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"In Search of Truth?" Integrating Religious Consultation into CBT to Address Ambivalence: A Case Study

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Abstract

Ambivalence—defined as the simultaneous experience of conflicting emotions, attitudes, or beliefs toward a specific person, object, or situation—is a complex construct that plays a critical role in psychological processes such as decision-making, emotional regulation, and interpersonal relationships. While Cognitive Behavioral Therapy (CBT) combined with Motivational Interviewing (MI) has been shown to be effective in addressing ambivalence, there is limited research on religiously sensitive interventions for individuals with strong faith-based values. This case study introduces an integrative approach that incorporates consultation with a Muslim religious leader into the therapeutic process to address ambivalence regarding family responsibilities. The client, a young Muslim woman, experienced psychological distress due to uncertainty about her religious obligations to maintain her relationship with her father. Initial CBT sessions targeted anxiety and interpersonal difficulties. However, the inclusion of religious consultation played a crucial role in helping the client clarify her values and resolve her inner conflict. This intervention provided a faith-based framework for interpreting her obligations, reduced ruminative thinking, and fostered a more future-oriented perspective. Post-treatment assessments indicated notable reductions in anxiety and depression levels, and the client's feedback highlighted the value of the religious consultation. These findings suggest that integrating religious consultation into psychotherapy may improve treatment outcomes for clients with strong religious commitments.

Keywords

ambivalence, religious consultation, cognitive behavioral therapy (CBT)

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Theoretical and Research Basis for Treatment

Ambivalence is a phenomenon central to human experience; it frequently arises in close relationships, identity development, social and political attitudes, decision-making processes, anxiety disorders, and psychotherapeutic change (Li et al., 2024; Moore et al., 2021; Oliveira et al., 2020; Zoppolat et al., 2023). In psychology, ambivalence is characterized by the simultaneous experience of conflicting emotions, attitudes, or beliefs toward a particular object, person, or situation (Lin et al., 2021; Schneider et al., 2020). This situation often occurs as the coexistence of opposite emotions—such as love and anger, or the desire to take action and the fear of the consequences (Dishkova, 2020; Fernándes-Pires et al., 2025; Hernández et al., 2024; Losada et al., 2016). This simultaneous emotional conflict is associated with emotional instability, insecurity, and difficulty in expressing one's genuine feelings, often resulting in internal conflict and cognitive confusion (Dishkova, 2020; Hernández et al., 2024).

Individuals experiencing ambivalence often report a sense of "being torn between two options" during decision-making processes, which may lead to delayed decisions or complete avoidance (Friedrich, 2022; Moore et al., 2021). Moreover, ambivalence has been associated with increased depressive and anxious symptoms, particularly in high-risk contexts such as caregiving, close relationships, and health-related decision-making (Cabrera et al., 2023; Huo et al., 2024; Losada et al., 2018; Zhang et al., 2024). Ambivalence also has interpersonal consequences, potentially leading to communication difficulties, conflicts, and reduced satisfaction in social relationships (Dishkova, 2020; Tighe et al., 2016).

In the context of psychotherapy, approaches that combine Motivational Interviewing (MI) with Cognitive Behavioral Therapy (CBT) have gained prominence as effective strategies for managing ambivalence (Button, 2018; Westra & Norouzian, 2018). CBT is a structured, evidence-based approach that links emotional and behavioral difficulties to maladaptive cognitive processes—such as dysfunctional core beliefs and interpretive schemas—that influence how individuals perceive and respond to life events (Durrani & Downing, 2022; Pineda et al., 2020; Ruggiero et al., 2018). However, even when individuals are rationally aware of the need for change, emotional conflicts and motivational fluctuations may still occur, which can hinder engagement in CBT—particularly among those with anxiety disorders (Heldt et al., 2014). At this point, MI emerges as a collaborative approach that acknowledges ambivalence, explicitly addresses internal conflict, and aims to facilitate change through dialogue that enhances intrinsic motivation (Miller & Rollnick, 2013).

Motivational Interviewing (MI) is frequently integrated with Cognitive Behavioral Therapy (CBT) and other therapeutic approaches to enhance individual motivation and improve treatment outcomes across various psychological and behavioral problems (Iarussi, 2019; Miller, 2023; Nix et al., 2025). An effective integration process requires the therapist to recognize the signs of ambivalence that emerge during sessions and respond appropriately, while also employing MI strategies that support the client's autonomy and strengthen an empathic therapeutic relationship (Constantino et al., 2019; Westra & Constantino, 2019).

Particularly in the treatment of Generalized Anxiety Disorder (GAD), the integration of MI with CBT has been associated with long-term reductions in anxiety and distress levels, higher rates of diagnostic remission, and lower treatment dropout rates compared to CBT alone (Constantino et al., 2019; Westra et al., 2016). Moreover, the integration of MI and CBT has been shown to significantly strengthen the therapeutic alliance, particularly among clients who exhibit high levels of ambivalence at the outset of treatment (Morrison et al., 2017; Norouzian et al., 2020).

Although these forms of intervention aim to strengthen the therapeutic alliance and enhance treatment adherence, they may fall short of providing a comprehensive framework that fully addresses the multidimensional nature of ambivalence (Dew et al., 2013). At this point, the

integration of religious beliefs into therapeutic practices presents a noteworthy potential for influencing individuals' coping mechanisms and overall mental health outcomes (Fekih-Romdhane & Cheour, 2021; Sánchez et al., 2014; Weber & Pargament, 2014). Indeed, a case study involving a client experiencing conflict related to religious beliefs reported that an intervention incorporating religious and spiritual elements contributed to lasting improvements not only in religious concerns but also in levels of depression, and anxiety (Işık & Toprak, 2025). Moreover, religion plays a vital role in individuals' decision-making processes regarding their own lives, often emerging as a determining factor in areas such as family structure and career choices (Sigalow et al., 2012). Such findings highlight the central role of religion—as a strong reference point for individuals' beliefs and values—in shaping attitudes and decisions, thereby underscoring the importance of faith-sensitive and integrative interventions within the therapeutic process.

In this study, we aim to examine religious consultation as a specific form of intervention for addressing ambivalence, with a particular focus on a case involving a Muslim individual. Among Muslims, the most commonly used methods for navigating indecision or critical decision-making processes are *istikhara* and *shura*. While *istikhara*—typically understood as seeking divine guidance through dreams or signs—is not practiced for every decision *shura*, which involves consultation with knowledgeable or experienced individuals, is widely accepted as a decision-making mechanism.

Shura—consultation with individuals possessing religious knowledge and experience—holds significant importance among Muslims as a method of decision-making, both individually and collectively. Consulting with competent individuals, in particular, enhances the reliability and legitimacy of decisions. The Qur'an highlights the value of consultation, stating, "*Their affairs are [conducted] by mutual consultation among them*" (*Ash-Shura*, 42:38). In Islam, adhering to a consensus reached through consultation strengthens a person's decisions and provides a firmer foundation for action (Türcan, 2024).

In this context, our study approaches religious consultation as a therapeutic intervention. Duba and Watts (2009) recommend that therapists collaborate with Muslim clergy or religious counselors to establish an effective therapeutic alliance and to address religious themes in a constructive manner. Similarly, the Clergy Outreach and Professional Engagement (COPE) model proposed by Milstein et al. (2008) aims to promote holistic care aligned with clients' spiritual needs by defining the roles and responsibilities of mental health professionals and religious leaders.

The literature includes a limited number of studies demonstrating that collaboration with religious leaders in addressing religious issues in therapy might be more effective in managing psychological distress (Cook-Masaud & Wiggins, 2011; Genç, 2022). In line with this, our study integrated a consultation process with a Muslim religious leader into the treatment of a female client experiencing confusion about her religious obligations. Through this approach, we aimed to address the ambivalence that negatively impacted the client's functioning by utilizing the clarifying effect of the consultation process.

Case Introduction

To protect confidentiality, certain personal and demographic details in this report have been altered, and the client's name was changed tos a pseudonym. The individual featured in this case study provided informed consent for the use of her anonymized information and clinical data.

The client, referred to as Ayse, is a 20-year-old single woman who decided to seek psychological support of her own accord.

Presenting Complaints

During the assessment interview, Ayse described a broad range of difficulties including persistent anxiety, emotional distress, and a pervasive sense of mental stress. Her primary concerns centered on interpersonal and family conflicts, particularly her estranged relationship with her father. This relationship had been shaped by prolonged exposure to verbal and physical abuse, domestic violence, and suspected sexual abuse during childhood.

She reported persistent intrusive memories, flashbacks, hypervigilance, social withdrawal, irritability, and chronic physical tension and pain. Additionally, Ayse exhibited cognitive distortions (Beck, 2021)—systematic errors in thinking that lead individuals to interpret situations in an overly negative or inaccurate manner—characterized by pervasive self-blame and feelings of worthlessness. Her symptoms were further intensified by unresolved internal dilemmas concerning her religious obligations toward her father, which complicated her emotional and behavioral responses. Despite these challenges, Ayse was motivated to engage in therapy and expressed a clear desire to alleviate her emotional burden and gain clarity regarding her religious and interpersonal values.

History

The client reported a history of severe family dysfunction and early developmental challenges. Her father had a history of chronic alcohol abuse and engaged in both verbal and physical aggression toward her mother. The home environment was described as emotionally volatile and unsafe, requiring the client to remain in a constant state of hypervigilance in order to avoid triggering any conflict.

Ayse also reported experiencing unpredictable and distressing verbal threats from her mother, including conditional statements related to parental affection and threats of placement in institutional care. The unpredictable nature of these interactions contributed to persistent fears of abandonment and emotional insecurity during her early years.

In addition, the client disclosed ongoing physical violence from her father until high school, along with behaviors that aroused suspicion of sexual harassment. She also reported repeated sexual harassment by her uncles, beginning at age nine and continuing through middle school. At the age of 19, her parents divorced, and she hasn't contacted her father since then.

As a result of these adverse childhood experiences, the client has been experiencing trauma-related symptoms, including intrusive recollections, flashbacks, heightened emotional reactivity to trauma-related cues, and persistent negative cognitions associated with past events. She also exhibited symptoms of hyperarousal—such as irritability, muscular tension, and exaggerated startle responses—as well as behavioral symptoms including interpersonal withdrawal, emotion regulation problems, somatic complaints, and impaired occupational and social functioning.

The client also reported persistent feelings of worthlessness and reluctance to express personal thoughts or opinions. She expressed ambivalence regarding her perceived moral and religious obligations toward her father, including internal conflicts such as "Do I have a responsibility toward my father?" and "Do I have a duty as a daughter?" These dilemmas contributed to her internal distress and difficulties with setting boundaries.

Ayse reported that she did not have any known health problems herself or in her immediate family. In terms of psychiatric and psychological history, she noted that her aunt had been diagnosed with obsessive-compulsive disorder (OCD). Ayse herself had received short-term psychological support regarding her traumatic experiences.

Assessment

To evaluate the client's symptom profile and diagnostic status, a combination of structured clinical interviews and standardized self-report measures was utilized. Prior to the treatment, the Structured Clinical Interview for DSM-5 Disorders—Clinical Version (SCID-5-CV; First et al., 2016) was administered to assess current Axis I disorders. Turkish version of SCID-5-CV, validated by Elbir et al. (2019), demonstrated high diagnostic reliability, with an agreement rate of 97.2% and a kappa coefficient of .74. Based on the SCID-5-CV results, the client met the diagnostic criteria for Generalized Anxiety Disorder (GAD) and Unspecified Trauma- and Stressor-Related Disorder.

To assess personality pathology, the Structured Clinical Interview for DSM-5 Personality Disorders (SCID-5-PD; First et al., 2016) was administered. Turkish version of SCID-5-PD by Bayad et al. (2021) demonstrated acceptable inter-rater reliability (κ = .49–1.00). According to this interview, the client met criteria for Obsessive-Compulsive Personality Disorder (OCPD) and displayed prominent avoidant personality traits.

In addition to the clinical interviews, several self-report measures were administered at four key assessment points: before treatment, after sixth session, after 20th session, and at the last session of therapy (30thsession). These measures were used to track symptom changes throughout the intervention.

Scales

Beck Depression Inventory (BDI; Beck et al., 1961**)** is a 21-item self-report measure assessing the severity of depressive symptoms over the past two weeks. Each item is rated on a 4-point Likert scale (ranging from 0 to 3), yielding a total score ranging from 0 to 63, with higher scores indicating greater depressive symptom severity. The Turkish adaptation by Hisli (1989) demonstrated adequate internal consistency (Cronbach's alpha = .80) and has been widely used in both clinical and research settings in Turkey.

Beck Anxiety Inventory (BAI; Beck et al., 1988**)** is a 21-item self-report scale designed to assess the severity of anxiety symptoms experienced over the past week. Each item describes a common somatic or cognitive symptom of anxiety (e.g., numbness, fear of losing control) and is rated on a 4-point Likert scale ranging from 0 ("Not at all") to 3 ("Severely—it bothered me a lot"). The total score ranges from 0 to 63, with higher scores indicating more severe anxiety. The scale does not contain subscales; it yields a single total score representing overall anxiety severity. The Turkish version of BAI, validated by Ulusoy et al. (1998), demonstrated excellent internal consistency with a Cronbach's alpha of .93, supporting its reliability for use in both clinical and non-clinical populations.

Generalized Anxiety Disorder Scale (GAD-7; Spitzer et al., 2006**)** is a brief self-report measure developed to screen for and assess the severity of generalized anxiety disorder symptoms over the preceding two weeks. Each item reflects a core symptom of generalized anxiety (e.g., excessive worry, restlessness, irritability) and is rated on a 4-point Likert scale ranging from 0 ("Not at all") to 3 ("Nearly every day"). Total scores range from 0 to 21, with higher scores indicating more severe anxiety. The GAD-7 provides a single total score and does not include subscales. The Turkish adaptation by Konkan et al. (2013) demonstrated good internal consistency (Cronbach's alpha = .85), supporting its use as a reliable screening tool in Turkish clinical settings.

In addition to these standardized measures, verbal feedback was received after the religious consultation intervention to qualitatively assess the client's therapeutic progress and subjective experience of change. All assessments were conducted by the therapist.

Case Conceptualization

At the initial consultation, Ayse presented chronic anxiety, interpersonal difficulties, and profound uncertainty related to her family and religious obligations. Her symptom profile was characterized by hyperarousal, persistent psychological distress, social withdrawal, and difficulty expressing her needs within close relationships. These difficulties appeared to originate from cumulative traumatic experiences, including verbal and physical abuse by her father, emotionally unpredictable and abusive behavior by her mother, and suspected sexual abuse by multiple male relatives during her childhood.

The psychological consequences of Ayse's traumatic experiences were reflected in deeply internalized core schemas, such as "I am not safe," "My needs are not important," and "I must avoid conflict at all costs." These beliefs contributed to her maladaptive relational patterns and difficulties with emotional regulation. A particularly distressing source of internal conflict was her estrangement from her father. Although Ayse had chosen to cut off contact due to the past abuse, she experienced ongoing doubts about whether this decision was compatible with her religious values. These doubts triggered intrusive thoughts and a tendency towards rumination, exemplified by questions such as, "Is it my religious duty to fulfill my obligations to my father as a daughter?" and "Is it a sin to sever ties?"

The treatment plan was multifaceted. The initial phase involved standard CBT techniques targeting anxiety management, setting interpersonal boundaries, and cognitive restructuring. While Ayse made progress in managing generalized anxiety symptoms, her ambivalence regarding religious obligations remained a salient clinical concern. As providing definitive religious judgments exceeded the scope of psychological expertise, and the therapy sessions were not intended to function as spiritual counseling, additional support from a qualified religious leader was deemed necessary. To address this, religious counseling was introduced as a culturally appropriate intervention, consistent with previous recommendations for collaboration between religious and clinical fields (Duba & Watts, 2009; Milstein et al., 2008), Ayse engaged in a consultation process with a Muslim religious scholar. This intervention helped clarify her perceived religious obligations, reduced cognitive dissonance, and supported the development of behavior plans aligned with her values. Following this integration, Ayse reported a notable reduction in rumination, an increase in cognitive clarity, a decrease in guilt, and an improvement in her ability to establish interpersonal boundaries without self-blame.

Course of Treatment and Assessment of Progress

Therapist and Supervisor

All sessions were conducted by a master's-level clinician in clinical psychology who was pursuing doctoral studies and had received formal training in CBT. The therapist participated in weekly face-to-face individual supervision provided by an assistant professor in clinical psychology, who is a certified cognitive therapist accredited by the Academy of Cognitive Therapy (ACT) and the European Association for Behavioral and Cognitive Therapies (EABCT).

Treatment

The treatment was conceptualized as a multi-phased process, consisting of classical psychotherapy techniques followed by the integration of religious consultation.

The initial phase consisted of CBT techniques delivered through weekly sessions lasting 40 to 50 minutes. This phase consisted of classical CBT interventions, including psychoeducation,

cognitive restructuring, and behavioral strategies targeting the client's anxiety and interpersonal difficulties.

Following this phase, the focus shifted to addressing the client's ambivalence regarding her religious obligations. To resolve this ambivalence and its associated symptoms, religious guidance was provided through a consultation with a Muslim religious leader. The leader, a respected Sunni scholar known for his work on family and youth issues, is a well-regarded scholar in the community—particularly among young people—for his ability to communicate effectively. The client was already familiar with him, having previously attended his seminars and lectures, and shared the same religious orientation, making him a suitable fit for this intervention.

In the final phase, the client's values were clarified, and value-oriented behaviors were promoted to support the development of a coherent and meaningful narrative in relation to her traumatic experiences.

Course of Treatment. A session-by-session overview of the therapeutic process is summarized in Table 1 and elaborated in the sections below, outlining the treatment focus, techniques used, and cognitive-emotional targets addressed.

Classical Psychotherapy

Sessions 1 to 5: Psychoeducation, Model Presentation, Case Formulation, and the Relationship Between Events, Thoughts, Feelings, and Behaviors. During the initial phase of treatment, the focus was on assessing and clarifying the presenting problems and therapeutic goals. Ayse reported pervasive anxiety affecting nearly all aspects of her daily life, along with interpersonal difficulties influenced by her personality traits. She initially presented exam-related anxiety and later shifted her focus of anxiety to challenges in close relationships.

Following differential diagnosis through the SCID-5, psychoeducation was provided on GAD and the cognitive-behavioral model, in alignment with the client's treatment priorities. The GAD protocol was then implemented, which included psychoeducation on anxiety and the introduction of worry diaries. A distinction was made between functional and non-functional anxiety, and Ayse's experiences were categorized accordingly to target the maladaptive cognitions contributing to non-functional anxiety.

Sessions 6 to 12: Cognitive Restructuring and Behavioral Interventions. Following cognitive restructuring focused on non-functional anxious thoughts, experimental exercises were introduced, including detached mindfulness and thought suppression experiments. The client was provided with practical tools such as an anxiety postponing strategy and an automatic thought record. Session discussions addressed both adaptive and maladaptive anxiety controlling strategies, and dysfunctional beliefs related to problem-solving were identified and challenged. Constructive problem-solving steps were then practiced through in-session exercises and homework assignments.

Despite a strong therapeutic alliance, no significant reductions in GAD symptoms was observed during this phase. As a result, the therapeutic focus was shifted toward the client's persistent interpersonal ruminations, which dominated much of her daily mental activity. At this stage, emotionally distressing experiences regarding her parents surfaced as a central theme. The client described this process as a "thought knot," stating, "I don't want to keep fighting with myself about my parents, but I can't stop thinking about them."

Sessions 13 to 20: Addressing Interpersonal Relationship Problems. To better understand the client's ruminations related to her family, the therapeutic focus was shifted toward exploring her family dynamics and close relationships. After gathering detailed information about family dynamics, the

Table 1. Course of Treatment Summary

Session(s)	Phase	Focus/Content	Technique(s)	Key cognition/ Conflict	Observed outcome
1–5	CBT Phase 1	Psychoeducation on GAD, formulation of thoughts, feelings, and behaviors	Psychoeducation, worry diary, CBT model mapping	"If I don't worry, everything will go wrong"	Client gained insight into anxiety patterns and functional versus non-functional worry
6–12	CBT Phase 2	Cognitive restructuring, anxiety control, interpersonal ruminations	Cognitive restructuring, detached mindfulness, thought suppression, problem solving	"I can't stop thinking about my parents"	Reduced dysfunctional beliefs, rumination became more central
13–20	CBT Phase 3	Interpersonal boundaries and worthlessness	Interpersonal skills training, DBT DEAR MAN	"I feel ashamed for asserting my needs"	Improved boundary setting, reduced self-blame
21–30	**Religious integration - consultation with a religious leader**	Clarifying ambivalence regarding religious obligations toward father	Values clarification, script preparation, religious consultation	"Do I have a responsibility toward my father?"	Clarity and reduced guilt following religious guidance
	Religious integration - value-based intervention	Integration of values, religious verses, and personal narrative building	Narrative construction, religious text application	"How can I act righteously despite my past?"	Future-focused orientation and religiously aligned behavior change

intervention targeted feelings of worthlessness and avoidant coping strategies that were developed in response to her interpersonal experiences. The client reported significant difficulty in expressing herself—especially in saying "no" within close relationships—and often experienced post-interaction rumination accompanied by feelings of self-disrespect for setting boundaries.

To address these challenges, effective communication skills for interpersonal contexts training was provided. As a supportive intervention, the DEAR MAN skill from the *Dialectical Behavior Therapy (DBT)* framework (Linehan, 2014) was introduced. This technique was used to help the client express her needs and desires assertively and respectfully—both to herself and to others—and was implemented successfully during sessions and homework practices.

Religious Integration

Sessions 21 to 30: Consultation with a Religious Leader and Value-Based Intervention. Following the previous interventions, Ayse showed increased capacity to reinterpret interpersonal challenges and began expressing herself more comfortably and spontaneously. However, she continued to

experience recurring negative thoughts related to her traumatic experiences with her father. These thoughts were associated with heightened stress and anxiety, occasionally triggering avoidant behaviors.

The core issue that remained unresolved was her uncertainty about how to define and structure her relationship with her estranged father. She felt torn between persistent suspicions of the past abuse, ongoing discomfort regarding his behavior, and conflicting beliefs about her perceived religious obligation—as a devout individual—to maintain a close relationship with him.

Although Ayse felt a strong emotional need to maintain distance, she continued to question whether this preference was in line with her religious values. As a result, despite the positive therapeutic achievements, her overall quality of life and level of functioning did not reach the expected level.

To address this issue, fistly, the amount of time Ayse spent ruminating on this ambivalence each day was identified, and the conflicting components of her indecision were delineated. It was determined that both her emotional needs and her perceived religious obligations contributed to two opposing inclinations: maintaining distance from her father versus remaining in close contact with him.

The identified therapeutic need for Ayse was to gain clarity on a value-consistent course of action that could help her resolve the ambivalence. To support this process, she was invited to consider consulting with a religious leader—someone who could understand her experiences, offer guidance regarding her responsibilities in such situations, and provide insight into appropriate actions, particularly in relation to her father.

Upon finding the suggestion reasonable and potentially beneficial, Ayse agreed to consult with a religious leader whose lectures she had previously attended and who was known for his expertise in communication with youth and family dynamics. With her consent, the communication process was facilitated via email, and the consultation was successfully arranged.

Concerned that she might have difficulty articulating her thoughts during the consultation, Ayse collaborated with the therapist to prepare a written script outlining her key issues. She attended the meeting with this document in hand. The content of the consultation was subsequently reviewed in detail during the following therapy session.

During the consultation, the religious leader conveyed that, given the current circumstances, Ayse held no specific religious obligation toward her parents. Instead, he emphasized that prioritizing self-preservation and focusing on her career and future aspirations would be more appropriate. Within this framework, Ayse was encouraged to make decisions that aligned with her emotional well-being.

As a result of this process, Ayse gained clarity on how to structure her relationship with her father in a way that aligned with her religious values. She was able to manage this relationship within healthy boundaries, without assuming an excessive sense of obligation. Consequently, she no longer experienced guilt when prioritizing her own time and well-being over maintaining contact with her father. This resolution reduced her ambivalence, created cognitive and behavioral space in her daily life, and enabled her to take purposeful actions consistent with her core values.

To help Ayse construct a meaningful narrative from her traumatic experiences, she was guided to reflect on questions such as: "Looking at these challenges today, what have you learned about life? What can you share with others? What can you do about them?" These reflective prompts were used to clarify her core values and promote value-driven behaviors. At this stage, religious knowledge—with its definitive and action-oriented framework—was also incorporated to support behavioral change. In line with this approach, Ayse compiled verses from the Qur'an related to associating with righteous individuals. During the session, the following verses were highlighted:

"Keep yourself patient with those who call upon their Lord in the morning and the evening, seeking His pleasure. Do not turn your eyes away from them desiring the adornments of the worldly life, and do not obey one whose heart We have made heedless of Our remembrance, who follows his own desires and whose affair is ever in neglect" (Surah Al-Kahf, 18:28).

"O you who have believed, fear Allah and be with those who are truthful" (Surah At-Tawbah, 9:119) (Presidency of Religious Affairs, 2011).

Ayse integrated these verses into her approach to interpersonal relationships, using them as guiding principles to align her actions with her religious values. When she became aware of avoidance behaviors in her interactions, she recalled these verses, which helped her navigate relational challenges with greater consistency between her faith and her actions.

Assessment of Progress

Throughout the treatment process, standardized assessment measures were used to monitor changes in Generalized Anxiety Disorder (GAD) severity, as well as symptoms of depression and anxiety. These measures were administered at baseline, and then at the sixth, 20th, and 30th sessions. Pre-treatment scores on GAD-7, Beck Depression Inventory (BDI), and Beck Anxiety Inventory (BAI) were 12, 22, and 11, respectively; and these scores decreased to 10, 16, and 0 at the 30th session.

To quantify the magnitude of change, percentage reductions were calculated for each measure. BDI score showed a 27% decrease, BAI score decreased by 100%, and GAD-7 score was reduced by 17%. These improvements reflect clinically meaningful progress, particularly in anxiety-related symptoms (see Figure 1).

Following the religious consultation, Ayse was invited to reflect on her experience with the scholar she met (see Appendix A). Her feedback indicated that the intervention played a pivotal role in clarifying her confusion regarding her perceived religious responsibilities:

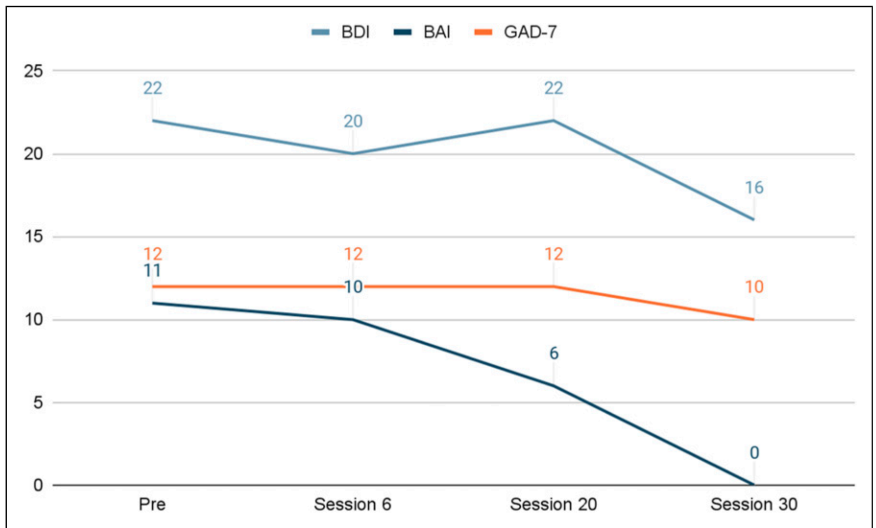

Figure 1. Assessment Measures at Pretest, Session 6, Session 20, and Session 30. *Note.* BDI = Beck Depression Inventory; BAI = Beck Anxiety Inventory; GAD-7 = Generalized Anxiety Disorder-7

> "I feel clearer about whether I have a duty towards my father. Now I feel more at ease. I'm glad I went and talked to him. Now, I'll try to focus on my tasks without overthinking issues related to my father. At least for a while, I don't need to dwell on it. I'll focus on what I want to do regarding my school and studies."

After the consultation, Ayse no longer engaged in rumination about her traumatic memories involving her father, and reached a more clear and value-aligned decision about how to manage this relationship.

As a result, ruminative patterns rooted in a specific ambivalence were replaced by future-oriented goals. Ayse also reported a significant reduction in future-related fears, including beliefs such as "Everything will go wrong." and "Others won't accept me." These cognitive shifts appeared to emerge as a direct outcome of resolving longstanding trauma-related conflicts.

Complicating Factors

Several key factors complicated Ayse's therapeutic process. These included complex childhood traumas and persistent ambivalence regarding her perceived religious obligations toward her father. While her religious beliefs functioned as a potential source of strength, they also conflicted with her sense of moral responsibility, thereby intensifying ruminative thoughts and complicating decision-making processes. Additionally, limited social support and cultural norms discouraging the disclosure of family issues constrained emotional expression and contributed to slower therapeutic progress.

Access and Barriers to Care

There were no significant barriers to Ayse's access to care. All therapy sessions were conducted face-to-face, and the client demonstrated consistent attendance. Session schedules were arranged flexibly to accommodate her academic commitments, which contributed to treatment continuity.

Follow-Up

A follow-up session was conducted one month after the intervention. The client reported significant cognitive and emotional shifts, particularly in relation to her ambivalence about her father. She described a marked reduction in guilt and self-blame, noting that her conversation with the religious leader had been "relieving" and helped her "stop blaming herself".

In terms of interpersonal boundaries, the client reported increased assertiveness and reduced emotional reactivity when declining invitations or requests—without experiencing the internal conflict that previously accompanied such situations. The value clarification and hierarchy of priorities interventions enabled her to evaluate decisions based on personal meaning, allowing her to act in accordance with her values without disturbing self-criticism.

Additionally, she reported that she gained enhanced insight into interpersonal dynamics, boundary awareness and reflective self-questioning. She attributed these gains to the techniques learned during therapy. The client also emphasized the impact of Islamic references introduced in sessions, particularly in managing interpersonal dilemmas with her mother. Recalling Qur'anic principles, she explained, facilitated emotional regulation and broadened her perspective.

Although family issues remained unresolved, the client described herself as better equipped to navigate these challenges within a value-based and spiritually grounded framework.

Treatment Implications of the Case

This case study presents a novel integrative approach that incorporates consultation with a religious scholar to address ambivalence in a Muslim female client experiencing confusion about her religious obligations. The client's ambivalent thoughts—particularly regarding whether avoiding contact with her abusive father was religiously appropriate—created internal conflict and hindered behavioral action. Such indecisiveness and avoidance are consistent with previous findings highlighting how ambivalence contributes to decision-making paralysis and action inhibition, particularly in emotionally and morally loaded contexts (Friedrich, 2022; Losada et al., 2018; Moore et al., 2021).

In this case, the integration of a religious consultation served as a culturally meaningful intervention aligned with the Islamic tradition of *shūrā*, or informed decision-making through dialogue with knowledgeable individuals (Sigalow et al., 2012; Türcan, 2024). Following the consultation, the client reported greater clarity regarding her religious obligations and a noticeable reduction in anxiety, as evidenced by diminished ruminative thoughts and physical tension. These findings are consistent with previous literature in which religious content was integrated into Cognitive Behavioral Therapy (CBT). Similar to those studies, the inclusion of faith-congruent content in the intervention in this case appears to have enhanced the client's motivation, reduced internal conflict, and promoted commitment to value-based actions (Işık & Toprak, 2024; Toprak et al., 2025; Çetiner & Toprak, 2025).

Client's feedbacks, such as "My mind is clearer about whether I have a duty toward my father. I feel more at ease now," and "Preparing the text with you made it easier to communicate with the religious leader" underscores the significance of pre-consultation preparation and post-consultation reflection. These practices appeared to strengthen efficacy of the intervention by promoting autonomy, emotional safety, and value-aligned decision-making—key factors emphasized in motivational and culturally responsive therapeutic frameworks (Miller & Rollnick, 2013; Norouzian et al., 2020).

Despite the promising clinical outcomes, this case study has several limitations. As a single-case design, generalization of the outcomes to other populations is limited. Furthermore, the lack of standardized measures specifically targeting ambivalence and related rumination represents a methodological constraint. This limitation was partially addressed by utilizing relevant items from the Generalized Anxiety Disorder Scale (GAD-7) and incorporating qualitative verbal feedback from the client. Additionally, the primary aim of this case study was to explore the clinical feasibility of religious consultation rather than to establish efficacy. Future research employing randomized controlled trial designs is needed to systematically evaluate the impact of religiously integrated interventions on decision-making and anxiety outcomes in religious clients. Nevertheless, this case contributes to the growing literature emphasizing the importance of religiously sensitive psychotherapy practices for clients navigating value-based conflicts (Cook-Masaud & Wiggins, 2011; Duba & Watts, 2009).

Recommendations to Clinicians and Students

This case highlights several important considerations for clinicians working with clients experiencing value-related ambivalence, particularly within religious or cultural frameworks. When clients express distress stemming from conflicts between emotional, relational, or religious obligations, clinicians are encouraged to explore culturally congruent interventions such as value clarification exercises, motivational interviewing strategies, and—when appropriate—referral for religious consultation (Button, 2018; Westra & Constantino, 2019). Integrating these tools within the cognitive-behavioral framework may help clients resolve moral dilemmas and reduce related rumination and distress.

For clients with strong religious commitments, collaboration with qualified religious leaders or counselors can promote spiritual congruence, enhance the perceived legitimacy of decisions, and alleviate inner conflict. These consultations should be carefully integrated into the therapeutic process via preparation and debriefing sessions, in line with the client's values and treatment goals.

Therapists-in-training should also be encouraged to develop competencies in working with religious and spiritual clients. This includes cultivating an understanding of the client's worldview, recognizing culturally embedded expressions of ambivalence, and applying ethically appropriate forms of religious integration. Prior research has emphasized that such competencies can enhance therapeutic alliance, improve treatment outcomes, and reduce dropout rates (Captari et al., 2018; Vieten et al., 2013). This case demonstrates how religious consultation can enhance therapeutic outcomes for clients facing moral ambivalence and trauma-related challenges.

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Consent for Publication

Written informed consent was obtained from the patient for the publication of this case study. A copy of the written consent is available for review by the Editor-in-Chief of this journal.

Author Contributions

Hanne Nur Özçelik: Writing – original draft, Writing – review and editing, Methodology, Research. **Taha Burak Toprak:** Writing – review and editing, Conceptualization, Supervision.

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Data sharing is not applicable to this article as no datasets were generated or analysed during the current study.

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Appendix A

Therapy Process Evaluation Form

The following open-ended questions were presented to the client at the end of the treatment process to qualitatively assess perceived changes in ambivalence, interpersonal functioning, and the impact of specific interventions including religious consultation and value-based strategies.

1. **During therapy, did your repetitive negative thoughts related to your father and your indecision about how to structure your relationship with him in accordance with your values change?** If yes, how did they change?
2. **Do you think the consultation session with religious leader had an effect on the situation described above?** If so, in what way did it influence you?
3. **Did the dilemmas you occasionally experienced change during the therapy process?** If yes, how did they change? How did therapy help?*(For example, you mentioned situations where you attended social gatherings due to insistence from friends, despite feeling uncomfortable and experiencing inner conflict afterward. You also expressed difficulty saying "no," and described confusion between selfishness and setting boundaries. Please reflect on such situations while answering.)*
4. **Do you think the "priority hierarchy" intervention we used to address the issue mentioned in question 3 had an effect?** If so, in what way did it help? *("Priority hierarchy" refers to clarifying and ordering values: What would happen if you didn't go to a social invitation? What happened when you did? How would you have preferred to spend that time? Why did you choose otherwise? This intervention aimed to promote value-based decision-making. For example: "If I hadn't come here for an hour, I might have prepared my assignment better—but I chose to come. Why? Because my friend urgently needed support. When I weigh the two, my friend's need is more important to me than improving the assignment.")*
5. **Have the interpersonal problems you experienced changed during therapy?** If yes, how did they change?
6. **Do you think the sessions in which we discussed references from the Qur'an and the Sunnah had an effect on these interpersonal problems?** If so, how did they help?