqyah syar'iyyah*, concurrent psychiatric treatment, structured rehabilitation routines, spontaneous fluctuation, or other unmeasured influences. The study did not report medication dosage, adherence, or treatment adjustments, which limits attribution of the observed improvement to the adjunctive intervention alone (Fillah & Kembaren, 2022).

Interpretation of changes in quality of life

Regarding the second research question, the study showed higher WHOQoL-BREF scores at post-intervention than at baseline across all measured domains. The increase in WHOQoL-BREF scores suggests that participants reported better perceived well-being after the intervention period, particularly in the psychological domain (Lanfredi et al., 2014). This pattern is compatible with the possibility that structured spiritual participation, repeated engagement, and a supportive rehabilitation context may coincide

with improved subjective well-being. Religious and spiritual practices may also influence how patients interpret illness, engage with treatment, and perceive coping resources, especially in Muslim settings where such beliefs are closely embedded in daily life (Faisal et al., 2024; Irawati et al., 2023). However, these observations should not be interpreted as proof of a direct therapeutic mechanism of *ruqyah syar'iyyah*, because the study did not directly assess mediating variables such as religiosity, coping, expectancy, therapeutic alliance, or environmental change.

Interpretation of the association between symptom severity and quality of life

Regarding the third research question, the study found a statistically significant negative association between changes in PANSS scores and changes in WHOQoL-BREF scores. This pattern is compatible with previous literature suggesting that lower symptom burden in schizophrenia is often accompanied by better subjective well-being and functioning (Degnan et al., 2018; Shafie et al., 2021). However, this relationship should be interpreted as an association between change variables within the same sample and not as evidence of a causal or mechanistic pathway. The present study did not assess neurocognitive, physiological, or adherence-related variables that would be needed to support a mechanistic explanation.

Comparison with previous studies

The present findings may be compared cautiously with prior literature on spiritually informed interventions in psychosis. Turner and Hodge (2020), in a systematic review of randomized controlled trials, reported that spiritually informed interventions may be associated with selected improvements in psychotic disorders, while also emphasizing heterogeneity in intervention format, study quality, and outcome measures (Turner & Hodge, 2020). Irawati et al. (2023) also highlighted the relevance of religious practice and spiritual well-being among Muslim individuals with schizophrenia, although that study did not evaluate *ruqyah syar'iyyah* as a standardized adjunctive intervention (Irawati et al., 2023). In this context, the present study supports the potential relevance of spiritual and cultural dimensions in psychiatric rehabilitation, but it does not establish definitive

efficacy. Differences in study design, intervention standardization, and rehabilitation context should therefore be considered when comparing findings across studies.

Practical implications and limitations

Several limitations should be considered when interpreting these findings. The absence of a control group substantially limits causal interpretation. The sample size was modest and derived from a single rehabilitation center, which limits external validity. Medication dosage, treatment adherence, and treatment modification were not controlled, making it impossible to distinguish the observed changes from concurrent psychiatric management. Confidence intervals, effect sizes, subgroup analyses, and missing-data handling were not available in the present report, which limits interpretation of clinical meaningfulness. At the same time, the present study provides preliminary data on changes in symptom severity and quality of life observed during adjunctive ruqyah syar'iyyah in a real-world rehabilitation setting. These findings may support the need for further controlled studies with standardized intervention procedures, broader outcome assessment, and clearer monitoring of concurrent treatment.

The practical contribution of the present study lies in showing that culturally relevant spiritual practices may be considered as supportive adjuncts within psychiatric rehabilitation settings, particularly in contexts where religious meaning strongly influences help-seeking behavior and engagement in care. However, such approaches should be positioned as complementary rather than substitutive, and should not replace evidence-based psychiatric treatment.

Taken together, the present study showed favorable pre–post changes in schizophrenia symptom severity and quality of life among participants who underwent adjunctive *ruqyah syar'iyyah* during a six-month rehabilitation period. PANSS scores were lower and WHOQoL-BREF scores were higher at post-intervention than at baseline. These findings should be interpreted cautiously because the study design did not include a control group, randomization, or blinding, and therefore does not permit causal attribution. The observed changes may have been influenced by multiple factors, including concurrent psychiatric treatment, structured

rehabilitation activities, natural symptom fluctuation, and contextual aspects of care. In this context, the present results are better understood as preliminary and hypothesis-generating rather than as confirmatory evidence of therapeutic efficacy.

5. CONCLUSION

Adjunctive *ruqyah syar'iyyah* during the rehabilitation period was accompanied by lower PANSS scores and higher WHOQoL-BREF scores at post-intervention than at baseline among patients with schizophrenia. These findings suggest favorable pre–post changes in symptom severity and perceived quality of life during the study period. However, because the study used a quasi-experimental one-group pre–post design without a control group, the observed changes cannot be attributed solely to the intervention. The results are therefore better interpreted as preliminary and exploratory rather than as definitive evidence of efficacy. Further studies using more rigorous designs, standardized intervention procedures, and clearer monitoring of concurrent treatment are needed to clarify the potential role of *ruqyah syar'iyyah* as a culturally relevant adjunctive approach in schizophrenia care.

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