



Clinicians, Imams, and the Whisperings of Satan

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Author Biography

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Introduction

Waswâs al-qahri, which means ‘overwhelming whisperings’ in Arabic, is a complex mental health disorder found in Muslim populations. *Waswâs al-qahri* is a presentation of obsessive-compulsive disorder (OCD) that is not included in the Diagnostic Statistical Manual (DSM)¹ or International Classification of Diseases (ICD) for several reasons including lack of research, diagnosis overlap and insufficient recognition of spiritually-based diseases by the American Psychiatric Association (APA). Muslims who suffer from *waswâs al-qahri* unwillingly take everyday acts of worship, like washing for prayer (*wudu*), or prayer itself, to extreme lengths. Obsessions are rooted in fear that their acts of worship are inadequate and that the acts must be repeated until perfect. Perpetuated by irrational fears and catastrophic thinking, these acts of worship become a source of anguish instead of spiritual nourishment.

Obsessive-compulsive disorders related to religiosity are known in clinical literature as *scrupulosity*, are found in all religions,² and are especially difficult to treat because of the religious appearance of the symptoms. *Waswasah* is not a Muslim disease—it is a religious presentation of OCD in Muslims. For Muslims, Islamic community leaders have been the primary treatment providers for this condition, although they do not have the clinical training nor the time to effectively address the needs of these individuals. General clinicians unfamiliar with *waswasah* also have difficulty providing treatment, or may cause the client more harm than good if they do not understand the religious nature of the obsessive thoughts and compulsive behaviors. As a result, those who suffer from *waswasah* are unsure where to get help, and when they do seek assistance these individuals often do not receive the specialized treatment they need. The purpose of this publication is to contribute to the growing field of Islamic psychology by providing mental health clinicians and imams with the foundational knowledge and tools

¹ A manual published by the American Psychiatric Association that identifies and categorizes mental illness. This is the standard book that all American psychologists, psychiatrists, and mental health therapists use to assess and diagnose their clients for potential mental illness.

² Pollard, A. (2010). *Scrupulosity*. Retrieved from <https://iocdf.org/wp-content/uploads/2014/10/IOCDF-Scrupulosity-Fact-Sheet.pdf>

necessary to help clients with this condition, which, I will argue, needs to be treated differently from other forms of OCD. In this publication, I will define what the disease is, discuss clinical treatment options and make recommendations for treatment providers.

Definitions, Context and Categorization

Waswasah consists of intrusive thoughts that cause cognitive dissonance (mental distress due to contradictory beliefs, values, or thoughts), and poses a risk to a person's spiritual and psychological homeostasis. In western psychology, there are different theories on the origins of intrusive thoughts, but most point to organic sources, indicating that these thoughts come from the brain or body (dysfunctional brain chemistry, imbalanced gut flora, etc.) of the sufferer. From an Islamic perspective, *waswasah* can come from either the *nafs*, which in English translates as the inner self or soul, or can come from external forces like Satan.³ *Nafs* is often used interchangeably with the term *ruh* but there is scholarly debate about whether the terms are the same; generally, *nafs* is the soul discussed in the context of the body whereas the *ruh* refers to the soul outside the context of the body.⁴ When *waswasah* comes from the *nafs*, the intrusive thoughts are from the soul and come from the wishes and desires of the self.⁵ Since the *nafs* is part of the body, biological and hereditary forces can affect the inclinations and predispositions of an individual's *nafs*.

From the Islamic perspective, it is believed that thoughts can also come from Satan. These intrusive thoughts are similar to those typically dealt with in the field of psychology in that the thoughts take place inside the person's head; however, the origin is antagonistic and from an external source. A person experiencing *waswasah* does not hear Satan's voice in their mind, but experiences thoughts that are very distressing to him or herself.

³ Utz, A. (2011). *Psychology from the Islamic Perspective*. Riyadh, Saudi Arabia: International Islamic Publishing House.

⁴ Ibn Kathir, H. (2003). *Tafsir Ibn Kathir* (2nd ed.). Riyadh: Durussalm.

⁵ Utz, *Psychology from the Islamic Perspective*.

Someone who is not familiar with the idea of intrusive thoughts coming from an external source may be initially confused by this concept. An easy way to visualize how this specific type of *waswasah* is conceptualized is to think about a person with a moral dilemma with an angel on one shoulder and the devil on the other with both telling him or her what to do. In this example, the conflicted person is being fed good thoughts by the angel and evil thoughts by the devil. There is an underlying assumption that the person is not actually hearing these beings; rather, that the thoughts are within the person, although they are triggered by external forces. From an Islamic perspective, good thoughts are believed to come from an angel, as well as from the *fitra* (intrinsic goodness of the soul), and the idea of Satan whispering to the individual is considered to be within the Islamic framework of belief. *Waswasah* from an external source is when Satan whispers to a person to do something that is not in his or her best interest, or instills doubt within a person who is striving to do something beneficial.

Historical Context

The concept of Satan misleading humans originates from the story of creation in the three Abrahamic faiths: Judaism, Christianity, and Islam. In the book of Genesis, the Serpent (Satan) told Eve to eat fruit from the forbidden tree (Genesis 3:1-3, The New King James Version) whereas in the Quranic version, Satan whispered to Adam to approach the forbidden tree. In Arabic, the Quran specifically uses the word *waswasah*:

Then Shaytaan (Satan) whispered to him, saying: ‘O Adam! Shall I lead you to the Tree of Eternity and to a kingdom that will never waste away.’ (The Quran, 20:120)⁶

According to the Quranic version of events (4:118-122), when Adam and Eve disobeyed God by listening to Satan, they were sent from Heaven to Earth. God eventually forgave them, but they had to continue living on Earth where Satan

⁶ Al-Hilali, M. & Khan, M. (1999). *Translation of the Meanings of The Noble Quran in the English Language* (reprinted ed.). Madinah, Saudi Arabia: King Fahd Complex for the Printing of the Holy Qur'an.

would try to mislead mankind until the Day of Judgment through his whispering. Those who are successful in not listening to Satan will be able to return to Heaven by God's Mercy.

Within the Islamic tradition, *waswasah* is considered a natural human phenomenon everyone experiences, to some degree, at some point in their life. Common examples of everyday *waswasah* can include jealousy (intrusive thoughts about something a person wants but can't have), lust (having intrusive thoughts about desiring someone that a person can't be with), doubts about major life decisions and conflicting thoughts about doing the right or wrong thing. International studies estimate that about 94% of the human population worldwide experience intrusive thoughts.⁷

Categorization

Since mild and occasional intrusive thoughts are part of the normal human experience, general *waswasah* must be differentiated from the type of *waswasah* that is regarded as mental illness. *Waswasah* that is excessive or overwhelming beyond the average human experience is called *waswâs al-qahri* (plural). A person who experiences *waswâs al-qahri* doesn't necessarily have a mental illness, but may, if he or she meets the criteria established by the DSM-V. *Waswâs al-qahri* reaches the diagnosis of Obsessive Compulsive Disorder (OCD) when it meets the following criteria outlined by the DSM-V:⁸

A. Presence of obsessions, compulsions, or both:

Obsessions are defined by (1) and (2):

1. Recurrent and persistent thoughts, urges, or impulses that are experienced, at some time during the disturbance, as intrusive and

⁷ Radomsky, A., Alcolado, G., Abramowitz, J., Alonso, P., Belloch, A., Bouvard, M., Clark, D., Coles, M., Doron, G., Fernandez-Alvarez, H., Garcia-Soriano, G., Ghisi, M., Gomez, B., Inozu, M., Moulding, R., Shams, G., Sica, C., Simos, G., & Wong, W. (2014). Part 1. You can run but you can't hide: Intrusive thoughts on 6 continents. *Journal of Obsessive-Compulsive and Related Disorders*, 3, 269-279. Retrieved from <http://dx.doi.org/10.1016/j.cbpra.2009.10.002>

⁸ American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing, pp. 129-130.

unwanted, and that in most individuals cause marked anxiety or distress.

2. The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion).

Compulsions are defined by (1) and (2):

1. Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.

2. The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive.

Note: *Young children may not be able to articulate the aims of these behaviors or mental acts.*

B. The obsessions or compulsions are time-consuming (e.g., take more than 1 hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The obsessive-compulsive symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

D. The disturbance is not better explained by the symptoms of another mental disorder...

Subtypes of OCD have been explored and categorized differently by different clinicians, but at the present time there is general consensus that there are four subtypes: contamination/decontamination, checking, obsessions without overt compulsive rituals, and hoarding.⁹ *Waswâs al-qahri*'s clinical presentation is unique in that the individual can fall into one or more of the OCD subtypes at the same time depending on his or her symptoms.

The author believes that *waswâs al-qahri* better meets the criteria for a condition called *scrupulosity*, which is well documented in the clinical literature, but not found in the DSM-V. Scrupulosity, which affects people of all faiths,¹⁰ is currently regarded as a presentation of OCD (though not an official subtype), and occurs when a worshipper is preoccupied with religious matters beyond what is considered within normal limits, the preoccupation is distressing, and the preoccupation negatively impacts the daily functioning of the person.¹¹ Some clinicians advocate that scrupulosity should be a separate disorder from OCD in the DSM-V, based on findings that those with scrupulosity have poorer insight than other OCD presentations, that there are weak correlations between scrupulosity and OCD measures, and that there is significant overlap between obsessive compulsive personality disorder and scrupulosity.¹² The author believes that *waswâs al-qahri*, like scrupulosity, also differs from regular OCD because it requires not only a clinician who is familiar with the nature of the disease and its treatment, but also the collaboration of an imam or a person with religious knowledge pertaining to the Islamic rulings on belief and worship.

The DSM-V and mental health community have clearly established the clinical diagnostic criteria for OCD, whereas Islamic scholars have not clearly defined official diagnostic criteria for *waswâs al-qahri*. This is because Islamic scholars are

⁹ Sookman, D., Abramowitz, J., Calamari, J., Wilhelm, S. & McKay, D. (2004). Subtypes of Obsessive Compulsive Disorder: Implications for Specialized Cognitive Behavioral Therapy, *Behavior Therapy*, 36(4): 393-400. Retrieved from https://www.researchgate.net/publication/222412431_Subtypes_of_obsessiveCompulsive_disorder_Implications_for_specialized_cognitive_behavior_therapy

¹⁰ Pollard, A. (2010). Scrupulosity. Retrieved from <https://iocdf.org/wp-content/uploads/2014/10/IOCDF-Scrupulosity-Fact-Sheet.pdf>

¹¹ Abramowitz, J., Jacoby R. (2014). Scrupulosity: A cognitive-behavioral analysis and implications for treatment. *Journal of Obsessive-Compulsive and Related Disorders*, 3, 140-149. Retrieved from: <http://jonabram.web.unc.edu/files/2014/05/Scrupulosity-model-2014.pdf>

¹² Ibid.

experts in Islamic jurisprudence, law, etc., but not experts in psychiatry. At the present time, there is no formal way to diagnose a person with *waswâs al-qahri*. Generally, a person suffering from the disease will either self-diagnose or an imam will tell the person they appear to have the condition in a consultation. This informal diagnosing generally happens when a person is (i) distressed or shows impairment due to irrational fears about aspects of the religion; (ii) for a significant period of time and; (iii) behaves in maladaptive ways (excessively repeating acts of worship, checking, ruminating, etc.).

Waswâs al-qahri can be comorbid with other mental health issues such as depression, panic attacks or personality disorders, and due to no formally established diagnostic criteria for the disease, it is important for mental health professionals to not attribute symptoms from other disorders to *waswâs al-qahri*. *Waswâs al-qahri* is a type of OCD and does not involve additional symptoms such as hallucinations, delusions, panic attacks, or depression. It is essential for therapists to not rely solely on a client's self-assessment and to do a thorough evaluation to determine if the client is experiencing *waswâs al-qahri*, another disorder, or both. For example, if a client seeks treatment for alleged *waswasah*, but reports that they visually see a devil whispering to them, a thorough assessment should be made for the spectrum of psychotic disorders, as this would warrant a different course of treatment.

Types of Severe *Waswasah*

Waswâs al-qahri, like obsessive-compulsive disorder, can manifest itself in many different ways, as no two clients will ever experience the exact same obsessions and/or compulsions. One of the goals of this publication is to address three common types of *waswâs al-qahri* the author has seen in clinical settings: *ibadah* (worship), *taharah* (purification), and *aqeedah* (belief). Although *taharah* (purification) is a form of *ibadah* (worship), it's important to explore both in detail, as they can manifest themselves differently in *waswasah* presentation. Each type of category of *waswâs al-qahri* will follow with a fictional case example for demonstration. It may be useful to point out here that severe *waswasah* almost

never has sudden onset; the growth in the severity of *waswasah* is gradual and increases over time if not addressed. *Waswasah* often begins in the form of a person being more careful and deliberate with acts of worship and progresses until the acts of worship that the individual ordinarily finds comforting or fulfilling become major hardships.

Ibadah

The word *ibadah* in Arabic refers to acts of worship. Most of the time *waswasah* related to *ibadah* regards compulsory acts of worship (like prayer, fasting, giving charity, etc.) because they are fundamentals of the religion. This is important to understand because a lot of the anguish that sufferers experience is due to feeling that they are doing compulsory acts of worship incorrectly, which in their mind could mean that they are not fulfilling the tenets of their religion, thus making them liable to God's punishment. Clients who suffer from *waswâs al-qahri* in *ibadah* feel that their acts of worship are never good enough and they constantly seek perfection. Any detail about their act of worship that might be imperfect will lead to irrational fear and catastrophizing that they have inadvertently apostatized from the religion and/or might go to Hell.

Case example: Lana is a practicing *Muslimah*. Over the past couple of months, she has been more stressed about work and her family life than usual. Lana has noticed that she has been forgetful and confused during prayers and this has led her to repeat her prayers to make sure she is doing them correctly. Sometimes Lana is unsure of how many units she did and other times she worries that she might have pronounced words incorrectly, invalidating her prayer. This didn't bother Lana much in the beginning because she figured that increased spirituality was always a good thing, however, in the last several weeks Lana can't stop thinking about her prayers being incorrect. These thoughts have become a major distraction during the day and she now struggles to find time to complete her regular day-to-day routines. Prayer used to take up half an hour of her day, but now is taking two hours. Prayer is no longer enjoyable, but Lana doesn't know how to stop obsessing about it.

Taharah

Taharah in Arabic means purity, of which there are three different types: physical, ritual, and spiritual.¹³ *Taharah* comes up most commonly in everyday life in relation to prayer. In order to pray Muslims need to be clean of impure things (like urine, feces, etc.) and to be in a state of *wudu* (ablution). To make *wudu* one needs to wash the face, arms, wipe over the head, and wash the feet (or wipe over socks). *Wudu* does not need to be performed before every formal prayer as long as the prior *wudu* was not invalidated by using the bathroom, flatulence, etc. Many people who suffer from *waswâs al-qahri* regarding *taharah* either have irrational fear of contamination from unclean things and/or have irrational fear that their *wudu* is not correct or somehow was invalidated. Under normal circumstances, one must be clean of impure substances and have proper *wudu* in order for prayer to be valid; for the average person this is not something that takes up much time and is not distressing. An average Muslim might take 3-4 minutes to perform *wudu* whereas a Muslim with *waswâs al-qahri* can take 20 minutes or sometimes an hour. Like the person who has *waswâs al-qahri* in *ibadah*, these clients also think that if they are contaminated or didn't make *wudu* correctly, something catastrophic will happen (like they will go to hell for invalid prayers).

Case example: Adam was diagnosed with OCD as a young child. When his parents were getting a divorce he became overly preoccupied with cleanliness and making sure things were not filthy. Adam went to therapy and his OCD subsided. When Adam went to college he met Muslim friends and converted to Islam. The process of becoming Muslim was not stressful for him, but his family members were sometimes critical of his decision. Family conflict reminded Adam of difficult feelings experienced during childhood and he began to experience anxiety again. Adam began to develop an extreme fear of having to use the restroom in general, and especially before prayer. Adam could not use the toilet without cleaning it first due to fear of contamination that something filthy would get on his body and invalidate his prayer. He then became preoccupied for long periods of time that his clothes were touching the toilet and getting contaminated as well. Adam would

¹³ Al-Haj, H. 2016, October, 18. Email.

spend 45 minutes from when he entered the bathroom until he was ready for prayer because he couldn't stop compulsively checking and cleaning his clothes. Since Adam prayed five times a day every day his intense anxiety was spread throughout the day, and getting ready for prayer took over his day-to-day life.

Aqeedah

In the Islamic tradition, *aqeedah* means belief with conviction in the religion or creed. Although there are differing opinions within Islam about some details of religion, there are tenets of faith on which there is unanimous consensus. Some of these pillars of faith include belief in God (Allah), belief in angels, the Day of Judgment, Heaven and Hell. Those who suffer *waswâs al-qahri* in *aqeedah* have intrusive thoughts and doubts about a particular aspect of *aqeedah*. Clients with *waswâs al-qahri* about *aqeedah* believe and love their faith wholeheartedly, but have intrusive thoughts that tenets of the religion are wrong. This phenomenon does not stem from a person secretly not believing in their religion and not recognizing it yet (denial). An analogous example for *waswâs al-qahri* regarding *aqeedah* is postpartum OCD in which new mothers have intrusive thoughts about harming their child. The vast majority of mothers—if not all—love their children and do not want to harm them.¹⁴ Mothers with postpartum OCD don't clandestinely have desires to hurt their children, and in fact, it is love for their children that causes distress when the intrusive thoughts cannot be controlled. The same applies to *waswâs al-qahri* in *aqeedah* in that the person's devotion to God is part of what causes the distress when experiencing intrusive negative thoughts about religion.

Case example: Sara grew up in a Muslim family and had practiced Islam all her life. Last year she watched a movie about sexual abuse and for the first time realized she was molested as a child. As expected, Sara started to experience many strong emotions such as anger, grief, and sadness. About 6 months ago, Sara began to have intrusive negative thoughts about Allah wanting this abuse to happen to

¹⁴ Abramowitz, J. (2009). *Postpartum and perinatal OCD*. International OCD Foundation. Retrieved June 28, 2016 from <https://iocdf.org/wp-content/uploads/2014/10/Postpartum-OCD-Fact-Sheet.pdf>

her. Rationally she knew her malicious thoughts about Allah were not true, but the thoughts would not go away. This caused Sara to feel that she was not a good Muslim or perhaps these uncontrollable thoughts took her out of the fold of Islam. Sara was consumed by these thoughts and it began to affect her productivity at work. Throughout the day Sara would feel compelled to say the *shahada* (declaration of faith in Islam: There is no God but Allah and Muhammad ﷺ is His messenger) because she feared she was no longer Muslim. In the beginning she would say this a few times a day and eventually it reached almost 100 times a day. If Sara was in a work meeting and had intrusive thoughts she would feel compelled to leave the meeting to say the *shahada* and come back. The few times Sara could not excuse herself from work duties to say *shahada* she would feel distressed to the point she would feel light-headed.

Treatment

Waswâs al-qahri is unique from other manifestations of OCD because it requires both a clinician who is an expert in the condition, and the partnership of an imam or a person with specific knowledge pertaining to Islamic rulings of belief, worship, and *waswâs*. It can be a challenging endeavor for a clinician to provide therapy to a person with *waswâs al-qahri*, especially if they are unfamiliar with the terms, concepts, and rulings to which the client is referring. An imam or person of Islamic knowledge has the expertise and authority to give religious instruction and rulings about questions related to *waswâs al-qahri* that is outside the realm of expertise for most therapists. Just as therapists often defer to psychiatrists for feedback and consultation regarding medical issues, a therapist will likely need to defer to and coordinate with a person of Islamic knowledge regarding *waswasah*. Often times the person with *waswâs al-qahri* already has an imam they have been working with, so the therapist will just need to sign a release of information to work in conjunction with them.

The reason imams cannot treat *waswâs al-qahri* alone is because they do not have the time or clinical skill to treat someone with a medical condition like OCD. The Islamic approach to *waswâs al-qahri* is that the client must ignore their intrusive

thoughts and resist urges to complete compulsive acts (such as repeating prayers over and over). There are some Islamic interventions, which will be elaborated on further in this publication, but that is the extent of Islamic treatment for those who have *waswasah*. It is the clinician's job and area of expertise to help execute what seems like a simple plan, but is in fact a long and difficult process. The brunt of the work in curing *waswās al-qahri* will come from the long-term process of helping the client cope with the anxiety from their obsessions and teaching them how to not give into their compulsions.

The Clinician's Role: Different Types of Therapy

Cognitive Therapy

Research indicates that cognitive therapy is effective in clinically treating Obsessive Compulsive Disorder.¹⁵ Cognitive therapy is where cognitive-behavioral therapy stems from and includes many subtypes of therapies, some of which will be addressed later in this publication. Understanding fundamental concepts from which cognitive therapy was derived is important in understanding both clinical and Islamic interventions.

On the most basic level, cognitive theory asserts that the way individuals perceive and interpret the world around them influences how they feel and act.¹⁶ In day-to-day life, individuals are constantly and rapidly interpreting stimuli in their environment into conscious and unconscious thoughts. Many of these thoughts are 'automatic thoughts' in which the accuracy is assumed to be correct, but not always. Over time, thoughts are interpreted and categorized into categories of information, called 'schemas,' based on relationships between the thoughts. Negative automatic thoughts can lead to dysfunctional schemas or 'cognitive distortions,' which may lead to maladaptive feelings and/or behaviors.

¹⁵ Foa, E., Yadin, E. & Lichner, T. (2012). *Exposure and Response (Ritual) Prevention for Obsessive- Compulsive Disorder* (2nd ed.). New York, NY: Oxford University Press.

¹⁶ Knapp, P. & Beck, A. (2008). *Cognitive therapy: Foundations, conceptual models, applications and research*. Retrieved from http://www.scielo.br/pdf/rbp/v30s2/en_a02v30s2.pdf

There are different cognitive theories as to how clients with OCD develop and maintain their OCD. One theory by Foa and Kozak (1985) proposes that OCD comes from many erroneous cognitions such as clients assigning high levels of danger to relatively safe situations, exaggerating the probability of bad things happening and concluding that objects or events need evidence of safety (versus the healthy cognition that objects or events are assumed safe unless there is evidence otherwise).¹⁷ Another cognitive theory of how OCD is formed is by Salkovski (1985), which holds that those with OCD hold five faulty cognitive distortions:

*(1) thinking about an action is the same as doing it; (2) failing to prevent harm is morally equivalent to causing harm; (3) responsibility for harm is not diminished by extenuating circumstances; (4) failing to ritualize in response to a thought about harm is the same as an intention to harm; and (5) one should exercise control over one's thoughts.*¹⁸

To address OCD from a cognitive perspective, clinicians need to examine core beliefs, challenge faulty assumptions, and modify cognitive distortions that are leading to the obsessions and compulsions. Over time, as cognitive distortions are gently challenged and replaced by more healthy cognitive schemas, the OCD symptoms should diminish.

Imams can play an integral role in helping the therapist address cognitive distortions related to religion as there are *fiqh* (jurisprudence) principles in Islam that directly address the above cognitive distortions. The following *hadith* (scholarly documented, authentic Prophetic narration) for example, helps counteract a few of the distortions from Salkovski's (1985) theory on the origin on OCD:

The Prophet ﷺ said: "Allah has forgiven for my ummah (followers) that which is whispered to them and which crosses their minds, so

¹⁷ Foa, et al. (2012).

¹⁸ Foa, et al. (2012).

long as they do not act upon it or speak of it.” [Narrated by al-Bukhari, 6664; Muslim, 127]¹⁹

When an imam explains the meaning and implications of this *hadith* it becomes evident that cognitive distortions 1 and 5, from Salkovski’s theory, are not Islamically sound. Clarifying these principles from an Islamic perspective will bolster the therapist’s cognitive work with the client.

Exposure Response Prevention

Exposure and Response Prevention (ERP), a type of cognitive-behavior therapy, has been proven to be quite effective in dealing with OCD.²⁰ The goal of ERP is for clients to confront identified fears and cease the compulsion or escape response by delaying gratification, or ideally forgoing gratification altogether. By disrupting the conditioned response (of the obsession and compulsion) the client becomes habituated to the previously feared stimulus and eventually the obsession and the strong urge to act on the obsession goes away.

ERP is compatible with the Islamic approach in treating *waswās al-qahri*; In fact, one can argue that the Islamic advice to ignore the obsession and resist the compulsion is the layperson’s form of ERP. Although the Islamic approach to *waswās al-qahri* and ERP are compatible, clinicians will have to be mindful that there may be some restrictions in the implementation of the therapy. For example, a client who has irrational fear of getting something *najis* (impure) on their body cannot purposely put impure things on their body during prayer or ignore something they know with complete certainty is impure, as this would invalidate the prayer. Clients however, can ignore doubts about something being impure on the clothes. For example, if a client has an obsession with cleanliness and the compulsion is to check their clothes repeatedly for the possibility of impure things, an exercise the therapist can ask the client to do is perform *wudu* in a public bathroom (which by most standards are not ideally clean) and not check his or her

¹⁹ Abdul-Rahman, M. (2004). *Islam: Questions and Answers - Jurisprudence and Islamic Rulings: Transactions, Part 5*. London, United Kingdom: MSA Publication Limited.

²⁰ Koran, L., Hanna, G., Hollander, E., Nestadt, G., & Simpson, H. (2007). Practice guideline for the treatment of patients with obsessive-compulsive disorder. *The American Journal of Psychiatry*, 164 (7), 5-53.

clothes for contaminants afterward. This is permissible because the general Islamic ruling is that all things that are pure remain pure until there is certainty that they are impure; doubts about something being impure cannot make the object impure.

Acceptance Commitment Therapy

Acceptance Commitment Therapy (ACT), which is a type of mindfulness-based cognitive therapy, has also been found effective in alleviating symptoms of OCD.²¹ The goal of ACT is to increase mindfulness of thoughts and accept them as they are instead of trying to change them. ACT sees negative and inappropriate thoughts as part of the normal human process. By accepting thoughts as thoughts, and not repressing them, the idea is that the thoughts will eventually stop as a by-product, not direct goal, of this therapy.²² ACT does not promote the violent, blasphemous or dangerous thoughts a person with OCD has, but helps clients accept the thoughts without judgment and without mental or physical duress. A person with OCD becomes tense when experiencing intrusive thoughts and tries to mentally or physically neutralize them, whereas ACT facilitates the thoughts passing through without holding on to them or repressing them.

This therapy can be effective in helping clients with OCD learn to decrease their specific and generalized anxieties, but can be very tricky to implement without a therapist who is culturally-spiritually competent. A Muslim client who is encouraged to blindly accept blasphemous thoughts will not likely come back to treatment; instead, a therapist needs to be skillful and mindful in explaining to the client that he or she is not accepting the actual blasphemous thought, but accepting that he or she is having the thought itself. The culturally-spiritually competent therapist can provide the proper psychoeducation and support on how the client can

²¹ Twohig M. P., Hayes S. C., Plumb J. C., Pruitt L. D., Collins A. B., Hazlett-Stevens, H., & Woidneck, M. R. (2010). A randomized clinical trial of acceptance and commitment therapy vs progressive relaxation training for obsessive-compulsive disorder. *Journal of Consulting & Clinical Psychology*, 78(5), 705-16.

²² Harris, R. (2006). Embracing your demons: An overview of Acceptance and Commitment Therapy. *Psychotherapy in Australia*, 12 (4), 2-8. Retrieved from http://www.livskompass.se/wpcontent/uploads/2012/11/Russ_Harr_A_Non-technical_Overview_of_ACT.2006.pdf

have inappropriate thoughts, without believing them, and not be distressed by them at the same time.

Additional Therapies and Techniques

Clinicians may find it helpful to the client to provide family therapy in addition to individual therapy. It is typical for family tension to build up between clients and their family members since *waswâs al-qahri* impairs daily functioning, social life, and relationships. Family members can experience a lot of difficult emotions about their family member suffering from *waswâs al-qahri* including sadness, anger and frustration. It is not uncommon for family members to call the client selfish, self-absorbed, fanatical, or even extreme. These accusations are hurtful because the individual suffering from such an affliction feels that their behavior is not something they can control. In family therapy clinicians can help provide psychoeducation to families about the nature of the disease. Clinicians can also teach family members to express difficult feelings in healthy ways and be more supportive of the client. Lastly, clinicians can offer individual therapy (or make referrals to other providers) to other family members, who may be having trouble coping with the client's behavior at home.

When a client is tolerating the urge to give into their *waswasah*, it's important to teach them that their stress and anxiety will initially go up when fighting the disease before they eventually go down. Clinicians can help clients tolerate their elevated levels of anxiety with a solid coping skills plan. The coping skills should be generated by the client as they will know best what activities can distract them and calm them down. Clinicians should consider typical coping skills like guided imagery, connecting with nature, physical activities, etc. as they would for most clients, but also consider spiritual coping skills if clients express interest in them.

Collaboration with Imams

The imam's role in treatment will be important in helping the client cope with anxiety related to religious questions, rulings, and concerns. As a religious authority, the client will be more likely to comply with therapy knowing that an

imam supports it, especially in communities where there is still a lot of stigma and/or myths associated with treatment (e.g., that western psychology is contradictory to Islam, or that therapy is only for people who have weak or no faith). In addition to answering religious questions, imams can also be very useful in assisting the therapist provide cognitive restructuring from a spiritual perspective.

While answering religious questions will be of great benefit to the client, it will be just as important that the imam teach underlying concepts that will help the client figure out answers to their own questions independently. For example, if a client continuously calls an imam asking for answers related to fear of losing *wudu* in prayer, it will be more useful for the imam to teach the Islamic concept that ‘doubt can not negate certainty,’ than to continue to address independent, but similar questions that all have the same answer. This will help prevent the client from building a sense of dependency on the imam, as seeking constant and unnecessary assurance can become part of the compulsion process.²³

For religious questions and concerns, the therapist and imam should encourage the client to keep a journal and write down religious questions organized by date. The client then can have a weekly appointment time (whether in therapy or with the imam) to go over their concerns. This approach is beneficial because it forces the client to delay gratification of the urge to repeat, which is an essential component in treating OCD. The journal also helps maintain a positive relationship between the client and imam. Due to irrational fears the client may have about being neglectful of their religious duties, some clients may call the imam incessantly during the day and at night. This can be disruptive for the imam who has many other obligations and will likely just eventually ignore calls (causing more panic for the client). With this journal arrangement, the client will understand that no calls will be answered except during the designated phone consultation time, which may cause stress in the short term, but should increase treatment efficacy in the long-term.

²³ Foa, et al.. (2012).

Islamic Interventions

Therapists who want to specialize in the treatment of *waswâs al-qahri* from a holistic perspective, for clients who desire that option, must be familiar with Islamic techniques prescribed in the Quran and Hadith. Therapists do not need to have in-depth knowledge of the techniques, but enough information to understand where their clients are coming from if they use the techniques or if the imam prescribes them. Having an understanding of these techniques increases cultural-spiritual sensitivity and competency, and will likely increase a stronger therapeutic bond between the therapist and client.

Since those with scrupulosity by default obsess and compulsively act on religious fixations, it's imperative for the therapist to know what is general Islamic practice and what is not. It is important that religious interventions are not used excessively to the point that they become a part of the disorder. Islamic interventions should be used as prescribed and should bring a sense of benefit and comfort to the person. When the individual with *waswâs al-qahri* begins to use them excessively or feels a sense of impending doom if he or she does not use the techniques, then the therapist or imam needs to point this out to the individual and modify the coping skills plan.

Below is a condensed list of Islamic techniques or practices that can be used to help reduce *waswâs al-qahri*. A brief explanation of each technique will be followed by the text in the Quran or Hadith from which the technique was derived.

Seeking Refuge in Allah

Seeking refuge in Allah is a commonly used technique by Muslims to help protect themselves from Satan. When Muslims seek refuge in Allah they are essentially calling out to Him to protect themselves from Satan's influence and mischief. A person with *waswâs al-qahri* may use this technique for protection from Satan giving them intrusive thoughts. Since there is direct evidence of this technique

being recommended to cope with *waswasah*, it is a commonly prescribed practice by imams in formal prayer and throughout the day.

*And if an evil whisper from Shaitan (Satan) tries to turn you away, then seek refuge in Allah. Verily, He is the All-Hearer, the All-Knower. (The Quran, 41:36)*²⁴

And say: "My Lord! I seek refuge with You from the whisperings (suggestions) of the Shayatin (devils). And I seek refuge with You, My Lord! lest they may attend (or come near) me. (The Quran, 23:97-98)
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*Abul-'Ula reported: 'Uthman bin Abul-'As came and said to the Prophet: "O Messenger of Allah, Satan is spoiling my prayers and confusing my reciting of the Quran." The Messenger of Allah ﷺ said: "That is a satan called Khinzab, so if you think that (he is around) say: 'I seek refuge with Allah from you.' Then blow breath with light spit on your left three times." Uthman said: "I did that and Allah took him away from me."'*²⁶

Ruqya

Ruqya is a practice in which Muslims read Quran, the names of Allah or a prayer over themselves by putting their hand on the area that is causing them distress and reciting over it. This technique can be recommended by imams for medical ailments as well as psychological ailments. Since an individual with anxiety might feel tension in their head or chest, they can place their hand and perform *ruqya* over that area.

Uthman bin Abu Al-'As Ath-Thaqafi narrated that he complained to the Prophet ﷺ of a disease in his body since embracing Islam. The

²⁴Al-Hilali, M. & Khan, M. (1999). *Translation of the Meanings of The Noble Quran in the English Language* (reprinted edition). Madinah, Saudi Arabia: King Fahd Complex for the Printing of the Holy Qur'an.

²⁵ Ibid.

²⁶ Al- Mundhiri, A. (2000). *The Translation of the Meanings of Summarized Sahih Muslim Arabic-English, Volume 2*. Riyadh, Saudi Arabia: Darussalam Publishers & Distributors, p. 767.

Prophet ﷺ said: “Put your hand in the place of pain and say: ‘With the Name of Allah,’ thrice, and say seven times: ‘I seek refuge with the Power and Majesty of Allah against what I suffer.’”²⁷

Dhikr

Dhikr, which means remembrance, is a useful tool prescribed for all Muslims, but can specifically be used by those experiencing anxiety to alleviate feelings of distress. The purpose of *dhikr* is to mindfully reflect on Allah, His Attributes, and blessings in attempts to obtain a closer relationship with Him. By feeling closer to Allah the Muslim reaps the psychological benefit of feeling protected by the Highest Power that has the ability to change all things including one’s self, circumstances, and well-being.

Research indicates that those who have a secure attachment to God have lower levels of depression and psychological distress, whereas those with an insecure attachment have higher levels of neuroticism.²⁸ *Dhikr* not only helps build a more secure attachment but can help alter cognitive distortions for clients with *waswās al-qahri* who use Allah’s Wrath, Hell, and punishment as means to justify their obsessions and compulsions. Using *dhikr* to focus on Allah’s Mercy and love for His worshippers, likely with the help of an imam, can create a healthier bond with Allah and alter unhealthy cognitions.

...Verily, in the remembrance of Allah do hearts find rest. (The Quran, 13:28)²⁹

Abu Hurairah narrated that the Messenger of Allah ﷺ said: “Allah says: ‘I am as My slave thinks of me, and I am with him if he remembers Me. If he remembers Me in himself, I too, remember him in Myself; and if he remembers Me in a group of people, I remember

²⁷ Ibid.

²⁸ Ellison, C., Bradshaw, M., Flannelly, K. & Galek, K. (2014). Prayer, Attachment to God, and Symptoms of Anxiety-Related Disorders among U.S. Adults. *Sociology of Religion*, 75 (2), 208-233. Retrieved from <http://www.baylorisr.org/wp-content/uploads/Sociology-of-Religion-2014-Ellison-208-33.pdf>

²⁹ Al-Hilali, M. & Khan, M. (1999). *Translation of the Meanings of The Noble Quran in the English Language* (reprinted edition). Madinah, Saudi Arabia: King Fahd Complex for the Printing of the Holy Qur'an.

him in a group that is better than that. And if he comes one span nearer to Me, I go one cubit nearer to him and if he comes one cubit nearer to Me, I go a distance of two outstretched arms nearer to him. And if he comes to Me walking, I go to him running. ’’³⁰

Duaa

Duaa, or supplication, is a prescribed tool for all Muslims; however, there are specific *duaas* Prophet Muhammad ﷺ recommended for when a person feels anxious. *Duaa* can be said during the Muslim’s five daily prayers and informally, at any time, when feeling distress. Someone with *waswâs al-qahri* can create their own *duaa* to ask for relief of general anxiety, the alleviation of specific obsessions, or help in not giving into compulsions; or can use the following specific *duaas* recommended by Prophet Muhammad ﷺ for anxiety:

O Allah, I am Your servant, son of Your servant, son of Your maidservant, my forelock is in Your hand, Your command over me is forever executed and Your decree over me is just. I ask You by every name belonging to You which You named Yourself with, or revealed in Your Book, or You taught to any of Your creation, or You have preserved in the knowledge of the unseen with You, that You make the Qur’aan the life of my heart and the light of my breast, and a departure from my sorrow and release for my anxiety.³¹

O Allah, I take refuge in You from anxiety and sorrow, weakness and laziness, miserliness and cowardice, the burden of debts and from being overpowered by men.³²

³⁰ Al- Mundhiri, A. (2000). *The Translation of the Meanings of Summarized Sahih Muslim Arabic-English, Volume 2*. Riyadh, Saudi Arabia: Darussalam Publishers & Distributors, p. 997.

³¹ Al-Qahtani, S. (1996). *Fortification of the Muslim through remembrance and supplication from the Qur’aan and the Sunnah*. Riyadh, Saudi Arabia: Safir Press, p. 156-157.

³² Ibid, p. 165.

Black Cumin

Black Cumin (commonly called Black Seed), or *Nigella sativa*, is highly praised amongst Muslims and is used to help treat an array of medical issues. Modern day research indicates that Black Cumin, in fact, has pharmacological healing properties and helps treat anxiety and depression, as well as many other medical conditions.³³ While more research needs to be conducted on how and to what extent Black Cumin affects different levels of severity of OCD, it can be a useful supplement to therapy and pharmacological drugs.

*Narrated Abu Huraira: I heard Allah's Apostle ﷺ saying, "There is healing in black cumin for all diseases except death."*³⁴

Clinical Analysis and Recommendations

ERP is the most highly recommended therapy for treating OCD, due to proven efficacy; however, ERP has some significant drawbacks. ERP is a highly detailed methodological approach in which few therapists are trained. The therapy is very intense and requires a large time commitment from both the client and therapist. Research indicates that the dropout rates (25%) and refusal rates (additional 5-22%) for ERP are high.³⁵ Based on these factors, ERP referrals should be made for clients who have access (and the time and financial means) to undergo this type of therapy from a trained professional. The average client who will not have access to this particular type of therapy should be referred to a therapist who is knowledgeable in cognitive therapy and/or ACT.

The author strongly emphasizes that therapist and imam competency are very important to the success and well-being of the client who is seeking treatment for *waswâs al-qahri*. This unique professional collaboration with dual knowledge in psychology and Islam is the primary differentiating factor between treatment for

³³ Beheshti F., Khazaei M. & Hosseini M. (2016). Neuropharmacological effects of *Nigella sativa*. *Avicenna Journal of Phytomedicine*, 6 (1), 124-141.

³⁴ Khan, M. (1995). *The Translation of the Meanings of Sahih Al- Bukhari*, Volume VII. Medina: Dar AHYA Us-Sunnah, p. 399.

³⁵ Twohig, et al. (2010).

waswâs al-qahri and other types of OCD. A therapist who is not culturally-spiritually competent and the imam who doesn't have an understanding and appreciation of psychology can be very detrimental to a client by relaying false information that can either turn the client away from treatment or be accepted by the client with negative consequences. One example of this is the therapist who might not explain ERP and ACT with cultural-spiritual sensitivity, leading the client to believe that he or she must accept blasphemous beliefs to get better, and ultimately causing the client to drop out of treatment unnecessarily. Another example is an imam who tells the client that their *waswâs al-qahri* is blameworthy and comes from their lack of religious devotion, leading the client to feel much worse about themselves. Due to the complexity of *waswâs al-qahri* it is understandable that there will not be many experts available to treat this specific condition; however, those clinical and religious providers who want to help should know the basics and be comfortable seeking more knowledge when their understanding is limited.

Psychoeducation by the therapist will be an integral component of treatment. For mental health professionals, it will be important to explain to clients that OCD is long-term disease even when treatment is 'successful.' Many clients come into treatment expecting rapid results and that they will be completely cured of all type of OCD thinking, which is unrealistic. Research indicates that treatment can help significantly reduce symptoms, but that for many people residual signs of OCD may linger.³⁶ To help address this issue clinicians need to assess OCD symptoms before and after treatment to help clients see their progress. Clinicians and imams should also recommend occasional visits after symptoms decrease, rather than terminating treatment, as periodically checking in with a therapist can help maintain long-term progress. Lastly, therapists need to work with clients on relapse prevention plans so that when clients begin to resort to previous behaviors they know exactly how to address them and when to come back to treatment.

Psychoeducation by the imam will also be important for treatment since the Muslim community has a significant amount of stigma regarding seeking mental

³⁶ Foa, et al. (2012).

health treatment.³⁷ It is important that the imam emphasize the importance of therapy (and medication management when necessary) in addition to Islamic interventions when symptoms are persistent and cause high amounts of distress. The author has observed that, in Muslim communities, seeking medical treatment for physical ailments, such as cancer or diabetes, in addition to Islamic interventions (like prayer), is seen as more acceptable than when a person has a mental health impairment; seeking medical treatment for physical ailments is not associated with a lack of faith, whereas seeking medical treatment for mental health is. Explaining that seeking medical treatment is a complement to Islamic interventions will likely increase client confidence in therapy and help prevent premature therapy dropout.

Research

At the present time, there is little research and clinical literature defining *waswâs al-qahri*, assessment of prevalence, and little to no evidence-based treatment for the condition. If one types *waswasah* into a regular search engine, hundreds of *fatwas* and informal articles will come up on the subject, but no research appears in medical journals written by clinicians in the field of psychology. The large number of informal articles and inquiries indicates that the problem of *waswâs al-qahri* is significant and that the prevalence is likely not proportionate to the amount of attention currently given to this disorder.

Waswâs al-qahri is not a new disorder, but due to the absence of quantitative and qualitative research, as well as any professional publications, it truly is a new disorder in the contemporary psychological literature. There needs to be quantitative research to determine the prevalence of *waswâs al-qahri* in different countries, risk factors, general demographics, and duration of illness. There also need to be trials completed to see the efficacy of different types of treatment, including management by medication. Research development on *waswasah* will help solidify

³⁷ Amri, S. & Bemak, F. (2013). Mental Health Help-Seeking Behaviors of Muslim Immigrants in the United States: Overcoming Social Stigma and Cultural Mistrust, *Journal of Muslim Mental Health*, 12 (1). Retrieved from <http://quod.lib.umich.edu/cgi/p/pod/dod-idx/mental-health-help-seeking-behaviors-of-muslim-immigrants.pdf?c=jmmh;idno=10381607.0007.104>

whether *waswâs al-qahri* should be classified as a type of OCD (as it is at the present time) and what interventions are best to treat it.

Clinicians who have clients with *waswâs al-qahri* can help contribute to this understudied field by documenting and publishing case studies. Writing qualitative summaries of experiences with these clients, especially those with positive outcomes, will help establish more therapeutic and religiously-sensitive interventions. Collaborating with other clinicians on a local or national level in the form of conferences or peer supervision can also generate more discussion, spread awareness of the disease, and build a stronger network of specialized clinicians.

Summary

Waswâs al-qahri is a complex disorder in which Muslims develop unwanted obsessions and compulsions related to religious beliefs or acts of worship that are excessive, dysfunctional, and distressful. *Waswâs al-qahri* is currently regarded as a type of OCD, but is unique from other types of OCD in that it needs more specialized treatments/interventions. The goal of this publication is to contribute to the growing field of Islamic psychology by defining what *waswasah* is, what the different types of *waswâs al-qahri* are, and how clinicians and imams can best treat the condition when it reaches levels of psychological impairment. Ideally, treatment for *waswâs al-qahri* will require a culturally competent clinician, collaboration with an imam, and effective cognitive behavioral therapy. More research is needed to better understand this condition and to identify what clinical and Islamic treatments yield the most effective results.