Using Islamically Integrated Psychotherapy for the Treatment of Sexual Issues in a Muslim Male: A Pakistani Case Study

Maryam Hussain*

The client, an unmarried male of 30 years of age, presented with the complaints of wanting to abstain from performing non-marital sex and feeling guilt about excessive masturbation. Islamically Integrated Psychotherapy (IIP) and Religious CBT (R-CBT) were administered, keeping in view the client's fair to high religious inclination. Both modalities were found to be highly efficacious. The findings of this case study will extend the literature and add strength to what is already known, as prior research has not addressed the step-by-step application of IIP and RCBT for helping a client deal with sexual issues.

Keywords

sex counseling • non-marital sex • premarital sex • ego dystonic masturbation (EM) • Religious Cognitive Behavioral Therapy (RCBT) • Islamically Integrated Psychotherapy (IIP)

Sample Characteristics and Presenting Complaints

The client was an unmarried male of 30 years of age, belonging to a lower-middle socioeconomic class, with an undergraduate education, and unemployed at the time he reported for therapy. He presented with the complaints of wanting to abstain from performing non-marital sex and guilt about excessive masturbation.

Case Presentation

The client was a 30-year-old Pakistani Muslim male who reported to the client consultation unit of a Pakistani public sector university in the summers of 2016. His problem started sometime around the year 2008, when he was 22 years of age. He reported that he was

*University of Management and Technology, maryam.hussain@skt.umt.edu.pk

https://orcid.org/0000-0002-6180-6978

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passing by a friend's house when that friend's wife stopped him to have a word with him. She complained to the client about her husband's rude and aggressive behavior. His friend's wife requested the client to talk to her husband about it. The client agreed to it and left for his own home. After that, the client reported that he had repeated encounters with that lady and soon they became close. According to the client, one day when the lady's husband and her children were not home, she called the client and took him to her room to have intercourse with him. She showed him pornographic movie clips and performed the same kind of sex with the client as shown in the movies. According to the client, he neither gave his verbal consent nor protested and just let it happen. He also did not report feeling any emotion at that time.

The client accounted that when he came home the first time after that woman talked to him about her home circumstances, he discussed it with his mother and sought her opinion whether he should talk to his friend about it but his mother protested and stopped him from intervening in their personal matter. The client reported that he did so anyway and now he sometimes blames himself for doing so. He added that he was taking training for commission in the forces and had also started a diploma but left both midways because he had been in a mental fix due to this situation and could not concentrate on anything else properly. He said that he did not find it hard to concentrate otherwise but that his circumstances led to poor concentration.

Thereafter, the two of them had intercourse repeatedly. Sometimes the woman would call the client and at other times, he would go to her himself. The intercourse was always performed at the woman's house. According to the client, he never felt any emotional attachment with that woman. The woman had three children from the client's friend and when she divorced the client's friend and married another man, the client still never felt any emotion. According to him, he never liked or loved her but only went to her to meet his need. He was even aware of the fact that whatever he does is morally wrong but according to him, it was a sudden drive that arose and took over his senses, ultimately leading him to contact that woman again.

The client reported that he had often tried to get away from her but somehow it all started again because either that woman would contact him or client himself would contact her. He had even deleted her contact number from his phone a couple of times but by now he had unintentionally memorized it and could always contact her when the same impulse overwhelmed him again.

According to the client, he was also habitual of masturbating excessively after having intercourse. He almost always masturbated after he returned home from her place. He said that he felt ashamed for masturbating because he believed it to be a highly immoral activity. He was extremely distressed for doing such immoral activities therefore, he seldom, if ever, masturbated or watched porn alone or for the mere purpose of enjoyment.

It was also reported that the same woman had tried to set the client up with other women but he never met them. He added that he never went to any other woman to have intercourse with whenever he felt the need nor did he have problems with controlling his desire when he saw other women. The only problem was that whenever he felt an urge to have intercourse, he always contacted that same woman though he did not even feel any emotional attachment. According to the client, the reason for this might be that this woman was more physically welcoming than any other woman and that she knew well by now how to satisfy the client.

The clinician inquired if the client was "guilty" of having a sexual relationship with his friend's wife or for masturbating, to which he responded in negation for the former but in affirmative for the latter. He reported that he did not particularly feel guilty about his illicit sexual

relationship because sometimes a complete year would go without them meeting, during which the feelings of minor shame and regret would subside. Another reason he did not feel guilty about it was that it was the woman who first approached him for this interaction; the client himself did not coerce her into it. The client also blamed the woman for being unrighteous and ignoble and for seducing random men to meet her physical needs. Though the client had reasoned with himself that it was not his fault that he was a full participant, he still felt somewhat ashamed for always falling into her trap. On the other hand, the reasons he gave for feeling guilty toward masturbation were religious in nature. Masturbation is what he did for his own satisfaction and he was extremely guilty for doing it because the religious scholars he sought counsel from had labeled it as haram (forbidden). When the client was asked if he had told anyone at home about his issues, he said that no one in his family or acquaintances knew about him meeting with his friend's wife this often.

In July 2016, the client sought therapeutic assistance for the presenting complaints of feeling ashamed of having an uncontrollable urge to have intercourse with his friend's ex-wife and excessively masturbating after having done that.

Religious Inclination

According to the client, he was really inclined toward religion. He prayed regularly and he had even been taking guidance from several religious scholars regarding the teachings of Islam.

Theoretical and Research Formulation

Until the first half of the 20th century, sexual relationship between two people prior to them being in wedlock was referred to as "premarital sex". The term fornication was replaced for the negative connotation it held.

More recently, the term is used more for any sexual relationship a person has before marriage and less for the nature of the relationship between people involved. This definition is somewhat ambiguous. What remains to be decided is whether the term should be specified for those uninterested in marrying or those legally forbidden from marrying (Thomas, 2010).

Because of the ambiguity of the term "premarital sex", some alternate terms such as, *youthful sex*, *young-adult sex*, *adolescent sex*, and *non-marital sex* (which overlaps with adultery) have been used. To some extent, all these terms remain to be rather vague.

The present interpretation of premarital sex is any sexual relationship between two people who are not married. In the past, premarital sex was considered a sin by most religions and a taboo by many cultures. The latter half of the 20th century saw acceptance of it by most Western societies.

There is some data regarding the prevalence of premarital and non-marital sex in Muslim countries in comparison to Western countries. A study conducted on global morality in 2014 concluded that public opinion in many Muslim nations (e.g., Saudi Arabia, Indonesia, Egypt, and Pakistan) considered premarital sex unacceptable, with over 90% disapproval rate. Contrarily, Western European countries including Spain, Germany, and France expressed less than 10% disapproval and largely showed acceptance (Pew Research Center, 2014).

Indonesia accounts for the world's largest Muslim population with over 209 million Muslims, 97% of which disapprove of adult premarital sex. Most religions strictly prohibit having sex before marriage. Therefore, countries that are ideologically religious, such as

Pakistan and Jordan are also of the same belief. European countries including France and Germany show 57 percent and 47 percent acceptance, respectively. The statistics for the United States show that 29 percent of people consider premarital sex morally unacceptable (Statista, 2014).

A study conducted in the American Sociological Review concludes that Muslims and Hindus, especially those in the developing zone, are more likely to abstain from extramarital sex as compared to Christians and Jews. The study compares practicing people from all religions and the figures depict Hindus to be the least in number (only 19%) to have reported of premarital sex. Other faith practitioners included 43 percent of Muslims, 65 percent of Buddhists, 79 percent of Christians and the highest percentage was reported by Jews, with 94 percent. In most Muslim countries around the world, the interaction between the sexes is relatively lesser, therefore the chances of them meeting a potential partner are also few (Adamczyk & Hayes, 2012).

Incidence of masturbation by partners after intercourse has been studied in a recent study by Regnerus, Price, and Gordon (2017). Partnered sex in relation to masturbation has been explained by two main theories. The *complementary theory* says that the quality of partnered sex enhances as a result of masturbation. Therefore, masturbation improves the partnered sex. The *compensatory model*, on the other hand, suggests that desires which go unmet during partnered activity are substituted by masturbation by people in relationships. The study found that the compensatory theory holds true for men, and complementary for women.

Despite having a history of general religious and social condemnation, masturbation is considered a part of normal sexuality and a common sexual practice. While masturbatory taboos cause a pervasive sense of guilt in those who practice it, there is little evidence to a subsequent decrease in its occurrence. The guilt is caused due to violation of internalized standards and the person desires to make amends or punish oneself (Castellini et al., 2016).

Cantor and colleagues (2013) described cases of sexual guilt in which clients reported distress as a result of sexual behaviors, whereby they often reported sufficient symptoms to have been previously diagnosed as depression. Greenberg and Archambault (1973) found that 40% of university students reported feeling guilty of indulging in masturbation-related activities. More recently, Choi and colleagues (2000) examined the masturbatory experience of young Korean men in military service, 10.9% (132 of 1,212) of which reported feelings of guilt. Castellini and colleagues (2016) coined the term ego-dystonic masturbation (EM) for masturbation followed by a sense of guilt. Distress after masturbation may be determined by the act of masturbating per se or by an excessive involvement of sexual cognitions and behaviors. The latter condition has been associated with several psychopathologic features (Kafka, 2009). Hypersexual behavior is often characterized by excessive masturbation which the person is unable to control. It is often accompanied by a sense of guilt and leads to functional impairment (Kafka, 2009; Bancroft, 2008). Most researchers agree that subjective distress and/or impairment in at least one important life domain as a result of excessive inappropriate sexual behaviors or cognitions is a chief characteristic of EM (Black, 2000).

An explanation put forth by some researchers holds that compulsive sexual behavior disorders are repetitive in nature which are aimed at anxiety reduction and lowering other related dysphoric affects such as depression and shame. This behavior is symptomatic of an underlying obsessive compulsive disorder (Black et al., 1997; Coleman, 1987). On the other hand, a group of investigators including Castellini and colleagues (2016) and Hoyle, Fejfar, and Miller (2000)

hold an opposing view; according to them, severity of ego-dystonic masturbation is not so much associated with obsessive-compulsive symptoms, which is one pole on the 'obsessive-impulsive continuum'. In their studies, they concluded that the EM group reported fewer anxiety/phobia symptoms as compared to non-EM group. The other end of the continuum is "sensation seeking", often similar in presentation to impulsive disorders. Impulse control disorder is defined by DSM as a failure to resist a drive, impulse, or temptation to perform an activity that end up harming the person himself or others. Usually, such an act is preceded by a heightened sense of arousal or tension which then results in immense gratification, pleasure, or relief at and immediately after the activity is done. The act may or may not result in self-reproach, regret, or guilt in the long run (American Psychiatric Association, 2000). As a support, the frequent occurrence of impulse control disorders in the studies by Raymond and colleagues (2003) and Black and colleagues (1997) confirm the impulsivity-spectrum hypothesis for EM.

The integration of religious teachings and spirituality with the mainstream psychotherapy (or Western models of mental health) has been long studied. The significance of spirituality and religion has been endorsed by many health care professionals who frequently incorporate spiritually oriented approaches into their clinical work (Jackson, 2014). The efficacy of spiritually oriented mental health treatment is evidenced by a number of psychotherapy outcome studies (Anderson et al., 2015). A term, Islamically Integrated Psychotherapy (IIP), has been assigned to the mode of psychotherapy that integrates Islamic principles, teachings, philosophies, and intervention modalities with Western therapeutic approaches (Al-Karam, 2018). Likewise, RCBT is a relatively newer therapeutic approach which incorporates principles of theism into the standard CBT, based on the faith of the client (Pearce et al., 2015).

Diagnostic Formulation

The client's problem was categorized under the following DSM-5 code:
V65.49 (Z70.9) Sex Counseling

Prognosis

The client had been very vocal about his problem and he entrusted the therapist readily with his information. He was also observed to be very compliant to treatment protocol and the inclusion of religious references, for he was greatly inclined toward religion and frequently sought advice of the imams of his local mosque. When asked about his family's financial condition, he accounted that he only had one brother who was married. The client's brother was employed as a lecturer in a government sector university. He was very supportive of the client and encouraged him to complete his education before looking for a job. The client's father was deceased and his mother was alive. His relationship with his mother was congenial. These characteristics of the client showed that he had good prognostic features. In addition, the client was, in Schofield's words (1964), YAVIS (*Youthful, Attractive, Verbal, Intelligent, and Successful*); these characteristics lend themselves toward a better prognosis in therapy.

Aims and Objectives

In a Muslim-majority, conservative country like Pakistan, the ratio of public opinion condemning non-marital sex and subsequent masturbation immoral and unacceptable is among the

highest. It is likely to lead those who practice it to feelings of shame, guilt, or distress. They may make deliberate efforts to abstain from it. If practicing such acts leads the person to mental health issues and guilt, which mainly stem from religious grounds, it is assumed that a wide array of techniques under the umbrella of IIP and RCBT will be able to bring relief to people who suffer from it.

Method

The case in question was approached via a single subject AB design. The client presented with the complaints of wanting to abstain from performing non-marital sex and guilt about excessive masturbation. On the premise of Religiously Integrated Cognitive Behavioral Therapy (RCBT), whereby religion is incorporated in the already established techniques of CBT, the client was assisted to develop distress-reducing thoughts and behaviors informed by his own religious beliefs, resources, and practices (Pearce et al., 2015). This approach will extend the literature and add strength to what is already known, as prior research has not addressed the step-by-step application of IIP and RCBT for helping a client deal with sexual issues.

Informal Assessment

Behavioral Observation

The client was dressed in casual pants and shirt. His hygiene looked appropriate. The pitch, tone, and intonation of his voice were all in normal range and his speech was comprehensible. He maintained little eye contact in the initial sessions while discussing his case, which was later increased as the therapy progressed. Regarding his problem, he was observed to be quite verbal throughout the sessions. He also seemed to comply readily with the suggestions of the therapist, which depicted his willingness to change his behavior.

Clinical Interview

The interview began with small talk regarding health and weather for the purpose of socialization and establishment of rapport with the client. It was conducted in a semi-structured way, consisting of both open- and close-ended questions. The client was very vocal about his problem since the very start so only little effort was required on the part of therapist to elicit further information. The client was assured that the information he provides will remain confidential and that he could freely discuss his issues at length.

Subjective Ratings

To assess the level of problem symptoms faced by the client, a visual analogue was generated on a 10-point scale with 10 equaling the highest level of distress, 0 equals no distress and a 5 is neither very high nor very low intensity of distress.

Table 1. Pre Assessment Visual Analogue by the Client

Presenting Complaints	Pre-ratings
Giving in to the urge to perform sexual intercourse with friend's wife	10
Having negative attitude about masturbation	10

Formal Assessment

Negative Attitude towards Masturbation Scale

Abramson and Mosher (1975) developed the inventory Attitudes toward Masturbation Scale to measure the construct of masturbation-guilt.

Quantitative Analysis

Scale	Score	Status
Negative Attitude towards Masturbation Scale	116	High level of guilt

Qualitative Interpretation

Negative Attitude towards Masturbation Scale is a 30-item inventory (10 of which have reversed scoring), consisting of a 5-point Likert-type scale, ranking from *not at all true for me* to *extremely true for me*. The possible range of scores lie between 30 to 150. Higher score shows higher guilt and negative attitude regarding masturbation. The client has scored 116 at the pre-assessment level, thus exhibiting that he experiences higher level of guilt toward masturbation.

Barratt Impulsiveness Scale-11

The Barratt Impulsiveness Scale (Barratt, 1994) is a questionnaire designed to assess the personality/behavioral construct of impulsiveness. Impulsivity is a multi-faceted construct and this multi-dimensionality is reflected in the BIS-11 factor structure.

Quantitative Analysis

2nd Order Factor	1st Order Factor	1st Order Factor Score	2nd Order Factor Score
Attentional	Attention	11	16
	Cognitive Instability	5	
Motor	Motor	16	23
	Perseverance	7	
Non-planning	Self-control	19	29
	Cognitive Complexity	10	
			Total Score= 68

Qualitative Interpretation

The second order factor scores for the client are highest on the factor of non-planning, exhibiting greater tendency to give in to urge without much planning about its future consequences. The overall score is 68 on the scale, which is suggestive of higher level of impulsivity.

Management Plan (Cognitive Behavioral Therapy)

- **Normalization** was done to de-pathologize client's issues and concerns regarding masturbation
- **Psychoeducation** was given to the client to make him understand the several contributing factors to his problem
- **Myths about sex and masturbation** were also clarified because the client had previously been misinformed about it with respect to religion and health
- **Diaphragmatic breathing** was done with the client to help him lower his level of arousal at the time of impulse
- **Imaginal desensitization** was done with the client to give him a sense of successfully mastering his impulse and letting it pass by
- **Activity scheduling** was assigned to the client to provide a distraction to him from his thoughts

Session-wise Summary of Therapeutic Interventions

In **Sessions 1 and 2,** history of present illness, other relevant history of the client, and rating of presenting complaints on visual analogue were taken. The technique of **Normalization** was done with the client, in which the therapist uses statements that refer to client's problems as not necessarily being pathological. Instead the symptoms are considered to stem from ordinary life difficulties (O'Hanlon & Weiner-Davis, 1989). The statements used for normalization also exhibit the therapist's implicit acceptance of the client. The client reported that he felt really awkward while talking about his problem initially, as he thought that he had a kind of problem that if he told anybody, people will look down upon him. He also considered that his problem was so unique in nature that it must be some kind of mental ailment. He was then told how common was the ratio of men and women with the problem he came with and how his willingness and compliance in the therapy could speed up his process of recuperation.

In **Session 3 and 4,** complete **Psychoeducation** was given to the client regarding his problem of masturbating after having intercourse with his friend's wife. He was informed about the prevalence of masturbation among the general public, and its commonality and ratio among both men and women (Javed, 2004). Because the client had a strong religious inclination, he was provided knowledge about how eminent religious scholars considered masturbation a lesser level of sin as compared to adultery or intercourse performed illegally without religious marital commitment (*Nikah*). The client was educated that jurists who follow Hanbali school of thought allow masturbation only if one fears committing fornication or he does not possess the means to marry. Therefore, Imam Ahmed bin Hanbal's interpretation may apply to a situation wherein the person experiences sexual excitation and may fear committing haram. As an example, an expat may travel to another country for the purpose of education or work and to avoid temptations, he resorts to this method. Care must be taken though, to not make a habit out of it (Ebrāhīm, 1989). Imam Hanbal's reasoning may be traced to two important legal principles:

a) Indulgence into a lesser evil is permissible in order to avoid a greater evil, and
b) Extreme or acute genuine necessity renders the forbidden (haram) permissible (halal).

The client was also provided reference to the following Hadith of the Prophet Muhammad (PBUH) and was suggested to fast in case he should ever find himself driven by the urge of contacting his friend's wife or masturbate afterward:

> Young men, those of you who can support a wife should marry, for it keeps you from looking at women (lower your gaze) and preserves your chastity; but those who cannot should fast, for it is a means of cooling sexual passion.
>
> (Compiled by al-Bukhâri as cited in Al-Qaradawi, Helbawy, Shukry, Siddiqui & Hammad, 1985, pp. 190–193).

The client was also given reference from Qur'an that the holy book had not even discussed masturbation as a separate topic, let alone specifying any punishment for it (Javed, 2004). Whereas, intercourse outside wedlock had not only been discussed at length in the Qur'an but also strictly been prohibited. As a result of this education, the client reported that he had previously been misinformed by the mullahs of his mosque. He also added that people who bragged about having knowledge of religion seldom, if ever, gave reference for what they said. They only told about what was sin without specifying the source from where that commandment had come from.

In **Session 5 and 6, sexual and masturbation-related myths were clarified** which were relevant in the client's case. The client reported that throughout his life, he had been a devout Muslim. He had been performing five daily prayers since he was an adolescent. He had also been indulged in religious discussions and had been actively attending lectures that were held at the mosque. The client reported that the religious teachers at the mosque strongly discouraged masturbation, calling it a sin. They labeled it as 'haram' and a practice that should not at all be indulged in. Furthermore, the client's own brother told him that some health dysfunctions may result from masturbation. Overall, the client was found to hold the following myths about masturbation: (1) Masturbation can damage the genitals, (2) masturbation causes mental health problems, and (3) it is wrong to indulge in sexual fantasies (Gillan, 1987). His mistaken beliefs were clarified by telling him that masturbation is extremely unlikely to damage the genitals. The biological purpose of life is to reproduce life, so genitals have evolved over eons to be tough, resilient organs. A little chafing of tender genital skin may occur during extended sessions, though, in which case a lubricant may be used. The client was also clarified that medically masturbation is considered normal, healthy, and doesn't cause physical or mental health problems (Castleman, 2013). Regarding sexual fantasies, for a culturally relevant education, the client was given reference of the following Hadith, narrating that occurrence of evil thoughts is not punishable unless acted upon:

> On the authority of Ibn Abbas (May God be pleased with him), from the Messenger of Allah (P.B.U.H), from what he has related from his Lord is: "Verily Allah has written down the good deeds and the evil deeds", and then explained it [by saying]: "Whosoever intended to perform a good deed, but did not do it, then Allah writes it down with Himself as a complete good deed. And if he intended to perform it and did perform it, then Allah writes it down with Himself as from ten good deeds up to seven hundred fold, up to many times multiplied. And if he intended to perform an evil deed, but did not do it, then Allah writes it down with Himself as a complete good deed. And if he intended it [i.e., the evil deed] and then performed it, then Allah writes it down as one evil deed." [Reported by Bukhari & Muslim].

Abu Hurayrah quotes the Prophet (P.B.U.H) as saying: "People said to the Prophet: "We entertain thoughts which we would not like to put in words even though we could have everything under the sun." The Prophet said: "Do you really feel that?" They answered in the affirmative. He said: "This is a clear sign of firm faith." (Related by Al-Bukhari in *Al-Adab Al-Mufrad*).

This Hadith shows the reluctance of the companions of Prophet Muhammad to verbalize the thoughts that occurred to them, even at the expense of everything the world has to offer. This is an indication of how evil or bad the content of the thought must be, to the point that they abhor entertaining them. This shows that such thoughts do not occur at their will yet implementing on them is out of question. Hence, the Prophet reassures them that if their reaction to such thoughts is extreme repugnance and disgust, it is an indication of true and firm faith. Such reactions stem from a well-established, strong faith. If the faith had been weak, the reaction would not be such (Salahi, 2004). It was clarified to the client then, that such thoughts are not punishable in this life or on the Day of Judgment, as long as they remain within the realms of thought and whim. If they are not acted upon or stated verbally, then they are overlooked by God.

In **session 7, Diaphragmatic breathing** (also known as abdominal breathing, belly breathing, or deep breathing) is breathing that is used to soothe oneself both physically and mentally (Timmons & Ley, 1994) was introduced. It is done by contracting the diaphragm, a muscle located horizontally between the chest cavity and stomach cavity. Air enters the lungs and the belly expands during this type of breathing. Alongside practicing this, the client was asked to think to himself that he was gathering all the worrisome thoughts inside of him at one place. At the time when he is about to release the air from his lungs, he was advised to think that all the worries that he had gathered at a place are now leaving his body with that breath he is exhaling. The client was instructed to practice it thrice per day, especially when he felt overwhelmed by sexual tension. This would not only provide his brain with sufficient oxygen resource needed for mental clarity but may also serve as a distraction from the impulse. He reported considerable improvement in his state as a result of this exercise. He appeared to be satisfied and was quite willing to practice it more often.

In the same session**, Daily Activity Schedule** was designed with the client and it was given as homework. It included healthy physical activity such as jogging or walking two times a day—morning and evening to sublimate his energy. The rationale for providing Daily Activity Schedule is that it engages the patient in constructive activities (Haddock & Slade, 1996). The client was also expected to indulge in healthier activities as a result of this schedule which mainly served as a way to channelize his energy in productive tasks.

Imaginal desensitization was done with the client in **Session 8** after eradicating his myth that it is wrong to indulge in sexual fantasies by giving him a more complete education from Islamic perspective that it is not entirely wrong if these fantasies are not acted upon. During this technique, progressive muscle relaxation is used with imagery of successfully overcoming the urge by better dealing with it (Hodgins & Peden, 2008). The client was first asked to completely and fully practice relaxing his body. He was then asked to imagine himself feeling heightened sexual tension and wanting to contact his friend's wife. He was advised to simultaneously keep practicing relaxation. When in the situation of feeling extreme level of sexual urge, he was then asked to imagine that he was cooling himself down and letting the urge pass by, ultimately successfully avoiding to contact that woman for intercourse. He was asked to keep still and practice relaxation until he could imagine that the urge has completely subsided and that he is extremely happy with himself for having been able to overcome his urge to contact her. The client practiced imaginal desensitization during the session first. It was assigned to him as homework. In the subsequent sessions, the client reported that he orgasmed while thinking of her in his imagination and felt himself feel lighter while he was performing this technique. He also reported that he was extremely happy to approximate the same pleasure that he could have achieved from the actual activity but more so, because he had successfully subsided his urge to contact her.

Session 9 involved a roundup of all of the procedures used throughout therapy sessions and a therapy blueprint consisting of an abridged version of the sum total of techniques.

Session 10 included a detailed feedback by the client regarding his progress thus far. The client's progress was monitored via post-management assessment. The intensity of his symptoms was decreased to a considerable extent and the symptoms nearly diminished on the visual analogue as well as on the formal assessment tools which included Beliefs about Masturbation Scale and Barratt Impulsiveness Scale.

Outcome of the Therapy

Huge improvement was seen in the client as a result of the aforementioned therapeutic interventions. He reported that he now felt very positive about himself. In his own words, "It seems now I have a queer force inside of me that can deal with any negativity I might experience in the future".

The improvement in client's symptoms has been depicted in the pre- and post-assessment visual analogue.

Graphical representation of pre- and post-visual analogue ratings of the presenting complaints.

Post-formal Assessment

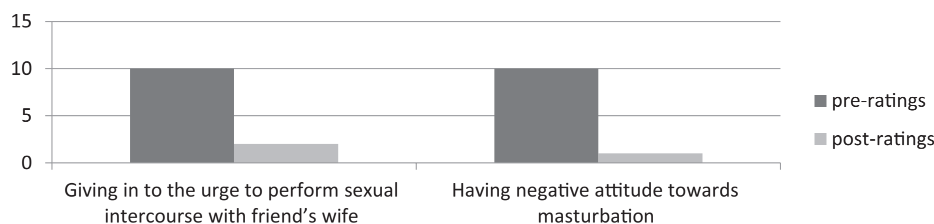
Negative Attitude towards Masturbation Scale

Quantitative Analysis

Scale	Score	Status
Negative Attitude towards Masturbation Scale	60	Low level of guilt

Table 2. Comparison of Pre and Post Assessment of Client's Visual Analogue

Presenting Complaints	Pre-ratings	Post-ratings
Giving in to the urge to perform sexual intercourse with friend's wife	10	2
Having negative attitude about masturbation	10	1



Graph 1. Comparison of Pre- and Post-Assessment of Client's visual analogue

Qualitative Interpretation

The client scored 60 on the post-assessment level of Negative Attitude towards Masturbation Scale, which shows a considerable 56 points decrease in his guilt regarding masturbation, thereby, suggesting that the therapeutic interventions had helped in bringing down his level of guilt.

Barratt Impulsiveness Scale- 11

Quantitative Analysis

2nd Order Factor	1st Order Factor	1st Order Factor Score	2nd Order Factor Score
Attentional	Attention	7	10
	Cognitive Instability	3	
Motor	Motor	10	17
	Perseverance	7	
Non-planning	Self-control	13	23
	Cognitive Complexity	10	
			Total Score= 50

Qualitative Interpretation

The client's second order factor scores have all decreased on the BIS-11. The total score has a 16-point decrease, thereby suggesting that the impulsive attitude of the client has also been decreased to some extent after the therapeutic interventions.

Discussion and Conclusion

This case study had two main arguments. The first concerns the use of religious mode of psychotherapy as quite beneficial for treatment of sexual concerns as exhibited in the amelioration of client's condition. Especially incorporating credible references from religious aspect can be efficacious in convincing a client with the same characteristics as the present case. However, the attributes that resulted in good prognosis of the present case may also be needed in future cases for therapies like R-CBT to be successful, lack of which thereof may question its usefulness.

The second argument revolves around establishing sexual behavior as an impulse or an obsessive tendency. There has been ample evidence for both in the past, as discussed under theoretical background but the present case adds weightage to it being an impulse, as in the words of client himself, "I feel a sudden urge to do so", which can clearly be interpreted as a drive or impulse and not an activity done merely in order to reduce anxiety or stress as a consequence of a thought. The latter explanation, advocated by proponents of obsessive compulsive extreme of continuum may however be a consequence of delayed impulse, an idea which is open to debate.

Recommendation

Case study is a method that is critiqued for its small sample size and lack of rigorous data collection and interpretation methods. While a single case may not be counted as a sufficient evidence to support or negate formal research, case studies can fairly benefit practitioners and, if replicated, may accumulate enough evidence to eventually add to normative data.

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