

Cultural Adaptation of Traditional Islamically Integrated Psychotherapy (TIIP) for Muslims with Obsessive Compulsive Disorder (OCD): Study Protocol for a Randomized Controlled Trial in Pakistani Population

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Abstract

Background: Obsessive-Compulsive Disorder (OCD) is a debilitating mental health condition marked by intrusive thoughts (obsessions) and repetitive behaviors (compulsions). Cultural and religious contexts significantly influence treatment, particularly in Muslim-majority countries like Pakistan, where mental health interventions often lack cultural sensitivity. Traditional Islamically Integrated Psychotherapy (TIIP) integrates Islamic teachings with contemporary psychotherapy, addressing this gap.

Objective: To evaluate the efficacy of a culturally adapted TIIP module in reducing OCD severity and improving associated mental health outcomes among Pakistani Muslims.

Methods: A randomized controlled trial (RCT) comparing the efficacy of TIIP against treatment-as-usual (TAU) will be conducted in an outpatient mental health setting in Pakistan, targeting a culturally representative sample. Sixty participants, aged 18-40 years, diagnosed with OCD according to DSM-5-TR and scoring ≥14 on the Yale-Brown Obsessive Compulsive Scale (Y-BOCS), will be randomized into experimental (TIIP) and control (TAU) groups. The intervention will involve eight individual therapy sessions using the adapted TIIP framework. Outcomes will be assessed using Y-BOCS and secondary measures, including DASS-21, TAF, TCQ, and SQOL-9, validated in Urdu.

Results: This is a study protocol so results are anticipated. Recruitment has started in August 2025. We expect to enroll 60 participants and complete data collection by December 2025. Primary outcome analyses (mixed-effects models) will compare changes in Y-BOCS between groups.

Trial Registration Number: ClinicalTrials.gov NCT06302712; <https://clinicaltrials.gov/study/NCT06302712> (registered March 15, 2024; prospectively registered).

Conclusions: This study aims to establish TIIP as a culturally and religiously sensitive intervention for OCD, addressing the unique needs of Pakistani Muslims. Findings will provide a foundation for integrating culturally adapted psychotherapies into broader mental health frameworks in low- and middle-income countries. Clinical Trial: ClinicalTrials.gov NCT06302712; <https://clinicaltrials.gov/study/NCT06302712> (registered March 15, 2024; prospectively registered).

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Original Manuscript

Cultural Adaptation of Traditional Islamically Integrated Psychotherapy (TIIP) For Muslims with Obsessive Compulsive Disorder (OCD): Study Protocol for A Randomized Controlled Trial in Pakistani Population

Introduction

Obsessive-compulsive disorder (OCD) is a serious mental ailment that causes intrusive thoughts (obsessions) and repetitive behaviours (compulsions) to relieve anxiety and stress caused by these thoughts [1]. Depression and anxiety related disorders play a significant role in the overall burden of the disease attributed to mental disorders. Globally, it is estimated that 4.4% of the global population suffer from depressive disorder, and 3.6% from anxiety disorder whereas anxiety related disorders alone led to a global total of 24.6 million years lived with disability (YLD) in 2015 [2]. According to a meta-analytic review analysis comprising of 34 articles with a community sample of adults age 18 years and above concluded that the average estimates for the prevalence of OCD over the previous, current, and lifetime were 1.1%, 0.8%, and 1.3%, respectively [3].

Studies show that compared to non-practising Muslim women, practising Muslim women reported more religious washing routines and had higher scrupulosity ratings [4]. There were substantial disparities between practising Muslim women and non-practising Muslim women in terms of both the severity of symptoms at the time of diagnosis and the amount of time it took after the onset of OCD symptoms before they sought professional care [5]. Additionally, there was a tendency for younger adults to have a higher lifetime OCD prevalence than older adults [3]. Recent studies have also documented that significant levels of OCD symptoms have been associated with low levels of quality of life [6].

In Muslim majority countries like Pakistan, Islam pervades nearly all aspects of life, ranging from food choices, daily routine, social interactions, education, and healthcare [7]. Islamic religious values have a great deal of impact on healthcare choices [8]. However, such empirical evidence is scarce in countries with a Muslim majority population in general, and Pakistan in particular. Moreover, OCD affects about 3% of people in Pakistan. This demonstrates that OCD is no longer a rare psychological condition, and that localised treatment is necessary [9]. Some considerable amount of literature suggests that OCD has an association with religious attributes. Religious people have often seen to suffer from OCD and they have symptoms like dirt related obsessions [10].

Therefore, the feasibility of western conceptualization and model of CBT is a pertinent issue and required to be addressed. Ignoring the Islamic culture and background of Pakistani populace would arguably alienate a segment of the population that might fear not having one's own beliefs system represented, or even understood. Furthermore, the feasibility of applying Western-based models to cultures whose foundations are intrinsically shaped and connected to Islam has been questioned [11].

It was found that even after engaging with mental health services, many patients continued to seek treatment from faith healers [12]. Muslims generally attribute the causes of mental illness to the supernatural [13], or to a test from God, or to being disconnected from the Creator [14]. Given that Muslims have a strong belief that recovery ultimately comes from God, many Muslims suggest that unless psychotherapeutic approaches are taken into consideration and incorporate indigenous values and beliefs, psychology will continue to be seen by Muslims as an alien discipline.

CBT is used in many high-income countries (HICs) due to its strong empirical evidence. Psychosocial interventions developed in HICs are relevant and applicable to the cultural, social, and economic backgrounds of people living in such regions [15]. Whereas, Asian patients' belief systems, particularly those concerning health, well-being, disease, and requesting assistance when in need, are influenced by the biopsychosocial-spiritual illness model that they adopt. Since CBT is based on Western norms, it must be modified in order for it to work in different cultural contexts. Moreover, in comparison to traditional CBT, there is evidence that culturally tailored CBT is more effective and can decrease therapy dropout rates [16]

There are very few studies which attempted to develop culturally adapted psychotherapy for OCD in low and middle-income countries (LMICs). Aslam et al. culturally adapted CBT for OCD in Pakistan [17]. The results were found to be significant and hence proving that culturally adapted CBT in combination with folk stories and examples relevant to religious beliefs are effective. Since religion is one of the most important psychosocial factors in people's lives, especially in Muslim-majority countries and Muslim people respond better to therapies with an Islamic component, and they even express a stronger desire to seek out medical professionals who combine their religious beliefs with their clinical work. Muslim patients are also likely to distrust conventional healthcare practitioners due to their intense anxieties and obsessions with maintaining their faith. Thus, how culture influences the perception, prevention, diagnosis, and treatment of mental disorders must be considered [17].

Mental health care and treatment are generally stigmatized among the Muslim population. The Muslim community is reluctant to seek therapeutic interventions for their psychological distresses. Muslims who are religiously and spiritually sensitive have concerns regarding therapies and they choose to avoid them which adversely affects their help-seeking behaviours. Research shows that therapists who follow a religiously inclined therapeutic framework with their clients tend to have a significant positive impact. To further this finding, modern-day therapeutic models are integrating Islamic literature into the therapeutic frameworks and one of them is Traditional Islamically Integrated Psychotherapy (TIIP) [18].

TIIP is a therapeutic framework that derives its basis from Islamic literature. It is an ever-evolving modality of psychological treatment originally developed by Keshavarzi and Haque [18] and since then there has been extensive research to diversify and utilize the framework in the mental health care facility [19]. TIIP is the culmination of the extensive work of an interdisciplinary team consisting of dully trained professionals and Islamic scholars. The integration of contemporary behavioural science into an Islamic framework is facilitated by the TIIP model [20].

TIIP model is put into practice using two different types of techniques: 1) innately Islamic approaches to psychotherapy that draw their inspiration from the Qur'an, Prophetic Tradition, and the traditions of the scholars, especially those of the spiritual sciences and adaptation and integration of conventional interventions (i.e., CBT) that are in line with the tenets of TIIP [20]. CBT has historically paid little to no consideration to religion. Nonetheless, some therapists contend that the concept is more compatible with Islamic principles than other treatments. The CBT idea of interconnectedness between cognitions, thoughts, bodily sensations, and behaviour is consistent with Ghazali's conceptualization of the human psyche (i.e., intellect, heart, self, behaviour, and spirit) [11].

Subjects and Methods

Design

We will use Randomized Controlled Trial (RCT) to evaluate the effectiveness of the treatment using the culturally adapted manual for Muslims with OCD. Participants were taken from the Psychology Clinic of Foundation University Islamabad. After screening for eligibility, informed consent for the trial will be taken. Participants will be randomized in a 1:1 ratio to either the intervention or control arm using a computer-generated block randomization sequence. Neutral staff responsible for enrolment will not be involved in sequence generation. It will be a single blind experiment where participant will be unaware of the type of treatment.

[Insert Figure 1 about here]

The RCT will follow the CONSORT flow Diagram as the procedure (see Figure 1). The CONSORT-SPI 2018 checklist can assist researchers in designing and reporting future trials, and it can also offer guidance to editors and peer reviewers for assessing manuscripts, grant funders for setting reporting requirements for grant applications, and educators for instructing trial methodology [21].

Sample size

60 participants will be recruited for the parallel-arm RCT. Thirty participants in each experimental and control group. A prior power analysis (G*Power 3.1) indicated that this sample size is sufficient to detect a medium effect size ($f = 0.25$; $\alpha = .05$; $1-\beta = .80$) for group $\times$ time interaction, allowing for a 20% dropout rate [22].

Below are the inclusion and exclusion criteria for the recruitment of the participants:

Inclusion criteria

- The client diagnosed with OCD according to DSM-5-TR.
- Client having a minimum score of 14 on Y-BOCS (e., indicating moderate level of symptoms).
- Age ranging from 18 to 40 years.
- Client with a minimum of eight years of formal education.
- Self-identified Muslim

Exclusion criteria

- Client with a comorbid severe psychiatric illness (e.g., psychotic disorders, personality disorder, substance use disorder, neurocognitive disorder).
- Client with a comorbidity of chronic physical illness/es.
- Client undergoing manualized faith-based CBT.
- The client who declines to provide the informed consent

Measures

Primary Outcome Measure

Yale Brown Obsessive Compulsive (Y-BOCS) is a 10-item self-report scale developed to assess the severity of both obsession and compulsion [23]. Each item rated from 0 (no symptoms) to 4 (extreme symptoms) (total range, 0 to 40). It will be validated in Urdu.

Secondary Outcome Measure

Depression, Anxiety, and Stress Scale-21 item (DASS-21): A 21-item self-report measure containing three subscales designed to measure depression, anxiety, and stress. The Likert scale ranging from 0 to 3 (0 “Did not apply to me at all” and 3 indicates “Applied to me very much or most of the time”). The higher the score the higher the psychological distress level. The internal consistency of depression, anxiety and stress subscale is 0.91, 0.81, and 0.89 respectively [24].

The scale has already been translated in the Urdu language by Aslam and Kamal (2017) and has shown excellent internal consistency of $\alpha = .93$ [25].

Thought–Action Fusion Scale (TAF): It is a 19-item self-report scale which measures intrusive thought interpreted as real threat. The TAF rated on a 5-point Likert scale (0 = strongly disagree and 4 = is strongly agree). The TAF contains two sub-scales one is TAF-Moral (i.e., the idea that considering performing a bad or immoral action is equally bad as actually doing it) and TAF-Likelihood (i.e., the interpretation of obsessional thoughts and forbidden actions). The Cronbach’s alpha of TAF-Moral is $\alpha = .95$ and TAF-Likelihood is $\alpha = .96$ [26]. It will be validated in Urdu.

Thought Control Questionnaire (TCQ): Developed by Wells and Davies in 1994, used to measure different techniques used by the clients to control the unwanted thoughts. TCQ is a 30-item self-report scale using a 4-point Likert scale (1 indicates “never” and 4 is “almost always”). It has five sub-scales: Distraction, Social Control, Worry, Punishment, and Reappraisal [26]. The alpha reliability of Distraction is 0.72, Social Control is 0.79, Worry is 0.71, Punishment is 0.64, and Reappraisal is 0.67. [27] It will be validated in Urdu.

Spiritual Quality of Life-9 (SQOL-9): The nine-item SQOL-9 [27] was designed to measure spiritual quality of life (SQOL). Responses are rated on a 5-point Likert-type scale from 1 (not at all) to 5 (completely), with higher scores indicating greater SQOL. The SQOL-9 has demonstrated a good internal consistency of .83 [28]. It will be validated in Urdu.

Measures which are not previously validated in Urdu, will undergo a standardized translation and validation process. This will include forward–back translation by independent bilingual experts, reconciliation by a panel of clinical psychologists, and pilot testing. Internal consistency (Cronbach

α), test–retest reliability, and construct validity (confirmatory factor analysis where appropriate) will be evaluated prior to main trial analyses.

Interventions

Experimental/Treatment Group

Experimental group will only receive Traditional Islamically Integrated Psychotherapy (TIIP) for OCD. The module is originally developed by Keshavarzi & Khan [29]. We will be using the culturally adapted module of TIIP that is translated into Urdu language for Pakistan Muslims with OCD. The treatment module is mainly based on the four domains Behaviour, Emotions, Thought, and Spirituality. We plan to design the adapted module for eight sessions. The session will be conducted in an individual format and the intervention will be conducted by the certified therapist in TIIP.

Each participant will receive individual weekly sessions (60 minutes each). The culturally adapted TIIP module is structured as follows:

Session No.	Session Theme	Core Activities and Content
Session 1	Psychoeducation & Concept of OCD in Islam	Introduction to OCD, its symptoms, types, and Islamic understanding of waswasa (scrupulosity); therapeutic alliance building.
Session 2	Thought Identification & Religious Misinterpretation	Help client differentiate between real sin and OCD thoughts; address spiritual guilt and moral thought-action fusion.
Session 3	Islamic Cognitive Reframing	Challenging distorted religious beliefs; providing correct Islamic understanding using Hadith/Quranic verses.
Session 4	Exposure and Response Prevention (ERP) - Part 1	Introduction to ERP with culturally relevant exposure hierarchies; psychoeducation about avoidance and rituals.
Session 5	ERP - Part 2 and Emotional Regulation	Continued ERP with more difficult items; identifying and managing emotional triggers through Islamic coping methods.
Session 6	Behavioural Activation & Coping Strategies	Focus on value-based living, daily routine restructuring, involvement in religiously meaningful activities.
Session 7	Spiritual Integration, Duas for Healing and Relapse Prevention & Maintenance	Teach supplications from Hadith; develop spiritual habits (e.g., mindful salah, gratitude); address tawakkul (trust in Allah). Moreover reviewing gains, relapse signs, developing long-term strategies for faith-based coping and self-monitoring.

Therapists are licensed clinical psychologists with at least 2 years of CBT experience and formal training in TIIP. All therapists will receive weekly supervision by senior clinicians. Treatment fidelity will be monitored by audio-recording sessions (with consent) and randomly reviewing 20% of them using an adherence checklist.

Control Group

The wait-list control group in the current study will receive treatment-as-usual (TAU)

(i.e., pharmacological treatment and/or psychological treatment and/or any other services as per their need) [29]. The type, dose, and frequency of all concomitant treatments will be documented at each assessment point.

Procedure

RCT will follow the CONSORT flow diagram as the procedures. After initial screening and informed consent, eligible participants will complete baseline assessments. The recruited participants will be randomized into two groups, Experimental and Control group. Follow-up assessment will be conducted after week 4, where both the primary and secondary outcomes will be measured. End-point assessment will be performed after week 7 where the primary and secondary outcomes will be examined again. Leading to a follow-up session after week 9. All outcome assessments will be conducted by trained research assistants who are blinded to group allocation.

Statistical Analysis

All analyses will be conducted using SPSS. The primary outcome (change in Y-BOCS score) will be analysed using a mixed-effects linear model with treatment group as a fixed effect and baseline Y-BOCS scores as a covariate. Time (baseline, week 4, week 8, follow-up) and the group $\times$ time interaction will be included in the model.

Secondary outcomes (DASS-21, TAF, TCQ, SQOL-9) will be analysed using similar mixed-effects models. Both intention-to-treat (ITT) and per-protocol (PP) analyses will be conducted. Missing data will be addressed using multiple imputation, with sensitivity analyses performed to ensure robustness. A two-sided significance level of $\alpha = .05$ will be applied. Exploratory subgroup analyses (e.g., by gender or baseline severity) may be conducted if sample size allows.

Ethical Considerations

The study has been reviewed and approved by Ethics Review Committee, Foundation University Islamabad (Approval ID: FUSST/IRB/091). All the procedures will be conducted in accordance with the Declaration of Helsinki and the local regulatory requirements.

Written informed consent will be obtained from participants prior to enrolment. Participants will be informed about the purpose, procedure, potential risk and benefits of the study and most importantly about their right to withdraw at any time, without any penalty.

All the collected data will be kept completely confidential. Data will be anonymous and will be reported in a way that no individual participant can be identified.

Participants will not receive financial compensation but will be reimbursed for travel expenses. De-identified data will be available at PI for a minimum of 5 years after study completion. This trial was prospectively registered on ClinicalTrials.gov (NCT06302712).

Expected Results

As this is a study protocol, no results are currently available. It is anticipated that the participants receiving the culturally adapted Traditional Islamically Integrated Psychotherapy (TIIP) will show significantly greater reductions in OCD severity, as measured by the Yale-Brown Obsessive Compulsive Scale (Y-BOCS), compared with the treatment-as-usual (TAU) control group.

Improvements are also expected in the secondary outcomes, including reductions in the levels of depression, anxiety, stress, thought-action fusion, and maladaptive thought control strategies, as well as enhancements in spiritual quality of life. Data will be analyzed using both intention-to-treat and per-protocol approaches, as outlined in the statistical analysis plan.

Discussion

Traditional Islamically Integrated Psychotherapy (TIIP) is a relatively new treatment for OCD. It is based on the TIIP model, which is rooted in an Islamic epistemological and ontological framework. This method offers general theoretical guidance and insight on fusing psychotherapy practice with the Islamic spiritual literature. Many of the pre-existing psychotherapy methods can be used, which avoids replacing current orientations in favour of offering a more sophisticated integrative approach within an Islamic context. Such a paradigm acknowledges the spiritual nature of the human person at its core and sees spirituality as a crucial factor in determining identity, affecting

thought and belief, influencing emotional expression, and impacting behavioural health [18].

People who are religiously oriented and actively pursue religious traditions are more susceptible to attracting OCD symptoms that interact with their religious beliefs and practices. Depending on the socio-psychological setting of the patient, OCD symptoms can manifest in a variety of ways. OCD symptoms can combine with religious beliefs and behaviours among groups of people who practice a particular religion, a condition known as OCD scrupulosity. Some of the common OCD manifestations are known as Scrupulosity (*Waswasa*) among Muslim populations [18].

The treatment of OCD according to the TIIP model is rooted in Islamically integrated interventions that are based on the Quran, Prophetic tradition, and Islamic scholarly writings. An Islamically integrated approach to psychotherapy and Exposure Response Prevention Therapy (i.e., behavioural strategy in CBT) is offered which draws its basis from Islamic faith-based healing [18].

TIIP model suggests a need for a more self-compassionate cognitive orientation to balance out the OCD patient's negative attribution bias and concomitant obsessive behaviours, which are the signs of excessive anxiety. Interventions include a cognitive restructuring element that makes use of cognitive techniques like "acting as if" and Islamic positive cognitive reframing. These techniques also include challenging the evidence, correcting false Islamic beliefs through psychoeducation, accepting intrusive thoughts and their inconsequentiality, and challenging the evidence. It is advised that exposure response prevention be used in conjunction with cognitive therapies in order to eliminate the anxiety that is brought on by intrusive thoughts and fuels behavioural compulsions [30].

In developed countries, CBT has managed to empirically mark its place among other extensively applied therapeutic techniques. Moreover, its efficacy is also evident while treating several disorders. Developing countries including Pakistan, on the other hand, are struggling to establish a similar standing of CBT in terms of efficacy and application. Apart from that, the improved efficacy of cultural adaptation of CBT (CaCBT) is also stressed for a variety of psychiatric conditions [16]. It highlights the significance of cultural factors in the therapeutic effectiveness of CBT. This study emphasises the significance of culturally adjusting CBT for clients from non-Western cultures such as Pakistan. Religious and cultural ideas can impact the content of obsessive thinking [17]. Understanding cultural variations in OCD symptom manifestation is essential for effective assessment and therapy.

This study aims to assess the adaptability of the TIIP model, to the Pakistani setting. This is the first time the TIIP model has been used in Pakistan, with an emphasis on determining its adaptation to the country's cultural context. The goal of the study is to evaluate the effectiveness of the model and compatibility with cultural differences in Pakistan.

The study exhibits several strengths, such as the randomization of participants into two groups and the careful selection of a clinically representative sample of individuals with OCD. However, it is not without its limitations. Because this approach is novel, there is uncertainty about its expected impact. Additionally, some people may not respond favourably to the religious elements in Traditional Islamically Integrated Psychotherapy (TIIP).

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Competing Interests

The authors have no relevant financial or non-financial interests to disclose.

Author Contributions

All authors contributed to the study conception and design. First manuscript was prepared by Ahmad Ali Ansari, Jamilah Hanum and Mujeeb Masud Bhatti. Then final version was prepared and finalized by Amna Basharat, Ayesha Saeed and Zoya Khalid. All authors commented on previous versions of the manuscript. All authors read and approved the final manuscript.

Data Availability

The data that supports the findings of this study will be made available from Principal Institute upon reasonable request.



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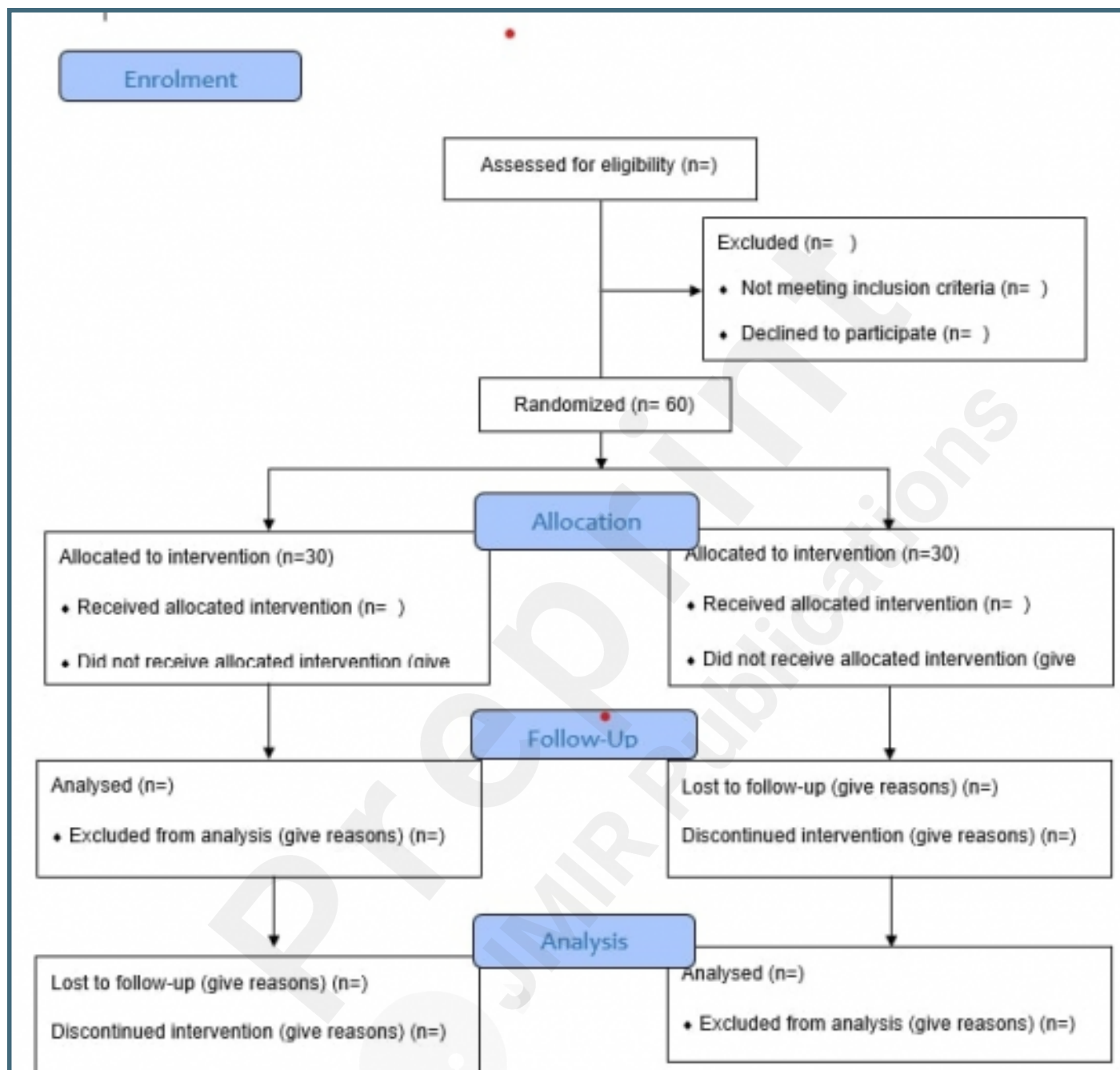
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Supplementary Files

Figures

Flow diagram of participant enrollment, allocation, follow-up, and analysis.



CONSORT (or other) checklists

CONSORT SPI Checklist.

URL: <http://asset.jmir.pub/assets/7ddf436d4ec2668995f67edd9551ee8d.pdf>

