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A Qualitative Exploration of Lived Experiences of Religious OCD within Muslim Communities

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Abstract

Obsessive-Compulsive Disorder (OCD) is an anxiety disorder that is characterised by two distinct symptoms; obsessions, compulsions or both (American Psychiatric Association [APA], 2013; Besiroglu, Karaca&Keski, 2012). Often overlooked, Religious Scrupulosity or Religious OCD (ROCD) is a subtype of OCD which manifests as pathological guilt, doubt and distress arising from intrusive, unwanted thoughts, images, or urges about violating their religious, moral, or ethical beliefs (Huppert &Siev, 2010; Miller & Hedges, 2008).

This research sought to fill the gap in understanding the personal, lived experiences of Muslims with ROCD and increase accessibility of mental health services for such individuals. Using thematic analysis, this study found 5 main themes of ROCD sufferers: Finding purity when engaging in compulsions, Black and white perspective of Islam, Physically and emotionally challenging experiences, Lack of support and Ways of coping. The present study concluded by providing insightful implications and avenues of further research for healthcare providers, mental health professionals and members of the religious clergy.

Obsessive-Compulsive Disorder

Obsessive-Compulsive Disorder (OCD) is an anxiety disorder that is characterised by two distinct symptoms; obsessions, compulsions or both (American Psychiatric Association [APA], 2013; Besiroglu, Karaca & Keski, 2012). Obsessions are repetitive, intrusive, distressing thoughts and ideas that the individual is unable to control (American Psychiatric Association, 2000). According to research, around 94% of the world's population encounters intrusive thoughts (Radomsky et al., 2010). Common obsessions can be presented as harm to oneself or others and fears of contamination (Foa & Kozak et al., 1995). Compulsions may be mental or physical

behaviours performed in accordance with specific rules that are implemented to reduce an individual's distress surrounding their obsessions (APA, 2000). Common compulsions include excessive cleaning and checking (Foa et al., 1995). What sets OCD apart from other anxiety disorders is that the obsessive thoughts, which are excessive and irrational, are then followed by compulsive actions to reduce the level of distress (Valentine, 2021), thereby significantly interfering with the person's daily functioning (American Psychiatric Association, 2005).

Conceptual models of obsessive difficulties propose that distress linked to doubt and obsessional preoccupation will lead to attempts, by the individual, to reduce this distress by attempting to control these thoughts, dismiss them, seek out their meaning, or take action to prevent feared consequences. For instance, the individual may repeat a particular act until perfect, ask others for reassurance about their doubts or avoid stimuli that trigger the thought occurrences. Thought suppression, compulsive rituals, avoidance behaviours, and other strategies though may seem helpful by reducing obsessional distress in the short-term, are actually counterproductive in the long-term. For example, these strategies can develop into strong patterns that impact functioning; they also prevent the individual from learning to cope with, or overcome these difficulties which leads to further distress (Abramowitz, & Jacoby, 2014). Also, due to the absolute certainty of some of these thoughts and the inability to prove them, these acts or reassurance from others and seeking absolute certainty will maintain levels of distress and obsessional thinking (Radomsky, Gilchrist and Dussault, 2006).

Religious OCD

Often overlooked, Religious Scrupulosity or Religious OCD (ROCD) is a subtype of OCD which manifests as pathological guilt, doubt and distress arising from intrusive, unwanted thoughts, images, or urges about violating their religious, moral, or ethical beliefs (Huppert &Siev, 2010; Miller & Hedges, 2008). Experts estimate between 10-33% of people with OCD may experience ROCD (McIngvale et al., 2017), with a notable prevalence of regional differences. For instance, research has demonstrated a higher level of ROCD within eastern areas of Turkey, compared to western areas (Karadag et al., 2006). Differences can also be observed across countries. Findings by Yorulmaz, Gencoz and Woody (2009) support that Turkish Muslims demonstrate increased levels of ROCD symptoms and concerns in their thoughts compared to Canadian Christians. However, Steketee, Quay and White (1991) found that a more religious individual, regardless of religious denomination, is more likely to experience religious obsessions.

ROCD obsessions typically include obsessive religious doubts, unwanted and intrusive blasphemous thoughts and images which stem from the fear of committing a sin and/or fear of punishment (Mohamed, Elsweedy, Elsayed, Rajab, and Elzahar, 2014; Nelson et al, 2006; Abramowitz & Jacoby, 2014). ROCD compulsions in response to obsessive thoughts may include ritualistic cleaning procedures, hypermorality, constant reassurance-seeking from religious leaders about religion matters, avoiding places of worship and excessive praying (Himle, Chatters, Taylor and Nguyen, 2011; Abramowitz et al, 2002). The individual may present their symptoms as excessive and unreasonable (Himle et al., 2011), such as focusing upon particular details of the religion while turning a blind eye to other aspects (Mohamed et al., 2014). Engagement in such behaviours exceed religious laws and are often concerned with minor dilemmas which do not contribute to the central practices and core beliefs of their associated faith (Nazar, Haq and Idrees, 2011).

Solaim and Loewenthal (2011) found that such symptoms were increasingly distressing, time-consuming and physically exhausting for the individuals experiencing them. For instance, individuals may become distressed when obsessive thoughts about cleanliness come to effect (Abouhendy& Jawad 2013). Having such irrational fear also leads to compulsions which compromises the repetition of Wudu or Islamic ritual cleaning (Zakaria, Halim, Ramli, Bakar, Fauzi, Sahran & Mamat, 2020). This is supported by a study which consisted of females of Saudi Arabian origin who had OCD. Findings showed that although religious symptoms dominated both the obsessions and compulsions, ultimately doubt was the most common feature among them (Mahgoub& Abdul-Hafez, 1991).

ROCD has been identified in many religions, including Christianity, Islam and Judaism. 2% of patients with ROCD have been reported in the UK (Greenberg & Huppert, 2010). The ROCD rate is much higher in other countries, such as Turkey who reported an average of 27% patients with ROCD and the Middle East with 52% (Greenberg & Huppert, 2010). It appears that religious issues in the context of OCD are more salient and present in clinical populations of Muslim, Jewish, and Middle Eastern cultures in comparison to populations in the West, India and the Far East.

Research by Abramowitz & Jacoby (2014) has found that different religious groups present ROCD differently, in which highly religious Protestant Christians were more susceptible to scrupulosity than their Jewish counterparts who scored lower in fear of Divine Punishment. This may be due to differing beliefs on punishments in the afterlife. Orthodox Jews may be more susceptible to scrupulous thoughts associated with committing sins, such as violating dietary guidance, than a Christian, who has no dietary requirements. Likewise, a Jew is less likely to concern themselves with confessing to a Rabbi as this is a practice exclusive to Christianity. Muslim individuals place a strong emphasis on the importance of controlling their intrusive thoughts (Yorulmaz et al., 2009) and are more likely to engage in ritualistic compulsions, which can be attributed to many Muslims believing that they achieve salvation by abiding by strict rules and guided rituals (Inozu et al., 2012). Individuals with scrupulosity from all religious backgrounds may experience anxiety connected with their religious beliefs, which can turn their normal religious practices and rituals into compulsive behaviour (Deacon & Nelson, 2008). This emphasises that scrupulosity can be influenced by religious creed and practices, therefore insinuating that diagnosis and treatment of ROCD requires a theologically-informed approach.

Mahintorabi et al. (2015) have contributed to some understanding of ROCD within the Muslim population through the investigation of Muslim Iranian women in Tehran with OCD washing subtype (OCD-W). It was found that the women who were attributed more religious characteristics engaged in more religious rituals and scored higher on a measure of scrupulosity compared to non-practicing Muslim women. However, this study focused predominantly on help-seeking and treatment for ROCD, and less on the experiences of Muslims with such difficulties. There is a clear gap within the literature that limits our understanding of ROCD within the Muslim community, namely, the specific day-to-day experiences related to cognitions and behaviours using rich and in-depth research designs.

ROCD, the Cognitive Behavioural Model & Religiosity

Psychological theories have recognised the association between religion and obsessive symptoms (Sica, Novara &Danavio, 2002; Yorulmaz, Gencoz &, Woody, 2009). For instance, cognitive-behavioural models of obsessions suggest that there are three processes that are salient in individuals with high levels of religiosity; threat appraisals of intrusions, heightened mental control, and misinterpretation of failed thought control.

Though high levels of religiosity are positively associated with beliefs that unwanted thoughts are significant, which are associated with scrupulosity, most religious people do not suffer from ROCD. This indicates that these associations are not always pathological. Clinical observations indicate that people with ROCD tend to have difficulty with the distinctions between sinful and non-sinful cognitions (Abramowitz, & Jacoby, 2014). Usually, people with ROCD will seek out evidence or proof that these thoughts are not true, for example, that they will not receive a punishment, though these matters cannot be proven.

A principal concern for clinicians may be differentiating scrupulosity from healthy religious practice, especially because scrupulous obsessions and compulsions often have some basis in conventional religious beliefs. Unintentionally, the person's religious community may also support or reinforce the scrupulous behaviour, perceiving it merely as an enthusiastic devout religious adherence. The individual with scrupulosity, however, typically has excessive and rigid (obsessional) concerns regarding a few particular facets of religious practice, which paradoxically tend to interfere with other valued aspects of religious observance. For example, one patient with an extreme fear of having blasphemous thoughts strictly avoided her church so as to not have such thoughts there. Conversely, healthy religious observance is generally typified by more moderate and flexible approaches to religious belief and practice, viewing perfect adherence as the ideal rather than as necessary to avoid severe punishment. Additionally, healthy religious practice and rituals are usually associated with positive emotions, whereas scrupulosity-driven rituals are typically linked with marked fear and anxiety (Greenberg &Shefler, 2002).

Furthermore, Abramowitz (2008) argued that over-emphasising the importance of controlling 'impure' thoughts might contribute to heightened OCD symptoms. Therefore, it was thought that individuals who are highly religious are more likely to have maladaptive beliefs in relation to controlling unwanted intrusive thoughts and an increased sense to refrain from 'sinful' or 'impure' cognitions. For example, if individuals misinterpret these unwanted thoughts as being highly significant and possibly sinful, they are more likely to experience doubt, guilt, fear of God, distress, and a need to control these thoughts (Abramowitz, & Jacoby, 2014).

Research has found that religiosity can influence the way in which ROCD is experienced (Tukel et al., 2005). For instance, ROCD symptoms have been found to occur earlier in the course of progression than other OCD symptoms (Greenbers&Witztum, 1994; Hasler et al.,2000). However, due to the cognitive association of morality, belief systems and religious observance, there is difficulty in distinguishing religious practice from scrupulous symptoms which delay diagnosis and the identification of ROCD as a potential problem, especially in highly devout and religious persons (Deacon et al., 2013; Mahintorabi, Jones, Harris &Zahiroddin, 2015; Yorulmax, Karanci &Tekok-Kilic, 2002). For example, research by Jones, Harris &Esfahani (2019) discusses that advice given by clergy can have an impact on professional help-seeking which can explain why more-practising Muslim women sought delayed help after consulting a religious leader. It was found that the majority of Imams (Muslim community leaders) in the study were unaware of scrupulosity being indicative of a mental health problem and were also unfamiliar with psychological treatment for OCD, such as Exposure and Response Prevention (ERP). Additionally, practising Muslim women reported a significantly longer time seeking professional help and presented more severe symptoms at the time of seeking help than non-practicing Muslim women (Besiroglu and Agargu, 2006). The nature of ROCD is that individuals struggling with scrupulosity confide in religious leaders and seek religious guidance instead of clinical treatment, which may further exacerbate the situation. This has led to Imams providing support that is inconsistent and in contradiction to recognised models of treatment, which can contribute to the aggravation of ROCD symptoms (Besiroglu and Agargu, 2006).

Furthermore, there is a general lack of diagnostic criteria for ROCD in psychology and psychiatric textbooks. The DSM-IV makes brief mention of scrupulosity in the context of Obsessive-Compulsive Personality Disorder (OCDP). However, this is problematic with consideration to the prevalence and clinical distress associated with scrupulosity. It remains unclear whether ROCD is a subcategory of OCD or OCPD and whether it may be a different disorder altogether within the OCD spectrum. According to the International OCD Foundation (2014), it can take anywhere between 14-17 years from the time an individual begins experiencing symptoms of OCD to access the right type of treatment and learn to manage their mental health, and this is without accounting for the barriers outlined above.

The current mental health system does not accommodate effectively for individuals suffering from ROCD. While 70% of patients with OCD benefit from Cognitive Behavioural Therapy (CBT) (International OCD Foundation, 2014), there is sparse research to show the efficacy of CBT in patients with ROCD, and there is also very limited research for those patients with an Islamic religious denomination.

Exposure with Response Prevention (ERP) is one of the most beneficial treatments for OCD (Koran, Hanna, Hollander, Nestadt, & Simpson, 2007; NICE, 2006). ERP involves repeated exposure to specific thoughts and actions while refraining from performing compulsive rituals, as a way to reduce the number and severity of OCD symptoms (Foa et al., 2007; McKay, 2006; Rowa, Antony, &Swinson, 2007). Scrupulosity has a very strong cognitive component, and is closely related to religious and moral belief systems, and to religious observances (Deacon et al., 2013; Mahintorabi, Jones, Harris, & Zahiroddin, 2015).

The Islamic Concept of 'Waswasa'

Religious OCD hides behind many barriers, including cultural and religious stigma, cultural suppression and the fact that these religious obsessions are associated with a positive, high level of religiosity and encouraged by religious leaders (Moron, Biolik-Moron & Matuszewki, 2022). While this claim may be valid, Islam is a religion of moderation and discourages extremity in all things.

"Do good deeds properly, sincerely and moderately, and always adopt a middle, moderate, regular course whereby you will reach your target."
Prophet Muhammad (ﷺ)

From scripture and Prophetic narrations to works by theologians, Muslim physicians, and traditional Islamic academics, researchers have investigated the prevalence and importance of intrusive recurring thoughts, as well as their influence or absence thereof on Islamic religious rites (Farfur, 2002, Badri, 2013; Bint Abdur Rahman, 2013).

Based on the Qur'an, Prophetic traditions, and Islamic academic publications, the concept of *Waswasa*, often known as 'overwhelming whisperings', is mentioned five times in the Qur'an.

فَوَسْوَسَ إِلَيْهِ ٱلشَّيْطَٰنُ قَالَ يَٰٓـَٔادَمُ هَلْ أَدُلُّكَ عَلَىٰ شَجَرَةِ ٱلْخُلْدِ وَمُلْكٍ لَّا يَبْلَىٰ

"But Satan whispered to Adam, saying, 'Adam, shall I show you the tree of immortality and power that never decays?'."
[Qur'an 20:120]

The theme of Satan misleading people originates from the story of creation in the three Abrahamic faiths: Islam, Christianity, and Judaism. The Serpent (Satan) **told** Eve to eat fruit from the forbidden tree in the book of Genesis (Genesis 3:1-3, New King James Version), whereas Satan **whispered** to both to approach the forbidden tree in the Quran (20:120). The word *Waswasa* is used exclusively in the Qur'an.

فَوَسْوَسَ لَهُمَاٱلشَّيْطَٰنُ لِيُبْدِىَ لَهُمَا

"Then Satan whispered to them that he might manifest unto them."
[Qur'an 7:20]

Whilst the interpretation in Islamic studies varies by *tafsir* (Islamic explanations) and scholars, it is associated as a type of OCD. The emphasis on cleanliness, purity, and religious practices is the standard in Islam. However, when these behaviours go beyond the requirements of religious practice, they are classified as *Waswasa*. This is a mental health disorder which is not recognised as being a religious presentation of OCD within western classifications, and this can be particularly limiting for many Muslims seeking support from traditional mental health services within the UK. It is commonly observed in the Muslim community however, it is not recognised by the Diagnostic and Statistical Manual of Mental Disorders (DSM) due to the lack of research in the topic area, its overlap amongst other diagnoses as well as American Psychiatric Association's lack of recognition of spiritually-linked mental health conditions (Latif, 2014). Researchers have emphasised the need of conducting research with Muslim populations in order to better understand this disorder, as prior studies on religion and OCD have mostly focused on the Judeo-Christian heritage (Rassool, 2019; Ahmad, 2022).

"Allah will forgive my ummah (followers) for whatever crosses their minds so long as they do not speak of it or act upon it." **Prophet Muhammad (ﷺ)**

Study Aims and Rationale

There are studies that have arrived at a conclusion as to what the best methods are to treat religious OCD (Huppert &Siev, 2010; Mahintorabi, Jones & Harris, 2017; Omranifard, Akuchakian, Almasi &Maraci, 2011; Rosli, Sharip& Thomas, 2019). These consider the role of Muslim leaders in helping to combat ROCD which have been investigated (Jones, Harris & Esfahani, 2019), the cognitive perspective and framework to observe religious OCD (Abramwitz& Jacoby, 2014; Besiroglu, Karaca & Keskin, 2014; Nelson, Abramwitz, Whiteside & Deacon, 2006), and the development of new measures to test for religious OCD have been established (Abramowitz, Huppert, Cohen, Tolin& Cahill, 2002; Ong, Betancourt &Fisak, 2021). There is no known research that takes an Islamic perspective into consideration that applies a closer look into everyday life, i.e. 'putting yourself in their shoes' and understanding how ROCD is perceived and experienced by Muslims, in particular the specific thoughts and rituals, related feelings, and general mental health and wellbeing. Arguably, there is a need for qualitative research to investigate the experiences of Muslims with ROCD. The purpose of this study is to improve our understanding of ROCD through a clinical and Islamic perspective using a qualitative design.

The purpose of this research is to improve our understanding by investigating the personal and lived experiences of a person who has ROCD. It is therefore hoped that this research will contribute by providing an insight into religious OCD and what it truly consists of with the aim that this research will support increasing the accessibility of mental health services for individuals with ROCD, from ethnically diverse communities. The research findings will hopefully provide new insights into avenues of support and inclusive service access. This study has the potential to inform treatment, specifically in regards to the processes experienced within the Muslim community.

Methodology

Research Design

The focus of this study was to investigate the lived experiences of ROCD within Muslim communities by utilising the thematic analysis approach (Braun & Clarke, 2006). Thematic analysis is an inductive qualitative method which is used to identify, analyse and report patterned themes within a dataset. The reason for selecting thematic analysis is because it explores an issue to a level of depth and flexibility that is not often obtained in quantitative methods (Attride-Stirling, 2001). Being an inductive approach, thematic analysis takes context into consideration, allowing for themes within the data to emerge organically and inform the dynamics

of a particular research area (Braun & Clarke, 2006). This enriches the study, and results in analysis that is suited to informing policy development.

The research process began by consulting the existing literature around ROCD experienced by Muslims, for which research was sparse, but present. This literature helped us narrow our target sample to those who have experienced symptoms of OCD related to religion and morality.

Data Collection, Storage & Analysis

This study used heterogeneous purposive sampling, which ensured that the sample was suitable for the research topic. Potential participants were first asked to answer a few screening questions which were based on our selection criteria. This selection criteria included common symptoms of ROCD, including obsessions and compulsions. Successful participants were selected by completing a consent form, and then were sent a template of diary entries for a period of 14 days or invited to a structured virtual interview. A total of 5 participants took part.

The diary process involved documenting parts of their experiences as they happened throughout the day and answering specific questions about their difficulties (for example, ROCD behaviours and/or thoughts). Participants that were contacted to take part in a structured virtual interview were audio-recorded with consent and further details around information and data protection was shared and agreed to in the consent form. After collecting the data from 5 participants, each audio file was transcribed manually and each participant was given a pseudonym to protect their identity. Following this, each transcript was read and re-read in order to identify codes, which were drawn out in a mind-map format.

The final level of analysis involved reviewing and combining these initial codes into overarching themes and the research question informed this process. Finally, the themes were presented in this Findings and Discussion section of this paper, drawing excerpts from the rich data transcripts.

Ethical Considerations

Ethical research procedures were adhered to in accordance with the British Psychological Society's (BPS) Ethical guidelines.

Prior to the experiment, participants were provided an information sheet in the consent form, including the reasons for the research being undertaken and outlining the participants' roles in the study and their right to withdraw themselves and their data from the study at any time. An email address was included to provide the participants with an opportunity to request further details regarding the research.

We acknowledge the potential of the participants experiencing psychological distress during the study when recounting their obsessions and compulsions, especially for those who may not be receiving treatment for their ROCD. This risk will be made very clear to participants on the information sheet prior to the experiment, alongside their right to halt the study at any point in which they felt distressed. The information sheet also signposted OCD support services for participants if they felt affected at any point throughout the study and participants were again made aware of these services when conducting the interview.

Participants consented to the audio recording of interviews, which were subsequently anonymised and transcribed.

Once the diary entries and interviews were completed, a participant debrief sheet was provided to all participants, which also included signposted support services for OCD and ROCD. Inspirited Minds was fully GDPR compliant during the research and continues to remain compliant.

Findings & Discussion

This study sought to understand the first hand experiences of Religious OCD (ROCD) as a Muslim and utilised Thematic analysis to capture the richness of lived experiences of mental health. As a result, this study found many key features of the experiences of ROCD that were common in all participants. These were organised into the following themes:

1. Finding purity when engaging in compulsions
2. Black and white perspective of Islam
3. Physically and emotionally challenging experiences
4. Lack of support
5. Ways of coping

Each theme was then divided into sub-themes based on the most prominent findings.

Figure 1: Themes and sub-themes presented in the present study.

Finding Purity when Engaging in Compulsions

This theme surrounded participants having ROCD-related obsessive thoughts and compulsions. The theme found that participants felt intrusive thoughts were mentally challenging and intense in nature, which led them to engage in religious-related compulsions to cope. There were ideas around these compulsions being physically demanding however, they had become habitual in nature over time and engaging in these behaviours led to feeling pure and more at peace with oneself.

This theme is therefore divided into the following sub-themes:

- Obsessive thoughts are about purity
- Feeling pure again when engaging in compulsions

There was a common theme around participants' experiences of instructive thoughts and beliefs relating to being 'impure' which led to a range of feelings such as anxiety, panic, fear, guilt and confusion. Participants engaged in compulsions or rituals in order to cope with these thoughts and feelings. For example, multiple participants expressed experiences of repeating their ablution (Wudu) multiple times due to thoughts of not doing the practice properly or as a way to become pure from beliefs that they believed were impure.

"I became scared of everything being so impure. I had to do washing in a specific way, and it couldn't be done, and then I'd be having a panic attack.... I'd pray and if my head touched the bed sheet then I'd go and wash it in the shower straight afterwards, so just like, so a lot of and if not, if I could not do it there and then I'd have to avoid touching my head on anything, or avoid touching my hand there." Participant 4

"When I was 19-20 it got very bad, I was doing continuous ablutions and staying on the Musallah [prayer mat]…"
Participant 3

Furthermore, compulsions were also individualised to the person. Whilst for some this looked like physically washing, for others impurity was experienced in the mind or in their lifestyle.

"I had to clean my mind, so I became very obsessed with listening to Qur'an and only Qur'an, and I don't watch much TV and if I do it's very 'PG' things. I can't remember the last time I picked up my Mushaf [Qur'an] not because I'm not physically clean but because I can't purify my brain. So I use my phone to recite the Qur'an instead."
Participant 5

"I didn't care about Riyya [ostentation] but as soon as I saw it was a form of Shirk, I was like OMG!... I have to limit what I am exposed to online, you know instagram reels and videos or even like people's comments - that can sometimes trigger it."
Participant 1

Rituals and compulsions are widely experienced by individuals with OCD. Individuals with washing rituals related to their religious beliefs also commonly experience significant impairments related to their ROCD (Himle et al, 2011). These rituals commonly involve washing or rinsing to make up for sinful thoughts or actions. Studies show that more often these rituals involve excessive washing and cleaning, whereby individuals experience relief after this (Himle et al, 2011). Furthermore, research from different cultures and religious populations propose that beliefs and practices of a particular religion could impact the expression of an individual's OCD symptoms (Rachman, 1997). For example, studies carried out in Australia found that individuals with OCD will wash because they feel contaminated by dirt and germs, and by carrying out these washing rituals they will prevent diseases (Jones & Menzies, 1998). However, studies from Iran, Egypt and Saudi Arabia reported that OCD washing rituals are more likely to be driven by beliefs about purity, and that these beliefs are related with cultural practices of religions such as Islam e.g., Greenberg and Shefler (2002), which support the current study's findings.

"I felt like my prayer will never be good enough, hence lacking validity and acceptance and I will never do it properly and it will always be imperfect and lacklustre. I felt hopeless, as I can't seem to do one of the basic acts of worship in Islam well."
Participant 2

"My thoughts were about being impure and I was disgusted with myself, then I would go do ghusl [major ablution]. I wanted to be pure again…"
Participant 3

"I'd pray and if my head touched the bed sheet then I'd go and wash it in the shower straight afterwards, so just like, so a lot of and if not. If I could not do it there and then I'd have to avoid touching my head on anything, or avoid touching my hand there."
Participant 4

Although participants were aware their compulsions were irrational, the urges were so strong that they had to carry these out despite having this awareness, and at times these behaviours were carried out habitually without the participant making great effort. Moreover, it was only until after participants carried out these behaviours that they felt a sense of relief and reduced levels of anxiety. Therefore, despite rituals or compulsions being demanding, they were a means to feel pure again, bringing a sense of comfort and peace.

"I would do it [ablution] over and over again until I was sure I was pure, until I felt peace."
Participant 3

'I don't know if I kind of fit into that box, of you know performing [rituals] them per se, erm, but they bring a sense of like comfort. I guess it is relief or just like erm, I'd rather do the act or go out of my way not to watch something rather than deal with like the visions and the thoughts and ideas that I get afterwards".
Participant 5

The functions of OCD have been widely studied, with the dominant function of compulsions being to alleviate distress or anxiety caused by the obsessions (Starcevic et al, 2011). However, compulsions have also been found to serve multiple functions. Pietrefesa and Coles (2008) reported a sense of incompleteness and harm avoidance were an underlying motivation for performing washing/cleaning, checking, and mental compulsions.

These findings align with our study, whereby participants reported a sense of relief and completeness during and after performing compulsions such as repeating Wudu over and over again. Similarly, in Wairauch et. al.'s (2024) study, participants shared their experiences of

negative feelings prior to beginning their rituals, and a significant sense of relief upon completing them. Participants reported positive feelings such as calmness and satisfaction.

Black and White Perspective of Islam

In our current study, all participants collectively shared that their perception of Islam played a key role in their lived experience of ROCD. Indeed, previous studies have found religion to be an important element of life for Muslims, and fulfilling religious practices in an inadequate manner have been observed to bring about fear-led responses, resulting in distress and anxiety (Solaim & Loewenthal, 2011). However, participants in the current study specified having a black and white perspective of Islam as a main factor in their presentation of ROCD. Black and white thinking (also known as all-or-nothing thinking or dichotomous thinking), is a cognitive distortion that is characterised by a rigid, all-or-nothing way of information processing, such that an individual's thought patterns consist of absolute terms (Knapp & Beck, 2008). Black and white thinking can feature in the symptomatology of OCD (Williams &Shafran, 2018). It may be that individuals with OCD engage in black and white thinking as it grants them a perception of control (Rowland, Jainer& Panchal; 2017).

In Religious OCD, this may present itself in an all-or-nothing perception of God. This cognitive distortion was clearly identified when interviewing the Muslim participants for this study. The presupposition that Allah (SWT) is a God who hates someone because of their 'bad deeds' and loves someone because of their 'good deeds' is observed as a black and white perspective of religion.

"Then I thought to myself - 'Oh no, I'm going to Hell'. Like, I was just constantly thinking to myself about Hell fire."
Participant 1

"You've had a tough life just because Allah wants you to have a tough life. Things aren't going to get better for you."
Participant 5

"At some point, I thought it was wrath from Allah."
Participant 3

An individual believing that they are going to go to Hell can be considered as having a black and white perspective of religion. This is because, for example, in Islam, a fundamental belief is that Allah (SWT) possesses qualities, i.e. being the Most Merciful and the Most Forgiving. Black and white thinking typically only views Allah (SWT) in one extreme, i.e. as a generally angry or wrathful God which notably is not in accordance with Islamic beliefs.

"I felt almost, like, betrayed by God… I felt like, that He doesn't really care, neglectful, felt abandonment. Yeah, like, a very, like, wrathful, vengeful God. That's the way I was perceiving it." Participant 1
"Allah doesn't like you… Allah hates you"
Participant 5

Studies have shown increased symptoms and religious obsessions related to OCD among practising Muslims and within Muslims countries compared to practising Christians and western countries (Himle, Chatters, Taylor & Nguyen, 2011). This study suggested that the way in which Muslims practice their faith may facilitate the expression of OCD. However, the current study illustrates that it is an individual's perception and understanding of religion that determines their experience of ROCD.

However, religion can also be a means of understanding ROCD, whereby individuals can learn more about moderate ways of thinking to cope and come to terms with their understanding of God, religion and their ROCD symptoms, hence providing permanent relief of obsessional symptoms (Solaim&Loewenthal, 2011). This also raises a point of concern for how religion is taught to individuals, particularly how Islam is taught to Muslims, i.e. having a black and white perspective of Islam and of Allah (swt).

"Growing up, I wanted to be perfect in the eyes of Allah…'
Participant 1

"But before 2020, in my university days when I was learning more about Islam, I noticed I had started developing anxious thoughts and became paranoid."
Participant 2

"I feel like everything is black and white with them [Imams and Sheikhs]."
Participant 3

One participant did express that this perspective of Islam led them to feel like their mind is their enemy:
"My mind has become my worst enemy."
Participant 1

Physically and emotionally challenging experiences

ROCD is a very emotionally draining disorder, in that it convinces the individual that their efforts in their religious identity are not sufficient, leading them to feel insecure and unfulfilled in their acts of worship. For example, as discussed in the theme above, praying excessively is the most common presentation of ROCD, and also consists of repeating the prayer multiple times due to anxiety and doubts surrounding the thought of whether the prayer has been performed correctly and in accordance with Islamic guidelines (Rosmarin, Pirutinsky & Siev, 2010).

Similar to existing studies, our study found that religious obsessions and ritualistic compulsions were also associated with personal insecurity, black and white thinking and/or personal trauma:

"I felt like my prayer will never be good enough, hence lacking validity and acceptance and I will never do it properly and it will always be imperfect and lacklustre. I felt hopeless, as I can't seem to do one of the basic acts of worship in Islam, well."
Participant 2

"I feel like my duas are not being heard. I feel like He is ignoring me. In some ways, I've given up making dua."
Participant 1

"I get these thoughts at the back of my head saying that 'You're not going to get the status of a mother in Islam because of what happened to you and because of the things that you imagine and the things that you do', and this has affected my relationship with my husband and child."
Participant 5

"I became stressed and hopeless, like I was doomed. It gets extreme to the point that I wish I didn't exist because I don't want to experience dying… I felt like I was becoming delusional. I felt paranoid and frazzled."
Participant 2

"I had this excessive fear of halal and haram."
Participant 4

Compulsions were also physically draining for participants. Some participants expressed washing for long periods of time and as a result injuring themselves. These findings support research showing that religious obsessions and compulsions can severely impact an individual's social, professional and academic life (Solaim & Loewenthal, 2011). This is further supported by our findings whereby participants expressed their difficulties impacted multiple aspects of their lives, and one participant even said they became bedridden from these difficulties.

"My most recent experience of this and probably my most prominent one is wiping different parts of my house with water, as I thought blood may have touched it. However, I was unsure and frazzled most of the time. So eventually, I became frustrated and panicked, as I thought that it was endless, due to the possibility that it may have transferred everywhere. I lost the reason to why I was even doing it. I wasn't even sure if the item had blood on it, so when it went on the floor, no visible blood was there. But I still went on a wiping spree, eventually doing it to different parts of my house including my prayer mat and prayer clothes."
Participant 2

"I get thirsty all the time but I rarely drink water. The main reason is because I don't want to use the bathroom because I can become impure… In the past, I could go a whole day without eating but now I am much better, I eat."
Participant 3

"I physically injured my foot from standing, uh, one foot in the sink and one foot outside it at a weird angle for 45 minutes plus. Hand-washing used to take 50 minutes, I used to dehydrate myself so that I don't have to use the toilet, so I'd only have to go once a day maximum."
Participant 4

One participant summarised it well when they explained that the entire experience of ROCD was traumatic for them:

"It was quite traumatic for me. When you are flooded with waswas, it's a terrible experience. I feel like I still have that stored in my memory or my body. I would get panic attacks, nightmares and chicken pox as well even though I was vaccinated. It was quite traumatic."
Participant 1

Lack of Support

It is clear that there are numerous ways in which ROCD presents itself. Not all presentations have been covered within this paper. However, the themes of doubts, the devil, insecurity and fear are prominent. This resulted in

participants reporting experiences of ROCD to be isolating:

"It's just so isolating, the whole experience. I can't connect with the Muslim community."
Participant 1

"I feel like I can't connect with people on a deeper level."
Participant 3

"Not many people understand religious OCD… This is something I am going through alone"
Participant 1

Experiencing isolation in OCD has been reported before, particularly as a result of feeling emotions of unworthiness and insufficiency (Petrocchi et al., 2021) and the present study also corroborated with previous findings. Within this study, participants consensually reported a lack of support from family and wider community when disclosing their experiences, including the following subthemes:

- Lack of understanding of ROCD leading to non-disclosure

"I didn't tell my parents at all because I didn't want to stress them. I didn't think they'd understand it very well."
Participant 4

"I remember trying to go to scholars but not really disclosing stuff… I guess at that time no one really knew about ROCD so I didn't feel comfortable to disclose stuff, so I just hid it the whole time." Participant 1

- Lack of understanding of ROCD leading to judgemental responses

"My father told me, 'You have gone forever. You have gone for good. You are the devil." over and over again… My relationship with my mum also deteriorated."
Participant 3

"If I did not know how to do something, they should have guided me instead of saying 'Oh, you are going to the hellfire', I know that already."
Participant 3

- Non-helpful advice from Religious Scholars

"I did tell my dad once when I was young, and he was nice enough to take me to this Islamic conference in Canada thinking that the Shuyukh might help me. But they didn't. It [advice from scholars] gave me temporary relief but it didn't make the Waswasa go away. Someone told me to say 'Shut-up Shaitaan' and I did that but it didn't work."
Participant 1

"I was told to ignore it, ignore it, ignore it. But that did not help me. It was not that easy, how do I ignore it? I did not receive the help I needed."
Participant 3

"The Imam kind of took advantage of my vulnerability now that I think about it. He told me some things that made me feel worse. He let me down."
Participant 3

Ways of Coping

Our participants shared their personal ways of coping and what helped them the most, which have been shared in this section.

- Separating trauma response from judgement of Allah (SWT)

"I've spoken to a person of knowledge that I have close contact with once, and they said 'You won't be held responsible for these thoughts because they are not coming from you, you are not intending them, they are a trauma response." This made me feel relieved."
Participant 5

"I tried separating my thoughts from myself, so acknowledging that I am thinking this right now and then realising that these thoughts are outside of me. This helped me."
Participant 1

- Engaging in self-care and self-compassion

"The journey to loving Allah came after I got out of bed, after I started making improvements." Participant 4

""I go out for a walk every Friday, which helps me stay positive."
Participant 5

"I engaged in Ruqyah which also helped."
Participant 3

Petrocchi et al. (2021)'s study revealed that a compassion-focused approach can significantly mitigate

feelings of isolation, unworthiness, insufficiency and lack of support, whether that is in the form of parental warmth, compassion-focused therapy or compassionate support from the community.

- Seeking integrative mental health support

"I've been seeing a therapist once a month for the past 6 years, which has been really helpful." Participant 5

One participant did share that they accessed therapy support for their ROCD experiences from a religious scholar who integrated ERP (exposure response prevention) therapy with Islamic teachings, which proved to be very helpful in their recovery journey:

"No Sheikh would give you the advice to spread impurities but he made me do it in a way that complied with Islamic teachings and ERP. That was one of my biggest worries in accessing support from the NHS. I was scared that they would try to treat the condition rather than look at the bigger picture, and religion is a big part."
Participant 4

This highlights the need of integrating religion with psychological treatment for ROCD which can make mental health support much more accessible, whilst simultaneously addressing the core ideas and beliefs of ROCD.

Implications

The present study offers insightful implications for healthcare providers, mental health professionals and members of the religious clergy. For example:

- The contents of this research can be used to inform the diagnosis and intervention for individuals with ROCD who need a more culturally-tailored and individual-centric approach. As demonstrated by the findings of this research, effective interventions for scrupulosity may need to address the meaning of unique symptoms for each individual.
- Previous research has revealed that the first and main source of guidance for scrupulous people will often be religious authorities, such as Christian clergy, Jewish rabbis, Muslim Imams and faith-based healers, rather than health professionals (Al-Solaim&Loewenthal, 2011; Greenberg &Shefler, 2008; Huppert &Siev, 2010; Wills &DePaulo, 1991). Thus, familiarising figures of religious authority in the community with the experiences of ROCD can guide them to better support and signpost for individuals struggling with these symptoms, which is something that this research provides.
- At the outset of this research, it was identified that a principal concern for clinicians may be differentiating scrupulosity from healthy religious practice, This research offers insight into the unhealthy religious practices that are engaged in by individuals with ROCD.
- Finally, this research can be used as a platform to further research into the sphere of ROCD and Muslim mental health, and the efficacy of faith-sensitive person-centric interventions as a treatment option for ROCD.

Limitations & Further Research

There are some presenting limitations which are worth noting. As this research consists of thematic analysis, the researchers could have potentially influenced the way themes unfolded through their subjective nature and different interpretations of a particular theme. Since the analysis aims to align with research presented, the themes will be a shadow of the conceptual framework adopted.

Additionally, it is prudent to note the extent to how representative this study is of all individuals who experience ROCD, as everybody's experience of ROCD may be unique to them. This study should therefore be used as a guideline bearing this in mind.

Finally, this research did not take into consideration how ROCD would present in those individuals who are seeking treatment. It is more likely that those actively seeking treatment would be more aware of their symptomatology and emotions related to their experience of ROCD. Therefore, further research in this area should seek to understand how an individual's experience of ROCD would be different when seeking treatment or intervention. Additional research endeavours should also seek to understand the link between trauma and OCD/ROCD as they may be correlated.

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