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Integrating the 4T Psychoeducational Model Into Cognitive-Behavioral Therapy: A Case Study of Harm-Related Obsessive-Compulsive Disorder

Taha Burak Toprak[1,2]

Abstract

Background: Obsessive-Compulsive Disorder (OCD) is a chronic psychiatric condition characterized by intrusive obsessions and repetitive compulsions that result in significant functional impairment. Harm-related obsessions and checking compulsions represent some of the most distressing and treatment-resistant symptom clusters. Cognitive-Behavioral Therapy (CBT) and Exposure and Response Prevention (ERP) remain the gold-standard interventions; however, their effectiveness may be limited in cases involving intrusive harm-related thoughts. **Methods:** This case study describes a 22-year-old male who presented with obsessions such as "What if I break his neck?", fears of poisoning others, and associated compulsive checking and avoidance behaviors. He completed 30 sessions of CBT and ERP integrated with the 4T Psychoeducation Model, a framework derived from the Islamic intellectual tradition. The model distinguishes involuntary cognitive processes – imagination (*tahayyul*), baseless assumption/suspicion (*te-wehhum*) and reasoning (*taakkul*) – from voluntary confirmation (*tasdiq*). **Results:** Standardized measures, including the Yale–Brown Obsessive Compulsive Scale (Y-BOCS), Padua Inventory, Beck Depression Inventory (BDI), and Beck Anxiety Inventory (BAI), were administered during treatment and at six-month follow-up. Results showed a clinically significant reduction in obsessive-compulsive symptoms (46% decrease in Y-BOCS), along with decreases in depression and anxiety. Qualitative feedback indicated that the 4T model helped the client differentiate intrusive images from responsible beliefs (confirmations), reducing thought–action fusion and excessive sense of responsibility. **Conclusions:** By the end of treatment, intrusive thoughts still occurred but were no longer perceived as threatening. This case highlights the value of integrating 4T psychoeducation into standard CBT protocols. Although initially developed for religious obsessions, the model provides a compelling cognitive framework for reconceptualizing thought-action relationships, emphasizing that thought processes are not inherently linked to actions, thereby emerging as an effective tool for improving treatment outcomes in harm-related OCD.

[1]Department of Psychology, Ibn Haldun University, Istanbul, Turkey
[2]Association for Psychology and Psychotherapy Research, Istanbul, Turkey

Corresponding Author:
Taha Burak Toprak, Department of Psychology, Ibn Haldun University, Kayabaşı, Rıfat Ilgaz Cd., 34494 Başakşehir/İstanbul, Turkey.
Email: tahaburaktoprak@gmail.com

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Theoretical and Research Basis for Treatment

Obsessive-Compulsive Disorder and Harm-Related Obsessions

Obsessive-Compulsive Disorder (OCD) is a psychiatric disorder characterized by recurrent obsessions and associatedcompulsive behaviors performed to reduce the distress they cause. An obsession refers to intrusive, distressing, and repetitive thoughts, urges, or images that enter a person's mind involuntarily; these thoughts often conflict with the individual's values and generate intense anxiety. A compulsion, in turn, refers to repetitive behaviors (e.g., hand washing, checking) or mental acts performed to reduce the anxiety caused by obsessions or to prevent a feared situation from occurring (Abramowitz et al., 2006; Bokor & Anderson, 2014; Heyman et al., 2006; Stein et al., 2019). However, there is not always a clear and rational connection between obsessions and compulsions. OCD follows a chronic course and time-consuming symptoms can lead to significant impairments in social, occupational, or other areas of functioning (American Psychiatric Association, 2022; Brock & Hany, 2020; Jalal et al., 2023; Leckman et al., 2010).

OCD presents with heterogeneous symptom patterns, which are determined by patients' predominant obsessions and compulsions. These patterns may include contamination obsessions and cleaning/avoidance compulsions; harm obsessions and checking compulsions (e.g., locking doors, checking the stove); symmetry/order obsessions and ordering/arranging compulsions; and sexual, religious, or aggressive obsessions (often manifesting as less overt, subtle compulsions). These subtypes have been consistently recognized as causing significant distress (Ball et al., 1996; Calamari et al., 2004; Haslam et al., 2005; Jalal et al., 2023; McKay et al., 2004; Starcevic & Brakoulias, 2008). Contamination obsessions with cleaning/avoidance compulsions and harm obsessions with checking compulsions are the most commonly identified OCD subtypes (Davoudi et al., 2023; Jalal et al., 2023; Starcevic & Brakoulias, 2008).

Harm obsessions and checking compulsions are among the most common and functionally impairing symptom clusters in OCD (Feusner et al., 2021; Fullana et al., 2009; Moreno-Amador et al., 2023). Harm obsessions consist of recurrent, distressing, ego-dystonic thoughts, images, or urges related to unintentionally or intentionally causing harm to oneself or others. Checking compulsions, in turn, are repetitive behaviors performed to avoid causing such harm or to prevent any potential danger (Feusner et al., 2021; Moreno-Amador et al., 2023; Pickenhan & Milton, 2024; Wu & Storch, 2016). These checking compulsions are typically triggered by doubts such as "Did I make a mistake that caused harm?" or "Did I leave something undone?" (Foa et al., 2002; Pickenhan & Milton, 2024; Zor et al., 2011). Over time, compulsions lose their functional purpose and become repetitive, time-consuming behaviors that significantly interfere with daily life (Pickenhan & Milton, 2024; Zor et al., 2011). In addition, one review reported that individuals experiencing these highly distressing symptoms frequently engage in help-seeking behaviors, such as consulting a therapist. (Fullana et al., 2009; Lahey et al., 2024).

Existing Cognitive-Behavioral Interventions and Their Limitations

Cognitive-Behavioral Therapy (CBT) with Exposure and Response Prevention (ERP) is considered the primary and most effective approach for treating harm obsessions and checking compulsions (Hudepohl et al., 2022; Reis et al., 2024; Salkovskis, 1999; Whittal et al., 2010; Wu

& Storch, 2016). The cognitive component of CBT focuses on the interpretation of obsessions and the restructuring of responsibility appraisals (Salkovskis, 1999; Whittal et al., 2010), whereas the behavioral component, involving ERP, aims to expose individuals to feared situations and prevent compulsive behaviors (Hudepohl et al., 2022; Wu & Storch, 2016). In clinical settings, additional approaches such ascognitive defusion techniques from Acceptance and Commitment Therapy (ACT) (Levin et al., 2012; Vakli et al., 2015), mindfulness-based interventions, and internet-based therapies are commonly implemented. ACT relies on distancing from obsessive thoughts and encourages the development of flexible responses to them (Lee et al., 2023; Çakmak, 2024). Mindfulness teaches individuals to observe and accept thoughts without judgment, enhancing treatment outcomes when combined with CBT (Reis et al., 2024). Internet-based CBT (ICBT) offers an effective alternative for individuals without access to face-to-face therapy, with both guided and unguided applications yielding significant reductions in obsessions and compulsions (Polak & Tanzer, 2024; Wootton et al., 2024).

However, CBT may sometimes conflict with clients' religious or moral beliefs, such as guilt, sinfulness, and perceptions of a punitive God (Siev et al., 2011). These conflicts may result in treatment resistance, weakened therapeutic alliance, and increased dropout rates (Hook et al., 2010). Therefore, it becomes crucial to develop value-sensitive therapeutic frameworks consistent with clients' religious and cultural values (Aten & Leach, 2009). This study primarily aims to investigate whether a religiously integrated intervention model can be clinically useful even for symptoms that are not religious in nature. Moreover, providing a broader and more hierarchical understanding of cognition compared to the classical CBT formulation, the model holds a more comprehensive potential to explain and modify symptoms.

The 4T Psycho-Education Model

In this context, the 4T model, developed by Toprak and Emül (2016) and drawing on conceptualizations of cognitive processes in the Islamic intellectual tradition, has been integrated into the psychoeducation phase of CBT. Within its dual structure, CBT tends to conceptualise cognitive contents and processes at a single analytical level and does not systematically differentiate them in terms of volitional control. In contrast, the 4T model proposes a hierarchical distinction among cognitive products based on whether they are volitional or non-volitional. In this framework, mental activity is conceptualized as unfolding acrossf four stages.

The first stage, tahayyul (imagination) refers to 'fantasy and imagination processes,' which arise beyond the individual's volition and thus fall outside the sphere of responsibility (e.g., intrusive sexual images involving the Prophet) (Çetiner & Toprak, 2025).

At a subsequent stage, tasawwur (conceptualization/detailed imagination) involves 'processes of conceptualization and mental representation' which are more structured but still arise beyond the individual's volition and sphere of responsibility (e.g., blasphemy sentences, aggressive action related concepts directed toward the Prophet or Allah) (Toprak, 2024).

Subsequently taakkul (reasoning/reflecting) refers to 'the process of reasoning or reflecting' which can be either volutional or non-volitional depending on the context (e.g., thinking 'Why would a merciful Allah allow such a world?).

Finally, tasdiq (confirmation) refers to the 'the stage of volitional confirmation' (e.g., deciding whether to accept or reject the idea of blasphemy towards the Prophet or Allah). Only thoughts that reach the stage of *tasdiq* fall within the scope of an individual's volitional control and moral responsibility.

In psychoeducation, individuals are guided to reinterpret obsessive images and thoughts through these stages, enabling them to distinguish involuntary thoughts from confirmed beliefs—that is, beliefs consciously and deliberately approved in accordance with one's free will and

values). Accordingly, the client's common interpretations, such as "If it comes to my mind, I might do it" or "What if I have already done it?" are reframed as stemming from cognitive processes that do not entail responsibility. Clinical applications have reported that this approach reduces cognitive distortions such as thought–action fusion and the over-importance of thoughts, while decreasing the severity of obsessions and compulsions (Toprak, 2024). In subsequent revisions of the model, the stage of *tasawwur* was merged with *tahayyul*, and the concept of *tewehhum* (suspicion/baseless assumption) referring to the process of engaging in baseless assumptions or suspicions (e.g., what if there is no God, afterlife or angel?) was introduced specifically to describe obsessions characterized by reactive doubt (Toprak, 2021). Within this framework, autogenic intrusive images that arise spontaneously and are not sustained by baseless assumptions/suspicions—such as involuntary and disturbing images involving perceptions of disrespect towards the sacred—are conceptualised as tahayyul and tasawwur. In contrast, reactive obsessions that arise in response to cognitive doubts or hypothetical questions (e.g., what if there is no God? What if there is no afterlife, what if there are no angels?) are conceptualised through the concept of tewehhum. This distinction is clinically important because autogenic images and reactive obsessions differ not only in terms of their phenomenological characteristics but also in terms of the cognitive processes that sustain them. Tahayyul-based images are imaginary, while tewehhum-based obsessions are sustained by baseless assumptions/suspicion and evaluation, indicating different therapeutic targets for individuals with OCD.

Furthermore, the model has been linked to ontological concepts found in classical sources—such as the heart, *waswasa*, and Satan—particularly in Nursi's (2012) writingson *waswasa*. This connection has allowed the model to move beyond solely a cognitive restructuring tool, situating it within a theoretical framework in which the heart—understood as the place where a person's values, beliefs and fundamental preferences for what s/he considers right or appropriate reside— is differentiated from the mind where spontaneous thoughts and images flow) as the locus of value confirmation. Furthermore, the source of thoughts that come to the client's mind has been formulated within the framework of the mind's operating principles (e.g., association principles) and the assumption that Satan may contribute to the emergence of disturbing content through waswasa (whisperings coming from Satan). This formulation is expected to facilitate cognitive defusion by weakening thought-action fusion. In its current form, the 4T model thus provides a religion- and culture-sensitive psychoeducational tool for religious-content OCD, reducing guilt while enhancing cognitive flexibility and preserving religious beliefs.

Comparison of the 4T Model with Exisiting Psychotherapy Approaches

From a CBT perspective, cognition is structured around three interconnected layers: automatic thoughts, intermediate beliefs, and core beliefs (Turkcapar, 2020). These layers are further separated into two groups: thoughts and images. Notably, these elements are not distinguished by any recognized hierarchy (Beck, 1979; Ellis, 1989; Tataryn et al., 1989; Turkcapar, 2008). Both verbal and visual components make up cognition; in the CBT framework, the verbal component is referred to as "thoughts" and the visual component as "images," both of which are parts of the flow of consciousness (Turkcapar, 2020). This cognitive model provides clinicians with a wide range of tools to understand and treat various psychological disorders. However, certain shortcomings of this cognitive model become apparent in conditions characterized by specific difficulties, such as OCD. Patients find it challenging to discriminate between their beliefs, values, and obsessions as cognitive therapy lacks a clear hierarchical distinction among beliefs, values, and other mental processes (Toprak, 2024). These classifications make it difficult to discern between routine thinking processes and obsessions, which might take the form of internal dialogue or imagery. Consequently, a major theoretical dilemma arises in OCD treatment regarding the weight

attributed to thoughts: Is there a hierarchical differentiation in terms of responsibility or worth among thoughts, pictures, and drives? Who defines what thoughts are considered obsessive? What standards are applied? The lack of structural differentiation among cognitive processes leaves a conceptual gap in distinguishing obsessions from normal thought patterns. Patients frequently comment on this ambiguity, wondering how to distinguish between ordinary thoughts and obsessions (Toprak, 2024). To address these issues, Toprak (2024) developed the 4T model, a psychoeducational model of cognition. It has been predominantly applied to OCD patients and provides a nuanced understanding of transitions between cognitive layers. The model explains that not every thought that enters an individual's mind is of the same nature and that thoughts can be evaluated at different levels in terms of responsibility.

ACT focuses on the function and behavior–context relationships (contingencies) of these specific experiences without interfering with their content. Rather than attempting to discuss or change their cognitive content or control emotions; its primary aim is to increase psychological flexibility (Soondrum et al., 2022). Accordingly, ACT's main goal in OCD is not to intervene in obsessions and compulsions, but to change the relationships established with them and teach non-intervention (Levin et al., 2012). In this context, ACT focuses on accepting obsessive thoughts and negative emotions and taking action towards valued life goals without engaging in any type of compulsive behavior as an intervention for OCD (Vakili et al., 2015).

When it comes to the metacognitive approach, the metacognitive model of OCD (Wells, 1997) posits that intrusive (unwanted) thoughts are both common in the general population and constitute a core symptom of OCD; with their impact determined by underlying metacognitive beliefs. In OCD specifically, metacognitive beliefs primarily appraisals of the importance or dangerousness of intrusive thoughts, as well as beliefs about the necessity of performing compulsions. Metacognitive therapy for OCD directly targets these metacognitive processes (Wells, 1997, 2009). However, these approaches generally promote complete defusion between thought and the individual, without differentiating which thoughts are truly obsessive, which are non-obsessive, or which represent the person's beliefs. In most approaches discussed so far, defusion is defined as a general detachment from all content in a person's mental life, whereas in the 4T model, defusion is conceived on a more selective and hierarchical plane. In this model, the client remains anchored at the level of confirmation— recognizing that faith and values reside within the heart and are confirmed there—. Maintaining their faith and value-based acceptances as a reference point; defusion occurs at the level of mental processes such as tahayyul (imagination), tewehhum (suspicion/baseless assumption), and taakkul (reasoning). Thus, obsessive and non-obsessive content are separated, allowing clients to defuse from mental processes with obsessive potential, grounding themselves in non-obsessive mental processes.

Empirical Evidence and the Present Study's Contribution

Clinical studies indicate that the 4T model substantially contributes to the treatment of religious OCD, by enhancing insight, alleviating symptoms, and reframing religious concerns (Karakan & Toprak, 2023; Toprak, 2024; Çetiner & Toprak, 2025). Findings from randomized controlled and case-based studies indicate that 4T psychoeducation helps clients understand the boundary between mental processes and religious responsibility, guiding them to evaluate intrusive thoughts at the levels of *tahayyul*/*tewehhum,* and religious doubts at the level of *taakkul*. In this way, the tendency to equate intrusive thoughts with faith is reduced. Moreover, the model has been shown to yield notable clinical improvements among clients who respond only partially to traditional CBT or who experience religious guilt following trauma, while also facilitating the transition to behavioral techniques such as ERP.

The common feature of these studies is that the 4T model has been applied primarily in cases of religious OCD. This case presentation, however, differs from the existing literature by offering an example of integrating the 4T model into CBT in a case of OCD with harm-related obsessions toward oneself and others, independent of religious content, and aims to discuss the contributions of this integration to the therapeutic process. Although extensive literature exists on CBT interventions for harm-related obsessions, case reports illustrating the integration of religion- and culture-sensitive models remain scarce. This study aims to address this gap and provide clinicians with a religion- and culture-integrated intervention framework.

Case Introduction

The client is a 22-year-old, single male working as an accountant. In February 2012, he presented to the outpatient clinics of Cerrahpaşa Medical Faculty with complaints of obsessions and compulsions. At the time of admission, he reported experiencing involuntary, aggression-related obsessive thoughts for approximately three years. These included fears of poisoning others, concerns about deceiving people by using their identification numbers, fears of hitting pedestrians, and violent mental images of harming others. The client also exhibited compulsive behaviors, including avoidance related to seeing blood, repeatedly checking whether he had run someone over, and engaging in other repetitive checking behaviors. These symptoms were observed to markedly restrict his daily functioning.

At the time of admission, the client had been receiving daily treatment with 20 mg of fluoxetine for approximately three years. His family history revealed obsessive-compulsive disorder in his mother and panic disorder in his maternal aunt, suggesting a potential genetic predisposition. The present study aims to provide a detailed clinical application example of the integration of the 4T psychoeducation model into Cognitive-Behavioral Therapy (CBT).

Presenting Complaints

The client sought treatment due to involuntary and distressing obsessive thoughts accompanied by compulsive behaviors. His obsessive thoughts were predominantly centered around the theme of harming himself or others. For instance, at home he experienced thoughts such as, "What if I poison them? What if I put detergent in their yogurt drink?" when eating meals with family members. He also reported fears of hitting pedestrians, violent mental images of harming others, and avoidance behaviors related to seeing blood.

In response to these obsessions, the client engaged in checking behaviors (verifying the stove and door locks, turning back to recheck), neutralization strategies (mentally convincing himself, seeking reassurance), and avoidance behaviors. Daily, he frequently experienced probability-based thoughts such as, "What if I did it? What if I do it? What if I get caught?" The client recognized that these rituals and checking behaviors temporarily reduced his anxiety, but, their intensity and frequency increased over time. These behaviors have been assessed as non-functional and as factors perpetuating the persistence of anxiety.

The onset of symptoms was reported around the ages of 17–18, coinciding with a period marked by reccurent panic attacks. Recalling his childhood, he also described fears such as "Someone will come from behind and stab me while I am walking down the street." Overall, he appeared to establish a direct connection between thoughts and actions, holding the belief that "people are responsible for what comes to their mind; if I monitor my thoughts sufficiently, I can prevent harm from occurring." This cognitive style, characterized by thought–action fusion and an exaggerated sense of responsibility, played a prominent role in the client's symptomatology.

History

The client reported having an anxious temperament since the age of six. The first obsessive-compulsive symptoms emerge around the ages of 17–18, following a period of panic attacks. These initial panic attacks were described as related to fear of death and were reported to merge with early fears, such as "Someone will come from behind and stab me while I am walking down the street."

In his childhood history, a preschool accident in which he fell onto a broken glass and lost the tip of his finger is noteworthy. From a developmental perspective, he described his father as calm, well-intentioned, and protective, and his mother as helpful but sometimes irritable, intrusive, and excessively anxious. In his relationship with his mother, particularly in early childhood, punitive approaches such as shouting, physical punishment, and being locked in a dark bathroom were prominent, whereas the father was perceived as assuming a more protective and calm role. The mother's persistent catastrophic thinking and excessively anxious behaviors were also identified as environmental factors contributing to the maintenance of his symptoms.

The family environment was generally characterized by a harmonious parental relationship and a cultural framework in which religious rituals (particularly attending Friday prayers) were emphasized. During childhood, he experienced moderate difficulties in forming friendships and developed only a limited number of close relationships.

Reviewing his past psychiatric history revealed that panic disorder preceded the onset of obsessive-compulsive symptoms. During panic attacks, he experienced intense fear of death, and similar anxieties recurred during his university years. For example, after falling off a bicycle, he thought, "What if I am having a brain hemorrhage?" and during an incident in which he mistakenly believed his brother had died, he reported "freezing completely."

When asked about a specific fear, he reported that in childhood he often thought, "Someone will come from behind and stab me while I am walking down the street." His academic performance was good in primary school and average throughout middle school, high school, and university.

Overall, the client's psychiatric history is characterized by an early-onset anxious temperament, panic attacks, and the subsequent development of obsessive-compulsive symptoms. Familial predisposition (OCD in the mother, panic disorder in the maternal aunt), traumatic experiences during childhood, and parental attitudes emerge as salient elements in his clinical history.

Assessment

The client first presented to the Psychiatry Outpatient Clinic of Cerrahpaşa Medical Faculty in February 2012 with complaints of obsessions and compulsions, where he was diagnosed with Obsessive-Compulsive Disorder (OCD). The initial assessment yielded the following scale scores: Yale-Brown Obsessive Compulsive Scale (Y-BOCS) = 22 (moderate OCD) and Padua Inventory = 74. These scores are consistent with marked obsessive and compulsive symptoms.

During the treatment process, symptom severity was monitored at regular intervals. Assessments were conducted at baseline, after the 10th, 20th, and 30th sessions, and at a follow-up meeting six months after the end of treatment. The evaluation included the Yale-Brown Obsessive Compulsive Scale (Y-BOCS), the Padua Inventory, the Beck Depression Inventory (BDI), and the Beck Anxiety Inventory (BAI). This allowed for systematic tracking of both obsessive-compulsive symptom severity and changes in depressive and anxiety levels. Psychotherapy was conducted by an experienced cognitive therapist (the author of this paper), certified by the Academy of Cognitive Therapy (ACT) and a member of the European Association for Behavioral and Cognitive Therapies (EABCT). At the time this case was addressed, he had four years of clinical experience and had also received ERP training as part of his CBT training. At that time, he

had been working with the 4T model for one year. The model was developed based on treatment challenges encountered in clinical studies conducted with OCD patients, systematic readings related to Islamic intellectual traditions, in-depth examination of Muslim scholars' texts on cognition and mental processes, and discussions and negotiations with contemporary experts.

Scales

Yale-Brown Obsessive Compulsive Scale (Y-BOCS) – Self-Report Form. The scale was developed by Goodman et al. (1989), translated into Turkish by Türkçapar (2005), and its validity and reliability study was conducted by Koçoğlu and Bahtiyar (2021). Y-BOCS is designed to assess the subtypes and severity of obsessive-compulsive symptoms. It consists of 10 items, each scored from 0 (no symptoms) to 4 (very severe symptoms), yielding a total score that ranges from 0 to 40. The total score is obtained by summing the first five items related to obsessions and the second five related to compulsions. Scores are classified as follows: 0–7 subclinical, 8–15 mild, 16–23 moderate, 24–31 severe, and 32–40 extreme. The Cronbach's alpha coefficient for the total sample was .96 in the Turkish validation study (Koçoğlu & Bahtiyar, 2021).

Padua Inventory (PI). Developed by Sanavio (1988) to assess the severity and distribution of obsessive-compulsive disorder symptoms, the PI is a 60-item self-report scale. It consists of five subscales: contamination, obsessional thoughts, impulsivity, checking, and reassurance. Each item is rated from 0 to 4. The total score is calculated by summing all subscales scores, with higher scores indicating greater severity of OCD symptoms. The Turkish validity and reliability study reported a Cronbach's alpha of .95 (Beşiroğlu et al., 2005).

Beck Depression Inventory (BDI). Developed by Beck et al. (1961) to evaluate behavioral symptoms of depression, the BDI is a 21-item self-report scale. Each item is scored from 0 and 3, yielding a total score ranging from 0 to 63, with higher scores indicating greater severity of depression. The Turkish validity and reliability study reported a Cronbach's alpha coefficient of .80 (Hisli, 1989). The study concluded that the scale is a valid and reliable measure of depressive symptoms.

Beck Anxiety Inventory (BAI). Developed by Beck et al. (1988) to assess anxiety severity, the BAI is a 21-item self-report scale. Each item is scored from 0 and 3, yielding a total score ranging from 0 to 63, with higher scores indicating more severe anxiety. The Turkish version of the scale demonstrated high internal consistency (Cronbach's alpha coefficient = 93) and was found to be a valid measure of anxiety severity (Ulusoy et al., 1998).

Case Conceptualization

This case was formulated based on Türkçapar's (2017) cognitive-behavioral model of OCD (see Figure 1). The client presents with symptoms consistent with a diagnosis of Obsessive-Compulsive Disorder (OCD). His primary obsessions center on themes of harming himself or others (e.g., "What if I poison my family's food?", "What if I accidentally run someone over?", "What if I mistakenly signed an official document?"). These intrusive thoughts are interpreted by the client as "If it comes to my mind, it means I might do it," an interpretation that triggers intense anxiety, guilt, and perceptions of danger.

To reduce this anxiety, the client engages in avoidance behaviors (e.g., keeping chemical substances away from the dining table, avoiding documents), compulsive checking (e.g.,

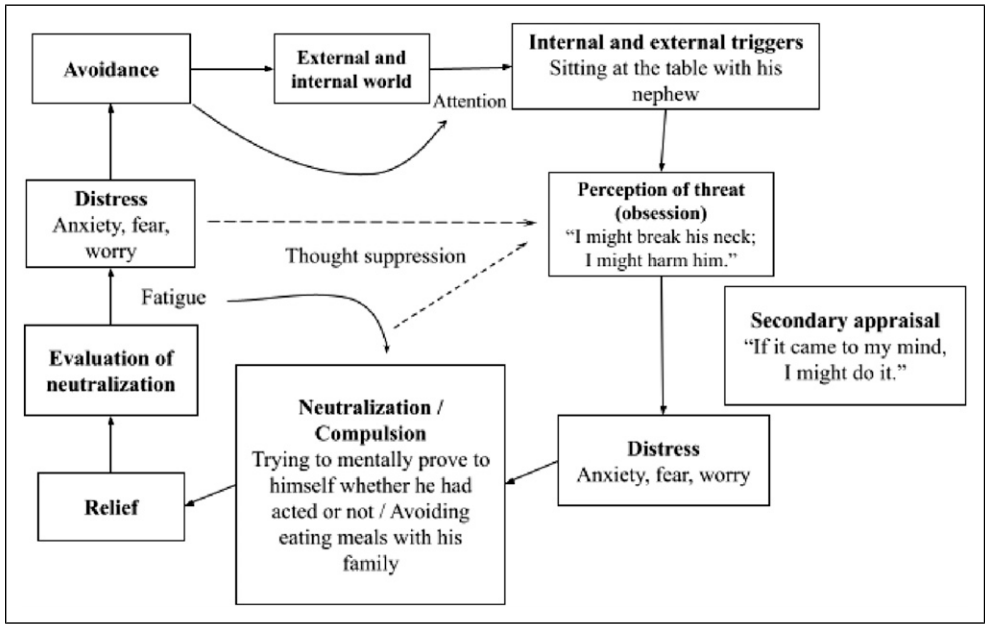

Figure 1. The cognitive-behavioral model of obsessive-compulsive disorder (adapted from Türkçapar, 2017)

repeatedly checking the stove and door locks, checking the rearview mirror while driving, reviewing documents multiple times), and neutralization (e.g., mentally convincing himself by repeating "I did not do it"). While these strategies provide short-term relief, in the long run, they contribute to the persistence of obsessions and anxiety.

The client's cognitive framework is shaped around a personal schema ("I am dangerous; I may harm others"), maladaptive assumptions ("People are responsible for what comes to their mind"), conditional beliefs ("If I monitor my thoughts sufficiently, I can prevent harm"), and related automatic thoughts ("What if I sign it?", "What if I put detergent in the yogurt drink?"). This belief structure is consistent with thought–action fusion and an inflated sense of responsibility.

The behavioral patterns are reinforced particularly by a tendency to organize life according to the principle of "minimum risk." The client's tendency to avoid close relationships is consistent with this tendency, reflecting an effort of "reducing the possibility of disruption." This cognitive-behavioral cycle has led to significant functional impairments, including considerable loss of time and distress in daily life areas such as decision-making and document processing at work, driving, and having meals with family members.

Cognitive-Behavioral Therapy (CBT) was employed as the treatment framework, targeting thought-action fusion, inflated responsibility beliefs, and compulsive safety behaviors. Core interventions included exposure and response prevention (ERP), cognitive restructuring, behavioral experiments, and the discontinuation of neutralization strategies. In addition, the integration of the 4T psychoeducation model, tailored to the client's religious and cultural context, aimed to help him grasp that obsessive thoughts do not entail responsibility and to facilitate the differentiation between intrusive thoughts and confirmed beliefs.

Course of Treatment and Assessment of Progress

General CBT and ERP Framework (Standard Treatment Framework)

The therapy process was carried out over a total of 30 weekly sessions, once a week. The initial sessions aimed to conduct a detailed assessment of the client's obsessions and compulsions, identify treatment goals, and establish the therapeutic framework.

During the first three sessions, the client's problem areas and OCD symptoms were examined in detail, and a cognitive-behavioral formulation was established based on examples of his obsessions and compulsions. The client was assigned homework to record the emotion–thought–behavior–situation cycle, and "golden rules" for coping with obsessions were introduced.

During the fourth and fifth sessions, the nature of obsessions was explained using metaphors (e.g., the beehive, the pink elephant), and psychoeducation was provided regarding the function of anxiety, stress postponement, and the assessment of anxiety severity.

During sessions six through eight, the client kept daily records of obsessions and analyzed the event–thought–emotion–behavior chain in detail. In this process, the client's cognitive formulation was restructured, and skills for coping with intrusive thoughts were developed.

Beginning with the ninth session, psychoeducation based on the 4T model was initiated, while ERP procedures were planned, and graded exposure to anxiety-provoking triggers was conducted.

Between sessions 13 and 20, the focus was placed on the client's harm-related obsessions. ERP interventions were conducted in situations such as signing documents, driving, and preparing meals (e.g., driving at least three times, preparing food in the kitchen without avoidance, eating meals with family members). In addition, coping cards were prepared, and behavioral experiments were implemented.

After the 20th session, a marked reduction in symptoms was observed, with the frequency and severity of obsessions significantly declining. Between sessions 22 and 30, the work primarily focused on the client's personality traits, relational patterns, and general coping styles. During this phase, the client reported a marked reduction in OCD-related avoidance behaviors, increased ability to confront triggering stimuli, and a significant return to normal daily functioning. At this stage, the client requested to address a longstanding fear of death and the associated stress; this fear was understood to have been present for a long time but had receded into the background with the onset of OCD symptoms. During the therapeutic process, stress related to the fear of death was identified as a trigger for the emergence of OCD; accordingly, interventions focused on managing daily life stress, tolerating death-related uncertainty, and developing resilience skills.

In subsequent sessions, the stress related to life events (return to job interviews, starting work, and sorting out family relationships) was addressed. The therapist guided the client in developing stress regulation skills and strategies for managing challenging thoughts. In the final sessions, the importance of managing life stress, tolerating uncertainty, and coping with distress in the context of OCD was re-emphasised. The process concluded with a review of core cognitive therapy skills and reviewing the 4T formulation.

By the end of treatment, the client had progressed in managing his obsessions and developed greater behavioral flexibility in behaviors areas of life previously constrained by a "minimum risk" principle.

The 4T Psychoeducation: an Original Intervention

The 4T Model is a psychoeducational framework grounded in Said Nursi's explanations regarding cognitive processes (Toprak, 2021; 2024). It was designed to facilitate a better understanding of religiously themed obsessions and help individuals distinguish involuntary thoughts from

voluntary confirmation. This approach clarifies interpretations, such as "If it comes to my mind, I might do it" or "What if I have already done it?" as cognitive events that do not entail responsibility.

In this case, the 4T model was implemented in a comprehensive manner, integrated with ERP interventions. The client first received psychoeducation based on the 4T model (Tahayyul–Tasawwur–Taakkul–Tasdiq). As illustrated in Figure 2, the model conceptualizes the formation of the client's obsessive thoughts across four hierarchical mental stages, distinguished by the level of volition and the degree of attributable responsability. In the *tahayyul* stage, spontaneous images or pictures come to mind involuntarily. These contents arise beyond voluntary control and remain only at the level of mental image. In Figure 2, the image of breaking a child's neck representss to the *tahayyul* stage; as there is no intention or confirmation at this level, there is no responsibility. In the tasawwur stage, this initial image evolves into a more detailed and structured thought; the mind constructs an imaginary scenario, but this process is still involuntary and automatic. For example, the mental re-enactment detailed as approaching the child, shouting at them, swearing at them, and breaking their neck corresponds to the *tasawwur* level. Although this stage presents more organised content than *tahayyul*, it still does not involve voluntary choice or confirmation. In the *taakkul* stage, the individual begins to evaluate the *tasawwur* in their mind according to moral, logical, or religious criteria. This stage may be partially voluntary, but it does not entail responsibility as long as the thought has not yet been confirmed. This reasoning process is illustrated in Figure 2: is it morally right to break the neck of an innocent person? *Taakkul* involves dwelling on a thought without necessarily embracing it. The tasdiq stage, however, marks the critical point where the thought is voluntarily confirmed or rejected, with the individual making a deliberate decision to accept or reject the mental content. In Figure 2, deciding whether or not to confirm the idea of breaking the neck represents the *tasdiq* stage. Responsibility[1] only arises at this stage, as the thought ceases to be a passive mental event and becomes part of a voluntary action. The fundamental distinction in this model is the difference between the emergence of mental content and its voluntary adoption/confirmation. This approach helped the client adopt a more flexible and detached attitude towards obsessive content, enabling a clear distinction between involuntary thoughts and voluntary confirmation processes. This distinction provides an explanatory framework, particularly in the moral interpretation of obsessive thoughts and clinical assessment.

ERP applications, on the other hand, were structured to have the client deliberately enter avoided situations and identifying the obsessive thoughts that arise during this time within the framework of the 4T model. For instance, when addressing obsessions related to harming children,

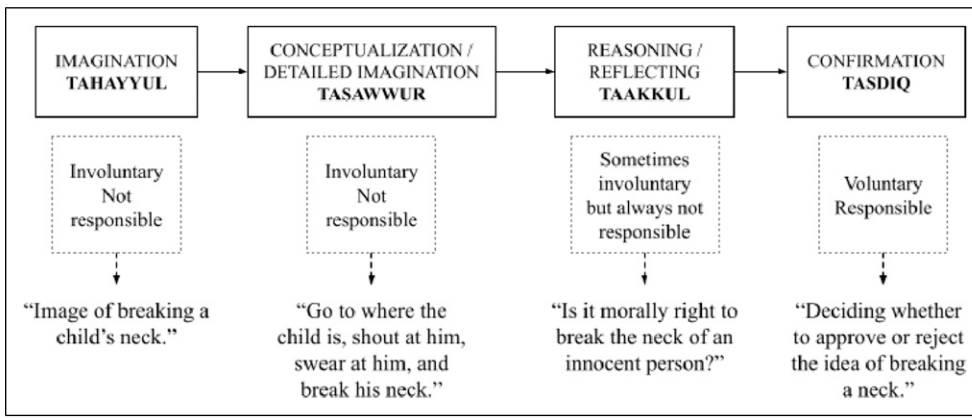

Figure 2. Formulation of the client's obsessions through the 4T model

the client was asked to remain in the presence of children, refrain from leaving, and continue exposure without resorting to any safety behaviors. Similarly, when obsessive thoughts about poisoning his father's yoghurt drink with a pill arose, the client was instructed to remain with his father and have breakfast together as part of the ERP protocol. During these exposures, the 4T model was repeatedly used to clarify that the content that commingto mind consisted of mental events that remained at the level of *tahayyul* or *tasawwur* and did not require action unless confirmed. The goal was for the client to tolerate uncertainty and anxiety while remaining in the environment instead of avoiding or neutralising obsessive thoughts.

Through systematic psychoeducation provided during sessions, the client learned to to distinguish between cognitive layers. It has been emphasised that obsessive content may arise at the level of *tahayyul* or *tewehhum*, but that the individual cannot be held responsible for this content until it reaches the confirmation stage. During ERP, this distinction enabled the client to remain in feared situations and to regard obsessive thoughts as temporary and involuntary mental events rather than interpreting them as indicative of intent or moral failings. This awareness contributed to a marked reduction in both anxiety levels and the frequency of resorting to compulsive behaviors.

Treatment Outcomes. Throughout treatment, standardized measures were used to monitor changes in OCD severity, depression, and anxiety. Assessments were administered at the 10th, 20th, and 30th sessions. Scores on the Beck Depression Inventory (BDI), Beck Anxiety Inventory (BAI), Yale–Brown Obsessive Compulsive Scale (Y-BOCS), and Padua Inventory demonstrated gradual and clinically meaningful improvement over the course of therapy (see Figure 3).

At Session 10, scores were BDI = 19, BAI = 24, Y-BOCS = 24, and Padua = 82. By Session 30, scores decreased to BDI = 16 (16% reduction), BAI = 15 (38% reduction), Y-BOCS = 13 (46% reduction), and Padua = 58 (29% reduction). The most pronounced improvement was observed in

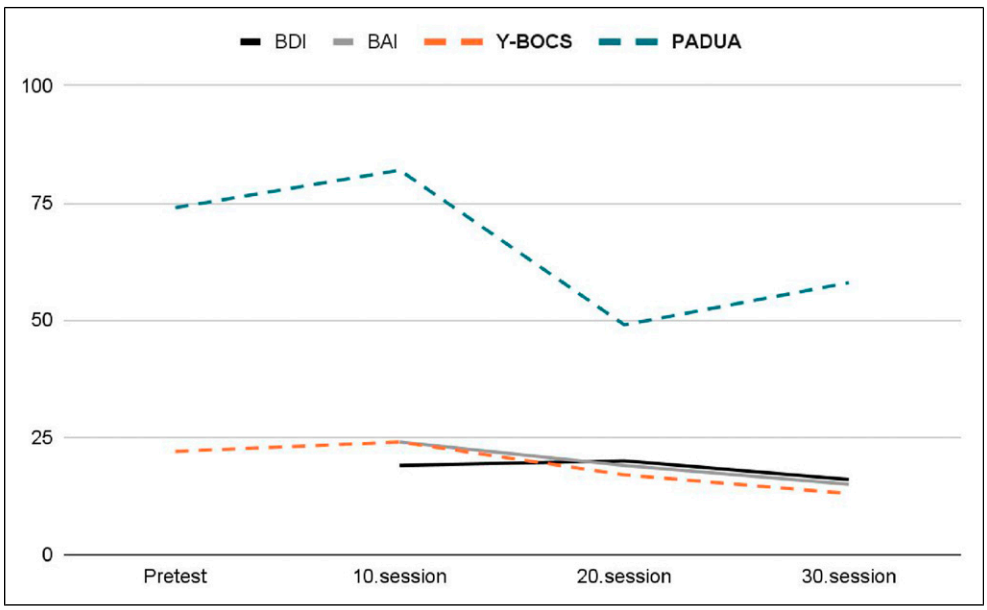

Figure 3. Assessment measures at pretest, session 10, session 20, and session 30.
Note. BDI = Beck Depression Inventory; BAI = Beck Anxiety Inventory; Y-BOCS = Yale–Brown Obsessive Compulsive Scale; Padua = Padua Inventory

obsessive–compulsive symptoms, with Y-BOCS scores decreasing by nearly 50%, while depressive and anxiety symptoms also showed consistent decreases.

Qualitative feedback provided by the patient supports these quantitative improvements. For example:

> "When you explained 4T by simplifying the terms, I was blessed to understand the difference between imagination and confirmation; I used to mix them up."

> "When I first envisioned that I was breaking the boy's neck, I looked at my hands, whether it was for real. Now I know this is merely an imagination."

These reflections highlight the role of the 4T psychoeducation in helping the patient distinguish involuntary thoughts from responsible confirmations, thereby reducing distress associated with intrusive harm-related obsessions.

Complicating Factors

During the therapy process, the client exhibited certain Cluster C personality traits (e.g., excessive need for control, tendencies toward perfectionism) alongside obsessive-compulsive symptoms. These traits particularly made it challenging to tolerate anxiety during exposure (ERP) exercises and increased the tendency to resort to compulsions.

Additionally, the client demonstrated pronounced anxiety sensitivity, interpreting physical anxiety symptoms (e.g., palpitations, restlessness) as indicators of danger, which intensified perceived threat elicited from obsessions. Obsessive personality traits and a significant level of anxiety, occasionally hindered adaptation to therapy. Although these factors initially slowed treatment progress, they were gradually addressed through structured psychoeducation and cognitive reframing over therapy. As the client gained clearer understanding of the meaning and source of the symptoms during the therapeutic process, and as the applied model became more acceptable to him, these adaptation difficulties gradually diminished.

Access and Barriers to Care

There were no significant barriers to the patient's access to care. All therapy sessions were conducted face-to-face in an outpatient setting, and the patient demonstrated consistent attendance throughout the 30-session treatment. Flexible scheduling supported treatment continuity and adherence.

Follow-Up

At the six-month follow-up, the client's scores were as follows: Beck Depression Inventory (BDI) = 12, Beck Anxiety Inventory (BAI) = 18, Y-BOCS = 13, and Padua Inventory = 45. Post-treatment, the Y-BOCS score had declined to the mild-moderate range. In the literature, a reduction of 35% or greater in Y-BOCS scores is considered a clinical significance criterion (Gershkovich et al., 2017), and a score of ≤12 is defined as the threshold for "clinical wellness" (Farris et al., 2013). The client's current outcome is quite close to this threshold.

Qualitatively, the client reported that obsessive thoughts still came to mind occasionally but were no longer perceived as threatening, that avoidance behaviors had decreased, and that he had learned that mere persistence of thoughts in his mind did not indicate their "truth." He also reported feeling generally well in terms of overall mood.

Treatment Implications of the Case

In this case study, a client presenting with symptoms of obsessive-compulsive disorder (OCD) was treated using cognitive-behavioral therapy (CBT) and exposure and response prevention (ERP), in combination with the 4T approach, an original psychoeducational model. Progress was evaluated through quantitative measures (Y-BOCS, Padua, Beck Depression and Anxiety Inventories) and qualitative feedback. The findings indicate a marked reduction in the frequency and severity of the client's obsessions, particularly a decrease in anxiety related to harm-related obsessions. The client also learned to differentiate between the processes of "imagination" and "confirmation," thereby distinguishing involuntary thoughts from responsibility-laden actions. Moreover, at baseline, the client demonstrated low confidence in therapy and treatment and showed limited insight into the obsessive nature of his intrusions. Over the course of therapy, both perceived treatment credibility and insight appeared to increase (e.g., the client more consistently labeled intrusive thoughts as obsessions), though, these process-level changes were based on the therapist's observations rather than formally quantified.

The findings of this case study are consistent with the broad literature highlighting the effectiveness of cognitive-behavioral therapy (CBT) and ERP in treating OCD (e.g., Abramowitz, 1996; Eddy et al., 2004; Olatunji et al., 2013). A marked reduction in the severity of obsessions and compulsions was achieved, once again demonstrating the clinical value of standard treatment protocols. However, as frequently emphasized in the literature (Clark, 2005; Stanley & Turner, 1995), religious and aggressive obsessions tend to be relatively more resistant to ERP. This case also supports that observation: while the standard protocol led to a notable reduction in symptoms, it was insufficient to fully address obsessions.

At this point, the 4T psychoeducation provided a culturally and religiously sensitive cognitive reframing, reduced the client's tendency toward thought-action fusion, and fosteredf a more flexible attitude toward intrusive thoughts. Furthermore, the client's ability to situate his thoughts within different cognitive layers through the 4T model demonstrated the efficacy of adding religious and cultural psychoeducation into treatment. This contribution supports the clinical value of recently emerging culturally and religiously sensitive psychotherapy approaches (Abu-Raiya & Pargament, 2011; Pargament, 2007).

Recent research on the clinical applications of the 4T Psychoeducation Model has highlighted its significant contributions to enhancing insight, alleviating symptoms, and reframing religious concerns, particularly in religiously themed OCD cases (Karakan & Toprak, 2023; Toprak, 2024; Çetiner & Toprak, 2025). Notably, the 4T model proved beneficial in this case despite the absence of religious content suggests that itsutility derives from cultural adaptation and the persuasive cognitive framework it provides. This observation indicates that the model may have a broader scope at the level of cognitive functioning and may also apply to different themes, such as harm-related obsessions.

Nevertheless, identifying the exact source of the 4T's effectiveness remains challenging. Its benefits may stem partly from the conforting nature of religious/cultural references and partly from its cognitive structure, which clearly differentiates between thought, action, and responsibility. Therefore, comparative studies with larger samples must clarify which components account for their contributions.

In conclusion, this case study suggests that the 4T psychoeducation may be a helpful intervention not only for religious obsessions but also for non-religious types of obsessions. This finding indicates that the model can be regarded as a religiously and culturally sensitive approach, as well as a functional tool for addressing thought-action fusion and maladaptive perceptions of responsibility.

This case study has several limitations. First, the generalizability of the findings is limited, as they are derived from a single client. In addition, the treatment process was conducted by a therapist proficient in both CBT/ERP and 4T psychoeducation, raising the question of whether the method would produce the same effects when implemented by different practitioners. Although the changes in scale scores were clinically significant, the follow-up period was relatively short and does not allow definitive conclusions about long-term sustainability.

Future research would benefit from systematically examining the effects of the 4T model across different obsessional themes (e.g., sexual, symmetry, contamination). Furthermore, the finding that 4T may be effective in both religious/cultural and non-religious obsessions should be tested in randomized controlled trials with larger samples. Finally, studies comparing the effectiveness of 4T psychoeducation when combined with ERP and CBT versus when applied alone are crucial for clarifying the model's clinical value.

Recommendations to Clinicians and Students

Treatment-resistant obsessive-compulsive disorder (OCD) remains a significant clinical challenge (Middleton et al., 2018; Mishra et al., 2007). Evidence-based cognitive-behavioral therapy (CBT) and exposure and response prevention (ERP) are recognized as the primary and most effective interventions for this disorder (Hudepohl et al., 2022; Reis et al., 2024; Salkovskis, 1999; Whittal et al., 2010; Wu & Storch, 2016). However, as illustrated in this case and noted in the literature (Clark, 2005; Stanley & Turner, 1995), CBT and ERP do not always yield sufficient clinical improvement; a more resistant course is often observed, particularly in religious and aggressive obsessions. In this context, complementary psychoeducational models, such as the 4T Psychoeducation Model, emerge as important options for clinicians, offering a promising cognitive framework. Previous research has shown that the model is beneficial in enhancing insight, alleviating symptoms, and reframing religious concerns in religiously themed obsessions (Karakan & Toprak, 2023; Toprak, 2024; Çetiner & Toprak, 2025). Notably, its effectiveness in harm-related, non-religious obsessions, as observed in this case, suggests that the 4T's strength lies in its religious/cultural adaptation and the persuasive cognitive explanations it provides.

Therefore, without disregarding the fact that CBT and ERP remain the core treatment protocols, the integration of psychoeducational models such as the 4T constitutes a promising tool for clinicians, particularly in cases of resistant obsessions. Such models may help clients restructure thought–action fusion tendencies, differentiate involuntary thoughts from voluntary confirmation processes, and enhance their motivation for treatment and insight into their obsessions. Future research should systematically investigate the applicability of the 4T across different obsessional themes (e.g., contamination, symmetry) and evaluate its effectiveness in combination with CBT/ERP and as a standalone intervention.

Author Note

This manuscript is a revised and expanded version of a poster presentation that included only quantitative outcomes and qualitative feedback from the same case, which was previously presented at the *23rd Annual OCD Congress* (Chicago, July 27–31, 2016).

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ORCID iD

Taha Burak Toprak https://orcid.org/0000-0001-7958-4181

Ethical Considerations

The study was conducted in accordance with the Declaration of Helsinki. In line with institutional regulations for case reports or case series, ethics committee approval was not required.

Consent to Participate

The patient was admitted to the university hospital as part of routine clinical care.

Author Contributions

Taha Burak Toprak: Conceptualization; Writing – Review & Editing.

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Data Availability Statement

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

Declaration of Generative AI and AI-assisted Technologies in the Writing Process

During the preparation of this manuscript, the author used ChatGPT for translation, grammar refinement, and improvements in readability and clarity. After using this tool, the author carefully reviewed, revised, and approved the final version and takes full responsibility for the published content.

Note

1. According to this model, the minimum condition for responsibility is that a person's interaction with certain content does not remain at the cognitive level but manifests itself at the level of action. In other words, the fundamental element that determines responsibility is the state of 'acting'; a person is held responsible not for the thoughts and associations that pass through their mind, but for the behaviors and actions they voluntarily exhibit. Similarly, the act of 'confirming' a thought or idea is understood not merely as an internal assertion of belief, but also its expression through speech, attitude, and behavior. Therefore, believing a thought to be correct does not, on its own, imply moral/religious responsibility unless it is expressed or acted upon. For example, related to the context in which the model was developed, for a person to be considered a non-believer, it is not sufficient for them to simply arrive at the conviction that 'non-belief is a more correct view'; it is assumed that this conviction must be clearly expressed and that corresponding actions must be taken.

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Author Biographies

Taha Burak Toprak: He completed his undergraduate studies in Sociology and Psychology at Istanbul University, and earned his Master's degree in Sociology at the same university as TÜBİTAK Domestic Graduate Scholarship holder. He subsequently completed the Master's Program in Clinical Psychology at Okan University, and in 2022, he completed PhD in Clinical Psychology at Hasan Kalyoncu University. Between 2010 and 2019, he worked as a clinical psychologist and psychotherapist at a hospital. From 2018 to 2023, he taught undergraduate and graduate courses in the Departments of Psychology of several universities. He is currently a faculty member in the Depertmant of Psychology at Ibn Haldun University, where he also serves as Head of the Department of Psychology, Head of the Clinical Psychology Division, and Director of the Center for Islam and Psychology. In the field of psychotherapy, he has received training both in Turkey and abroad in Psychoanalysis, Cognitive Behavioral Therapy, Existential Therapy, Family Therapy and Group Therapy. His academic work focuses on the philosophical foundations of psychology and psychotherapy, the relationship between the theoretical and practival sources of the Islamic intellectual tradition and modern psychology and psychotherapy, and the development of original explanatory and intervention models within this framework. He conducts research and has publications on family, obsessive-compulsive disorder, trauma, psychotherapy and morality. Within this scope, he continues to serve as the founding president of the Association for Psychology and Psychotherapy Research, which he co-founded with colleagues in 2020.