Family Therapy in Iran: An OCD Case Study

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Abstract:

Iranian clinical psychologists have devised family therapy methods, based on cognitive behavioral models, fitting their collectivist, Islamic culture. We review Islamic-based strategies and describe family therapy in a culturally-specific childhood OCD case. Family therapy, using integrated, religious-based cognitive behavioral therapy, seems more appropriate for clients from collectivist, religious cultures.

Introduction

Cognitive Behavioral Therapy (CBT) has been proven effective through clinical observation and controlled experiments (Dobson & Dobson, 2009). Clinical psychologists in the Islamic Republic of Iran have adapted CBT to fit their collectivist, Islamic environment (Khodayarifard, Rehm, Khodayarifard, 2007). We discuss these methods, exploring issues important to Western therapists. How do practices of Iranian therapists differ from those in the West? How might practices and findings from an Islamic collectivist society be of value to Western therapists? We hope to extend discussions regarding Islamic-based therapy (Ahmed & Reedy, 2007; Daneshpour, 1998; Erickson & Al-Timimi, 2001; Hamdan, 2008; Hedayat-Diba, 2000; Hodge & Nadir, 2008; Jafari, 1993) by reviewing strategies found useful in Iran. We describe an Iranian therapist's treatment of a culturally-specific form of childhood OCD to illustrate how CBT can be modified to fit a collectivist environment. Iranian methods differ from Western approaches in that Iranian therapists integrate family therapy, Islamic-based therapy, CBT, and strengths perspectives to fit clients' needs.

Family Therapy, Islam, and CBT

Islamic therapists argue that the assumptions of Western psychotherapy are not universal and cannot be generalized to non-Western cultures (Al-Issa, 2000; Al-abdul-Jabbar & Al-Issa, 2000, p. 277; Alishah, 2001; Jafari, 1993; Rahman, 1998). Western therapists are thought to overemphasize individual transformation, self-concern, assertiveness, self-growth, ego-strengthening, and self-actualization. In response, Islamic-based therapists focus on interdependence, self-restraint, perfection of self, integration, harmony, conformity, selflessness, and healthy altruism. Treatment focuses

on group faith, prayer, hope, patience, and responsibility (Al-abdul-Jabbar & Al-Issa, 2000; Jafari, 1993). As a result of these differences, research conducted mainly on Western patients "may not be applicable to another environment" (Jafari, 1993, p. 329).

Islamic therapists believe that Muslim families have unique characteristics requiring special methods. They argue that Western, Eurocentric models "do not account for non-Western criteria or cultural variations in family dynamics" (Daneshpour, 1998; Hall & Livingston, 2006, p. 140). Although variations exist among societies and social strata within societies, Muslim families tend to prefer greater connectedness, are less flexible, are more hierarchical, and more often use implicit communication styles. Individuality is less important than are interdependence and collectivism. Unity, connectedness, and generational family ties take precedence over individualistic orientation and behavior (Daneshpour, 1998).

Iranian families have non-Arab, Shi'ite traditions resulting in special treatment issues. Iranians have unique ways of interpreting emotional distress – with sadness and melancholy seen as indicating inner depth (Good, Good, & Moradi, 1985). Like many non-Western peoples, Iranians tend to attribute problems to outside processes (grief, school failure, heartbreak) resulting in somatization (Jalali, 1996). Iranians speak Farsi, an Indo-European-based language, different from the Semitic Aramaic spoken by Arabs. Among Iranians, 93% are Shi'ite while most Arabs are Sunni Muslims. Shi'ite/Sunni differences, originating with succession disputes following the Prophet Muhammad's death, have led to basic divergences in belief, practices, traditions and customs. As in all societies, religious beliefs affect mental disorder symptoms. Many Iranian Shi'ites await the return to earth of the twelfth Imam (within their tradition, Muhammad's twelfth

successor), known as the *Mahdi*, a prophesied redeemer of Islam. While some Western Christian psychotics report they hear, or are, Jesus, some Iranian psychotics claim to be the returning *Mahdi* (McClenon, 2007).

Similarities within religious-based therapies reflect religion's capacity to provide evolutionary survival advantages. Religiosity has physiological basis, associated with shamanism, humankind's first religious form. Much evidence indicates that all Paleolithic hunter/gatherers practiced forms of shamanism for over 30,000 years, that religious propensities have physiological, genetic basis, and that religious practices contribute to physical and psychological well-being (Koenig, 1999, 2005; McClenon, 2002). The similarities among religious-based therapies coincide, to a degree, with CBT. Various religious practices replace dysfunctional, unwholesome, and non-productive thoughts with therapeutically valuable ideations (Hodge & Nadir, 2008; Nielsen, Johnson, & Ellis, 2001; Tan & Johnson, 2005). As a result, religious-based CBT is believed more effective for treating religious clients than secular CBT, particularly for anxiety and depression. A review of six controlled studies indicate that Christian-based CBT "could be considered a well-established intervention for treating depression among Christians" and two controlled studies regarding Islam-based treatment of depression are deemed "promising" (Hodge, 2006, p. 162, 163).

Yet religion, by itself, is not always functional. In some cases, psychopathology is expressed in religious forms with religious beliefs contributing to the problem (Spilka, Hood, & Gorsuch, 1985). We argue that, in some cases, CBT can aid therapists and clients in identifying dysfunctional religious thoughts and in devising effective religious-based strategies to replace these cognitions.

Differences between Islamic and Christian-based therapies reflect cultural and theological divergences. Islam began with the Prophet Muhammad's recitation of the Holy Qur'an. Islam specifies prayer five times a day, fasting in the Islamic month of Ramadan, giving to charity, and performing the pilgrimage to Mecca at least once during the believer's lifetime, if possible. These four acts and the affirmation, "There is no god but God, and Muhammad is His Prophet" form the five pillars of Islam (Ahmed & Reddy, 2007, p. 208). Muslims regard Islam as the completed version of the Judeo-Christian monotheism revealed to prophets such as Abraham, Moses, and Jesus. Islamic CBT is grounded in the Holy Qur'an and the *hadith*, the sayings and practices of Muhammad. Islamic belief in *tawheed*, the oneness of Allah, provides the basic meaning of life, spiritual salvation, and mental well-being. This uncompromising monotheism distinguishes Islam from all other major religions. Although Christians find therapeutic value in salvation through Jesus Christ, Islam rejects the idea that God exists in three persons or that someone other than Allah can forgive sins. Islamic therapists do not use guided imagery based on religious figures, as do some Christians, since Islam prohibits construction of sacred images. Christian and Islamic-based CBT methods for replacing false schemas differ due to cultural and theological variations (Nielsen, et al., 2001; Hodge & Nadir, 2008).

Islam has characteristics that make it well suited for use with CBT. "Reason, logical discussion, education, and consultation are widely affirmed in Islamic discourse," making CBT, coupled with a strength-based approach, "a good fit for many Muslims" (Hodge & Nadir, 2008, p. 33). Islamic CBT advocates replacing negative, false thoughts with correct, rational thoughts through prayer, piety, changes in ritual practice, and

emphasis on moral behavior. Clients replace automatic, dysfunctional thoughts by focusing on specific Qur'anic verses or Islamic concepts (Alavi, 2001; Azhar and Varma, 2000; Hamdan, 2008). For example, the Iranian therapist Alavi (2001, p. 6) treated anxiety disorder by having a patient ponder Qur'an verse 5: 69: "Surely those who believe, those who are Jewish, the converts, and the Christians, any of them who believe in God and in the Last Day and lead a righteous life, have nothing to fear, nor will they grieve." As a result, the patient focused on God's mercy rather than personal anxieties. Recited in Arabic, the verse has a powerful poetic quality, suitable for repetition. Although Iranians speak Farsi, they learn to recite the Qur'an in Arabic at an early age and its poetic power contributes to therapeutic efficacy.

Basic Islamic beliefs regarding one God are parallel to those in Christianity, but with altered focus. Muslim therapeutic cognitions include an understanding the temporal reality of this world, focusing on the hereafter, recalling the purpose of distress/afflictions, understanding that after hardship comes ease, and remembering, trusting, and focusing on Allah (Hamdan, 2008). As among Christian therapists (McMinn & Campbell, 1996), Islamic therapists often use integrative approaches, adjusting strategies to fit clients' religiosity and addressing issues related to symptoms, schemas, and relationships. Although there is much variation in individual religiosity, religion is more salient in Iranian daily life than in the USA. Iranian psychiatric hospitals have bureaucratic offices whose goal is to encourage integration of therapy and religion. Although younger Iranians (70% of the population is under 30) appear less religious than their elders (Varsi, 2006), a random-sample survey of Tehran students revealed high adherence to traditional Islamic tenants (Khodayarifard & McClenon, 2010). We

illustrate an Islamic-based, integrated family therapy approach using a childhood OCD case.

Iranian Case Study Within the Context of Western Research Literature

Although CBT is the only psychological therapy proven effective in the treatment of childhood OCD, Western standardized treatment programs are largely modeled on methods designed for adults (March & Mulle, 1998; Wagner, 2003; Turner, 2006). Western treatments focus on exposure and response prevention (ERP) since this method has been proven through controlled studies as more effective than cognitive treatments (Abramowitz, Whiteside, & Beacon, 2005). OCD patients are presented with the situations triggering obsessions/compulsions (exposure), prevented from engaging in the obsessive/compulsive behavior (response prevention), and, over time, find that their anxiety declines.

OCD frequency in Iran is unknown but thought to be relatively prevalent (McClenon, 2007). The DSM-IV-TR (2000) reports that USA adult lifetime prevalence is 2.5%, with children and adolescent lifetime prevalence at 1%-2.3%. These rates are thought to be "similar in many different cultures around the world" (DSM-IV-TR, 2000, p. 460). This last claim may not be valid. A coordinated series of epidemiological surveys reveal great variations among nations in mental disorder prevalence with highest rates in the USA (Kessler & Ustun, 2008). An Iranian national survey found mental disorder rates equivalent to those of other countries but lower than those in the USA (Noorbala, et al., 2004). The survey did not specifically ask about OCD symptoms.

Iranian therapists see childhood anxiety disorders, such as OCD, as triggered by stress within dysfunctional family environments (often overly patriarchal). Therapy

goals include improving family relationships with the father's attitudes and behaviors an important target for change. They find that childhood disorders can be resolved by correcting dysfunctional family environments. Although this argument coincides with Western family therapy theories (Waters & Barrett, 2000), family therapy in the West is generally regarded as an adjunct to ERP – playing an important but supportive role (Berg, Rapoport, and Wolff, 1989; March & Mulle, 1998; Turner, 2006). There have been no evaluations of the relative benefits of intensive family involvement (Turner, 2006). One childhood OCD manual, for example, specifies that 3 out of 19 sessions involve the child's parents (March & Mulle, 1998) and CBT treatments typically include only the mother (Nichols, 2008, p. 196).

Western childhood OCD literature notes obstacles reducing CBT effectiveness (Abramowitz, Taylor, & McKay, 2005). Many children are inappropriate for treatment, drop out of treatment, or continue to reveal symptoms after therapy is concluded (Hill & Beamish, 2007; March & Mulle, 1998, p. xiii; O'Kearney, Anstey, & von Sanden, 2008; Turner, 2006). OCD symptoms involving religious practices can be particularly problematic since symptoms resonate with deeply held beliefs (Suess & Halpern, 1989). For example, Christian pre-adolescents, alarmed by growing awareness of their sexuality, may engage in OCD-like prayers – expending more than an hour a day in rituals associated with marked distress which significantly interfere with functioning, activities, or relationships.

The most common type of compulsion among Western children and young adults involves hand washing (ablutomania), a behavior involving fear of dirt, germs, bacteria, toxins, etc. In one study, 40% of child/adolescent OCD patients reported this concern

(Swedo & Rapoport, 1989, p. 21). In Muslim cultures, OCD often takes an alternate form: excessive hand washing before prayer due to the sufferer feeling unable to gain sufficient spiritual purity (Mehrabi et al., 2000). This symptom is sometimes referred to as *waswas* **[note to editor: there is a line over the second "a" in waswas],** a set of behaviors described as early as 1100 A.D. (Pfeiffer, 1982, p. 212). Waswas is attributed to Shaytan (Satan) who whispers into people's hearts (Qur'an, 114: 5). Sufferers may incorrectly interpret Qur'anic verses such as, "…Allah loves those who purify themselves" (Qur'an 9:108) to justify their behavior.

The Subject and Treatment (18 weekly sessions)

MJA was a 9-year-old girl in the third grade of a Tehran elementary school. She was the third child of the family; her father was 42 and her mother was 40, both employed and with doctorate degrees. Her brother was 18 and studying abroad; her sister was 15 and in the third year of high school. During early sessions, the therapist determined that MJA's parents had a tendency to be very rational. They rarely expressed their emotions and could be considered perfectionists. MJA's parents emphasized her excelling in school since school performance determines future life chances. The parents, as well as MJA, were devout Muslims, regarding the Qur'an and daily prayers as extremely important.

During the initial session, MJA's mother stated that her youngest daughter had suffered from severe anxiety for the past year. She reported that MJA would wake up at night, cry, and say she was worried that she might not know her math lesson for the next day. She would ask her mother to check her homework again and again to make sure that she had done everything correctly. Even through her mother repeatedly checked her

homework, MJA's anxiety continued. MJA also worried about the location of her school bag. She asked repeatedly, "Have you checked my bag and my school stuff? Is something wrong with it? Do I have the notebook ready that I need for tomorrow? Have I missed anything?" Then she would cry and say "I am afraid I will not know my lessons for tomorrow. I'm afraid that I have forgotten something."

MJA also suffered from compulsive hand washing in preparation for the five-times-a-day Islamic prayer. She often could not pray since she felt unable to attain sufficient ritual purity. "Everything I do must be perfect," she stated. "If my hands are not clean, I cannot pray." She believed that, if she did not pray, "God will punish me." As a result, attempts to pray led to increasingly intense anxiety.

MJA stated that her problems began with a particular math class. The instructor frequently threatened his students with failure. MJA stated, "I hate math now. I am preoccupied with the idea that I might score low in math or might fail to perform well in class. I am always worried. I cry and sometimes even decide not to go to school. I feel like crying all the time. I like all my other teachers but I don't like my math teacher." MJA also expressed anxiety about being separated from her mother and about the possibility that her mother and father might die. "If my father dies, what will I do?" she asked. "If my mother dies, how will I live?" She was particularly worried about a future trip that her mother was taking to a foreign country to visit her brother: "I am extremely worried because I will be left alone and I cannot do my homework properly without my mother. I do not want to be separate from her."

MJA was evaluated through a clinical interview based on DSM-IV-TR criteria. MJA's score on the Children's Yale-Brown obsessive-compulsive scale (CY-BOCS;

March and Mulle, 1998, p. 237-8), which varies from 0 – 40, was 25, indicating severe OCD. Her symptoms included unrealistic, repetitive, and time consuming behaviors aimed at reducing distress (fitting diagnostic criteria for OCD). She found it difficult to control her excessive anxiety and worry, revealing restlessness, difficulty concentrating, muscle tension, and clinically significant distress (diagnostic criteria for Generalized Anxiety Disorder). Her symptoms were not better accounted for by diagnoses of separation anxiety disorder, depression, or school phobia; her anxiety seemed more general than specific. MJA was diagnosed as suffering from OCD and Generalized Anxiety Disorder.

The therapist explained MJA's diagnoses to her parents. He stated that the family plays an important role in the shaping and treatment of children's psychological disorders, particularly anxiety, phobia and obsession. MJA's parents were asked to discourage her obsessive thinking and behavior by not responding to her repeated demands for checking of homework. They were to check her homework one time and to refuse all further requests.

In order to avoid increasing MJA's separation anxiety, she was allowed to accompany her mother on the planned trip out of the country. When she returned, MJA's anxiety had declined and she cried less, but she was still obsessive about hand washing before prayer and class preparation. The parents were advised to avoid over-emphasizing orderliness, discipline, and cleanliness and to give MJA more choice and freedom. They were also asked to devote more time to playing and talking with her, to create a peaceful atmosphere at home, and to avoid placing pressure on her to get good marks in all her school subjects. This advice was followed by much discussion since MJA's parents were

highly concerned with her grades. The therapist argued that understanding school work is more important than the final grade, a concept that initially seemed strange to MJA's parents. They argued that MJA had to study hard to achieve good grades in order to get into a good school. The therapist directed their thinking to the OCD behavior – why was she acting the way that she was? Both parents and MJA believed that God would not forgive a person who violated certain norms – such as telling a lie, for example. Their value of obedience to authority was part of their religious beliefs, linked to their emphasis on achievement and avoiding errors. The therapist argued that schoolwork should not be evaluated within this context. Schoolwork should focus on learning, not on avoiding doing wrong. Over-focus on good grades was labeled as a type of false thinking. The idea that God will punish those making schoolwork errors was identified as false thinking. These schemas could be replaced by logical thinking.

Many elements within family therapy sessions were equivalent to those practiced in the West. Therapy included encountering, modelling, training for problem-solving, self-monitoring through self-reporting obsessive ideas and compulsive behaviors, positive thinking, relaxation, and aversive therapy. Iranian CBT differs from Western CBT in that it includes the entire family, has a strength-based focus, and places less direct emphasis on client symptoms and ERP.

MJA's therapy included homework assignments, devised by the therapist, involving the whole family. One assignment, "Focusing on One's Own and Others' Points of Strength," required family members to list each other's best qualities. They were required to acknowledge these strengths to each other and, as a result, increased their understanding of the reasons they valued each other. Other therapy sessions focused

on increasing expressions of emotion (love) within family interaction. Later exercises built on these assignments, requiring family members to list each other's positive traits and inform them of these traits. Some sessions sought to increase problem-solving skills, focusing on group processes.

Rather than advocating that MJA not wash her hands extensively, the therapist suggested that parents and school authorities make MJA's prayer voluntary. This was innovative since prayer is required of Muslims, one of the five pillars of Islam. MJA's parents expressed deep concern. The therapist asked them, "Why did she think that she could not achieve religious purity?" He argued that MJA's compulsive washing was linked to her fear of making mistakes. He suggested that MJA not be compelled to pray so that her prayers could be free of anxiety. The therapist argued, "Religion must be voluntary, something done from the heart." He stated that children should not be compelled to be religious, that they will find their natural way of religion on their own (Qur'an 2:256, "Let there be no compulsion in religion…"). After considering these issues, MJA's parents contacted her school officials and asked them to end all requirements that she pray. At first, MJA was concerned about not praying, but, over time, as her symptoms disappeared, she came to think about prayer differently, something done with relaxed focus.

This treatment differed from standard ERP; MJA was not prevented from washing her hands or praying. In a way, her parents were required to practice ERP; they ceased monitoring MJA's behavior, placed less emphasis on schoolwork, and adjusted to the emotional distress they experienced as a result. MJA and her parents found that God did not punish them when she did not pray or achieve perfect grades.

Within the context of family therapy, ERP might be said to have taken place in gentle, indirect forms (not praying, not stressing performance in school) rather than direct forms (preventing MJA from praying or washing her hands). MJA's parents learned during therapy sessions how to create a more relaxed and peaceful environment and to express their emotions more fully. Family CBT, with the focus on relationships, was the central focus of therapy with direct ERP being a secondary element.

At the end of treatment and during a follow-up interview, MJA reported no OCD or anxiety symptoms (CY-BOCS score = 0). A complete cessation of symptoms would be considered unusual in the Western childhood OCD literature (Abramowitz, Taylor, & McKay, 2005; Hill & Beamish, 2007; March & Mulle, 1998, p. xiii; O'Kearney, et al., 2008; Turner, 2006). MJA's obsessions were completely eliminated and she considered herself to be peaceful, happy, and at ease. The therapist asked each family member to briefly report on his/her feelings regarding the therapy outcome. Each said that they were absolutely happy with MJA's state of health. One year later, MJA was again evaluated and showed no signs of recurrence of the disorders.

Discussion

MJA's treatment differed from typical Western OCD strategies in its focus on family therapy, less direct forms of ERP, integrated approach, strengths perspective, and religion-based aspects. Both parents were centrally involved in all therapy stages. MJA's treatment was parallel to that advocated by other Iranian therapists interviewed by the second author during visits to Iran in 2006 and 2007 (McClenon, 2007). These therapists described family dynamics as a common problem, affecting marital relationships and children's psychological well-being. Unmarried males and females

who are not biologically related are not permitted to socialize freely with each other in the Islamic Republic of Iran. Many marriages are arranged. As a result, Iranian therapists find that families seeking counseling have special needs. They argue that marital expectations derived from rigid, patriarchic norms can have negative consequences and that many clients lack skills for solving relationship problems. These types of problems exist even in non-arranged marriages, such as that of MJA's parents.

Iranian national survey data suggests that rigid, patriarchic structures affect women's psychological health. Iranian females are about three times more likely to suffer from depression than males, a difference attributed to "biological factors or to social inconveniences experienced more by women than by men" which "may differ among cultures" (Noorbala, et al., 2004, p. 72). Family CBT is thought to be particularly valuable for helping husbands and wifes modify their thinking in ways that allow better interaction. The strength perspective, felt especially suitable for Islamic-based therapies, has been found useful by Western researchers for treating culturally diverse clients (Chazin, Kaplan, & Terio, 2000).

Family-based CBT seems particularly suitable for symptoms with religious elements. Therapists help clients replace dysfunctional religious schemas with beneficial religious schemas. MJA's family therapy did not reduce religiosity but replaced ideas regarding Allah's wrath with functional beliefs regarding freedom from compulsion. We believe that CBT has become a major paradigm among Iranian therapists due to their ability to adapt it to their Islamic, collectivist environment.

In summary, we provide three recommendations for Western therapists treating appropriate clients from Islamic, collectivist cultures: (1) Family CBT may be more

applicable than individual CBT. (2) Family CBT should have an integrated approach, focusing on symptoms, schemas, and relationships among family members. (3) Family CBT can be adapted to fit the family's religion. Dysfunctional religious schemas can be identified and replaced with functional religious schemas. Therapists can design therapy plans to fit their clients' culture and unique family problem.

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