Introduction to Transdiagnostic Multiplex CBT for Muslim Cultural Groups

In spite of the popularity of cognitive behavior therapy (CBT) and much evidence supporting its overall efficacy (e.g., Blanchard, 2003; Cohen, Mannarino, & Murray, 2011; see also, Foa et al., 2008), there are few culturally sensitive CBT treatments available for Muslim cultural groups. There are currently around 1.6 billion Muslims in the world (a number expected to rise to 2.2 billion by the year 2030), with about 3.5 million Muslims living in the United States and 2.5 million in the United Kingdom (Pew Research Center, 2013). Additionally, given social and political unrest in the Middle East, Western countries (e.g., Europe, North America, and Australia) are likely to see an influx of Muslim refugees and immigrants in future years, many of whom suffer from mental disorders, including anxiety (e.g., post-traumatic stress disorder [PTSD]) and depressive disorders. There are also an increasing number of Muslims in the West currently finding themselves in need of therapeutic and social work services due to the negative impact of Islamophobic victimization, which likewise speaks to the pressing need for culturally sensitive treatments for this population.

Multiplex therapy as adapted for Muslim groups seeks to fill this gap by providing an accessible CBT treatment manual tailored primarily (but not exclusively) for Muslims living in the Western world (i.e., North America, Europe, as well as Australia), including immigrants and refugees, and other subgroups such as African Americans and second, third, and fourth generation American and European Muslims. The treatment manual is unique in that it takes into account the religious, spiritual, social, and cultural dimensions of individuals with a Muslim religious and/or cultural background. That is, the therapy frames treatment elements – that include mindfulness, loving-kindness meditation, attentional shifting, emotion regulation, yoga-like stretching, psychoeducation, anger management, and addressing catastrophic cognitions, pathological worry, and sleep-related problems (including sleep paralysis and nightmares) – in the context of well-known Islamic terms and concepts. Such cultural framing promotes treatment adherence and creates positive expectancy about treatment (Hinton & Jalal, in press), a major predictor of positive outcome in psychological research (e.g., Price, Finniss, & Benedetti, 2008). Indeed, culturally sensitive treatments have increased beneficial effects compared to non-adapted ones through the framing of treatment in terms of the patient’s own understanding of disorder (Benish, Quintana, & Wampold, 2011).

Multiplex CBT has been shown to be effective for multiple cultural groups including Southeast Asian groups and South African tribes (Cambodian, Vietnamese, Sepedi) (Hinton, Pham et al., 2004; Hinton, Chhean et al., 2005; Hinton, Hofmann, Pollack et al., 2009; Hinton, Hofmann, Rivera et al., 2011; Jalal et al., in review) as well as multiple Muslim populations (Afghan, Egyptian, Syrian, and Turkish) (Acarturk, Abuhamedeh et al., 2019 Acarturk, Alyanak et al., in press; Jalal, Samir, & Hinton, 2017; Shaw et al., in press). Those
studies have demonstrated the efficacy of culturally adapted (CA) Multiplex CBT as compared to waitlist and applied muscle relaxation with large effect sizes similar to those resulting from traditional CBT. These studies have shown the efficacy of CA Multiplex CBT in both individual and group formats.¹

Multiplex CBT takes into account issues like prominent somatic symptoms, low education, multiple comorbidities, ongoing life difficulties (e.g., financial stresses), and stigma about mental health, all of which are common challenges in Muslim populations and minority groups living in the West (Amer & Jalal, 2011; Jalal, Samir, & Hinton, 2017). Overall, Multiplex Therapy aims to be consistent with core Islamic beliefs, which may encourage this large population to seek treatment for their mental health problems. This is important, as there is often a distrust of mental health treatment among Muslims; psychotherapy and counselling, especially among first-generation immigrants, are seen as a secular science incongruent with basic Islamic values (Amir & Jalal, 2011). As such, this treatment manual is an important tool for therapists working in culturally diverse mental health settings.

Multiplex CBT as adapted for Muslim populations is also clinically relevant for non-Muslims. Indeed, its cultural framing could be considered as comparative examples that are used to better illustrate general therapeutic principles, as done with meditation and other Buddhist practices and principles, which are taught regardless of the religion of the individual in question. That is, showing how the treatment was adapted for Muslim populations illustrates general issues of adaptations as well as universal therapeutic principles, and the adaptation for a group of those universal principles.

Overview of Multiplex CBT

There are many obstacles when adapting standard CBT interventions (Foa & Rothbaum, 1998; Resick & Schnicke, 1996) to minority or cultural/religious groups. Such groups, including refugees and immigrants, may have low education, experience stigma about mental health and, crucially, have often undergone extensive traumas. As a result, standard treatment CBT techniques such as prolonged exposure for trauma may not be ideal for such groups, particularly those currently living in situations of stress and adversity (Hinton & Good, 2016; Hinton, Rivera et al., 2012), like those living in refugee centers and impoverished urban areas. Moreover, standard CBT does not make somatic symptoms a key therapeutic target and does not take into consideration that catastrophic cognitions about symptoms such as somatic symptoms, and comorbid conditions like worry, may vary across ethnic and cultural/religious groups (Hinton & Good 2016; Hinton, Rivera et al. 2012).

Multiplex CBT addresses many such challenges arising from working among refugee and minority populations (Hinton & Good, 2016; Hinton, Rivera et al., 2012). The key elements and overall session structure of Multiplex Therapy are shown in Table 1. For example, Multiplex CBT focuses on somatic symptoms and sensorial experiencing, as well as attentional processes, and stresses the importance of identifying and addressing key catastrophic cognitions that emerge from ethnopsychology and ethnospirituality such as catastrophic cognitions about “worry” and worry-induced symptoms; another

¹ All the treatment trials we have done have been with groups with minimal English ability and low education. The treatment techniques have been well accepted. As will be clear from the description of the treatment, its techniques have been designed to be easily understood by such groups.
### Table 1: Sessions in Multiplex Therapy and key components of each session

<table>
<thead>
<tr>
<th>Session Number</th>
<th>Session Title</th>
<th>Emotional Exposure Followed by Practice of the Indicated Protocol</th>
<th>Applied Stretching Lesson at Session’s End</th>
<th>Mindfulness Lesson at Session’s End</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Education about Anxious-Depressive Distress and the Treatment and Introduction of Emotion Regulation Techniques</td>
<td>Anxious-Depressive Distress</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>2</td>
<td>Applied Stretching and the Toe-to-Head Muscle Relaxation with Visualization</td>
<td>Anxious-Depressive Distress</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>3</td>
<td>Review of Toe-to-Head Muscle Relaxation with Visualization and the Introduction of the Dysphoria (Anxiety/Depression) Protocol, Education about Anxious-Depressive Distress and Teaching the Bad Memory Protocol (Emotion Regulation Toolbox)</td>
<td>Anxious-Depressive Distress</td>
<td>X</td>
<td>X</td>
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<tr>
<td>4</td>
<td>Education about Anxious-Depressive Distress, Modifying Catastrophic Cognitions, and Teaching Emotional Distancing</td>
<td>Anxious-Depressive Distress</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>5</td>
<td>Interoceptive Exposure I: Head Rotation</td>
<td>Anxious-Depressive Distress</td>
<td>X</td>
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focus is arousal and symptoms of arousal such as anger, which is a major treatment issue in cultural groups in stressful contexts (Hinton, Rasmussen et al., 2009).

Multiplex CBT is presented in an accessible way so that it can be administered both by highly trained clinicians (psychiatrists and clinical psychologists) and also by lesser-educated therapists. This is to ensure broader public health impact. The therapy is designed in a way that makes it accessible to patients with minimal or no schooling/education, which may be the case in refugee and immigrant populations and other lower-socio-economic status (SES) groups. To have wider public health impact (as dropout rates are typically high in minority groups such as among immigrants and refugees and other lower-SES communities), the treatment is relatively short, consisting of ten sessions (approximately one hour/session) that can be delivered once, twice, or three times a week, and can be administered to both individuals and groups of patients.

Multiplex CBT relies on a unique approach to exposure, with an emphasis on the emotion regulation of dysphoric states induced by asking about recent distressful memory recall and events. The patient is asked to describe such recall or other distressful events and then instructed to engage in emotion regulation techniques (i.e., what we call the Bad Memory Protocol [Emotion Regulation Toolbox], see Table 1) following the elicitation of distressing memories, including mindfulness, loving kindness, and applied muscle stretching with

<table>
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<th>Applied Stretching Lesson at Session’s End</th>
<th>Mindfulness Lesson at Session’s End</th>
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<tbody>
<tr>
<td>6</td>
<td>Interoceptive Exposure II: Hyperventilation</td>
<td>Anxious-Depressive Distress</td>
<td>X</td>
<td>X</td>
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<tr>
<td>7</td>
<td>Worry and Distress</td>
<td>Anxious-Depressive Distress</td>
<td>X</td>
<td>X</td>
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<tr>
<td>8</td>
<td>Anger and Anger Protocol, and Education about Breathing and Its Use for Relaxation</td>
<td>Anxious-Depressive Distress and Anger</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>9</td>
<td>Somatic Complaints and Sleep Disturbance</td>
<td>Anxious-Depressive Distress and Anger</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>10</td>
<td>Cultural Syndromes and Ethnophysiology Related to Distress</td>
<td>Anxious-Depressive Distress and Anger</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
a visualization. It also includes interoceptive exposure to somatic sensations, many of which are thought to encode distressing events; the somatic distress cue is paired to a positive association (e.g., dizziness paired to positive memories of experiencing dizziness). Multiplex CBT uses yoga-like stretching and meditation techniques to promote emotional and psychological flexibility. It emphasizes the treatment of somatic sensations, targets comorbid anxiety conditions and anxiety-type psychopathological processes such as worry and panic attacks, and aims to reduce anger.

Finally, Multiplex Therapy is transdiagnostic in its approach, targeting anxiety and mood disorders, making it broad in its scope and applicable to a large segment of mental health patients. Such a transdiagnostic treatment also offers benefits such as ease of implementation (due to a decreased need for multiple manuals/treatments) and the possibility of providing group treatments to patients diagnosed with heterogeneous emotional disorders. The transdiagnostic therapeutic approach is increasingly being adopted as the preferred method of treatment, and as such is highly relevant to this cultural group.

We refer to the treatment as multiplex CBT because it targets multiple processes in our model of how anxious-depressive distress is generated, which is shown in Figure 1. As can be seen, the model emphasizes the role of somatic and mental symptoms, cultural understanding of symptoms, and emotion regulation processes. Our treatment targets processes in this model, as shall be discussed in more detail.

Cultural Framing for a Muslim Population

Culturally adapted Multiplex CBT takes into account the fact that Muslims living in the West have immigrated or may be the descendants of immigrants from a multiplicity of countries (e.g., Iraq, Syria, Turkey, Lebanon, Afghanistan, India, Pakistan, Bangladesh, and Somalia) and thus may represent, in some cases, diverse cultures. In America, there is, for instance, a strong presence of culturally distinct Muslim subgroups such as African American (approx. 20 percent of the US Muslim population) and, to a lesser extent, Caribbean Muslims. Similarly, there is a large group of Western Muslims who have converted into the faith. Although these groups may have unique cultural traditions, they all have in common basic Islamic beliefs as derived from the Quranic scripture and prophetic tradition (i.e., the "hadith literature"). This Islamic foundation should appeal across ethnicity, racial group, gender, SES, and age.

This approach of emphasizing basic Islamic teachings should appeal to persons from the various denominations of Islam. This includes major branches like Sunni (roughly 90 percent of all Muslims) and Shia (roughly 10 percent of all Muslims [often originating from Iran, Iraq, and Bahrain]). Whereas groups such as Sufi and Salafi (the latter prevalent in a Saudi Arabian context) are characterized by unique traditions in their own right, their teachings and practices broadly fall under the umbrella of Sunni Islam. It is worth pointing out that the hadith tradition, unlike Quranic scripture, may vary for Sunni and Shia Muslims. While Multiplex CBT refers to hadith literature derived from Sunni tradition (as noted, the largest Islamic denomination), the vast majority of Islamic references used in Multiplex CBT are quite basic and generally accepted and thus should appeal to all Muslims regardless of denomination.

Multiplex Therapy as adapted for Muslims aims to target heterogeneous Muslim populations by appealing to their underlying Islamic cultural heritage and belief systems. As an integral part of their culture, these group members would likely be familiar with basic Islamic concepts such as salah (ritualistic prayer that includes...
Poor emotion adaptation
(poor emotion regulation skills, negative affect, and psychological inflexibility)

Triggers of somatic and mental distress

- Worry
- Negative emotions (anxiety, depression, fear, anger)
- Interpersonal conflict
- Stress
- Bereavement-type (recalling the deceased or others from whom one is separated)
- Trauma-type (trauma recall, startle, hypervigilance)
- Panic-type (exertional intolerance, hyperventilation and chest breathing, motion sickness [e.g., traveling in a car], agoraphobia-like syndromes [e.g., public spaces], out-of-the-blue autonomic surge)
- Sleep-related phenomena (e.g., nightmare, sleep paralysis, nocturnal panic)
- Metaphor-guided somatization (e.g., through cognizing distress in somatic metaphors)
- Hypervigilant surveying of the mind and body for evidence of a syndrome (e.g., “heart disease”)

Somatic and mental distress
(e.g., dizziness, poor concentration, anger)

Negative memory
and self-imagery
conjured by
somatic and mental distress

Increasing
dysphoria

Concerns
about somatic and mental symptoms

Worry
Negative emotions (anxiety, depression, fear, anger)
Interpersonal conflict
Stress
Bereavement-type (recalling the deceased or others from whom one is separated)
Trauma-type (trauma recall, startle, hypervigilance)
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Figure 1. The Multiplex Model of the Generation of Anxious-Depressive Distress
bodily motions), dua (supplication, that is, asking God for various worldly favors or spiritual elevation and forgiveness), fitra² (one’s natural or primordial state), sadaqah (charity), tazkiyah³ (inner purification), wudhu and ghusl (ritualistic washing), dhikr (religious chanting as narrated in authentic hadith literature), husnu dhun bilah (having positive thoughts about Allah), shukr (gratefulness), sunnah⁴ (prophetic customs and etiquettes), haya (chastity), istighfar (asking for forgiveness), qadr (predetermination), and asma-ul-husna (Allah’s 99 names as mentioned in the Quran). Members of such populations should readily identify with and accept well-known Quranic verses such as “Allah doesn’t burden a soul beyond its capacity” (Quran 2:286) and “in the remembrance of God the hearts find rest” (Quran 13:28); prophetic sayings (e.g., “smiling in the face of your brother is charity”⁵) and narrations that emphasize the importance of cheerfulness and optimism; and stories of the prophets, for example, those of Yusuf (Joseph), Yacub (Jacob), and Ayub (Job), who remained optimistic, grateful and patient in spite of facing much adversity. Such cultural and religious terms, concepts, and parables are incorporated into the therapy thereby making it potentially more culturally consonant, acceptable, and relatable. In short, culturally adapted Multiplex CBT for Muslim populations emphasizes basic Islamic terms and concepts, thus making it accessible and relevant to Muslims of various ethnic and cultural backgrounds.

Nonetheless, regardless of the general appeal of Multiplex CBT’s cultural adaptation, clinicians working with Muslim patients should always be flexible vis-à-vis religious adaptation. These must be personalized to the individual client’s needs and background. Ideally, such a personalized approach would entail an initial assessment (e.g., in the form of an open dialog during the intake) about the patient’s level of religiosity and cultural background (e.g., whether the patient is an African-American convert from Detroit versus a recent refugee from war-torn Syria) (see also, e.g., Amer & Jalal, 2011). By so doing, the therapist is able to better determine how much to emphasize and how to frame religious/cultural adaptation. For patients who are not religious, the religious rephrasing may be used as an example to make the concepts more understandable.

**Key Treatment Dimensions of Multiplex CBT and the Adaptation for Muslim Populations**

Here we discuss key treatment dimensions of Multiplex CBT and their adaptation for Muslim populations.

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² *Fitra* refers to man’s innate nature with which all humans are born, believed to be intrinsically wholesome and good.

³ *Tazkiyah* refers to the engaging in inner purification of the soul, considered a type of worship. The soul might be purified by various means including contemplating the majesty and beauty of God, abstaining from all sin, and asking God for guidance and mercy.

⁴ The *sunnah* refers to the prophet Muhammad’s sayings, doings, and customs, that is, his overall practice (e.g., how he used to worship). The *sunnah* thus constitutes the prophetic path to be followed by Muslims guiding people to the worship of God. Indeed, the prophet Muhammad is regarded as the role model for all Muslims to emulate.

⁵ Narration found in the at-Tirmidhi collection.
Normalizing Treatment and Promoting Adherence and Positive Expectancy

One way to normalize the treatment and create positive associations and expectancy is to provide certain descriptions of the entire treatment and its specific elements, grounding these elements in terms of culturally salient practices and metaphors. For example, in Multiplex CBT, treatment is compared to the making of a special cultural dish that involves multiple culinary steps in order to promote positive expectancy and to teach patience about the timeframe of improvement. As Muslims living in the West often have migrated from a multiplicity of countries with unique cultures and cuisines, one can refer to a special dish from the patient’s culture, for example, by directly asking the patient about such cultural foods. This metaphor naturalizes treatment and teaches the patient that the treatment process takes multiple steps and requires patience, as does cooking. Thus, such metaphors that emphasize the need to complete all parts of the treatment, like those in which all elements of the treatment are analogized to the myriad steps needed to prepare a dish, may help increase credibility, positive expectancy, and tolerability, and address structural barriers.

As another way to increase overall adherence to the treatment, the therapist may similarly highlight the numerous verses from the Quran and sayings of prophet Muhammad stressing the importance of being patient in order to achieve one’s goals (examples will be provided in the sessions that follow). In addition, as noted previously, Multiplex CBT frames CBT techniques in terms of Islamic healing traditions, thereby normalizing the process of treatment and increasing acceptance and positive expectancy. Examples include doing dhikr (i.e., engaging in the remembrance of Allah) to change attentional focus to a positive attentional object by engaging in the consecutive articulating of different names of God, which embodies attentional shift and a kind of descriptive flexibility, a viewing of an “object” from different perspectives.

Cultural Education about Anxious-Depressive Distress: The Inner Child

Educating patients about the anxiety-depressive state and psychopathological distress is another key part of Multiplex CBT. To this end, we use the metaphor of the “inner child” (an analogy for the brain’s limbic system). This is a way of analogizing a distress state and its resolution to a common daily-life event; that is, using a disturbance-and-resolution analogy, a grounding image of emotion regulation. It helps to attain distance from the negative state and mobilize self-soothing capacities. It is also an opportunity to teach emotion regulation techniques. The inner child metaphor is introduced in the following way, using the example of negative memory or an upsetting event. We explain that an inner child keeps thinking about the distressing event(s), is continually frightened by it, and that this inner child, when reminded of the past, causes one to have strong emotions, such as feeling angry or sad, or somatic symptoms such as a fast-beating heart and so on. We then suggest that this inner child needs to be soothed.

For a Muslim population, the therapist can suggest soothing the child by using dhikr (which literally means “remembrance” in the Arabic language and in this context refers to the remembrance of Allah’s names and attributes). Dhikr entails chanting religious phrases, for example, evoking and contemplating the meaning of different names for God. According to the Islamic faith, God has many names (an infinite number). Some of these were revealed to the prophet Muhammad, such as ar-Rahman (the Most Gracious), ar-Raheem (the Most
Merciful), al-Wadood (the Ever-Most Loving), al-Mumin (the Granter of Security), al-Muhaymin (the Protector), al-Salam (the Ultimate Provider of Peace), al-Muqit (the Nourisher), and al-Gafur (the Forgiving). In this regard, one may mention to the patient that the Quran (Islam’s holy book) encourages Muslims to call upon God using these different names (see verse 17:110–111), and that he or she may evoke these names of God to soothe the inner child (see Table 2 for selected names for God). Also, one can mention how this child is safe and protected in the presence of God. A special dhikr that a patient may say to soothe the inner child is repeating each of three distinct praises of God – subhanAllah (glory be to God; thirty-three times), alhamdulilah (praise be to God; thirty-three times), Allahuakbar (God is the greatest; thirty-four times) – all the while using his or her fingers to count (called tasbeeh). Also, the clinician can mention to the patient the following verse in the Quran, in which God says, “in the remembrance of God the hearts find rest” (Quran: 13:28), a reassurance that the dhikr may bring inner peace and comfort to the “inner child.”

It is important to note that this inner child analogy should be used cautiously when working with male Muslim patients. In our pilot work in Egypt using this metaphor, we found that a subset of Muslim Arab males found it somewhat problematic. This is probably

<table>
<thead>
<tr>
<th>Name of Allah</th>
<th>Meaning</th>
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<tbody>
<tr>
<td>Ar-Rahman</td>
<td>The Most Gracious</td>
</tr>
<tr>
<td>Ar-Raheem</td>
<td>The Most Merciful</td>
</tr>
<tr>
<td>As-Salam</td>
<td>The Provider of Peace</td>
</tr>
<tr>
<td>Al-Ghaffaar</td>
<td>The Ever-Forgiving</td>
</tr>
<tr>
<td>Al-Wahhaab</td>
<td>The Bestower</td>
</tr>
<tr>
<td>Ar-Razzaaq</td>
<td>The Sustainer</td>
</tr>
<tr>
<td>Al-Mu’izz</td>
<td>The Giver of Honor</td>
</tr>
<tr>
<td>Al-Latif</td>
<td>The Most Kind</td>
</tr>
<tr>
<td>Al-Khabir</td>
<td>The All-Aware</td>
</tr>
<tr>
<td>Al-Hafiz</td>
<td>The Protector</td>
</tr>
<tr>
<td>Al-Muqit</td>
<td>The Nourisher</td>
</tr>
<tr>
<td>Al-Karim</td>
<td>The Most Generous</td>
</tr>
<tr>
<td>Al-Mujib</td>
<td>The Responsive</td>
</tr>
<tr>
<td>Al-Wadud</td>
<td>The Most Loving</td>
</tr>
<tr>
<td>Al-Wali</td>
<td>The Protecting Friend</td>
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</table>

Note: While the names of Allah may be evoked at any given time, they can also be evoked depending on one’s circumstance. A person in need of protection may evoke the name al-Wali (the Protecting Friend), the person who craves inner peace the name al-Salam (the Provider of Peace), and the person worrying about financial difficulties the name ar-Razzaq (the Bestower).
because the idea of rocking an inner child may go against conventional Arab ideals stressing male masculinity. Many Muslims living in Western countries originate from Middle Eastern or Asian societies with similar ideals of masculinity (the same may be the case for African-American Muslims and second and third generation European Muslims including converts, originating from inner city and urban areas). As an alternative to the inner child metaphor, the clinician could refer simply to the “inner part of oneself,” which we have found to be more appropriate in an Arab/Muslim Egyptian context.

Teaching Mindfulness and Attentional Control

Mindfulness meditation techniques are an integral part of many types of CBT (i.e., the so-called third wave of behavior therapies: Hayes, Strosahl, & Wilson, 1999; Linehan, 1993; Segal, Williams, & Teasdale, 2002). Such techniques include being mindful of sensorial experiencing and acceptance of negative internal sensations and thoughts as opposed to trying to change them through an observational mindset (Brown, Gaudiano, & Miller, 2011; Herbert, Forman, & England, 2009). More generally, mindfulness involves being aware of the current attentional focus and learning to distance from that attentional focus in order to select a certain attentional focus (e.g., taking the mind away from worry to attend to the breath). We consider mindfulness and attentional control to be closely related. We will consider mindfulness in a broad sense as the taking of a certain attentional object with a certain emotional and/or cognitive frame so that it includes, for example, attending to the breath, attending to ambient nature, and loving kindness. (The mindful taking on of a certain attentional object with a certain frame that may be emotional, cognitive, and bodily; a certain emotion-cognitive-body set.)

Multiplex CBT teaches the importance of attentional focus. For instance, how the attentional object determines mood, and the fleeting nature of mood. It teaches techniques to help patients attend to the sensorial experience of the current environmental surrounding and to the body itself, and to notice the mood change that happens when shifting the mind from rumination to attending to the surrounding visual scape – leaves moving in the wind, for instance. It uses religious-based strategies derived from Islamic tradition to promote attentional-shifting, and to teach the patient to move the mind away from worries to a positive attentional object. For example, as ways to shift attention and to teach how the attentional object shapes mood, we recommend dhikr, such as the practice of remembering and evoking the names of God (usually while moving just the tongue without producing any vocal tract sound) and contemplating their deeper meanings. See Table 2 and the following sessions for various ways to do dhikr that include tasbeeh; reciting the Quran (Islam’s holy book); engaging in dua (supplication, e.g., while evoking God’s names and attributes); and engaging in salah (a ritualistic form of prayer where the individual prostrates, bows, and stands).

We integrate into treatment the practice of salah, which entails attentional focus and performing bodily stretching. As such, it is a way to embody flexibility (analogous to yoga). It is simultaneously a method to shift emotional focus to a positive object, to promote a low-impact physical activity (a type of “behavioral activation”), and to break vicious cycles of inactivity and inertia (e.g., sedentary habits that are exacerbated by psychopathology). As salah is to be performed throughout the day (five times per day) within specified time periods (morning, noon, afternoon, evening, and night), it is ideal for breaking sedentary habits. During salah, while uttering praises of God, the person bows down in a 90-degree