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"Worship is Not Merely About Form": Religiously Integrated Cognitive Behavioral Therapy in a Case of Scrupulosity

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Abstract

Treating clients with scrupulosity (religious obsessive–compulsive disorder) requires clinicians to be prepared for various forms of resistance and ambivalence. These individuals may experience hesitation not only during therapy but also when initially seeking help. In particular, concerns about not being fully understood, being misinterpreted, or unintentionally misrepresenting their faith may contribute to hesitation in seeking professional support, especially among individuals with strong religious sensitivity. This case study presents the therapy process and outcomes of a client with scrupulosity, using a cognitive-behavioral therapy (CBT) approach integrated with religious interventions. In previous attempts to receive treatment, the client had avoided fully disclosing his symptoms due to feeling inadequately understood, perceiving that his concerns were normalized without sufficient exploration, and experiencing discomfort due to concerns about misrepresenting his religiosity. The client was assessed using the *Yale-Brown Obsessive Compulsive Scale (Y-BOCS)*, *Beck Depression Inventory (BDI)*, and *Beck Anxiety Inventory (BAI)* scales before treatment, after treatment, and at follow-up stages. The results showed significant improvement: his obsessive–compulsive disorder symptoms remained below the clinical threshold at the 9-month follow-up, and his overall functioning increased considerably. To better understand which aspects of the treatment contributed to the observed outcomes, qualitative data were obtained from the client's responses to an open-ended therapy evaluation form. These responses emphasized the importance of the therapist's sensitivity to the client's religious values and the effective use of religious references throughout the therapy process. The case illustrates how a therapeutic approach that respects the client's faith-based concerns can foster trust, improve treatment engagement, and contribute to both clinical and spiritual well-being.

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Introduction

Obsessive–compulsive disorder (OCD) is a mental health disorder characterized by the presence of obsessions and/or compulsions. Obsessions refer to intrusive, unwanted, and recurrent thoughts, impulses, or images. Compulsions are repetitive behaviors or mental acts that an individual feels driven to perform in response to an obsession or according to rigidly applied rules (American Psychiatric Association, 2013). The prevalence of OCD in the general population is estimated to range between 1.1 and 1.8% (APA, 2013). However, due to methodological variations across studies, some report higher prevalence rates, ranging from 1.9 to 3.3% (Karno et al., 1988). Given the diverse presentations of OCD, several subtype classifications have been proposed to clarify clinical manifestations and tailor treatment approaches (Abramowitz et al., 2011; Clark, 2019). Although the specific content of obsessions and compulsions may differ among individuals, common themes include contamination (e.g., obsessions about dirt and cleaning compulsions), symmetry (e.g., obsessions with order and compulsions involving repetition, arranging, or counting), taboo thoughts (e.g., aggressive, sexual, or religious obsessions and related compulsions), and harm (e.g., fears of causing harm to oneself or others and checking compulsions) (APA, 2013).

Scrupulosity

Obsessions and compulsions centered around religious themes have received significant attention from researchers (Abramowitz & Hellberg, 2020; Besiroglu et al., 2014; Greenberg & Huppert, 2010; Toprak & Özçelik, 2024). Scrupulosity, which literally means fearing sin where there is none, is characterized by obsessive doubts related to religious matters, intrusive blasphemous thoughts and images, compulsive religious rituals, reassurance-seeking behaviors, and avoidance (Abramowitz & Jacoby, 2014). Researchers point out that religion appears to be one more arena where OCD expresses itself, rather than being a determinant of the disorder (Tek & Ulug, 2001). The reported prevalence of religious symptoms among individuals with OCD varies significantly across cultural contexts, ranging from 2% in the UK, 18% in the USA, 12% in India, 11% in Japan, and 27% in Turkey, to 52% in the Middle East, and 62% in Israel (Greenberg & Huppert, 2010). Prevalence rates may be underestimated due to clinicians' limited ability to recognize religious-themed psychopathology, as well as patients' feelings of shame, fear of being judged, or the belief that simply sharing their obsessions is sinful or blameworthy (Glazier et al., 2015). Although scrupulosity is not a rare subtype of OCD, it remains understudied in terms of treatment. There is also a lack of clarity regarding its conceptualization, diagnosis, severity assessment, and the effectiveness of religious or culturally sensitive interventions (Toprak, 2024a, b; Toprak & Özçelik, 2024).

CBT for OCD

Various approaches have been proposed for the treatment of OCD in the literature. Among them, cognitive behavioral therapy (CBT) stands out as a well-established, evidence-based method (National Institute for Health & Care Excellence, 2005). Depending on the severity of the clinical presentation, treatment may involve CBT alone, pharmacotherapy alone, or a combination of both. Studies indicate that the combination of CBT and pharmacotherapy is generally the most effective (Foa et al., 2005). Among these approaches, CBT has received particular attention for its focus on cognitive mechanisms underlying OCD.

CBT highlights the central role of beliefs, evaluations, and interpretations related to obsessions in OCD. Six belief domains commonly associated with OCD have been identified: "inflated responsibility," "overimportance of thoughts," "excessive concern about the need to control one's thoughts," "overestimation of threat," "intolerance of uncertainty," and "perfectionism" (Obsessive Compulsive Cognitions Working Group, 1997). As an example of the belief domains, individuals with OCD may interpret intrusive thoughts, images, or impulses—which are common in the general population—through the lenses of "overestimation of threat" and "inflated responsibility" perceiving them as evidence that they may harm themselves or others. Over time, such interpretations contribute to the development and maintenance of the disorder (Salkovskis, 1999). The same applies to other belief domains. In CBT for OCD, cognitive interventions aim to evaluate and restructure these beliefs and interpretations (Whittal & McLean, 1999).

CBT for Scrupulosity

Among the different subtypes of OCD, scrupulosity presents unique challenges in therapy due to its strong association with religious and moral concerns. While the core principles of CBT remain applicable, the nature of scrupulosity-related obsessions often complicates the restructuring of beliefs (Abramowitz & Jacoby, 2014). This complexity arises from the difficulty of distinguishing pathological perfectionism from religious devotion, as well as the challenge of addressing intrusive thoughts in a way that respects the individual's faith (Toprak, 2018). One of the key obstacles in treating scrupulosity is bridging the gap between CBT's fundamental premise—that intrusive thoughts are common and not inherently meaningful—and the client's religious belief system, which may view such thoughts as morally significant (Toprak, 2024a). Moreover, since the interpretation of these thoughts is often guided by the therapist's clinical judgment, the absence of clear criteria distinguishing harmful perfectionism from sincere religious commitment may lead individuals to withdraw from therapy. A potential solution to this issue lies in developing specialized intervention strategies that acknowledge these nuances and integrate them into the therapeutic process (Karakan & Toprak, 2023; Toprak, 2024a, b).

Numerous studies involving clients with scrupulosity have been published. Toprak (2022), who categorized these studies based on intervention content and methods, identified two main approaches: (1) religiously sensitive psychotherapies and (2) psychotherapies that incorporate unique interventions based on religious knowledge. Studies in the first category emphasize the therapeutic benefits of helping clients explore their personal religious beliefs, encouraging worship, and even accompanying them to places of worship (Badri, 2017; Siev & Huppert, 2016). Similarly, Peris and Rozenman, (2016) highlighted the positive effects of collaborating with religious figures, promoting the learning and practice of individual religious values and rituals. In the second category, which includes interventions directly informed by religious teachings, approaches often involve helping the client reconceptualize their OCD experience through religious frameworks, distinguish their true religious responsibilities, and integrate religious concepts with psychotherapeutic principles. These interventions have shown promising results in treatment outcomes (Mohamad Arip et al., 2018); Md Rosli et al., 2018; Toprak, 2022; Toprak & Emül, 2016). As the findings suggest, it is essential for therapists working with scrupulosity to be respectful of religious sensitivities, to possess adequate knowledge to distinguish OCD symptoms from religious practices, and to collaborate effectively with religious authorities when needed (Abramowitz & Jacoby, 2014). Such collaboration not only fosters a respectful therapeutic approach but also helps clients recognize their condition as a psychological disorder and increases their willingness to engage in ERP (Exposure and Response Prevention) practices (Abramowitz & Jacoby, 2014; Keshavarzi et al., 2020).

The Aim of the Current Study

This study aims to present the treatment process and clinical outcomes of a client with scrupulosity, integrating religiously sensitive interventions into cognitive-behavioral therapy, and to explore the therapeutic value of addressing religious concerns in a way that respects the client's beliefs and values.

Method

Case Presentation

The client was a 24-year-old single Muslim male with a bachelor's degree, who identified himself as religious, regularly performed acts of worship, and actively participated in religious practices. He presented with persistent doubts regarding whether his words, body language, or behaviors—whether intentional or unintentional—constituted *alfaz-ı kufr* (a term in Islamic theology referring to utterances or actions believed to nullify one's faith). In response to these doubts, he engaged in behaviors such as seeking religious rulings (fatwa) for specific situations, frequent repentance, mentally reviewing and verifying past actions, and avoiding worship, social interactions, and social settings.

These symptoms had persisted for approximately 9 years, beginning when he was around 15 years old. He reported that the intrusive thoughts occurred especially in social settings, but also emerged when he was alone. The condition had significantly impaired his quality of life, social relationships, and professional functioning. He described a marked decline in his ability to engage in daily activities due to the constant presence of doubt.

The client was the middle of three sons. He described his father as 'perfectionistic, critical, and emotionally distant.' In recounting his life story, he noted that he had witnessed ongoing conflict between his parents since early childhood, which had caused him considerable emotional distress. The client, who completed a bachelor's degree, had maintained strong academic performance throughout his education. However, he experienced adjustment difficulties in kindergarten and gradually became more introverted during his school years. He was unable to achieve the score he had hoped for in the high school entrance exam and, due to his father's insistence, enrolled in a boarding school that he did not want to attend.

The client came from a religious family who regularly practiced their faith, including attending communal worship at the mosque. He also reported that, from an early age, he chose to live a devout life by his own will. Although his parents took a balanced and reasonable approach to religious education during his early years, he stated that he tended to interpret religious teachings in a rigid and rule-bound manner.

Before the onset of his current OCD symptoms, he experienced anxiety during middle school related to behaviors mentioned in hadiths that might prevent someone from being a good Muslim. By the time he entered high school, these concerns had intensified and developed into severe obsessions. OCD symptoms began in the early years of high school (2014). During that time, while researching religious topics online, he unintentionally encountered radical interpretations regarding *alfaz-ı kufr*. Due to his shy temperament and his perception of emotional distance from his family, he was unable to discuss these issues. When he tried to express his concerns, he was met with rejection, which further deepened his sense of isolation.

He stated that he felt deep loneliness during those years, that he heard his friends crying in the dormitory at night, and that he also cried. He also reported not receiving enough attention from his family and feeling sadness and longing because of it. Reflecting on that time, he said: "During high school years, contradictory thoughts and doubts about my faith would come to my mind (e.g., What if there is no Allah?). I felt responsible, thinking that I was different because I was negatively affected by these things. There was a time in those years when I continuously recited the shahada. I continued researching online. I was waiting for someone to help me; I became lonely; I lost my self-esteem."

Psychiatric History

The client was first diagnosed with obsessive–compulsive disorder (OCD) in 2014. Treatment was initiated with medication (Ignis = Aripiprazole), which he used for approximately 1 year. Observing some improvement, he decided to discontinue the medication on his own. However, his OCD symptoms subsequently

relapsed. In 2016, he sought psychiatric treatment again and was prescribed medication (Prozac = Fluoxetine), which he continued for 4 years. During this period, his adherence to the medication was inconsistent, and he reported minimal benefit. Eventually, he discontinued the medication on his own due to perceived ineffectiveness. Family psychiatric history revealed that his brother had a history of periodic nervous breakdowns and was under psychiatric follow-up with prescribed medication. His uncle also reportedly received psychiatric treatment for similar episodes, although no specific diagnoses or medications were documented. Approximately 5 months after completing the current psychotherapy process for OCD symptoms, the client consulted a psychiatrist again, this time primarily for social anxiety symptoms. He was prescribed medication (Misol = Sertraline), which he reported to be significantly beneficial in reducing both his social anxiety symptoms and the intensity of his obsessions.

Therapist and Supervisor Background

The therapist (first author) holds a master's degree in clinical psychology and received training and supervision in cognitive behavioral therapy (CBT) during his graduate education. In addition, he has served as a co-therapist in the treatment of clients with religious OCD/scrupulosity (Toprak, 2022).

The supervisor (second author) holds a PhD in clinical psychology. He completed formal training in cognitive behavioral psychotherapy and is certified as a "Cognitive Therapist" by the Academy of Cognitive Therapy (ACT). He has extensive experience in working with OCD, with a particular focus on scrupulosity.

The first author has been conducting studies for approximately 4 years, and the second author for nearly 10 years, in areas where Islam, psychology, and psychotherapy intersect. Both authors focus on the integration of Islamic sciences into psychotherapeutic practice, as reflected in their scholarly and clinical work (Çetiner & Toprak, 2025; Işık & Toprak, 2024); Karakan & Toprak, 2023; Toprak, 2018, 2022, 2024a, b; Toprak & Özçelik, 2024; Toprak et al., 2025).

They are affiliated with the Association for Psychology and Psychotherapy Research (Psikoloji ve Psikoterapi Araştırmaları Derneği), an organization that both provides and receives ongoing education in this field. Their current work continues under the auspices of this association.

Assessment and Case Conceptualization

The diagnostic assessment was conducted by the first author, a licensed clinical psychologist, through a clinical interview based on DSM-5 diagnostic criteria (APA, 2013). During the assessment, the client was found to meet the DSM-5 criteria for both obsessive–compulsive disorder and avoidant personality disorder. Thus, the prior OCD diagnosis made by a psychiatrist was confirmed. This diagnosis was supported by findings from his life history, clinical interviews, and behavioral observations. Although a structured personality inventory was not administered, the client exhibited characteristic patterns, including heightened

sensitivity to negative evaluation, social inhibition, and persistent feelings of inadequacy. These avoidant traits, evident since early childhood, were considered a potential vulnerability factor in the development of OCD. During adolescence, possibly due to his social inhibition, he tended to seek information about religious matters online rather than engage in interpersonal dialogue or seek guidance through mutual consultation. During that time, while researching religious topics online, he encountered radical interpretations regarding *alfaz-ı kufr*. Due to his shy temperament and his perception of emotional distance from his family, he was unable to share or discuss these concerns. When he attempted to express them, he was met with rejection, which further deepened his sense of isolation. His OCD symptoms began to emerge during this period. These personality characteristics—particularly experiences of isolation and a perceived lack of social support—seemed to interfere with his ability to critically engage with religious content and to develop a balanced understanding of religious responsibility.

Following the clinical assessment, and given the client's reluctance to use psychotropic medication, it was decided that psychiatric support would be reconsidered during the later stages of therapy, depending on the progression of OCD symptoms and level of functioning. The client did not take any psychotropic medication throughout the therapy process. His symptoms were formulated according to cognitive behavioral therapy (CBT) principles.

In the assessment interview, the client's primary difficulties were identified as distressing and involuntary doubts about *alfaz-ı kufr*, and the behaviors aimed at reducing the resulting anxiety. These included researching religious rulings, reciting the shahada, repenting, mentally reviewing events to gain certainty, avoiding worship to escape distressing situations, and avoiding social settings and relationships. As part of the problem formulation, triggering situations, obsessions, belief and interpretation patterns, compulsions, and avoidance behaviors were identified and organized.

Prior to beginning treatment, his OCD symptoms had worsened in response to a distressing romantic relationship and work-related stress. He reported experiencing intrusive doubts/obsessives such as: "What if I acted in a way that contradicts my religion?"—especially during conversations about religious prohibitions or when recalling his own speech and behaviors.

His related beliefs and interpretations included the following:

- "I may have approved of speech that contradicts religious principles, which would cause me to lose my faith."
- "If I don't warn others about the inappropriate language they use, I'll be held accountable."
- "There are so many words and behaviors that contradict religion that I may have unknowingly used one."
- "Regardless of my intention, saying such words—even unknowingly—would nullify my faith."
- "There should be no room for doubt or uncertainty in these matters."
- "If I don't make an effort to resolve doubts, I'll still be responsible."

The belief and interpretation themes—including perfectionism, intolerance of uncertainty, and overestimation of threat—as well as his coping strategies/compulsions (reciting the shahada, seeking religious rulings, mentally reviewing past behaviors, postponing or avoiding worship, avoiding social settings, and refraining from using words of approval such as “beautiful” or “good”) were identified as maintaining factors of the disorder.

Although the client presented with avoidant personality traits, which were considered a potential hindrance to therapeutic progress, several strengths facilitated the treatment process. These included strong motivation for therapy, good intellectual capacity, and a cooperative attitude. Together, these factors supported the development of a positive therapeutic alliance.

Measures

Yale-Brown Obsessive Compulsive Scale (Y-BOCS)–Self-Report Form

The original version of the scale was developed by Goodman et al., (1989), and the Turkish adaptation was validated by Kocoglu and Bahtiyar (2021). The first ten items assess the severity of obsessions and compulsions and are scored on a 0–4 Likert-type scale. Total scores range from 0 to 40. Cut-off scores are as follows: 0–7 = subclinical symptoms, 8–15 = mild, 16–23 = moderate, 24–31 = severe, and 32–40 = extreme (Wootton & Tolin, 2016).

Beck Depression Inventory (BDI)

Originally developed by Beck et al. (1961), the Turkish validity and reliability study was conducted by Hisli (1989). The scale consists of 21 items scored on a 0–3 Likert-type scale, measuring the severity of depressive symptoms. Total scores range from 0 to 63. Cut-off scores are 0–9 = minimal, 10–18 = mild, 19–29 = moderate, and 30–63 = severe (Beck et al., 1988b).

Beck Anxiety Inventory (BAI)

Developed by Beck et al. (1988a), the Turkish adaptation was conducted by Ulusoy et al. (1998). The scale includes 21 items scored on a 0–3 Likert-type scale, assessing the severity of anxiety symptoms. Total scores range from 0 to 63. Cut-off scores are 0–7 = minimal, 8–15 = mild, 16–25 = moderate, and 26–63 = severe (Maust et al., 2012).

The Therapy Evaluation Form

This form was developed by the authors to explore the client’s subjective experience of the therapy process. It consists of five open-ended questions addressing the client’s initial attitude toward therapy, perceived benefits, factors attributed to those benefits, and the most helpful insights gained during treatment.

Ethical Considerations

This study was conducted in accordance with the ethical principles of the Declaration of Helsinki. As the participant was a client of the first author, a formal approval from a research ethics committee was not sought. Nonetheless, all ethical guidelines relevant to single-case studies were strictly observed. Written informed consent was obtained after the participant was fully informed about the purpose and nature of the study, the procedures involved, and his rights regarding confidentiality and voluntary withdrawal at any point. The participant voluntarily agreed to the anonymized use of his data for research and publication purposes and received no compensation. Particular attention was given to addressing his religious beliefs and mental health needs with sensitivity and respect. Throughout the therapeutic and research processes, every effort was made to uphold the participant's dignity, privacy, and autonomy. Although formal ethical approval was not required, the study was carried out with rigorous adherence to ethical standards. The intervention took place in a private psychological counseling clinic that operates independently and is not affiliated with any academic or governmental mental health institution. Clinical trial number: not applicable.

Course of Therapy

The client, being a devout individual, expressed a strong desire for the treatment process to respect his religious beliefs and to proceed in a way that would not compromise his faith. In response to this request, the therapy was structured within the framework of cognitive behavioral therapy (CBT), while also integrating relevant religious references and content throughout the treatment. The following treatment protocol outlines the specific stages at which religious references were consulted, the types of religious information that were included, and how these elements were incorporated into the therapeutic interventions. In terms of structure, the therapy process consisted of weekly, face-to-face sessions, each lasting approximately 50 min. A total of 26 sessions were conducted over a period of 26 weeks. The client was not taking any psychotropic medication during the course of therapy, and no pharmacological intervention was implemented throughout the treatment process. The intervention was not based on a manualized CBT protocol; rather, it followed core CBT principles—including cognitive restructuring and exposure with response prevention (ERP)—and was flexibly adapted to the client's religious and clinical needs.

Sessions 1–2

In the first two sessions, a clinical evaluation and differential diagnosis were conducted based on DSM-5 criteria. The client was assessed to meet the diagnostic criteria for obsessive–compulsive disorder (OCD) and, additionally, avoidant personality disorder. To evaluate symptom severity, the following self-report measures

were administered: the Yale-Brown obsessive compulsive scale (Y-BOCS) for OCD symptoms, the Beck depression ınventory (BDI) for depressive symptoms, and the Beck anxiety ınventory (BAI) for anxiety symptoms. The client's OCD symptom severity (Y-BOCS = 31) was at the upper end of the "severe" range. His depressive symptoms (BDI = 19) fell within the "moderate clinical depression" range, while anxiety symptoms (BAI = 6) were in the "subclinical" range.

Session 3

This session aimed to provide psychoeducation on obsessive–compulsive disorder (OCD) and avoidant personality disorder (APD). OCD-related complaints were identified as the client's primary area of concern. An introduction to the cognitive-behavioral model of OCD was provided. Within this framework, the three core components of OCD symptom formulation were explained: (1) the triggering situation, (2) the obsession, and (3) the compulsion, avoidance behavior, or neutralization. An example formulation was completed collaboratively during the session. As homework, the client was asked to organize his own symptoms and experiences using this three-component model in preparation for the next session.

Session 4

This session aimed to review and expand the client's symptom formulation. The three-component formulation the client had prepared as homework was reviewed; necessary revisions were made, and incomplete parts were completed collaboratively. In this session, the formulation was expanded by adding two new components: (a) beliefs and interpretations about obsessions and (b) emotional/physiological responses. As a result, the updated formulation consisted of five elements: (1) the triggering situation, (2) the obsession, (3) the belief/interpretation related to the obsession, (4) the emotional or physiological reaction, and (5) the resulting compulsion, avoidance behavior, or neutralization. An example was completed together during the session. As homework, the client was asked to revise his previous examples by incorporating the two new components and to complete any missing elements before the next session.

Session 5

This session aimed to consolidate the five-component formulation and introduce the complete OCD symptom cycle. The client's previously prepared five-component formulations were reviewed; necessary revisions were made, and incomplete sections were completed collaboratively. Additional attention was given to the "beliefs and interpretations related to the obsessions" component, and the missing elements in this area were addressed. In this session, two additional components were introduced to complete the OCD cycle: (a) the temporary sense of relief following a compulsion or avoidance behavior, and (b) increased attentional sensitivity and vigilance toward related stimuli after the relief fades. With these additions, the updated

formulation consisted of seven elements: (1) the triggering situation; (2) the obsession; (3) the beliefs and interpretations about the obsession; (4) anxiety/distress and physiological reactions; (5) the compulsion, avoidance behavior, or neutralization; (6) temporary relief; and (7) increased attentional sensitivity toward similar triggers. Example formulations based on this extended model were completed together during the session. As homework, the client was asked to complete any remaining parts before the next session.

Session 6

This session aimed to initiate cognitive interventions by identifying and prioritizing the key targets within the OCD symptom cycle. The client's previously completed seven-component OCD cycles were reviewed, and necessary revisions were made. The structure and progression of the upcoming treatment process were explained using this seven-component model. It was emphasized that therapeutic interventions would primarily focus on two core components of the cycle: (a) the beliefs and interpretations about obsessions and (b) compulsion/avoidance/neutralization behaviors. Cognitive interventions began with the *beliefs and interpretations about obsessions* component. In this context, six common maladaptive belief domains observed in individuals with OCD were introduced: *inflated responsibility*, *overimportance of thoughts/thought–action fusion*, *beliefs about the importance of controlling one's thoughts*, *overestimation of threat*, *intolerance of uncertainty*, and *perfectionism* (Obsessive–Compulsive Cognitions Working Group, 1997). The client was then invited to consider which of these maladaptive belief patterns felt familiar or applicable to his own beliefs and interpretations about obsessions. His reflections and evaluations were discussed, and feedback was provided. As homework, the client was asked to review the *beliefs and interpretations about obsessions* component within each of his seven-component OCD cycles and to identify any relevant maladaptive belief domains.

Session 7

This session aimed to deepen cognitive restructuring by identifying thematic patterns in the client's interpretations and by introducing the concept of intrusive thoughts. The client's completed work was reviewed; necessary revisions were made, and missing sections were completed collaboratively. Based on this review, the most prominent maladaptive belief themes within his *beliefs and interpretations about obsessions* were identified as *perfectionism*, *intolerance of uncertainty*, and *overestimation of threat* (for clarity and brevity, this component will hereafter be referred to as interpretations). To foster insight and normalization regarding the nature of intrusive thoughts, psychoeducational content was presented using findings on the prevalence of intrusions in non-clinical populations (Purdon & Clark, 1993). This intervention was conducted through Socratic questioning and guided discovery. Following this, the process by which intrusions develop into obsessions

and contribute to the onset of OCD was explained using cognitive-behavioral principles. Client feedback indicated that the intended normalization effect had been achieved.

Session 8

This session aimed to further enhance the client's experiential understanding of the nature of obsessive thoughts. The session began with a brief review of the insights gained in the previous session. A new intervention was then introduced to help the client better grasp the nature of obsessional thinking. This involved a two-stage thought suppression experiment inspired by Wegner (2011): first, the client was instructed "not to think of a white bear", and second, "to think of nothing but a white bear". The exercise was conducted using Socratic questioning and guided discovery. Through this intervention, the client experientially discovered that it is not possible to fully control one's thoughts, that trying to think continuously about a single topic or forbidding oneself from thinking about something both tend to fail, and that attempts to suppress unwanted thoughts can paradoxically increase their frequency. Together with previous psychoeducation and normalization interventions, this experiential exercise aimed to deepen the client's awareness of intrusions, obsessions, and the natural functioning of the mind.

Session 9

This session aimed to address the client's perfectionism-themed interpretation errors related to his obsessions. Some of these interpretations included the following: "No matter what my intentions were when I said the word, it would cause me to lose my faith, even if unknowingly.", "I should not give room for doubt and uncertainty in these matters.", and "If I make no effort to deal with situations in which I have doubts, I will also be responsible." The cognitive intervention began by exploring the effects of *perfectionism* in the client's daily life. This was followed by an evaluation of the short- and long-term consequences of his perfectionistic tendencies, both in everyday contexts and religious practice. In the final part of the session, the impact of the client's perfectionistic expectations and efforts regarding *alfaz-ı kufr* (a term in Islamic theology referring to utterances or actions believed to nullify one's faith) became more apparent. To consolidate this work, the client was asked to research both the concept of *alfaz-ı kufr* and the perfectionistic attitudes associated with it. Specifically, he was encouraged to explore relevant religious recommendations and the perspectives of respected religious figures, and to bring the information he gathered to the next session.

Session 10

This session aimed to build on the client's previous assignment by integrating his religious findings into a structured therapeutic intervention. As part of the task assigned in the previous session, the client brought materials he had gathered

regarding both *alfaz-ı kufr* and the perfectionistic attitudes associated with these concerns. These resources—drawn from religious references and the perspectives of respected religious figures—were reviewed together and served as the foundation for the intervention introduced in this session. Based on this work, a structured worship program was developed as an alternative to perfectionism-driven compulsive behaviors:

Religious Intervention 1: Sustainable Righteous Deeds and Worship Program

Guided by the hadith "Actions are according to intentions," which the client had brought through his own research, the discussion centered on what best leads to *divine approval*: striving for literalistic avoidance of any utterance suspected of being *alfaz-ı kufr*, or engaging in meaningful and sustainable acts of worship—such as non-obligatory prayers, dhikr, and voluntary charitable acts (such as *sadaqah* or other forms of giving). The client chose to adopt the latter approach and selected religious practices supported by the sources he had studied. He expressed readiness to begin incorporating these actions into his daily life. He was encouraged to finalize the draft of his personalized worship plan by making any necessary adjustments and to begin implementing at least one sustainable righteous deed each day.

Session 11

This session aimed to address the client's intolerance-of-uncertainty-themed interpretation errors related to his obsessions. Some of these interpretations included the following: "I may have approved with the words that do not take into account the provisions of the religion; this will cause me to lose my faith." The session began with a review of the client's ongoing engagement with the Sustainable Righteous Deeds and Worship Program. The client reported that he had taken a small but meaningful step toward engaging in reasonable, sustainable, and recommended religious actions, and expressed a desire to gradually increase them. He was given feedback on his efforts and was encouraged to maintain this practice as an integrated part of the therapeutic process. The intervention began by collaboratively identifying common situations in daily life that naturally involve uncertainty. Step by step, the client was guided to recognize that uncertainty is an unavoidable part of life, and that he already tolerates it in many areas—such as at work, at home, and in social settings. Next, the client was supported in identifying the coping strategies he uses in those situations (e.g., making assumptions, continuing with daily tasks, accepting ambiguity). These strategies were then discussed in terms of how they could be transferred to religious contexts where uncertainty was perceived as more threatening. To consolidate the work, the client was asked to research religious principles related to tolerating uncertainty, as well as the practices of respected religious figures, and to bring his findings to the next session.

Session 12

This session aimed to deepen the work on intolerance-of-uncertainty-themed interpretation errors by integrating religious content and addressing the client's difficulties in seeking religious knowledge in ambiguous situations. The session began with a discussion of the client's findings from his research assignment. Together, examples of tolerance for uncertainty found in religious references and the practices of respected religious figures were reviewed. Through this process, the client gained a clearer understanding that the application of religious principles can vary depending on context, intention, individual circumstances, and the nature of the situation. It was also discovered that some of the uncertainties the client struggled to tolerate were linked to ambivalence resulting from limited religious knowledge. This led to a religiously integrated intervention:

Religious Intervention 2: Religious Uncertainty Management Plan

The client's usual methods for obtaining religious knowledge were explored, along with his approach when encountering uncertainty. It became apparent that he habitually consulted a wide range of sources and believed that there must be a specific ruling for every specific situation—and that he was personally responsible for finding it. This unrealistic expectation was formulated as another manifestation of his intolerance of uncertainty. Together, the client and therapist reformulated his areas of uncertainty into concrete questions. Instead of persistently searching multiple sources or seeking definitive rulings for every possible scenario, the client was encouraged to consult a trusted religious authority or institution of his choice and to ask the questions developed during the session. This step was also designed to help the client build the ability to engage with religious authorities without compulsive reassurance-seeking or avoidance. In doing so, he would be more capable of seeking functional religious guidance post-therapy when needed, without reinforcing OCD-related behaviors (Abramovitz & Jacoby, 2014). The client was asked to note the responses he received and to bring them to the next session for review.

Session 13

This session aimed to continue the Religious Uncertainty Management Plan and to address the client's interpretation errors related to overestimation of threat. The session began by reviewing the client's follow-up on the previous assignment. The client reported that he had consulted with a trained religious scholar to seek clarification on his religious concerns. He shared that he was able to ask his questions and received clarifying and perspective-giving feedback. The scholar explained that the client's condition is known in Islamic literature as "waswasa" and that some individuals may experience such fears. However, the scholar emphasized that there was no religious basis for the client to view himself as being in danger or at risk of faith loss. Rather than attempting to analyze every behavior and statement or engage in constant searches for religious rulings, the scholar advised the client to continue

participating in his medical and psychological treatment. The client noted that this information was comforting, though he still experienced occasional doubt and distress. He was reminded to apply the principles of tolerance for uncertainty specifically in those moments and to engage in corresponding behavioral responses.

After mutual agreement, this session aimed to address the client's overestimation of threat-themed interpretation errors related to his obsessions. Some of these interpretations included the following: "…which would cause me to lose my faith," "…I'll be held accountable," and "…it would nullify my faith, even if unknowingly." A new cognitive intervention was initiated to address these interpretation errors. As part of this intervention, the actual nature of the problem the client was currently experiencing was explored through Socratic questioning. Two alternative problem definitions were explored: (a) "I am a careless, ignorant, and inattentive person regarding religious matters, which puts me in real danger. My fears are justified, and I must remain vigilant to avoid losing my faith and being punished with eternal hellfire"; (b) "I am a person with OCD, and the anxiety and doubts I experience stem from this disorder. I already possess adequate religious knowledge and sensitivity." For each of these definitions, the following questions were addressed collaboratively during the session: (1) What are the pieces of evidence supporting this definition? (2) If this is the problem, what actions would be necessary? (3) What would be the long-term consequences of taking such actions? (4) What does this problem definition imply about the kind of person you are? After the first four questions were answered collaboratively during the session, a fifth question was added as a transition to the next religiously integrated intervention: "What does this definition suggest about the image of God in Islam?". The client was asked to research Islamic references and the views of respected religious figures to explore what image of God is presented in Islam. He was instructed to bring his reflections to the next session as a preparation for the religiously integrated intervention planned for the following session.

Session 14

This session aimed to help the client reflect on how his perception of God differed depending on which problem definition he adopted. Accordingly, a religiously integrated intervention was initiated:

Religious Intervention 3: Reconstructing the Image of God Based on Islamic Teachings

The information the client had gathered was reviewed during the session. He stated that the image of God significantly differed depending on which problem definition he endorsed. He recognized that when he adopted the first definition, he tended to hold a perception of God as *"rule-based and punitive*." In contrast, he recalled that Islamic sources frequently emphasize God's infinite mercy, forgiveness, and His concealment of faults. These insights were discussed and evaluated together with the client. Based on the information he obtained, the client expressed the following

reflections: “Disbelief does not occur unknowingly or unintentionally. Our Lord forgives our mistakes, as long as we do not act in ignorance deliberately.” He added: “In Islam, forgetfulness is considered a valid excuse. Instead of constantly focusing on these matters, it is more appropriate to stay generally mindful and entrust the rest to Allah.” As a result of this process, the client gained increased clarity that the second problem definition—attributing the symptoms to OCD—was more accurate. With this, the intervention was concluded. At the end of the session, the client was informed that a new intervention would be introduced in the following session. He was encouraged to review previous therapy notes to refresh his memory in preparation for this upcoming phase, and the session was then concluded.

Session 15

This session aimed to prepare the client for the transition from cognitive to behavioral interventions by introducing the treatment rationale for exposure and response prevention (ERP). At the beginning of the session, the cognitive-behavioral formulation model of OCD was reviewed. The client was reminded that the previous work had focused on misinterpretations related to obsessions within this model. It was explained that from this point forward, the interventions would shift toward the behavioral domain, focusing on compulsions, reassurance-seeking, avoidance, and neutralization behaviors. A Socratic dialogue was used to explore what kinds of internal reactions the client might experience when he stops engaging in compulsive and avoidant behaviors. This was followed by psychoeducation on the time-based course of distress and anxiety, including the roles of the sympathetic and parasympathetic nervous systems. Based on this information, the rationale for exposure and response prevention (ERP) therapy was introduced. After the client’s questions were addressed, a list of the client’s compulsive and avoidant behaviors was initiated. The anticipated distress resulting from stopping these behaviors was used to construct a graded hierarchy from least to most difficult. The client was assigned the task of completing any missing items on the list and was encouraged to attempt the easiest (i.e., least distressing) target before the next session.

Session 16

This session aimed to support the client in implementing ERP tasks and to strengthen his understanding of the principles necessary for their effective execution. The client’s previously developed hierarchy was reviewed, and the progress of ERP implementation was discussed. Emphasis was placed on key nuances necessary for the correct application of ERP. The client was further informed about common mistakes that may reduce the effectiveness of the intervention. He was encouraged to monitor and record how his anxiety and distress levels change over time during exposure tasks. Avoidance of worship had already significantly diminished prior to the ERP phase. Therefore, such behaviors were not included in the ERP task hierarchy presented in this session.

Sessions 17–25

During these sessions, the client's ERP process was regularly monitored, and his weekly experiences were explored in detail. Particular attention was given to what the client noticed, discovered, and learned throughout this process, as well as to the changes he reported in his daily life. Feedback was provided as needed. Over the course of these nine sessions, the client successfully completed his exposure targets. By the end of this phase, he reported that his life had largely returned to normal.

ERP tasks were conducted as homework rather than in-session exercises; however, the client's experiences were reviewed and discussed thoroughly each week. He was encouraged to monitor his distress levels during each exposure and to repeat the task until discomfort dropped below a manageable threshold. SUDS ratings were actively re-evaluated and recorded throughout the sessions to monitor progress and habituation.

The exposure hierarchy included compulsive behaviors—such as repeated repentance, checking for blasphemy or disrespect in speech, scanning bodily sensations and facial expressions, seeking verbal reassurance, and conducting extensive religious research—that were consistently performed in response to obsessional fears. As stated in the first row of Table 1 (Exposure and response prevention hierarchy list), each task was designed to elicit obsessional distress while simultaneously preventing the associated compulsive responses.

To support this process, the client was initially provided with a structured tracking form. This form included items such as "Triggering situation," "Feared worst outcome," and "Did the feared outcome occur?" In addition, the client was instructed to record his distress levels beginning in the first 5 min and then at 15- and 30-min intervals for up to 4 h.

Table 1 Exposure and response prevention hierarchy list. The target is to stop performing compulsions (e.g., repeated repentance, analysis of speech/body language/behavior, and detailed religious research) in the following situations

Situation	SUDS*
When a song containing religiously forbidden content or explicit *alfaz-ı kufr* is played in the environment	9
After saying "beautiful" about something containing religiously forbidden (e.g., a movie)	8
After beginning an activity suspected to be religiously forbidden by saying the Basmala	7
When a song suspected to contain *alfaz-ı kufr* is played	6
After hearing irreverent religious speech and participating in the conversation	5
When obsessional doubts about past events arise- stopping engagement in retrospective mental review	4
After describing something potentially religiously forbidden as "beautiful" or "good."	3
After leaving an environment where irreverent religious speech took place	2
After expressing satisfaction with something that contains forbidden elements (e.g., saying "it was a beautiful trip" despite a part of the trip involving backbiting)	1

*SUDS: Subjective Units of Distress Scale

The beliefs tested throughout the ERP process concerned the client's anticipated distress-related outcomes if he refrained from performing compulsions or rituals—such as what he feared might happen if he tolerated the discomfort without engaging in his usual responses. At the end of each exposure task, the client recorded whether the feared consequence had actually occurred. While he used the form consistently during the early phase of ERP, he later discontinued formal tracking but continued to carry out the tasks as planned.

Session 26

In this final session, the knowledge and skills gained throughout the treatment process were reviewed. A relapse prevention plan was developed, and specific steps to follow in case of future difficulties were identified. The therapy process was formally concluded. Follow-up assessments were conducted by contacting the client at 5 and 9 months after the end of treatment.

Outcomes

The scale scores obtained from the client at the start of therapy and during follow-up assessments are presented in Fig. 1.

1. Monitoring OCD Symptom Severity

The client's OCD symptom severity was monitored throughout the treatment using the Yale-Brown obsessive compulsive scale (Y-BOCS). The scores obtained are presented in Fig. 1. As shown in the graph, OCD symptoms, which initially fell at the upper end of the *severe* range (24–31 points), began to decline even before the ERP phase and reached the *mild* range (8–15 points) by the end of ERP. At the first follow-up, conducted 5 months after treatment, symptoms had risen to the *moderate* range (16–23 points). However, by the second follow-up at 9 months post-treatment, symptoms had once again declined to the *mild* range.

2. Monitoring Symptoms of Depression and Anxiety

The client's symptoms of depression and anxiety were monitored throughout the treatment using the Beck depression ınventory (BDI) and the Beck anxiety ınventory (BAI). The scores obtained are presented in Fig. 2. The graph indicates that the client's depression symptoms steadily decreased from a *mild clinical* level (19 points) at the start of therapy to a *subthreshold* level (4 points) by the end of treatment. In contrast, while anxiety symptoms were initially below the clinical threshold, they gradually increased, reaching a *severe* level (35 points) at the 9-month follow-up.

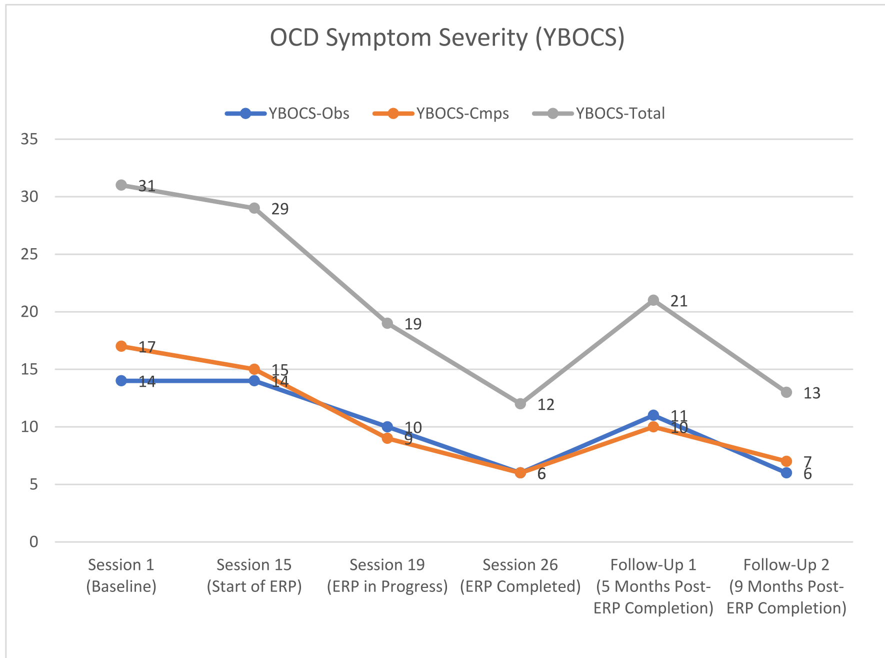

Fig. 1 Changes in Y-BOCS scores over the course of treatment. This figure illustrates the changes in Y-BOCS obsession and compulsion subscale scores observed in the client from the baseline assessment through to the second follow-up

3. Qualitative Data

At the end of the therapy, the client was asked to complete a qualitative questionnaire developed by the researchers. The aim of the questionnaire was to explore the client's overall experience with the current therapeutic process, beginning with past treatment attempts, the extent of benefit perceived from this therapy, and the factors contributing to that benefit. The information obtained through this questionnaire is summarized below.

(a) Attitudes Toward Seeking and İnitiating Treatment:

> "At first, I felt ashamed about consulting a specialist for my OCD symptoms. However, I motivated myself by thinking that what I was experiencing was normal and eventually decided to go. Since my main concern was related to alfaz-ı kufr, I assumed the psychiatrist would not understand these issues. Therefore, I chose to disclose only the less distressing obsessions related to ablution. At the same time, I was deeply unsettled by the possibility that I might give the impression that religion has a pathological influence on individuals (hasha, Allah forbid). For this reason, in subsequent visits to psychiatrists, I consistently tried to minimize the severity of my problems. Even when I wasn't feeling any better, I acted as though I was improving.

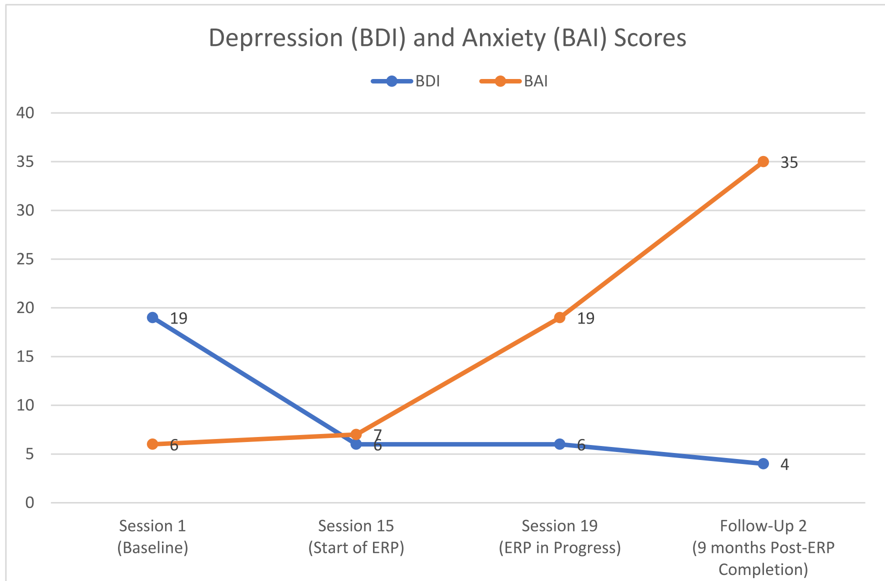

Fig. 2 Changes in BDI and BAI scores over the course of treatment. This figure illustrates the changes in the client's BDI and BAI scores from the baseline assessment through to the second follow-up

> Although I did share a little with Mr. ***, I couldn't fully open up because I felt a sense of embarrassment toward him.
> Even though the first psychiatrist I saw, Ms. ***, said, "We have clients like you as well; you've approached this quite consciously," I did not feel at ease. I didn't feel understood. I can say that my later experiences were similar to this one."

The client's statements reveal several barriers encountered during the process of seeking professional help for OCD symptoms. While fear of not being understood is a common experience among individuals with OCD, the client's perception that the attitudes of the professionals he consulted were not reassuring appears to have hindered his treatment adherence. In particular, the concern about creating a negative impression of religiosity seems to have contributed to additional hesitation in seeking help, which is often observed among individuals with strong religious sensitivity. This was evident in the client's account of a psychiatrist who remarked, "We have clients like you as well; you've approached this quite consciously," after which the client still reported, "I did not feel at ease." This reaction may reflect a form of premature reassurance or normalization that, although intended to be comforting, lacked the attuned curiosity and space necessary to fully explore the client's religious concerns. These factors led the client to downplay his symptoms and conceal his actual distress, thereby limiting his full engagement in the therapeutic process. Furthermore, the client's lack of trust in the mental health services he received appears to have contributed to his continued reluctance to disclose symptoms in later stages. His avoidant personality

traits also seem to have reinforced these barriers, further complicating the process of seeking and receiving psychological support.

(b) Perceived Benefits of the Current Psychotherapy.

> "I did benefit from the therapy, alhamdulillah. First of all, I realized that I was truly understood, and that alone brought me great relief. Later on, especially through interventions targeting interpretation errors in scrupulosity, the impact and credibility of the disorder significantly diminished. I came to understand how one's interpretations can shape everything in the mind, and this was particularly comforting in relation to scrupulosity. Therapy also helped me recognize my own self-worth. I began to realize that my time and energy are valuable, and that spending them on unnecessary matters was a mistake. This awareness was especially helpful for my social anxiety. I used to judge myself very harshly—sometimes I still do—but I can say that I've developed a greater awareness about being more compassionate toward myself. I've started to think that always focusing on the negative side of things doesn't make sense. Life is not as bad as I thought, and the future isn't as hopeless as I feared. I also believe that the therapy was effective because the therapist was well-trained, knowledgeable, and had clearly invested effort in scrupulosity. I felt that they treated me with great dedication. Moreover, I was also very attentive and motivated, especially during our work on scrupulosity—because overcoming OCD had once felt like an unattainable dream. For the first time, I felt genuinely hopeful."

The client's feedback demonstrates the multidimensional positive effects of psychotherapy on scrupulosity. First, the client emphasized a sense of being understood—an experience they attributed to the therapist's knowledge and sensitivity regarding scrupulosity. In the client's view, the therapist's competence, effort, and dedication contributed significantly to perceiving the therapeutic process as trustworthy and effective. Cognitive restructuring and interventions targeting interpretation errors helped the client question the credibility of his obsessions and recognize how his thoughts shaped his experiences. This highlights the effectiveness and importance of cognitive strategies prior to introducing behavioral interventions such as exposure and response prevention (ERP). The client's expression of having benefited from therapy—and doing so with joy—suggests that the process was not only effective, but also personally meaningful and transformative. The client also emphasized the role of his own effort and active participation in the healing process, underscoring the contribution of personal responsibility to therapeutic outcomes. One of the most notable therapeutic gains was that the reduction in OCD symptoms extended beyond obsessions and compulsions, fostering positive changes in broader domains such as worldview, time management, and value orientation. Moreover, the client reported becoming aware of the impact OCD had on his social withdrawal and stated that therapy had also been helpful in addressing this aspect. Finally, the client noted that—for the first time—they had experienced such a strong sense of hope. This indicates that therapy not only alleviated symptoms but also enhanced psychological flexibility and promoted a more optimistic outlook toward the future.

In conclusion, the impact of therapy extended beyond the symptom level, creating transformative change across multiple dimensions—including cognitive flexibility, social functioning, and self-compassion—ultimately enhancing the client's overall quality of life.

(c) Feedback on Religious İnterventions.

1. Sustainable Righteous Deeds and Worship Program:

> "It felt quite good. I came to a deeper understanding that worship is not merely about form. For example, at one point, I set a goal for myself to perform dhikr 100 times for each compulsion I experienced. Later, I stopped setting a quantitative target and realized that what initially brought me peace had turned into something burdensome due to OCD." Implementing a reasonable program of righteous deeds and worship "helped me grasp the essence of worship, which in turn reduced the credibility of OCD. I came to better understand what it means that 'Satan approaches from the right' (he deceives even through seemingly righteous concerns). I also developed the habit of turning to prayer and supplication, especially during moments of distress. Even when I don't engage in extra acts, I make an effort to preserve the ones I already practice whenever I sense the risk of compulsions. I also try to prioritize being of benefit to others."

The client's reflections reveal a growing awareness of how scrupulosity had distorted his relationship with worship and religion. The therapeutic process supported a transformation in which religious practices, once experienced as compulsive burdens, became a source of inner peace and meaning. Despite having felt satisfaction in performing religious duties from an early age, the client realized that OCD had imposed rigid, formalistic, and quantitative demands that turned worship into a source of distress and mental exhaustion. Over time, however, the client discovered that focusing on the spiritual essence of worship made it possible to move away from these obsessive patterns. He came to understand that performing religious rituals with compulsive precision was not a requirement of genuine faith. In particular, recognizing the concept of *Satan approaching from the right* enabled him to realize that religious intrusive thoughts were not signs of piety, but rather a form of deception. This insight helped him reduce his compulsions. He also began to engage in practices such as dhikr, prayer, and helping others—not as ways to neutralize anxiety, but as genuine spiritual acts aimed at cultivating inner peace. Instead of creating additional obligations, he began to see consistency and care in his existing religious routines as sufficient. Altogether, these changes indicate that the client moved away from the rigid cognitive structure imposed by OCD and developed a more flexible, conscious, and spiritually fulfilling approach to religious practice.

2. Religious Uncertainty Management Plan

> "At first, I naturally struggled a lot, but later I realized that religion is not something to be lived constantly on edge. I learned that Allah's mercy is vast—that even if I follow a fatwa that turns out to be incorrect, He can still forgive me. This realization kept me from relying on artificial means of self-reassurance. In the long run, it brought genuine comfort. For example, for quite some time

> now, I haven't felt the need to read anything about the issue of alfaz-ı kufr. I no longer investigate doubts that come to my mind—unless they are entirely new. As I mentioned, it has been a long time since I've felt the urge to consult others or seek out religious texts about alfaz-ı kufr."

The client's reflections demonstrate how his persistent need for reassurance regarding religious rulings gradually diminished, giving way to the development of an internal sense of balance. Initially, he struggled to commit to a single fatwa, but over time, realizing that Allah's mercy is vast—and that even an error could be forgiven—allowed him to approach religious rules with greater flexibility and inner peace. This shift in understanding supported his transition from compulsively seeking information to relying on a self-developed strategy grounded in spiritual trust and emotional regulation. In particular, he adopted a principle of not investigating religious doubts unless they were entirely new, which helped break the obsessive–compulsive cycle and reduce the intensity of his need for religious certainty. In the long term, this approach enabled the client to manage obsessive thoughts more effectively. The disappearance of his constant search for fatwas contributed to the establishment of a healthier and more balanced relationship with religious concerns.

3. Reconstructing the Image of God Based on Islamic Teachings

> "The sentence that stayed with me most from the therapy was this: the therapist told me that my deeds were incomplete—and that it was Allah (swt) who would complete them. I realized that I had been acting as if I were trying to leave no room for that. In fact, I came to understand that I had overstepped my bounds as a servant and had mistaken this for piety. This realization lifted a heavy burden from me. I feel more at peace now. Additionally, the therapist's consistent emphasis on Allah's mercy helped me recognize that this was something I had been lacking in my own perception. It played an important role in correcting the distorted beliefs in my mind. Although I didn't expect such an outcome when I began therapy, it turned out to be very beneficial for me."

The client's reflections illustrate how the therapist's active use of religious knowledge—particularly the consistent emphasis on Allah's mercy—contributed to a meaningful shift in the client's religious understanding. Initially, his rigid commitment to performing acts of worship without any perceived deficiency had placed him under intense psychological pressure. However, coming to the realization that it is Allah (swt) who completes what His servant cannot helped him relinquish this burden. The therapist's reminders of Allah's mercy were especially impactful—not by introducing new theological concepts, but by drawing the client's attention back to what he already knew through his own religious learning. This reactivation of knowledge about divine forgiveness helped him see that his excessive efforts to compensate for possible errors were not a requirement of sincere faith, but rather reflections of scrupulosity. Although the client entered therapy primarily seeking relief from his obsessions, he ultimately experienced a deeper transformation in his perception of God. This unexpected but profound outcome allowed him to approach religious practice from a more balanced and peaceful perspective—guided not by fear and over-responsibility, but by trust, humility, and spiritual clarity.

Discussion

The client's symptoms of scrupulosity, conceptualized as manifestations of obsessive–compulsive disorder (OCD), were addressed within the framework of cognitive-behavioral therapy (CBT), and treatment was implemented with the integration of religious interventions, particularly during the cognitive restructuring phase.

Based on six measurement points, the client's obsession severity demonstrated a steady decline over the course of treatment. Although a slight increase was observed in the 5-month follow-up compared to the post-treatment measurement, a marked reduction was once again evident at the 9-month follow-up. Overall, the findings suggest that CBT combined with religiously integrated interventions contributed significantly to the reduction in obsession severity. This outcome is consistent with previous findings in the literature (Akuchekian et al., 2015; Omranifard et al., 2011). The client expressed this reduction with the following words: "…especially through interventions targeting interpretation errors in scrupulosity, the impact and credibility of the disorder significantly diminished." "…for quite some time now, I haven't felt the need to read anything about the issue of alfaz-ı kufr (discourses or behaviors believed to invalidate one's faith). I no longer investigate doubts that come to my mind—unless they are entirely new. As I mentioned, it has been a long time since I've felt the urge to consult others or seek out religious texts about alfaz-ı kufr." The literature highlights the importance of the therapist's sensitivity and knowledge in addressing religious concerns (Abramowitz & Jacoby, 2014). Supporting this, the client noted that in previous treatment experiences, he did not feel safe and thus avoided disclosing his symptoms fully. In contrast, during the current intervention, he felt understood due to the therapist's religious sensitivity and knowledge, which allowed him to open up.

The severity of compulsions followed a pattern parallel to that of obsessions across six measurement points. A slight increase was observed at the 5-month follow-up, but a substantial decrease was recorded again at the 9-month point. These results are consistent with studies showing reductions in both obsessions and compulsions in clients who received CBT or religiously integrated CBT (Aouchekian et al., 2017; Toprak, 2022). The client described this change by saying, "I still have difficulties from time to time. But the severity has decreased considerably."

Depressive symptoms were assessed at four time points and showed a steady decline, reaching subthreshold levels. This improvement can be attributed to the reduction in OCD symptoms. Previous research has demonstrated a similar pattern, where decreases in depressive symptoms occur alongside OCD symptom reduction (Haland et al., 2010; Toprak, 2022; Toprak & Emül, 2016). The following quote from the client illustrates this emotional relief: "The therapist told me that my deeds were incomplete—and that it was Allah (swt) who would complete them. I realized that I had been acting as if I were trying to leave no room for that. In fact, I came to understand that I had overstepped my bounds as a servant and had mistaken this for piety. This realization lifted a heavy burden from me. I feel more at peace now."

Anxiety symptoms, on the other hand, were assessed at four points and showed a gradual increase over time, peaking at the 9-month follow-up. This finding

contrasts with the other clinical outcomes and appears inconsistent with the literature (e.g., Haland et al., 2010; Şafak et al., 2014; Toprak, 2022). However, client feedback clarified that the rise in anxiety was related to life stressors such as the transition to marriage, new responsibilities, a job change, and adapting to a new work environment. Additionally, the increase in anxiety may also be associated with the reduction of avoidance and compulsive behaviors. It is a well-documented phenomenon that anxiety often intensifies during the ERP phase, including the experience of somatic symptoms (Foa & Kozak, 1986). Although the identified life stressors could reasonably be expected to trigger a relapse of OCD symptoms (Rosso et al., 2012), this was not observed in the present case. Instead, the client reported an increase in anxiety symptoms. This may be viewed as a noteworthy and potentially meaningful observation, which could indicate that the disorder was effectively treated. It may also suggest that the client was able to draw upon the skills acquired during therapy to regulate distress without reverting to avoidance or compulsive behaviors typically associated with OCD.

Conclusion

The client's feedback aligns with key findings in the literature on individuals with scrupulosity. First, the client reported ambivalence about seeking treatment, primarily due to concerns about being perceived as strange or misunderstood. Additionally, because his OCD symptoms were religious in nature, he expressed heightened concerns about misrepresenting religiosity and reported feeling that his problems were not understood in previous treatments. From this perspective, offering clients with scrupulosity, a treatment environment that clearly communicates respect and sensitivity toward their religious concerns, can significantly enhance their motivation to engage in therapy. While CBT is a well-established treatment for OCD, the client's attributions of therapeutic benefit were primarily directed toward interventions with religious content, rather than typical CBT techniques. Religious content-based interventions contributed meaningfully to the client's transformation in his image of God, his perceived hierarchy of religious obligations, and his understanding of the essence of worship. These interventions supported his functionality in both general life and religious life.

Limitations and Future Research

The primary limitation of this study is that it is based on a single case, which limits the generalizability of the findings. Another limitation is the absence of a scale specifically designed to assess scrupulosity. Although the PENN Inventory of Scrupulosity and its Turkish adaptation are available, this measure was not used due to several limitations noted in the literature—namely, that it may lack cultural validity in non-Christian populations (Huppert & Fradkin, 2016), may insufficiently assess compulsions (İnözü et al., 2017), and includes items that may be affirmed by devout Muslim individuals due to their religious sensitivity, which may lead

to underrepresentation of clinical improvement—as observed in one study where symptom reduction reflected in Y-BOCS scores did not appear in PENN scores (Toprak, 2022). Finally, the client began pharmacological treatment after the 5-month follow-up, and its contribution to the reduction in symptoms at the 9-month measurement should not be overlooked.

Future studies should explore the careful integration of mental health services with culturally and religiously sensitive approaches, ideally through collaborations with qualified religious scholars. Public awareness campaigns using mass communication tools may also help reach individuals with scrupulosity who hesitate to seek treatment. More generalizable results can be obtained through randomized controlled trials testing similar intervention models.

Key Points for Pactitioners

- This case study indicated that a client with scrupulosity experienced ambivalence about seeking treatment, primarily due to fear of being misunderstood or stigmatized. The client was concerned that his religious concerns might be dismissed by mental health professionals. This highlights the importance of establishing a safe and non-judgmental space where the client can feel encouraged to express his concerns openly.
- Scrupulosity, or religious OCD, typically involves an intense fear of committing sin and the performance of compulsive rituals to prevent perceived religious transgressions. In this case, an in-depth understanding of the client's specific religious framework contributed to more effective and ethically appropriate treatment.
- The client also expressed hesitation about entering therapy out of fear that discussing his symptoms might reflect negatively on his religion. Practitioners working with similar cases may consider explicitly conveying respect for the client's religious beliefs and emphasizing that the goal is to treat the disorder—not to critique any faith tradition.
- The case further suggested that some individuals may be unaware that such symptoms are treatable, or that psychotherapy can align with religious values. Community outreach and psychoeducational efforts that highlight the availability of religiously sensitive therapeutic approaches may help reduce stigma and facilitate earlier treatment-seeking.

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Author Contributions Yakup Işık was responsible for the investigation, including the therapy process, and drafted the original version of the manuscript. Taha Burak Toprak contributed to the conceptualization of the study, supervised the overall research process, and provided critical revisions during the review and editing of the manuscript. Both authors reviewed and approved the final version of the manuscript.

Data Availability The data that support the findings of this study are not publicly available due to privacy and ethical considerations, but are available from the corresponding author upon reasonable request and with approval from the relevant ethics committee.

Declarations

Conflict of Interests The authors declare no competing interest.

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