European Journal of Trauma & Dissociation 8 (2024) 100441

Contents lists available at ScienceDirect

European Journal of Trauma & Dissociation

journal homepage: www.elsevier.com/locate/ejtd

Case Report

Case Report: Recovery from sexual assault: A religion-adapted cognitive behavioral therapy for a woman sexual assault survivor

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Introduciton

Long-term prevalence estimates for PTSD among female victims of sexual assault vary from 54.8 % (Oosterbaan et al., 2019) to 70 % (Bownes et al., 1991) and 87 % (Mgoqi-Mbalo et al., 2017), according to studies. Even sexual assault-related PTSD is significantly more prevalent than PTSD unrelated to sexual assault (Oosterbaan et al., 2019). Furthermore, Temple et al. (2007) found that rape, particularly by a current partner, is a significant risk factor for PTSD, stress, and dissociation. A significantly higher prevalence of PTSD as well as sexual problems and eating and mood disorders has been observed in raped women (Faravelli et al., 2004; Mgoqi-Mbalo et al., 2017; O'Loughlin & Brotto, 2020; Steketee & Foa, 1987). These findings underline the need to provide treatment for victims (Chivers-Wilson, 2006; Cowan et al., 2020). Existing research indicates that there is a need for a greater number of studies examining psychosocial interventions for victims of sexual assault; however, the prevailing body of evidence supports the effectiveness of interventions utilizing video and cognitive behavioral therapy (CBT) techniques (Lomax & Meyrick, 2022). However, trauma-related disorders may vary by culture, as may their therapies (Schnyder et al., 2016). Culture influences individual interpretation and interaction with the world and with others; it influences religious beliefs, rituals and social change (Geertz, 1975). Considering the influence of culture on post-traumatic symptoms (De Jong et al., 2001), coping styles (Stevens-Watkins et al., 2014) and treatment (Bryant-Davis, 2019) cultural sensitivity, which entails taking an empathic and nonjudgmental approach, is required for properly caring for trauma patients. In the context of cultural sensitivity, evidence-based treatments may need to be tailored to the patient's cultural background (Schnyder et al., 2016). Current evidence on culturally sensitive interventions suggests that culturally adapted interventions are effective, with most meta-analyses showing a moderate to large effect (Naeem et al., 2023). Studies on trauma-specific cultural adaptation have demonstrated that culturally adapted cognitive behavioral therapy (CA-CBT) is effective, acceptable, and applicable for traumatized Syrian refugees (Eskici et al., 2021). Furthermore, it has been found that when combined with problem-solving training, culturally adapted cognitive behavioral therapy (CA-CCBT) can enhance refugees' ability to actively cope with psychosocial problems (Kananian et al., 2022). Furthermore, in addressing sleep problems, which are a significant component of post-traumatic stress responses, cultural adaptations have consistently and significantly reduced negative sleep outcomes compared to control groups (Alcántara et al., 2021). These results add weight to the argument that therapists should develop their cultural awareness (Schnyder et al., 2016).

Similarly, religious convictions are among the crucial elements that influence how people understand and manage life's challenges (Harrison et al., 2001; Krägeloh, 2011). In general, there is ample evidence that religiosity is positively associated with improved mental health outcomes (Weber & Pargament, 2014). In parallel research on trauma indicates that incorporating religious and spiritual pracices into psychotherapy is an effective treatment for both general and sexual assault-related PTSD (Fortuna et al., 2023; Kerlin & Sosin, 2017; Koenig et al., 2020; Smothers & Koenig, 2018; Murray-Swank & Pargament, 2005; Murray-Swank & Pargament, 2008). As a matter of fact, current trauma approaches in CBT support practices of religion when suitable for therapy (Wild et al. 2020). Adding religious and spiritual contents into trauma treatment not only lessens post-traumatic stress symptoms (Pearce et al., 2018), but also contributes to an increased feeling of meaning and purpose (Fontana & Rosenheck, 2004), improved communication and emotional support in close relationships (Sherman et al., 2018), and enhanced positive mood and emotional recovery (Exline et al., 2005). Religious and spiritual practices assist individuals manage stress and anxiety more efficiently and avert the emergence of withdrawal, isolation, and alienation issues (Hasanović et al., 2011).

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https://doi.org/10.1016/j.ejtd.2024.100441
Received 7 May 2024; Received in revised form 18 July 2024; Accepted 30 July 2024
Available online 7 August 2024

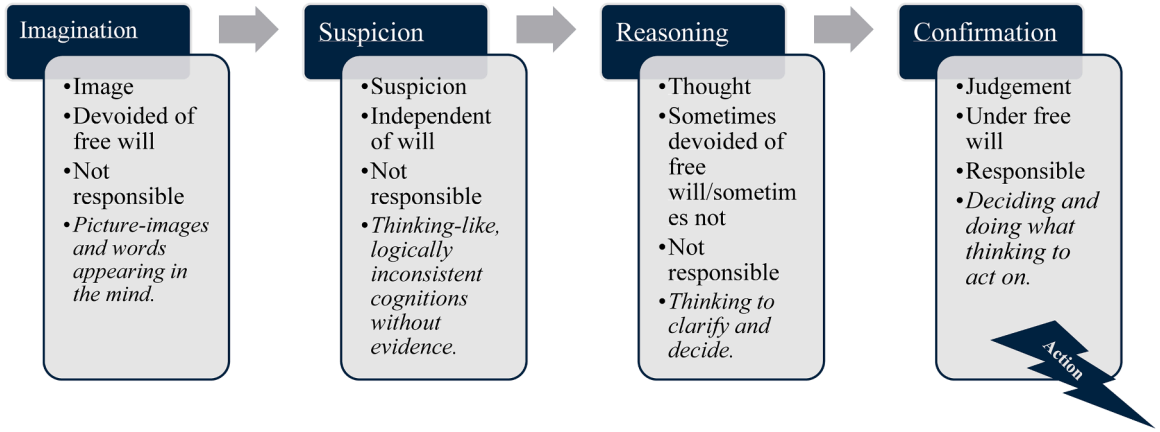

Fig. 1. 4T Model.

Considering religious and spiritual needs in trauma treatment can result in increased treatment engagement, whereas neglecting these needs may lead to decreased treatment participation (Zagożdżon & Wrotkowska, 2017). Notwithstanding, some therapists and counselors may feel uneasy about addressing religion and spirituality with their clients (Magaldi-Dopman et al., 2011) due to ethical concerns like not providing room for the client or imposing their own values (Ekşi et al., 2016). Whereas when religious and spiritual needs are ignored, individuals may feel unsupported and misapprehended, which can consequence in the aggravation of their symptoms (Falsetti et al., 2003). Additionally, religious beliefs supply individuals with significant social support. Inadequacy to unify these beliefs into trauma therapy may dispossess individuals of this vital social support for trauma recovery (Mölsä et al., 2017). Likewise, individuals may fail to catch the possibility for positive religious coping, which considerably benefit in regulating traumatic stress (Koenig et al., 2001).

The overarching term for individuals' capability to regulate traumatic stress, adjust and adapt to traumatic situations is psychological resilience (Wu et al., 2013). Based on the aforementioned findings, it can be posited that incorporating religious beliefs into therapy may not only alleviate symptoms but also enhance the psychological resilience of individuals. Studies in the field of religion, spirituality and psychological resilience have shown that students with high spirituality and spiritual resilience are more resilient, can better cope with and adapt to stress factors, and have a sanguine view on negative situations (Güldaş & Karslı, 2023; Morato et al., 2023; Sinchana & Joy, 2023). Faith and spirituality have been shown to be an important resilience strategy in the face of drastic life events such as earthquakes (İme, 2023) and sieges (Pundato, & Wapaño, 2023).

It is well-known that individuals can experience not only mental health problems following trauma but also personal development and growth. Post-traumatic growth, involves individuals finding new meaning in their lives, recognizing their strengths, strengthening their relationships, and achieving spiritual maturity after a traumatic event (Tedeschi & Calhoun, 2006). The utilization of religious spiritual coping mechanisms as a resilience strategy can facilitate post-traumatic growth in individuals (Shaw et al., 2005). The positive reframing of trauma is crucial for post-traumatic growth (Castro et al., 2019). Undoubtedly, religious and spiritual beliefs play a significant role in this reframing process (Holton & Snodgrass, 2023). Studies have found that individuals who can interpret their trauma within a broader religious or spiritual framework exhibit higher levels of post-traumatic growth (Park, 2013). Similarly, positive religious coping, religious openness, willingness to confront existential questions, and intrinsic religiosity have been associated with post-traumatic growth (Shaw et al., 2005). There is substantial evidence indicating that trauma survivors who rely on spiritual or religious beliefs to cope with their trauma possess a heightened capacity for post-traumatic growth (Askay & Magyar-Russell, 2009; Fayaz, 2023; Ofei et al., 2023; Sultani et al., 2023). Spirituality plays a crucial role in post-traumatic growth among adolescent girls who have experienced dating violence (Kerinina & Kusristanti, 2023) and can aid survivors of sexual trauma in transitioning from feelings of frustration and hopelessness to states of calm, comfort, security, and freedom, thereby fostering growth and well-being (Eytan & Ronel, 2023).

It has been summarized in studies of religiously adapted Cognitive Behavioral Therapy (CBT) that religious content is often apply to restructure automatic thoughts or distorted beliefs, privy religious activities are encouraged, and participation in religious community events is promoted (de Abreu Costa & Moreira-Almeida, 2021). Additionally, value systems that may guide the individual are combined into therapy, and sometimes the therapeutic relationship is strengthened by utilizing the common value system between the therapist and the client. Furthermore, positive religious-spiritual coping strategies have been implemented to address psychological distress such as fear, anger, frustration, shame, and guilt (Anderson et al., 2015).

After trauma, individuals often experience feelings of guilt, believing they are responsible for what happened and that they have done something wrong (Kubany & Watson, 2003). Guilt is intensely felt following trauma and significantly impacts the severity of the trauma. Therefore, addressing it in therapy is crucial (Norman et al., 2018). Religious individuals may turn to repentance to cope with guilt (Al-Nuaimi & Qoronfleh, 2020; Bahari, 2020). Repentance (tawbah) helps the individual who has sinned to repair their feelings of guilt and regain inner peace (Karakas & Gecimli, 2017; Koç, 1983). Indeed, studies have shown that treatment procedures including repentance (tawbah) are beneficial in lowering depressive symptoms and feelings of guilt (Hamdan, 2007), as well as a variety of other mental health issues (Baharudin et al., 2019; Karakas & Gecimli, 2017; Wani & Singh, 2019). Another intense psychological reaction that emerges after trauma involves cognitions related to injustice (Clark, 2010). It is apparent that views towards justice are intricately connected with afterlife beliefs (Flannelly et al., 2012). To cope with injustice cognitions, individuals may turn to belief in the afterlife (Kula, 2002). Belief in the afterlife can help individuals reduce their hopelessness and better cope with the losses and difficulties they face (Carr & Sharp, 2014; Hassankhani et al., 2010; McClain-Jacobson et al., 2004; Lee, 2016).

In some cases, guilt arises from thoughts that the individual deems morally inappropriate. This phenomenon, often encountered in obsessive-compulsive disorder and defined as moral thought-action fusion (Shafran et al., 1996), can also be observed in various other pathologies such as depression, anxiety, and eating disorders (Berle & Starcevic, 2005). Additionally, it has been found in individuals who experienced trauma during childhood (Berman et al., 2013). The 4T psychoeducational cognitive model (Toprak, 2024) is an innovative

strategy that hierarchically categorizes cognition based on volitionality and seeks to alleviate people's feelings of guilt arising from intrusive thoughts related to sexual, religious, and other themes. The proposed model posits a hierarchical structure for cognitive processes based on the degree of voluntariness exhibited throughout each phase, namely tahayyul (imagination), tewehhum (suspicion), taakkul (reasoning), and tasdiq (confirmation, judgment) (Fig. 1).

Tahayyul refers to images or fantasies that emerge in the mind involuntarily and exceed the individual's control; thoughts at this stage are purely at the level of imagination and have not yet been conceptualized. Tevehhüm involves baseless assumptions or doubts without any real foundation. These thoughts are involuntary and emerge without intention, so the person is not liable for them. Taakkul represents the logical way of thinking, such as reasoning or reflecting. It can sometimes be voluntary but generally occurs involuntarily. At this phase, the individual scrutinizes thoughts more profoundly to clarify them. As thoughts have not matured into decisions, there is no responsibility involved. Tasdiq is the process of affirming and confirming thoughts, which is completely voluntary. At this stage, the individual either approves or disapproves of their thoughts. Approved thoughts are internalized as values and beliefs and directly guide behavior. Hence, the person bears responsibility at this phase. In this respect, while people are religiously responsible for voluntary thinking processes (tasdiq), they are not religiously responsible for non-voluntary (tahayyul, tewehhum, taakkul) thinking processes (Toprak, 2022; Toprak, 2024). The model has shown efficacy in reducing maladaptive guilt among Muslim clients resulting from moral thought-action fusion (Toprak, 2022). Although this model has only been employed in the area of scrupulosity so far, it is considered that it may be useful in lowering the guilt induced by intrusive thoughts with moral content in a number of psychopathologies, including PTSD.

From this point of view, the aim of this study is to investigate the incorporation of religious interventions in addition to cognitive behavioral therapy techniques, especially in intervening in beliefs about guilt and injustice, within the therapeutic approach for the treatment of a female case with posttraumatic stress disorder due to rape.

Case presentation

Case description

The case is a 29-year-old Muslim woman from Turkiye. She is married. She has a 1-year-old daughter. The case has no past psychiatric history. Verbal consent was obtained from the case, and the identification information was changed.

Presenting complaints

The case sought therapy because of recurrent nightmares. She stated that the nightmares made her very angry, and her relationship with her husband deteriorated because of her anger and angry behaviors. She expressed her sadness about her anger and her sense of wrongdoing towards her husband. Additionally, she expressed a lack of interest and procrastination. She mentioned delaying her household responsibilities. While desiring to spend more time with her husband and prepare his favorite dishes, her mood prevented her from doing so. Additionally, she was unable to provide the level of care for her child that she desired.

The case's recurring nightmares are associated with the rape she faced. She was raped by her ex-boyfriend (A) in 2016 when she was 21 years old. She said that she was paralyzed with fear and unable to take any action at that moment. Once this happened, A started to threaten the case to tell other people what happened, and they had more forced sex. Following that, the case continued to have sex willingly, believing that "we would get married anyway." However, their relationship did not continue due to A's bullying of the case, and they separated. The rape lasted a year and ended in 2017. One year after the rape in 2018 she met her husband and got married in 2020. She stated that she was happy from the time she met her husband until they got married and that she did not remember the rape too much. However, after marriage, she was unable to have sexual intercourse with her husband and began to have flashbacks and nightmares about the rape. The symptoms continued until she started therapy in 2022 (Fig. 2).

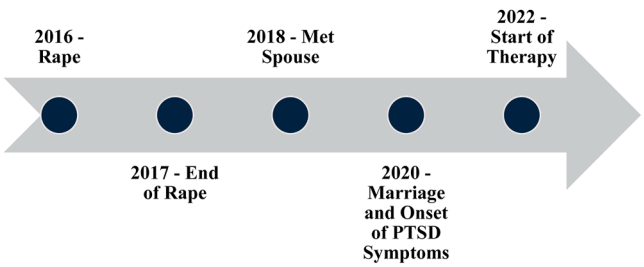

Fig. 2. Timeline of post-traumatic stress symptoms.

Evaluation

Diagnostic analysis

A clinical interview was conducted to evaluate the case of, revealing distressing memories, flashbacks, and intense distress. The case avoided situations related to the trauma, causing negative changes in cognition, mood, and behavior. She lost interest in activities and became distant from people. The symptoms were significantly impairing family functioning and had no known medical condition or substance use. The case's negative mood, lack of interest, and ruminative thinking pointed out depression, but due to the connection to the traumatic memory, it was ruled out. Also, the case's idealization and devaluation of her husband, identity confusion, inconsistency in affect, difficulty controlling anger, and dissociative symptoms suggest borderline personality disorder. However, it's challenging to determine if these are trauma-related problems without excluding trauma. Consequently, PTSD was the most suitable diagnosis for this case.

Quantitative evaluation

The Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5) was used to assess the case.

Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5): To measure PTSD symptoms, Weathers et al. (2013) updated PCL-5 in accordance with DSM-5. Boysan et al. (2017) conducted the Turkish adaptation of the scale. The scale consists of 20 items based on self-assessment and measures PTSD symptoms in the last month. It is a five-point Likert-type scale. The responses range from 0 (none at all) to 4 (extremely high). Scores on the scale range from 0 to 80. The scale may be assessed based on its total score. For the Turkish adaptation, 47 is the cut-off point (Boysan et al., 2017).

Qualitative evaluation

A qualitative form was prepared by the researcher to evaluate the results of the religion-adapted interventions. The case answered the questions in a self-report format.

Intervention

In the treatment, depending on the specific needs of the case, the 4T psychoeducational cognitive model (Toprak, 2024) and other religious practices were combined with cognitive behavioral therapy (Ehlers & Clark, 2000; Türkçapar, 2018) and acceptance and commitment therapy (Orsillo & Batten, 2005) techniques. The therapist was a clinical

Table 1
Content of the interviews.

Interview number	Content
1–2–3	Evaluation
4	Psychoeducation and treatment rationale
5–6	Reliving with cognitive restructuring Session 5: Repentance (tawbah) ınterventıon
6–7–8–9	Techniques for the content of thought and relation to thought Session 8: 4T cognitive model psychoeducation
10–11–12–13–14	Interventions for life problems
15–16–17–18	In vivo exposure
19–20	The hereafter view and the court metaphor interventions

psychologist and doctoral student in the department of clinical psychology. She is also a cognitive-behavioral therapy practitioner. The process was supervised by the second author of the study, who is an academician and ACT (Academy of Cognitive Behavioral Therapy) accredited therapist who gives an advanced interview skills and supervision course at a university clinical department. The interventions are described in Table 1.

The case attended weekly 60-minute sessions for 18 weeks. A 16-session trauma-focused CBT is generally known to be effective for adults (Ehlers & Clark, 2003; Roberts et al., 2009). In our study, 22 sessions were planned, tailored to the case's needs. However, for practical reasons related to her life course, she wanted to end treatment at session 18. As a result, the exposure hierarchy was not completed. Nevertheless, the intended treatment goal—elimination of PTSD symptoms and increased value-oriented behaviors—was achieved. In the follow-up interview conducted approximately 1 year later, it was observed that the improvement was maintained.

Evaluation

The evaluation interview took up the first three sessions. The trauma history was briefly heard, and the hot spots, dysfunctional behaviors, and avoidances related to the history were identified. Values were used to clarify therapy goals. For this purpose, psychoeducation on values was conducted; value domains and domain-specific values and therapy goals consistent with these values were identified. The aim of the treatment was to reduce the case's post-traumatic stress symptoms that interfered with value-oriented behaviors and to increase value-oriented behaviors.

Psychoeducation and treatment rationale

Sharing PTSD diagnostic criteria with the case ensured normalization. A problem formulation of the case's symptoms was made, and a cognitive-behavioral explanation of PTSD was made through this formulation. The existence of symptoms and the rationale of reliving were explained using the wound metaphor (Rechsteiner et al., 2020).

Memory interventions

Reliving with cognitive restructuring

Assuring to create a holistic story of the traumatic moment, the memory was narrated in detail. In order for the case to stay with the memory, she was asked what she saw, how she felt, and what was going through her mind at that moment. With an empathic accompaniment, she was made to express the details. Hot spots were identified during the reliving of the memory and described below. These hot spots refer to the specific, distressing cognitive moments that were particularly intense and vivid for the patient during the traumatic event (Ehlers & Clark, 2000).

Cognitive interventions

Techniques based on changing the relationship with thought

It came to light during the problem formulation process that the case's predominant way of thinking was self-critical rumination, which significantly limited her effectiveness. Hence, interventions intended primarily for rumination were favored. The case was given an explanation of rumination and asked to keep an eye out for ruminative periods during the week. Once the case began to distinguish ruminations, repentance practice was given as an acceptance skill (details will be explained in the section on religious interventions).

Techniques for the content of thought

Cognitive restructuring was implemented to treat the case's challenging cognitions—hotspots—connected to memory. During cognitive restructuring, sympathetic nervous system psychoeducation and psychoeducation on tonic immobility (Gbahabo & Duma, 2021), coping with the worst-case scenario, double standards, direct alternative explanations, defining terms, and benefit-harm analysis techniques were utilized.

Motivational intervention

Creative hopelessness

Creative hopelessness was reached by having the case recognize how her ruminations cost her and how they disengaged her from her values.

Behavioral interventions

In vivo exposure

The case exhibited avoidance in three specific areas: engaging in sexual intercourse with her husband, discarding the napkin she used to wipe the blood from her hymen during the rape, and being in places where she could encounter A. Since it was understood that her husband's sexual problems also played a role in her sexual avoidance, she was referred to couple therapy (however, she did not start couple therapy during the PTSD treatment process). Alternative thoughts about the napkin that the case avoided throwing away were generated, and they were prepared as a coping card to read while throwing away the napkin. So the case was able to throw the napkin. The exposure hierarchy was built around the locations where the case was most likely to see A. In vivo exposure started with the least disturbing location but the treatment ended before moving on to the other locations.

Reclaiming one's life with value-oriented behaviors

The negative effects of social isolation and behavioral inhibition and their relationship with motivation were explained to the case, and social and behavioral activation was encouraged to regain her pre-trauma life. In this direction, it was noticed that the most prominent values of the case were sincerity, compassion, devotion, and caring. In relation to these values, value-oriented behaviors in the areas of marriage, parenting, and close relationships (neighborhood, friendship) were defined. Texting, hugging, cooking, focusing on what to be grateful for, and praying for a better relationship were determined in the area of marriage; in the area of parenting, increasing playing games and doing educational activities with her daughter; and in the area of close relationships, making delicious meals for her neighbors and hosting them, as well as doing fun activities with friends she loved but saw less frequently, were determined. The case was encouraged to do at least one of these each week.

Interventions for life problems

Problem solving

Problem-solving techniques for husband, family and other relationship problems were used in the weeks needed.

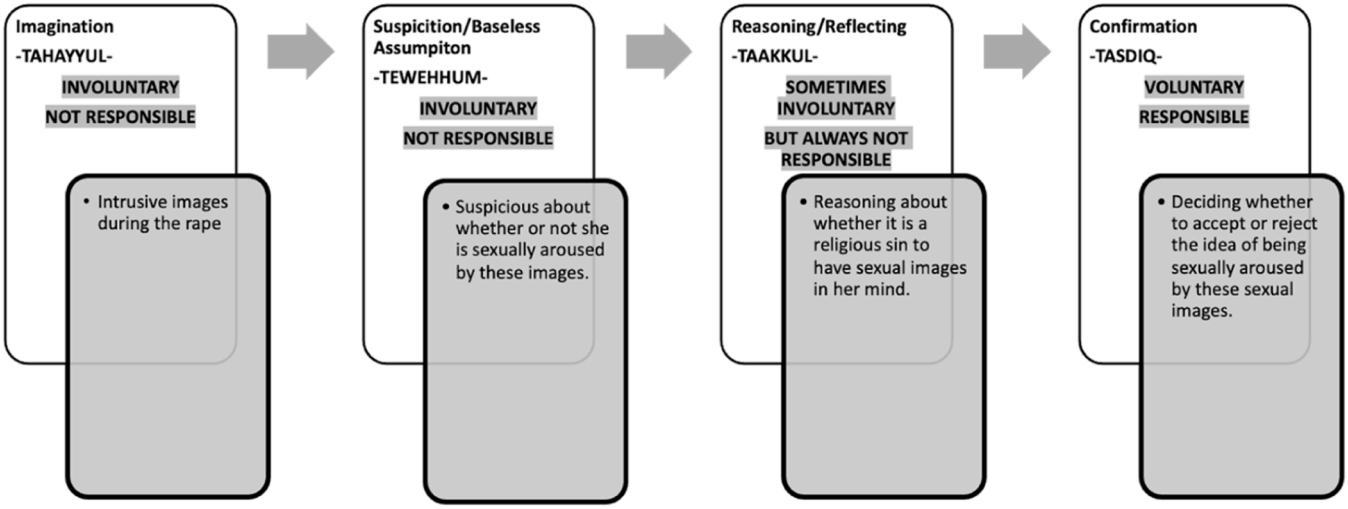

Fig. 3. 4T formulation of the case's cognitions.

Religious interventions

Repent (Tawbah)

The case believed she had sinned and felt guilt and regret both for the out-of-wedlock relationship and for continuing to have voluntary sex after the rape. To balance her guilt, first the religiously sinful behaviors were clarified with her according to Islam, and she was asked what she might do for these points in accordance with her religious values. She said she might repent and ask Allah for forgiveness. Based on her words, the practice of repentance (tawbah) as an acceptance strategy when thoughts of sin came to mind during the week was given. Repentance intervention was made once more in response to the hot spots of the case that "I am dirty; I have lost my innocence." The hadith "The one who sincerely repents of his sins is as if he has never sinned" (Özafşar, 2013, İbn Mâce, Zühd, 30) was discussed in this context. As the case progressed, it began to make sense of the following: "I regret the error I had committed and beseech Allah for absolution; Allah is omniscient and forgives sins. I hold the conviction that Allah will forgive and purify me." She developed a new perspective and regained optimism.

4T Psychoeducational cognitive model

Sexually intrusive images preoccupied the case's mind as a result of the rape she endured and the sexual issues she encountered with her husband. As a result of these intrusive images, she felt culpable and questioned whether she was religiously responsible. In order to provide a response to this concern, 4T psychoeducational cognitive model was used. According to 4T formulation of the case's cognitions, the images that come to the patient's mind about rape are "tahayyul", her doubting whether she is sexually aroused by these images is "tewehhum", her reasoning about whether it is a sin to have sexual images in her mind is "taakkul", and deciding to accept or reject the idea that she is sexually aroused by these images is the "tasdiq" stage (Fig. 3). This formulation was explained to the case and it was stated that since she did not confirm (tasdiq) the involuntary sexual images that came to her imagination (tahayyül), she was not religiously responsible for her unwanted sexual images.

The hereafter view and the court metaphor

The case had difficulty accepting the rape and ruminating about "I had been treated unfairly, he had not been punished and he has a happy life. But I'm in pain and he must be unhappy too." In relation to these hot spots she was angry. For this reason, she occasionally checked the perpetrator's social media accounts to see if he was happy. But this behavior increased her suffering even more. At this point, it was thought that the

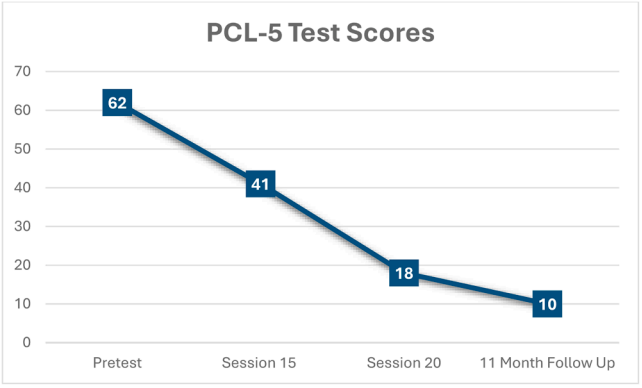

Fig. 4. PCL-5 Test Scores at Pretreatment, Sessions 15, 20 and 11 Month Follow Up.

case could get help from her religious beliefs to accept the rape and to repair her belief in justice. For this reason, hereafter perspective (Çağrıcı, 2020) and court metaphors (Nursi, 2004) were generated based on religious sources. Before these interventions, the case was asked whether she could initiate legal action for justice. The case stated that she did not want to take legal action. After that, the case's hot spots about injustice was restructured by using the hereafter view and court metaphor. The hereafter view metaphor was applied in such a way that the case imagines that the trouble she suffered in the world will be written into her good deed purse and lead her to enter heaven at the moment when she is called to account in the afterlife. In the court metaphor, the world's courts were equated to a tiny court and the afterlife to a huge court, and petty offenses can be dealt with in small courts, but great crimes require vast courts. Relevant verses and hadiths were shared. It was discussed that a great crime such as sexual assault can only be fully punished in the hereafter, in the great court. Thinking that "every person entitled will get what they deserve in the hereafter" lent some comfort to the case after this intervention. When she tends toward rumination and social media checking behavior, the case was given the practice of remembering these metaphors and turning to value-oriented behaviors.

Results

PTSD symptoms

Initially, the case was diagnosed with PTSD using clinical assessment and PCL-5. The pre-test PCL-5 score for the case was 62. Accordingly, the case met the diagnostic criteria for PTSD in the pretest (Boysan et al., 2017). In the 15th session, the measurement had decreased to 41 points, and the case no longer met the diagnostic criteria for PTSD. It was observed that her symptoms decreased to 18 points at the 20th session and to 10 points at the 11-month follow-up (Fig. 4).

Qualitative results of religious interventions

As follows, the case expressed her satisfaction with obtaining religiously appropriate treatment: "I was grateful. While I was losing faith as a result of the rape, I remembered my religious principles and faith and began to have boundless confidence." Her thoughts on the repentance practice are as follows: "First of all, it was good for me to clarify my religiously sinful behaviors in this traumatic experience. This unfortunate event happened without my permission, but I am aware that I committed a sin by continuing to have sex afterwards. I was repenting before I started the therapy, which was a great relief for me, but then I became pessimistic. I started to think that my Lord would not forgive me, and I stopped repenting. The fact that I remembered repentance again with the questions asked of me in therapy revived my hope for forgiveness. I hope I have been forgiven, and if my Lord has not forgiven me, I will repent for these experiences until the day I die. I know that one day He will forgive me, so I am very hopeful."

She stated that the 4T psychoeducational cognitive model was also very helpful for her and that she stopped blaming herself. She said, "I was suffering from remorse; I thought that I was sinning when sexual intrusive thoughts came to my mind, and I was always angry, and it was reflected in my sexual life with my husband. I had no sexual desire. Now that I know I think of reasons I cannot control, I do not feel sorrow, I do not linger on it, and it passes by. No more dwelling on these ideas. I am now more patient and mild."

She also benefited from the afterlife and court metaphors. She described her thoughts, feelings, and behaviors before this intervention as "I felt sad, depressed, and disappointed since I viewed his life from afar and thought he was happy. I felt he forgot what he had done to me and didn't care about my broken lady. This devastated me, and I cried at night. It affected my entire existence. My marriage was failing, I couldn't care for my child, and I didn't want to see my friends. I was lonely since being alone brought up horrible memories. I enjoyed torturing myself because I felt guilty." After the intervention, she remarked, "I don't care about his happiness. Water filled my heart with this idea. This calms me and clears my conscience. My anger towards him has decreased because I know that he will be punished for what he did in the big court. The individuals around me show my emotions. I'm more patient, loving, and less angry today, thank Allah."

Discussion

The aim of this study was to investigate the incorporation of religious interventions in addition to cognitive behavioral therapy techniques, especially in intervening in beliefs about guilt and injustice, within the therapeutic approach for the treatment of a female case with post-traumatic stress disorder due to rape.

According to the findings, the patient's PTSD symptoms decreased and no longer met the PTSD diagnostic criteria, and these results were maintained during follow-up. According to the case's written feedback, it's probable to say that religious interventions raised hope, patience, and trust while balancing guilt and anger. Additionally, the case's value-oriented behaviors increased in the value domains of marriage, parenting, and close relationships.

Due to the absence of a control group and experimental design in our study, it is not possible to attribute the observed outcomes only to the impact of religiously sensitive treatments on symptom reduction. Nevertheless, it is worth noting that existing literature provides support for the efficacy of treatments that incorporate religious values in addressing post-traumatic stress disorder (PTSD) stemming from both general trauma and sexual assault (Fortuna et al., 2023; Kerlin & Sosin, 2017; Koenig et al., 2020; Murray-Swank & Pargament et al., 2005; Murray-Swank & Pargament, 2008; Smothers & Koenig, 2018). Furthermore, drawing on the written feedback in the case, it can be asserted that interventions with religious content yielded positive outcomes.

The case stated that with the repentance (tawbah) intervention, she accepted to thoughts of guilt and regained her hope for forgiveness and that she would repent with the hope of being forgiven throughout her life. With hopeful thoughts about forgiveness and repentance as an active behavior, ruminative guilt thoughts seem to be replaced by striving with a sense of responsibility. Consistent with the literature, it may be argued that this intervention enhances the case's behavioral activation and facilitates her ability to manage stress (Al-Nuaimi & Qoronfleh, 2020; Bahari, 2020), while concurrently diminishing their depression symptoms (Hamdan, 2007). The case's feelings of guilt were related to her concern about sinning, and treatment that was not sensitive to this concern would undoubtedly have made the case feel misunderstood. However, the case frequently stated in her verbal feedback that understanding her concerns about sin made her feel understood and safe. This may suggest that the culturally sensitive stance adopted, consistent with the literature (Naeem et al., 2023), helped the case significantly.

In accordance with Toprak (2022), in our study, the 4T psychoeducational cognitive model helped reduce unhelpful guilt due to moral thought-action fusion. The statements of the case, "Now that I know that it comes to my mind for reasons beyond my control, I do not feel remorse; I do not dwell on it when it comes to my mind; it goes away on its own," seem to have increased the cognitive defusion (Hayes et al., 2006) skill after learning the model.

The case's belief in justice was seriously harmed, similar to the women victims of sexual assault (Clark, 2010), who indicated that individual justice could never be attained since whatever action was taken to obtain justice would not alleviate the impacts of the rape. In this instance, the hereafter view and court metaphors showed that she felt more tranquil, her anger had diminished, and her relationships had improved since she understood that the perpetrator would be punished in the afterlife. It seems, as suggested by the literature, that these approaches helped the case by accepting her difficulties (Hassankhani et al. 2010) and strengthening justice beliefs (Flannelly et al. 2012). As the client's bad feelings lessened and her negative thoughts were modified, she became more sociable.

The case expressed in her written feedback that she was appreciative of the therapy, which had facilitated a reconnection with her faith, resulting in a newfound and boundless confidence. These reflections suggest that religious interventions may have played a role in enhancing her psychological resilience, as supported by Güldaş and Karslı (2023), Morato et al. (2023), and Sinchana and Joy (2023). Furthermore, the patient's acknowledgment that she had become more patient and compassionate following the treatment, in conjunction with reestablishing her faith, may be indicative of the onset of post-traumatic growth. This observation aligns with the findings of Eytan and Ronel (2023) and Kerinina and Kusristanti (2023).

Without a doubt, this research possesses some shortcomings that are commonly found in the majority of case studies. Due to the limitation of relying on data from a single individual, this study lacks the necessary control over experimental conditions. Therefore, it fails to account for potential factors such as therapeutic alliance and treatment length, which may significantly influence treatment outcomes. As a result, clear inferences and generalizations on the effectiveness of the treatment

cannot be drawn.

Furthermore, a notable inadequacy is the absence of quantitative assessments for treatments that are sensitive to religious factors. In prospective investigations, the implementation of quantitative assessments before and subsequent to targeted treatments may yield more robust findings. Furthermore, it would have been advantageous to use more frequent and regular intervals for the assessment of post-traumatic stress disorder (PTSD). This would have provided insight into the specific intervention that resulted in the reduction of particular symptoms.

Notwithstanding these constraints, the present study offers preliminary data suggesting the potential efficacy of a religiously sensitive approach in addressing post-traumatic stress disorder (PTSD). Moreover, the findings may serve as a valuable resource for therapists, providing guidance on the specific therapeutic interventions that may be employed within this context. In this regard, it is acknowledged as being therapeutically and scientifically valuable.

Conclusion

In summary, the implementation of religion-adapted cognitive behavioral therapy interventions in the treatment of a female patient diagnosed with post-traumatic stress disorder (PTSD) resulting from rape yielded a reduction in PTSD symptoms and the extinction of diagnostic criteria in the patient. Furthermore, it can be posited that the patient's degree of acceptance regarding the traumatic event she encountered exhibited a rise subsequent to the implementation of religious interventions. Notably, her unhelpful feelings of guilt and anger witnessed a decline, while her levels of trust, patience, and hope showed an enhancement. Additionally, the case's value-oriented behaviors increased in the value domains of marriage, parenting, and close relationships.

The findings of this study make a minor but valuable addition to the existing body of knowledge, suggesting that including cultural sensitivity and religious content into treatment sessions might potentially yield positive outcomes for religious people who suffer from post-traumatic stress symptoms.

Portions of these findings were presented as a poster at EABCT 2023 Congress, Antalya, Türkiye. We have no conflict of interest to disclouse.

We thank Yakup Işık, Hanne Nur Özçelik, Beyza Karakan and Nurşin Çetiner for critiquing our manuscript.

During the preparation of this work, the author(s) used ChatGPT developed by OpenAI for assistance with English translation. Additionally, the author(s) used Consensus for access to current literature. After using these tools/services, the author(s) reviewed and edited the content as needed and take(s) full responsibility for the content of the publication.

CRediT authorship contribution statement

Hatice Rumeysa Işık: Methodology, Investigation, Writing – original draft. **Taha Burak Toprak:** Conceptualization, Resources, Supervision.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.