

Article

Exploring Professional Help Seeking in Practicing Muslim Women with Obsessive Compulsive Disorder Washing Subtype in Australia

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Received: 27 June 2017; Accepted: 27 July 2017; Published: 1 August 2017

Abstract: Religion and religious practices can affect Obsessive Compulsive Disorder (OCD) symptom expression and influence the way that people with OCD seek advice or treatment. This study investigated the expression of OCD symptoms and help seeking for religious OCD symptoms among practicing Muslim women. Method: Five practicing Muslim women aged 33 to 45 years who had immigrated to Australia from Iran, Iraq, Turkey, and Afghanistan and were diagnosed with OCD washing subtype (OCD-W) took part in semi-structured interviews. Data Analysis: Thematic Analysis within a scientific realist framework was employed. Results: The most common compulsions reported by participants were performing excessive washing and repeating rituals before prayer, and these behaviours were carried out to prevent being punished by God. All participants had sought help for their OCD symptoms from an Imam before seeking help from a mental health professional, and the delay between symptom onset and OCD diagnosis by a psychiatrist ranged from 5 to 13 years. Conclusion: Effective evidence-based interventions for OCD are available and increasing awareness of OCD symptoms and treatment among Imams has the potential to reduce the delay between symptom onset and access to treatment for practicing Muslims who seek help and support.

Keywords: Obsessive Compulsive Disorder; religion; Islam; women

1. Introduction

Obsessive-Compulsive Disorder (OCD) is a common and disabling mental health disorder characterised by obsessions and/or compulsions ([American Psychiatric Association 2013](#)). Obsessions are repetitive and persistent thoughts, urges or images that cause marked anxiety and distress and are experienced at some time during the disturbance as intrusive and unwanted ([American Psychiatric Association 2013](#)). Compulsions are repetitive, time consuming, overt actions (e.g., washing, ordering, checking) or covert behaviours (e.g., counting, repeating words silently) typically carried out in response to an obsession so as to decrease distress and anxiety ([Abramovitch et al. 2013](#)). Contamination obsessions and washing compulsions are generally the most commonly reported OCD symptoms ([Matsunaga et al. 2008](#)) and the findings from several studies conducted in non-Middle Eastern countries have revealed that OCD washing behaviours are related to contamination obsessions, that is, people wash because they feel contaminated by dirt and germs and washing is carried out to reduce the risk of catching a disease or illness (e.g., ([Jones and Menzies 1998](#))). However, in some samples, washing behaviours appear to be related to concerns about purity rather than contamination ([Okasha et al. 1994](#); [Ghassemzadeh et al. 2005](#)).

While effective treatments for OCD are available ([Vaccaro et al. 2013](#); [Overton and Menzies 2005](#); [St Clare et al. 2008](#)), the condition has a chronic course if untreated for most of those with OCD

(Marcks et al. 2011). Research has focused on identifying factors associated with response to treatment in order to improve treatment outcomes for those with OCD, and there is evidence that poorer outcome after treatment for OCD is associated with longer time from treatment onset to seeking treatment (Catapano et al. 2006; Hollander et al. 2002; Steketee et al. 1999); higher symptom severity when treatment commences (Catapano et al. 2006; Hollander et al. 2002; Steketee et al. 1999); and having religious OCD symptoms.

Religiosity is a broad term that encompasses spiritual activity, enthusiasm, and faith (Gill and Lundsgaarde 2004) which has been associated with OCD, where religious obsessions (e.g., blasphemous thoughts) and compulsions (e.g., repeating a prayer) are common symptoms (Abramowitz et al. 2002). There is evidence that religiosity can influence the way in which a person experiences OCD (Greenberg and Witztum 1994; Tukul et al. 2005), as religious OCD symptoms have been found to occur earlier in the course of OCD than other OCD symptoms (Tukul et al. 2005; Hasler et al. 2007) and are more resistant to cognitive behavioural therapy (CBT; Ferrao et al. 2006; Alonso et al. 2001; Mataix-Cols et al. 2002). Some studies conducted in Middle Eastern countries such as Saudi Arabia, Iran, and Israel have found religious obsessions to be more common than contamination obsessions (Ghassemzadeh et al. 2005; Ghassemzadeh et al. 2005; Greenberg 1984) and purity is closely associated with some cultural practices of religions such as Islam (e.g., (Al-Solaim and Loewenthal 2011; Ghassemzadeh et al. 2005; Shooka et al. 1998)).

Previous research concerning religiosity and OCD has mainly focused on Western Christian religions (Abramowitz et al. 2004; Sica et al. 2002; Siev et al. 2010). However, Mahintorabi, Jones, Harris and Zahiroddin (Mahintorabi et al. 2015) examined religiosity and OCD symptoms among Iranian women living in Tehran comparing practicing Muslim women with OCD washing subtype (OCD-W) to non-practicing Muslim women with OCD-W. These authors found that the practicing Muslim women reported more religious washing rituals and higher scores on a measure of scrupulosity compared to the non-practicing Muslim women. Importantly, there were large and significant differences between both the severity of symptoms at the time of diagnosis and the time from appearance of OCD symptoms to seeking professional help, where practicing Muslim women reported a much longer time to receiving professional help and more severe symptoms at the time of receiving help compared to non-practicing Muslim women.

There are many reasons why the practicing Muslim women in Mahintorabi et al. (2015) study took longer to seek professional advice from health practitioners. It is possible that these women did not recognise their meticulous and repeated cleansing rituals or excessive prayer as symptoms of OCD but rather saw them as a normal part of religious practice that exemplified their commitment to God (Al-Solaim and Loewenthal 2011). The delay may also have occurred because other religious practices, such as prayer, may have assisted the practicing women to cope with their distress so that they endured their OCD symptoms for longer (Al-Solaim and Loewenthal 2011; Perez 2008). In addition, the practicing Muslim women may have been unwilling to consider any aspect of their religious devotion as problematic, as this may have been perceived as distancing themselves from their faith and from their community, or may have thought that going beyond the minimum standard of religious requirements might abate their propensity for sin and fear of God's vengeance and/or prove their spiritual devotion and worth, while bringing them closer to God (Steketee et al. 1991). Alternatively, since in Iran there is no insurance coverage for visiting a psychologist or a psychiatrist, practicing Muslim women with OCD-W may have first turned to religious leaders such as Imams for advice since this was available to them free of charge while non-practicing Muslim women may not have seen this as an option, thus explaining the difference in time between the two groups in regard to seeking professional help for their OCD, particularly if the advice given by religious leaders did not include recommendations that they should seek professional help. Further research is needed to clarify these possible explanations.

Imams, with authority, knowledge and expertise of the laws and rules of Islam, are likely to be an important source of assurance and information about core beliefs and rituals in Islam for practicing

Muslims living with OCD. Research conducted in the United States has demonstrated that religious clergies' responses to Christian parishioners' OCD scrupulosity symptoms may exacerbate fear of sin and compulsive rituals (Deacon et al. 2013). It is possible that Imams may not recognise the concerns of Muslims with OCD as excessive or as requiring health professional intervention, and that responses from Imams may have similar effects to those of Christian clergy, since having a fear of God is a cherished attitude in Muslim worship and one of the elements of Islamic doctrine (Inozu et al. 2012b). Thus, Imams or clergy members may be giving advice that inadvertently exacerbates OCD symptoms and/or delays treatment seeking. For example, in one study it was reported that the main advice given by religious advisors to address OCD symptoms among Arab Muslim women was to read verses from the Quran (Al-Solaim and Loewenthal 2011).

Greenberg and Shefler (2002) found that those with OCD who practiced Judaism preferred to receive medication for their non-religious OCD symptoms but preferred to talk to their Rabbi about their religious OCD symptoms and (Al-Solaim and Loewenthal 2011) found that all of their Muslim OCD participants first asked for help from faith-based healers rather than mental health professionals (MHPs). In Al-Solaim and Loewenthal's study, participants reported seeking professional help when they acknowledged that the suggestions they had received from the faith based healers benefited only temporarily and when the symptoms started to deteriorate. Similarly, Mahintorabi et al. (2015) found that the practicing Muslim OCD-W group waited longer before seeking professional help compared to the non-practicing Muslim OCD-W group. This may be because the practicing Muslim women first sought help from a spiritual source rather than a mental health practitioner. This highlights the importance of religious leaders being able to identify OCD symptoms and assist people to seek professional help.

Delays in seeking help for OCD have been reported in several studies (Ghassemzadeh et al. 2005; Mancebo et al. 2006; Crino et al. 2005), and some work has focused on predictors of delay in seeking professional help for OCD (Demet et al. 2010). However, there is a paucity of research examining the role of religion in treatment-seeking delay, although for those with strong religious affiliation, religion has been suggested to play an important role in both seeking advice about OCD symptoms and how to address them from religious leaders (Deacon et al. 2013). Arguably, there is a need for qualitative research to explore the experiences of Muslims with OCD in seeking help and advice for their OCD symptoms to reduce the time to receiving health professional assistance and improve treatment outcomes for this chronic and serious condition. Thus, based on our review of the literature, the present study sought to explore treatment seeking among practicing Muslim women living with OCD-W in Australia.

2. Method

2.1. Participants

Five Muslim women with OCD washing subtype, age range 33 to 45 years, were recruited. The inclusion criteria were: (1) female; (2) at least 18 years old; (3) current or previous diagnosis of OCD (DSM-IV-TR; American Psychiatric Association 2000); (4) have, or have had, washing compulsions for more than one hour per day; (5) identified as practicing Muslims; and (6) no diagnosis of organic mental disorder, psychotic disorder, or mental retardation. All participants were assigned abbreviations to ensure anonymity. The characteristics of participants are included in Table 1.

Table 1. Characteristics of participants.

Participant	Age (Years)	Born in Australia *	Employment Status	Endorsed Item 4 on the DRI	Age at OCD-W Symptom Onset	Age First Discussed OCD-W Symptoms with Imam	Age at Diagnosis by Psychiatrist	Y-BOCS Currently in Clinical Range
AA	33	No	Part-time	Yes	20	22	25	Yes
BB	35	No	Unemployed	Yes	17	18	26	Yes
CC	42	No	Unemployed	Yes	22	28	29	Yes
DD	40	No	Unemployed	Yes	16	19	23	Yes
EE	45	No	Part-time	Yes	13	20	26	No

Notes: * Participants had immigrated to Australia from Iran, Iraq, Turkey, and Afghanistan. DRI: Duke Religion Index; Item 4 on the DRI: “My religious beliefs are what really lie behind my whole approach to life”; OCD-W: Obsessive Compulsive Disorder washing subtype. * Participants had immigrated to Australia from Iran, Iraq, Turkey and Afghanistan.

2.2. Measures

- Demographic Questions. Participants were asked about their age, employment status, and country of birth, education, ethnicity, occupation, and income level.
- The Dimensional Obsessive-Compulsive Scale (DOCS; [Abramowitz et al. 2010](#)) is a 20-item self-report measure that assesses the severity of four OCD symptom dimensions (contamination, responsibility for harm and mistakes, symmetry/ordering, and unacceptable thoughts) on a scale of 0 to 4 (total scores ranges from 0 to 80) with the clinical cut-off score of 21 for OCD. The DOCS has been shown to be a valid and reliable assessment of OCD symptom dimension severity across clinical populations ([Abramowitz et al. 2010](#)). The DOCS has excellent internal consistency (Cronbach's $\alpha = 0.90$; [Abramowitz et al. 2010](#)).

The Duke Religion Index (DRI; [Koenig et al. 1997](#)). The DRI was included to assess religiosity. The DRI has five items and item 4 on the DRI ("My religious beliefs are what really lie behind my whole approach to life") was used as an indicator of religiosity. Total scores on the DRI range from 5 to 27, and the reliability of the DRI is satisfactory with a Cronbach's α of 0.90 ([Storch et al. 2004](#)).

The Yale-Brown Obsessive Compulsive Scale (Y-BOCS; [Goodman et al. 1989a, 1989b](#)). The Y-BOCS was used to assess current OCD symptom severity. The Y-BOCS is a 10-item clinician administrated scale with a clinical cut-off score of 16 ([Goodman et al. 1989a](#)). This scale was translated into Persian ([Ghassemzadeh et al. 2005](#), [Rajezi Esfahani et al. 2012](#)); and [Rajezi Esfahani et al. \(2012\)](#) calculated the internal consistency scores (symptom checklist 0.97, severity scale 0.95) split-half reliability (symptom checklist 0.93, severity scale 0.89), and test-retest reliability (0.99) which indicated the acceptable level of reliability and validity of translated Y-BOCS. The 10-item severity scale was employed in the current study.

Semi-Structured Interview. The semi-structured interview asked about the individual's history of OCD symptoms, their religious symptoms (if any), the professionals and non-professionals from whom they had sought advice, their views regarding the professional and non-professional advice they had received, the religious and non-religious strategies they used to cope with their OCD symptoms, and their understanding of the role, if any, of religion in the development, continuation, and treatment of their OCD symptoms.

2.3. Procedure

Ethical approval for the study was obtained from the University of Sydney Human Ethics Committee. Participants were recruited using convenience sampling. Advertisements requesting interested people to contact the researcher via phone or email were placed in psychology clinics, a University medical centre, and medical practices in areas of an Australian city with a high proportion of Muslim residents. Clinicians with clients who met the inclusion criteria were also asked to invite their clients to contact the first author by phone or email if they were interested in participating in the research. Potential participants who contacted the first author were screened concerning their religious practices. Practicing Muslim women with OCD-W who were washing/cleaning for more than 60 minutes a day and who endorsed item 4 on the DRI ('My religious beliefs are what really lie behind my whole approach to life') were invited to participate in the study. This is similar to the recruitment strategy previously employed by other researchers examining the relationship between religiosity and OCD (e.g., ([Inozu et al. 2012a](#))).

For those who met the inclusion criteria and agreed to participate in the study, assessments were arranged at a university clinic. Following provision of a participant information statement and the signing of a consent form participants were assessed using the clinician administrated Y-BOCS. The Persian version of the Y-BOCS was used for the two participants from Iran and the English version was used for the other three participants. Participants also completed the DOCS and then completed a brief questionnaire concerning demographic information before taking part in the semi-structured

interview. The qualitative interviews were audio recorded for later transcription. The data collection was conducted individually in a single session of approximately two hours.

2.4. Data Analysis

Thematic Analysis was used for analysing the data obtained from the semi-structured interviews within a scientific realist framework. Three interviews were conducted in English. Two interviews were conducted in Farsi and were translated to English. All answers were read, reread, and theoretical codes emerged from the data. Thematic Analysis was applied to identify, analyse, and report patterns (themes) within data via transcribing data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and finally, producing the report (Braun and Clarke 2006). Specifically, in the beginning, codes were set to low-level categories, however, in the progression of the repeated process of reading the interviews, associations between low-level categories were recognised, and they were combined into higher level categories by a standard coding pattern. This categorization system normally started at the descriptive level and gradually advanced to become more abstract. At the end, connection was initiated between high-level categories in all five interviews and, finally, predominant themes developed.

To check the reliability of data analysis, an assessor independent of the study and skilled in qualitative data analysis was asked to review 20 quotes extracted from the interviews and five themes that emerged from the data and match the quotes to the themes. This matching process resulted in 100% accuracy. This procedure has been applied in previous qualitative studies in this area (e.g., (Al-Solaim 2006)). The quantitative data was analysed applying the Statistical Package for Social Sciences.

3. Results

Four of the interviewees currently met the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (American Psychiatric Association 2013) criteria for OCD washing subtype. The Y-BOCS symptom severity range was 15 to 32 and the DOCS range was 24 to 34.

3.1. Themes

The following themes emerged from the combined data collected from interviews:

- Types of obsessions and compulsions. The most commonly reported obsessions in the sample were doubt about correctly performing prayers or being pure. The most commonly reported compulsions were washing rituals before daily prayers and repeating religious rituals, such as repeating prayer in order to perform it 'just right'. For example, DD stated:

'I repeated Wudu before prayer for several times; I always have doubt about the number of 'rakat' [part of prayer] and if I am performing prayer in a correct order or not. I also wash everything related to myself especially when I have a doubt about touching anything wet or probably impure'.

All interviewees found these symptoms to be very distressing, time-consuming, and physically exhausting. Consequently, their religious OCD symptoms were observed as causing the most interference with normal life activities and the leading reason for seeking treatment. Their OCD symptoms not only put pressure on their lives, but also their family members and loved ones. For example, EE expressed disturbances related to her purity-related symptoms as such:

'During the time of my period, I tried not to touch many things as I definitely believed that I will make them impure which subsequently make me more anxious. After my period, I used to wash all my clothing separately with hands for three times and sometimes more than that to make sure they are pure ... I remember I hated myself during my period because of being impure. I was really scared of not performing religious rituals in a right way, especially five-time daily prayer ... It took

me about an hour every time I wanted to use bathroom and I used to ask my family members if they want to use the bathroom in the next hour or not to decrease the inconveniency of my symptoms . . . '

All participants experienced excessive washing rituals that were related to religious practices and religious washing rituals were reported as the most common compulsion among participants. One of the participants reported also having non-religious OCD washing symptoms resulting from the fear of getting contaminated or sick. As BB said:

'When my symptoms started, I washed my hands frequently, I did not drink water in any one's cup, I used to wash my plate, knife, spoon before using them in other people's house before eating things. I was very fussy in eating food in others' homes as I have thought other people's things were dirty. And if I ate something that is not clean, I might get sick, and I also felt disgusted with having something not clean . . . I did not use to shake hands with anyone, because I was not sure if their hands are clean. I felt really uncomfortable'.

- Triggers for Religious OCD Symptoms. All participants reported holding strong beliefs about fear of sin and fear of punishment by God resulting in being sent to hell that they had learned from parents, teachers, or family members. In all cases, participants tried hard to avoid actions and thoughts which may cause punishment by God. For example, EE stated:

'I wash excessively because I thought I always needed to be pure for doing my religious rituals like prayer. I was told by my parents that if my prayers were not accepted by God, none of my other good things will be accepted and I will be sent in the hell. So I had this fear that if I am impure or not clean, my religious practices won't be accepted after my death. After three-time washing of my clothing and belonging I feel much better and am ready to perform my rituals and also do my normal activities'.

In another case, CC said:

'I think at that time I tried to prove myself to my husband that I am doing everything right in my religion, and I am a good Muslim . . . I got really nervous and anxious . . . I also felt guilty because I thought if I do not correctly perform my rituals, God won't accept them, and I won't be a good Muslim . . . And consequently, I will get punished and being sent to hell'.

DD mentioned that the most important adverse consequence of not performing religious OCD rituals would be losing God's love and attention, she stated:

'It is also really important to be clean in our religion; there is a quote that: 'cleanness is a part of religiosity in Islam'. And I think if somebody is not clean enough to perform her rituals and do not take care of herself, God won't love her; If one does not have the love and support of God what will happen to her? Left alone in this world . . . I didn't want this happen to me . . . '

Overall, four participants appeared to perform their religious OCD rituals to prevent themselves from being punished by God, with the exception of one participant who was more afraid of losing God's love and his positive attention rather than getting punished.

- Non-Professional Help-Seeking. All interviewees stated that their first approach to seeking help for their OCD symptoms was to speak to an Imam. Four of the participants considered the Imam to be an appropriate source for help and followed the advice provided. One participant did not accept the Imam's advice as she perceived that it was not aligned with her religious beliefs and upbringing.

Some of the advice from Imams reported by participants was to engage further in the prayers and rituals, for example, by reading verses from the Quran, praying more to ask God's forgiveness, and washing impure things three times so as to make things pure. Some of the illustrations from participants are presented below.

AA explained:

'The first time I asked for help, I talked to an Imam . . . , and he recommended that I read Quran more and he reassured me God will help me if I ask for his forgiveness'.

DD has been given the following advice by an Imam:

'he told me I should pray more, and ask God to help me in this situation, as God is the only one who can help me now'.

EE described her journey to seek help for her obsessional symptoms:

'I guess my symptoms started when I was 13, at the time I got my first period and one year after that, my doubting obsessions and washing compulsions started. I repeated wudu before prayer for several times; I have asked my friends and family members to watch me during prayer and tell me if I am performing it in a right way. Performing these religious rituals took a lot of time and I tolerated them for almost seven years; then, I decided to talk to an Imam who prayed at our mosque, he recommended me to read Quran more, and he reassured me God will help me if I ask for god's forgiveness. I did read Quran more, and it gave me a temporary relief, but the symptoms persisted. I have been visiting my doctor every few months and I feel much better now'.

Other interviewees also reported that religious related methods and advice provided a temporary relief rather than a long-lasting improvement for obsessional symptoms. One participant, DD, did not want to seek help at all, until she realised that her symptoms were impacting on her family members, and generally, the last option that interviewees acted on was seeking the help of psychiatric services. Specifically, there were long delays of between 5 and 13 years between the time when OCD-W symptoms were first noticed and when the women sought psychiatric help. There were also delays between first seeking help from a religious source to diagnosis of OCD of between one to eight years. Moreover, patients visited the mental health professional (MHP) after accepting that the benefits of religious advice were limited in terms of treating their OCD symptoms. As DD stated:

'I did not want to ask for help, I was fine to do things like that . . . But when I was 18, my mom passed away, my symptoms got worse afterwards, and my little sister and brother tried to convince me not to wash things and myself excessively . . . I remembered my little sister used to come to the bathroom with me, watching me and trying to stop me from washing more. After few months, I realised that my behaviours are extreme, and I have put too much pressure on my family members, so I did try to talk to a religious advisor (Imam) which was not helpful. Eventually, at the age of 23, I sought professional help and went to see a psychiatrist; he did diagnose me with OCD'.

In contrast, two participants were given advice from their Imams about not paying excessive attention to their doubts and to disengage from their rituals. For example, CC stated:

'An Imam told me that everything impure needed to be washed three times for the next time I want to use it, in order to make it pure and clean. He also mentioned that when I am not sure about purity or impurity of something, I should consider that object as a clean and pure one'.

Another Imam gave this advice to BB:

'He told me, I don't need to do the extra washing rituals continuously, and should stop having doubt about the rightness of my rituals and do whatever I have been asked to do in Islamic practices and not more, if I have excessive doubt about correctly performing my rituals, I should stop repeating, once is enough; however, that advice didn't help me. I couldn't accept it when I compared it with whatever I have learnt before; I continued to do what I was doing before'.

Professional Help-Seeking Behaviour. All participants reported that they were diagnosed by a psychiatrist for their OCD symptoms and three had also seen a psychologist. Psychiatrists prescribed medication, mostly Serotonin Reuptake Inhibitors (SRI), Serotonin Selective Reuptake Inhibitors (SSRI), or Tricyclic Antidepressants (TCA), and some of the interviewees were satisfied that the medications decreased their OCD symptoms. For example, EE stated that:

'I decided to see a psychiatrist in advice of one of my friends. I was diagnosed with OCD at that time. My psychiatrist prescribed clomipramine and then changed it to Fluoxetine which I have taken since then and my washing symptoms got less severe afterward . . . It was like I felt less urge and anxiety to wash things . . . I am more relaxed now'.

However, in two cases, participants mentioned that the medications they had taken were not helpful in decreasing their OCD symptoms, and they still suffered from religious OCD symptoms. DD stated:

'I have tried taking Fluoxetine which could not help me at all. My symptoms are not under control according to my psychiatrist opinion . . . Life still seems so difficult to me, I have all my symptoms . . . I still spend at least two hours a day performing my washing rituals'.

Two participants had received psychotherapy; one had received Cognitive Behavioural Therapy (CBT) and one Exposure Response Prevention Therapy (ERP). Both participants who had received psychotherapy still had OCD. BB did not tolerate ERP well and discontinued treatment. She explained:

'In the second session my psychologist asked me to touch anything in the bathroom, like the floor and hand basin, and do not wash my hands or take a shower after that as a take home task. I could not tolerate that way of doing things or stop washing my hands and body . . . It made me sick and I did not continue seeing him as it was too much for me'.

Relationship between Religion and OCD Symptoms. Interviewees were asked about the relationship between their religious beliefs and practices and their OCD symptoms, and responses indicated that interviewees saw religion as both positively and negatively related to their symptoms. For example, DD thought that her religious upbringing had made her life more challenging and stated:

'I am sure the way of upbringing at home and in school gave shape to my symptoms, praying to God did not help in decreasing my symptoms, if my mom was not sensitive to impurity and cleaning rituals in our religious rituals, I might never experience those symptoms, my religion made my symptoms worse, At the time I was trying to do things that might be accepted by God'.

Similarly, AA, stated:

'Since my childhood, I just tried to make everything in a perfect way in relation to my religion like being clean and pure before prayer . . . One of my teachers at school made me feel more sensitive to cleaning things, because she said God will not accept our rituals if we do not perform religious rituals in a right way, then I started checking many things in my rituals which increased the amount of symptoms that I had. That made me more uncomfortable with what I was doing . . . I tried so hard to get accepted by other important persons of my life like my teachers, parents and friends and I was not happy . . . '

However, CC indicated that religion both exacerbated her symptoms and provided a support for her in dealing with challenges:

'The way my husband treated me at that time, the intimidation he applied towards me and the fear he wanted me to have from sinning, have influenced the initiation and also maintenance of my symptoms . . . I still do have those sorts of fears . . . Although I believe having God in my world always helps me tolerate many difficult situations, however, I guess religious concerns increased my level of anxiety and OC symptoms'.

Moreover, EE said:

'I am not sure if my religion did make an impact on my OCD symptoms, I guess God loves purity, cleanness is also recommended in our religion; at the same time, doing excessive rituals is not recommended...therefore, I am not sure if I am doing the right thing regarding my religion or not . . . it is confusing . . . '

Overall, it seems that religious upbringing at home or school was perceived to play an important role in some of the participant's OCD symptoms. However, many Muslims may be hesitant to admit that religion has a negative impact on their lives because they consider it as a kind of blasphemy that can trigger a fear of punishment. On the other hand, religion is also perceived as a positive coping mechanism in Muslim's lives and they do not want to detach themselves from its positive effects, as well as God's mercy.

Role of Religion in Coping with Symptoms. Participants had different views about the role of religion in coping with OCD symptoms. For two participants performing religious rituals like praying was their main means of coping with OCD symptoms, as AA stated:

'At the time when my symptoms were severe, sometimes I read Quran and prayed which helped me in relation to decreasing the anxiety I encountered and also increasing the hope regarding acceptance of my rituals by God, and to be loved by God which made me tolerate my symptoms more and to be more satisfied and happier'.

Another participant, CC, stated:

'I am sure God loves me and his love, mercy and forgiveness will help me to overcome my symptoms in the end, I am praying and fasting more and hoping he will forgive me for what I have done wrong and also incorrect, regarding performing of religious rituals ... I have felt much better after praying ... at least for a while ... '

However, two participants considered their religiosity to add negative effects to their life, as EE stated:

'I think God helped me in many challenging situations in my life, but I guess I cannot say my religion did help me to specifically reduce my OCD symptoms, on the other hand, it made me feel more guilty most of the times ... I did control my symptoms with the help of my psychiatrist and medication I am taking now ... '

Overall, it appears that some participants saw a positive role for religion as a coping mechanism to tolerate their OCD symptoms; however, others believed it had an adverse effect and made their symptoms worse, in addition to making them feel more guilty about their performance of religious rituals.

3.2. Discussion

In a recent study conducted in Iran, [Mahintorabi et al. \(2015\)](#) found that religious OCD symptoms occur more commonly among practicing Muslim women with OCD-W compared to non-practicing Muslim women with OCD-W. This study sought to investigate the reason for these differences with the aim of informing approaches to manage OCD symptomatology in this group. We used a qualitative semi-structured interview to explore the experience of OCD symptoms, help seeking, and religiosity among practicing Muslim women diagnosed with OCD-W. The sample included five practicing Muslim women from Iran, Iraq, Turkey, and Afghanistan living in Australia whose ages ranged from 33 to 45 years.

The most common symptoms reported were related to washing rituals before prayer. This is consistent with the findings of ([Al-Solaim and Loewenthal 2011](#)) from their research conducted in Saudi Arabia and is consistent with the importance of cleaning rituals in Islamic practice ([Al-Bukhari 1979](#)) and the requirement that washing rituals related to prayer are performed frequently before praying so that Muslims approach God in a ritually pure condition. Notably, Muslim women are required to perform more washing rituals than males, and this may make them more vulnerable to developing OCD or more at risk of having their symptoms exacerbated if they are already living with OCD ([Besiroglu et al. 2014](#)).

The majority of participants stated that they had a fear of sin, a fear that their rituals would not be accepted by God, and a fear of being sent to hell for not performing their religious rituals properly.

The fear of sin and God has also been observed in religious participants with OCD by [Olatunji et al. \(2007\)](#), and [Mahintorabi et al. \(2015\)](#) identified the presence of a high fear of sin and God in their sample of practicing Muslim women with OCD. In relation to help-seeking, participants did not seek help immediately after they first noticed their OCD symptoms and, instead, tolerated them for up to seven years before seeking advice from an Imam. Additionally, they waited up to six years before seeking professional help. This is consistent with the findings of other studies that have also demonstrated a long delay in seeking help among Muslim patients with OCD ([Ghassemzadeh et al. 2005, 2002](#); [Demet et al. 2010](#)). The findings are also in line with reports from other studies whereby highly religious participants sought help from religious authorities and faith-based healers regarding their OCD symptoms that involved religious themes ([Greenberg and Shefler 2002, 2008](#); [Al-Solaim and Loewenthal 2011](#); [Deacon et al. 2013](#)).

Similarly, [Mahintorabi et al. \(2015\)](#) identified a large and significant delay between the time the practicing Muslim women with OCD-W were diagnosed with OCD and the time they sought professional help regarding their OCD symptoms (12.48 years delay for practicing Muslim women and 6.16 years for non-practicing Muslim women with OCD-W). Moreover, the practicing Muslim women with OCD-W reported a higher severity of symptoms at the time they were referred to a MHP compared with the non-practicing Muslim women with OCD-W. In the current study a poor response to treatment was found in the sample, with four of the five participants still in the clinical range for OCD on the Y-BOCS. It is suggested that women with religious OCD symptoms may prefer to receive help from a religious MHP ([Al-Solaim and Loewenthal 2011](#); [Greenberg and Shefler 2002](#)) or to try a treatment plan which is modified and compatible with the patient's religious beliefs and standards ([Bonchek and Greenberg 2009](#); [Ferrao et al. 2006](#)).

The findings regarding the subjective relationship between religion and OCD among our interviewees were inconsistent. Some participants stated that their religious upbringing was the reason for their OCD symptoms and mentioned that their symptoms got worse due to the teaching of Islamic rules and values at school. Similarly, others reported that religion had an adverse effect and made their symptoms worse as a result of experiencing guilt. This is consistent with the findings of [Steketee et al. \(1991\)](#) from a Catholic sample with OCD and also consistent with the research of [Greenberg and Shefler \(2002\)](#) and [Huppert, Siev, and Kushner \(Huppert et al. 2007\)](#) among practicing Jewish participants. However, some participants did not endorse this view, perhaps since the mention of religion as having a negative impact on individuals' lives could be viewed by participants as being blasphemous and, as such, participants may not want to admit this due to their fear of sinning and the possibility of getting punished by God. Religion was also perceived as a positive coping mechanism in interviewees' lives, with some using religion to cope with their OCD symptoms. This is consistent with the findings of [Al-Solaim and Loewenthal \(2011\)](#) among Muslim adolescents with OCD.

While the findings of the current study contribute to our understanding of the relationship between religion and OCD symptom expression and treatment seeking, the study is not without limitations. Although we employed an independent assessor to review a sample of 20 quotes extracted from the interviews against the five themes that emerged from the data and matched the quotes to the themes, we did not employ other types of triangulation, such as member checking. Additionally, our research employed a small sample size and used a data sampling method of convenience with participants who had been informed about the research via an advertisement placed in mental health settings. It is possible that the present sampling strategy was biased toward people with more severe OCD symptoms, as participants were likely to have been seeking help at the time of the study. Perhaps those with less severe symptoms and who were not seeking professional help at the time of the study would have reported different experiences. Therefore, future research examining the experiences of Muslim women who have successfully recovered from OCD is warranted. Another limitation is the common experience of immigration among our sample, none of whom were born in Australia, which makes comparison with homogeneous samples from countries such as Iran difficult.

Overall, the findings of the present study revealed that the most frequent rituals experienced by participants were related to praying. Moreover, all participants had sought help from Imams regarding their religious OCD symptoms. Some participants had been given advice by Imams to pray more, read verses from the Quran, and regularly ask for God's forgiveness, which sometimes helped participants in temporarily alleviating stress and OCD symptoms but generally did not assist in the longer term. It should be noted, however, that two participants said their Imam's had given them CBT-consistent advice. It seems probable that some Imams may unintentionally provide suggestions that increase and aggravate the OCD symptoms of religious help seekers, which is consistent with the findings of Deacon, Vincent, and Zhang (Deacon et al. 2013) among Christian clergy members. If these findings generalise beyond the sample examined here, then this would provide an important direction for targeting early intervention for Muslim women with OCD-W symptomatology, as shorter delays between emergence of symptoms and commencing treatment have been associated with better outcomes (Rufer et al. 2005). More research examining the experience of Imams in regard to their understanding of OCD and also the nature of the advice provided to Muslim help-seekers regarding their religious OCD symptoms would be beneficial and could inform the development of strategies to overcome large delays in seeking appropriate treatment.

Author Contributions: The authors were co-contributors to the design of the research. The first author collected the data. All authors contributed to analysis and writing of the research. All authors read and approved the final manuscript.

Conflicts of Interest: The authors declare no conflict of interest.

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