

## ARTICLE

# Effective factors in the psychotherapy of religious obsessive-compulsive disorder: A qualitative study

Taha Burak Toprak<sup>1,2</sup> <sup>1</sup>Department of Psychology, Ibn Haldun University, Istanbul, Turkey<sup>2</sup>Association for Psychology and Psychotherapy Research, Istanbul, Turkey**Correspondence**Taha Burak Toprak, Department of Psychology, Ibn Haldun University, Istanbul, Turkey.  
Email: [tahaburaktoprak@gmail.com](mailto:tahaburaktoprak@gmail.com)**Abstract**

**Background:** Religious obsessive-compulsive disorder (religious OCD; scrupulosity) presents unique challenges in psychotherapy due to the interaction between religious beliefs and obsessive-compulsive symptoms. Understanding how individuals benefit from psychotherapy in this context can inform more effective and culturally sensitive treatment approaches.

**Aims:** This study aimed to explore the factors that make psychotherapy effective for individuals experiencing religious obsessions and compulsions.

**Method:** A qualitative design based on a phenomenological approach was employed. In-depth semi-structured interviews were conducted with nine participants diagnosed with religious OCD. The collected data were analysed using thematic analysis to identify the core themes that contribute to therapeutic benefit.

**Results:** The findings revealed several dimensions that enhanced the therapeutic process. The therapist's competence in religious knowledge and ability to apply this knowledge meaningfully contributed to treatment effectiveness. Participants emphasized that the therapist's religiosity fostered trust and a sense of being understood. Additionally, evidence-based psychotherapeutic methods, such as normalization and psychoeducation, added value to the process. A key finding was that an integrative approach combining religious and scientific psychotherapy knowledge substantially improved outcomes. The therapist's non-judgemental, empathetic and sincere attitude further facilitated clients' sense of safety and engagement in therapy.

**Conclusions:** Effective psychotherapy for religious OCD requires a holistic approach that integrates religious sensitivity

This is an open access article under the terms of the [Creative Commons Attribution-NonCommercial-NoDerivs](https://creativecommons.org/licenses/by-nc-nd/4.0/) License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial and no modifications or adaptations are made.

© 2026 The Author(s). *British Journal of Clinical Psychology* published by John Wiley & Sons Ltd on behalf of British Psychological Society.

with evidence-based therapeutic skills. Such integration plays a crucial role in enhancing client trust, understanding and overall recovery.

#### KEYWORDS

qualitative research, religious obsessive-compulsive disorder (scrupulosity), thematic analysis, therapeutic factors

## INTRODUCTION

Obsessive-compulsive disorder (OCD) is a mental disorder that significantly restricts an individual's life and affects approximately 1–3% of the global population (APA, 2013; Strom et al., 2021; Zai et al., 2019). Diagnostically, obsessions are defined as persistent thoughts, urges, or images that cause distress, while compulsions are repetitive behaviours or mental acts performed in response to these obsessions (APA, 2013). OCD demonstrates high comorbidity with diagnoses such as depression and generalized anxiety disorder and is considered one of the psychiatric disorders with the most significant impact on functioning (Stein et al., 2019).

In the treatment of OCD, the combined use of psychotropic medication and psychotherapy is recommended (Rasmussen & Eisen, 1997). From a psychotherapeutic perspective, the method with the strongest empirical support is cognitive-behavioural therapy (CBT). In particular, exposure and response prevention (ERP) has emerged as a well-established intervention with demonstrated efficacy (Foa et al., 1984; Gava et al., 2007; Koran et al., 2007; Öst et al., 2014; Reid et al., 2021; Rosa-Alcázar et al., 2008). While ERP aims at gradual habituation to anxiety-provoking stimuli, cognitive interventions focus on restructuring dysfunctional beliefs (NICE, 2006). Systematic reviews have shown that ERP, along with integrative CBT approaches, is among the most effective interventions (Carpenter et al., 2018; Eddy et al., 2004; Öst et al., 2014, 2022; Rosa-Alcázar et al., 2008).

Nevertheless, despite these established methods, some patients do not achieve sufficient symptom reduction or experience relapse. For example, a meta-analysis reported a 48% reduction in symptoms following ERP, with a substantial portion of patients continuing to experience symptoms post-treatment (Abramowitz et al., 2002). Similarly, Abramowitz (2006) and Eddy et al. (2004) reported that not all patients benefit equally from treatment. Indeed, despite appropriate protocols, 40–60% of patients struggle with residual symptoms (Hirschtritt et al., 2017; Pallanti & Quercioli, 2006). These findings demonstrate the need for new intervention strategies and a better understanding of factors influencing treatment response (Reis et al., 2024).

Treatment resistance or limited benefit becomes particularly evident in OCD subtypes. Research has shown that sexual and religious obsessions are among the subtypes predicting poor treatment outcomes (Abramowitz et al., 2003; Alonso et al., 2001; Ferrão et al., 2006; Mataix-Cols et al., 2002; Rufer et al., 2005). In this context, religious OCD (scrupulosity) stands out as a subtype characterized by its unique challenges (Buchholz et al., 2019; Deacon & Nelson, 2008).

Religious obsessions may manifest as doubts about having committed a sin, anxiety about engaging in immoral behaviour unintentionally, fear that impulses may get out of control, doubts about one's devotion to God, fears that prayers will not be accepted, or concerns about being punished with hell. Accompanying compulsions include the flawless repetition of prayer, recitation, remembrance and repentance; verification that religious obligations have been completely fulfilled; constant reassurance-seeking; self-punishment behaviours; or avoidance of people, topics and environments perceived as threatening to one's faith (Abramowitz & Hellberg, 2020; Abramowitz & Jacoby, 2014; Toprak, 2018).

The treatment difficulties associated with this subtype stem from several factors. First, because religious obsessions are not readily subject to “disconfirming” evidence, they may limit exposure exercises. Second, as therapists are not religious authorities, they are not expected to explain the religious consequences of specific thoughts, which adds further complexity to the process (Steketee et al., 2011).

### Practitioner points

- Therapists treating clients with religious obsessive-compulsive disorder (scrupulosity) should integrate religious sensitivity with evidence-based psychotherapeutic methods.
- Therapists' religiosity and competence in religious knowledge can strengthen client trust, understanding and therapeutic alliance.
- Combining religious and scientific (psychological) expertise—the “dual-wing” approach—enhances treatment engagement and outcomes in religious OCD.
- Non-judgemental, empathic and sincere therapeutic attitudes are essential for creating a safe environment where clients can openly discuss religious cognitive content.

Moreover, questions such as how to distinguish everyday religious practices from obsessive-compulsive behaviours, how to adapt exposure exercises to religious sensitivities, and when to involve religious authorities in the process constitute significant challenges in therapy (Huppert & Siev, 2010).

Furthermore, CBT faces certain limitations when addressing the sources of obsessive content, particularly in differentiating between faith and obsessive thoughts (Toprak, 2024). To address such difficulties encountered during treatment, three approaches have emerged: (1) increasing sensitivity to the values of religious individuals, (2) integrating religious knowledge and practices into existing theoretical models and (3) developing original models derived from religious texts (Toprak, 2022).

One such original model, the 4T model, divides cognitive processes into layers and specifies the level at which responsibility is attributed. Through this approach, patients learned that they were not responsible for certain types of obsessional thoughts, and they benefited from therapy as a result (Toprak, 2024). Integrating a religious figure into the treatment process has also been beneficial (Huppert & Siev, 2010). Similarly, in cases where religious OCD patients were treated by a team including experts in religious sciences, patients addressed uncertainty and avoidance symptoms under the guidance of a religious mentor and also received religious knowledge from scholars, which contributed to their improvement (Akuchekian et al., 2011; Almasi et al., 2013). In another intervention, Aouchehian et al. (2017) integrated religious perspectives on OCD and jurisprudential knowledge into therapy, and patients reported benefiting from this approach. Likewise, a study in which the teaching of religious rules formed part of the intervention reported positive outcomes for the patient (Dehaghi et al., 2022).

In conclusion, the literature indicates that the therapeutic process in religious OCD carries unique challenges and that various intervention strategies may provide potential benefits. However, most of these studies have focused on treatment outcomes and have not sufficiently illuminated patients' subjective experiences of psychotherapy. This study, therefore, aimed to explore, in their own words, which aspects of psychotherapy individuals with religious OCD find beneficial, which elements contribute to recovery, and which areas remain insufficient. The findings are expected to deepen clinicians' insights and contribute to developing more effective intervention strategies tailored to different patient profiles.

## METHOD

### Research model and design

This study aimed to gain an in-depth understanding of the elements from which individuals with religious OCD benefited during the therapeutic process and to reveal these elements. Accordingly, a qualitative research approach was adopted. In qualitative research, the aim is not to generalise to a population but to examine in depth a central phenomenon, human experiences and perceptions (Creswell, 2011; Hatch, 2023; Merriam & Grenier, 2019).

The study was conducted within the framework of a phenomenological approach, one of the qualitative research designs. Phenomenology is a methodological framework that focuses on how individuals perceive, experience and make sense of the phenomena they encounter (Sokolowski, 2000). In this study, the descriptive phenomenological method was chosen because the objective was to explore participants' subjective experiences regarding the elements they found beneficial in the therapeutic process and to describe the underlying structure of meaning in these experiences.

In order to elicit participants' experiences in their own words, in-depth semi-structured interviews (Turner, 2010) were planned. This method involved pre-structured questions, which, however, could be varied or reordered depending on the course of the research process.

## Participants

The study group consisted of a total of nine Muslim participants who had been diagnosed with religious obsessive-compulsive disorder (OCD) and had undergone psychotherapy. Since the study specifically focused on the religious subtype of OCD, the primary inclusion criteria for participant selection were that individuals experienced religious obsessions and compulsions and had received psychotherapy for these symptoms. Other OCD subtypes or different psychopathologies were excluded from the scope of this research.

In order to use limited resources efficiently and effectively to reach valuable data sources, purposive sampling was employed (Yağar & Dökme, 2018). This method allows for the deliberate selection of participants who can best reflect a particular phenomenon and is widely preferred in phenomenological research (Creswell & Poth, 2016).

To access individuals with psychotherapy experience related to religious OCD, the researchers contacted psychotherapists practicing cognitive-behavioural therapy (CBT) through whom participants meeting the study criteria were identified.

The interviews were conducted between 07.07.2025 and 17.07.2025. Detailed information regarding the demographic and clinical characteristics of the participants is presented in [Table 1](#).

## Procedure

The study was approved by the Scientific Research and Publication Ethics Committee in Türkiye (Decision No: E-71395021-050.04-61,645). All procedures were carried out by ethical principles and standards to protect participants' rights.

The semi-structured interview form used in the study was developed based on a literature review and the opinions of field experts, and it consisted of seven main questions (see [Appendix A](#)). This structure

TABLE 1 Summary of participant characteristics (N=9).

Characteristic	Value
Gender	7 male (77.8%), 2 female (22.2%)
Age	$M = 31.6$ years, range = 15–46
Type of obsession	Autogenous: 6 (66.7%) Reactive: 3 (33.3%)
Psychotherapy status	Completed: 5 (55.6%) Dropped out: 4 (44.4%)
Religious approach in first therapy	Yes: 5 (55.6%) No: 4 (44.4%)
Y-BOCS obsession score	$M = 8.2$ , range = 1–17
Y-BOCS compulsion score	$M = 7.1$ , range = 0–16
Y-BOCS total score	$M = 15.3$ , range = 1–33

Abbreviation: Y-BOCS, Yale–Brown Obsessive Compulsive Scale.

provided flexibility to the interview process, allowing the researcher to ask in-depth follow-up questions while enabling participants to share their experiences naturally (Creswell & Poth, 2016).

The interviews were conducted with participants' consent and by principles of confidentiality. The study's purpose, method and voluntary nature were explained to participants before each interview. Audio recordings were taken only with participants' explicit consent and were subsequently transcribed for analysis. The participants' identities were kept confidential, and each was assigned an anonymous code.

## Qualitative analysis

The audio interview recordings obtained in the study were transcribed using the Transgate platform, and the researchers subsequently verified each transcript through repeated listening. As a result of this process, 112 pages of written data were obtained, and 240 codes were identified during the preliminary analysis.

The data were analysed following the six-phase thematic analysis approach proposed by Braun and Clarke (2006). First, all transcripts were examined holistically through repeated readings, and the researchers became familiar with the data (Phase 1: familiarization with the data). Next, meaningful data segments were systematically assigned to initial codes (Phase 2: generating initial codes). At this stage, the initial coding process was conducted by the author, after which two independent clinical psychologists/experts reviewed the codes and conducted a comparative evaluation. Differences between coders were discussed, and consensus was reached to form the final code list. This process aimed to increase reliability and consistency in the analysis.

Similar codes were grouped in the third phase to form candidate themes (Phase 3: searching for themes). In the fourth phase, these candidate themes were reviewed for consistency with the data, and necessary refinements were made (Phase 4: reviewing themes). In the fifth phase, themes were more clearly and comprehensively defined and named (Phase 5: defining and naming themes). In the final phase, the analysis results were interpreted and reported within the framework of the final thematic structure (Phase 6: reporting).

In qualitative research, it is generally acknowledged that the researcher's knowledge base and biases may influence the data during the analysis process (Sandelowski & Barroso, 2002). To enhance the study's trustworthiness, the process was conducted through comparative discussions among independent coders, and consensus was reached on codes with potential for divergent interpretations. Thus, the qualitative data obtained from therapy experiences related to religious OCD were analysed through a systematic, transparent and replicable thematic analysis process, in line with Braun and Clarke's (2006) recommendations.

## FINDINGS

### Overview

Five main themes and six subthemes were identified based on the thematic analysis of the interview data. These themes and their corresponding subthemes are presented in Table 2. The themes clustered around the following dimensions: the therapist's religiosity, the therapist's competence in religious knowledge and its application when necessary, the therapist's competence in and use of scientific psychological knowledge, the therapist's simultaneous competence in both religious and scientific knowledge, and the therapist's characteristics/attitudes in approaching the patient.

These themes holistically illustrate the different aspects of the benefits that individuals with religious OCD derive from psychotherapy. In the following section, each central theme will be examined in detail along with its subthemes and illustrative participant quotations. This structure aims to go beyond merely naming the themes by demonstrating the meanings contained within participants' experiences and how these contributed to psychotherapeutic benefit.

TABLE 2 Main themes and sub-themes.

*Theme One: The therapist being religious*

*Theme Two: The therapist's mastery of religious knowledge and its use when necessary:*

- Feeling understood
- Strengthening trust and reducing psychological tension
- Benefiting from religious figures
- Use of religious texts
- Referral to religious authorities
- Use of religious terminology

*Theme Three: The therapist's mastery and use of scientific psychological knowledge:*

- Normalization
- Formulation & Psycho-education for religious OCD
- Cognitive Interventions

*Theme Four: The therapist's mastery of both religious and scientific knowledge simultaneously*

*Theme Five: The therapist's approach/attitude toward the patient*

## Theme one: The therapist being religious

Participant accounts indicated that one of the important factors from which some individuals benefited during therapy was the therapist's religiosity. Particularly for individuals with strong religious sensitivities, the therapist's sharing of similar beliefs and values emerged as a factor that reinforced trust, facilitated the feeling of being understood and created a common ground for communication:

That is why, being religious and paying attention to such matters increases the likelihood that he could understand me better.

(P9)

I thought you had a more spiritual life, that you could understand me better, that we shared the same mindset.

(P6)

For many, the therapist's religiosity signalled an ability to empathize with experiences grounded in religious practice:

(As a religious person) He can empathize and put himself in my place.

(P4)

When I live my daily life praying, fasting, and attending to worship, if the therapist is also in this state, then it is easier for him to understand me.

(P1)

Some participants highlighted that having a therapist with similar sensitivities reduced the fear of being dismissed or misunderstood:

You share the same sensitivities. You can understand me by looking from my perspective.

(P6)

The therapist's religiosity was also linked to enhanced trust and emotional safety within the therapeutic relationship:

When a religious person says something, it quiets my inner voice more effectively.

(P2)

If a person is sincere in their religious life... you think, 'He believes what he is saying to be true.' Without that sincerity, trust is less.

(P3)

Several participants preferred a religious therapist because they believed that religious commitment ensured sincerity, accuracy, and moral responsibility:

At the end of the day... the fear of God comes into play. He fears God, not me.

(P8)

In addition, participants reported that religious therapists' guidance felt more credible than that of nonreligious professionals:

If a nonreligious doctor says, 'Don't worry, just do your prayer,' I interpret it differently. If a Muslim says it, I think his knowledge tells him it should be done this way.

(P5)

Finally, some explicitly stated that nonreligious therapists were unable to address religious concerns adequately:

They try to apply Western approaches to concepts like religion, faith, life—but they fail. They cannot speak about matters in which they have no grounding... It was completely useless.

(P3)

## **Theme two: The Therapist's mastery of religious knowledge and its use when necessary**

The interviews with participants revealed that another important factor contributing to the therapeutic process was the therapist's mastery of religious knowledge and integrating this knowledge into therapy when appropriate. A detailed analysis of this theme showed that participant accounts clustered into five subthemes: (1) feeling understood, (2) benefiting from religious figures, (3) use of religious texts, (4) referral to religious authorities, (5) use of religious terminology.

Many participants reported actively seeking a therapist knowledgeable about religion:

The others (therapists who do not know about religion) are no good anyway. So I need someone like that.

(P3)

What I was looking for was someone who could help me with religious OCD... someone familiar with (religious) terms.

(P6)

### **Feeling understood**

Religious knowledge was seen as essential for accurate understanding of obsessions involving theological concepts. Participants felt misunderstood by therapists unfamiliar with religious terminology:

It is expected that he has at least some background knowledge... so that he can understand the situation.

(P1)

When I said ‘waswasah,’<sup>1</sup> she used phrases like ‘evil thoughts’... She was completely secular. I realized I needed a religious psychologist.

(P8)

Someone without religious knowledge wouldn't understand me, but someone with religious knowledge would.

(P7)

I feel that the therapist understood me better... that person is religious and knows about religion.

(P9)

## Strengthening trust and reducing psychological tension

Participants stated that religious knowledge increased trust and made guidance more credible:

There will be evidence... a foundation, something religious that will enable us to take action. Otherwise, we would be acting according to our own minds.

(P3)

It reassured me that I was talking to someone who knew about religion.

(K7)

Receiving a satisfying answer... like ‘if you do this, you will not leave the faith,’ brought me relief.

(P3)

## Benefiting from religious figures

Religious narratives and examples from prophetic traditions served as persuasive and comforting tools:

What would Allah's Messenger say if he saw you?... Religious reminders are needed; the therapist must be religious and knowledgeable.

(P5)

The hadiths<sup>2</sup>... and that companions<sup>3</sup> also experienced similar doubts were very useful information for me.

(P9)

The Prophet's words calm my fears and help me go through the moment more beautifully.

(P9)<sup>4</sup>

<sup>1</sup>The whispers coming from Satan.

<sup>2</sup>The recorded reports of words, actions or silent approvals of Prophet Muhammad.

<sup>3</sup>The early Muslims and/or muslim friends of Prophet Muhammed who met or saw the Prophet Muhammad during his lifetime, believed in his message, and died as Muslims.

<sup>4</sup>Some statements made by participants who dropped out of therapy before achieving full recovery may reflect a search for reassurance or confirmation rather than full recovery. This situation raises the possibility that individuals who have not completed the recovery process may express that they have benefited from the therapy as a superficial search for confirmation. Therefore, when evaluating the findings, it should be kept in mind that these statements may not only be an indication of the effectiveness of the treatment, but also a reflection of a tendency to seek confirmation.

## Use of religious texts

Participants described religious texts as illuminating and emotionally grounding:

There was a quote from Badiuzzaman<sup>5</sup>... such information gave me a way out. (P8)

That's what you explained by drawing. You gave examples from treatises.<sup>6</sup> That was the answer I was looking for. (P6)

Yes. Yes. And I am reading Risale-i Nur.<sup>7</sup> That is, a little bit about the topic of waswasah. Yes. You know. A little bit about the topic of waswasah, connecting some things. He did something at this point. He helped at that point, too. (P1)

Later, after therapy, it started to feel different to me... It was really lighting a light for me. (P4)

## Referral to religious authorities

Therapists' referrals to religious experts provided reassurance and validation:

The first thing you told me was to get a fatwa from places I trust... which helped convince me. (P7)

We went to speak with Nurettin Hodja... They really sped up the process. (P8)

Getting information from someone with religious knowledge made me feel I wasn't doing anything wrong. (P7)

## Use of religious terminology

Religious language contributed to comfort and meaning, even if details were not consciously remembered:

Marifatullah<sup>8</sup>... Even though I can't explain it now, it touched me; I internalized it. (P6)

<sup>5</sup>Said Nursi (1878–1960), who was born in the Ottoman State's Bitlis village of Nurs, received a thorough education that covered a wide range of subjects, including religious studies, logic, philosophy, anatomy, mathematics, and physics, in addition to madrasahs, which are traditional Muslim educational establishments. He was able to bridge the gap between traditional Islamic teachings and modern philosophical and scientific ideas owing to his varied education.

<sup>6</sup>religious texts written by Badiuzzaman.

<sup>7</sup>It is a collection of books written by Said Nursi between 1926 and 1949 as a commentary on the Qur'an in Ottoman Turkish, comprising over 6000 pages (Beşiroğlu et al., 2014).

<sup>8</sup>Marifatullah refers to experiential and intimate knowledge of God, emphasizing inner awareness, spiritual insight, and transformative knowing rather than merely doctrinal belief.

Thinking about blasphemy is not blasphemy... such information gave me a way out. (P8)

### **Theme three: The Therapist's mastery and use of scientific psychological knowledge**

Another theme from the interviews was the therapist's mastery of scientific-psychological knowledge and the ability to integrate this knowledge with clinical skills when necessary. Within this framework, the elements that participants found beneficial can be classified into three subthemes: (1) normalization interventions, (2) the formulation and psycho-education of religious OCD within CBT and (3) cognitive interventions.

#### **Normalization**

Realizing that intrusive thoughts were common and not unique to them helped participants reduce fear and shame. Being informed that these experiences occur in the general population was especially reassuring:

So this isn't something unique to me... After seeing that it could happen to anyone, I felt a little more at ease. (P1)

I realized that there were many patients like me, that I was not alone. This kind of information helped me. (P9)

Several participants noted that understanding the natural functioning of the mind reduced the perceived abnormality of their thoughts:

First, recognizing that this is an illness. Second, realizing that you're not alone... That was quite a relief for me. (P4)

He said, 'These are thoughts that can come to the mind and feelings of a normal, healthy person.' I was surprised... I thought, 'Oh, so this is something different.' (P1)

#### **CBT formulation and psycho-education**

Participants reported that diagrams, schemas and cyclical formulations enhanced their understanding of the disorder and helped them internalize the therapeutic process:

There is a cycle diagram for this OCD. (P1)

We would draw arrows forming a circle... obsessions... thought errors... These cycles were quite useful for me. (P9)

Seeing the structure of OCD visually made the process clearer and more meaningful:

When I saw it schematically, it really made sense to me... I really internalized it. (P4)

Participants also valued learning how obsessions are triggered and maintained:

It helped me understand how these processes start, get triggered, and turn into compulsive actions... It changed my perspective on recovery. (P5)

## Cognitive interventions

Participants described gaining cognitive flexibility, especially in relation to uncertainty—an important component of OCD treatment:

He said this is actually about living as a Muslim... being between fear and hope... finding the balance. (P1)

Yes, yes, uncertainty... the brain can be sure of nothing... you tolerate uncertainty. (P8)

## Theme four: The Therapist's mastery of both religious and scientific knowledge

Another theme that emerged from participant accounts was that the therapist's mastery of religious and psychological knowledge, and the holistic use of these two domains within the therapeutic process, provided significant benefits for clients. Participants stated that this “two-winged” approach simultaneously fulfilled their faith-based needs and their scientific-psychotherapeutic requirements.

I have such concerns... That's why I think it's important to have both technical (scientific) knowledge and religious sensitivity... The two must go together. (P1)

Participants described this combination as enhancing the clarity of treatment and increasing trust in the process:

I also received religious information... that religious information was also useful. (P9)

We proved it scientifically... We tried to learn how it works religiously. We combined the two. That was quite advantageous. (P4)

For some, the therapist's religious identity made the scientific explanations easier to accept:

One was that he was religious like me, and the second was that he spoke scientifically. (P2)

Others emphasized the necessity of this integration specifically for religious OCD:

For a psychologist to approach religious OCD and provide good treatment, I think he/she needs to have a good understanding of Islam. (P10)

The dual-knowledge approach also reassured participants who needed both doctrinal clarity and clinical guidance:

He answered my questions in terms of religion, and at the same time approached me medically. (P7)

That there is also a medical explanation for this, and that both of these come together in you... you were the person I was looking for. (P6)

Participants contrasted this with previous experiences where therapists lacked one of the domains:

Yes... they were doing something related to waswasahs in the light of hadiths... but you were the one who combined the two. (P6)

### Theme five: The Therapist's approach/attitudes toward the patient

An examination of the elements participants found beneficial revealed that the various attitudes displayed by the therapist toward them played an important role in the therapeutic process. In this context, participants stated that being listened to without judgement or blame was one of the helpful factors. Participant P6 expressed this as follows:

Your tone of voice... your expression while looking—there was nothing... that felt blaming... I had seen that with previous psychiatrists. (P6)

A caring and non-dismissive stance helped participants feel understood even when their symptoms might appear trivial to others:

Someone without expertise may say, 'What's the big deal?'... But an expert doesn't approach with that attitude. (P1)

Trust in the therapist's sincerity and integrity also contributed to engagement:

You have to believe in the other person's sincerity. (P5)

Collaboratively evaluating thoughts without criticism allowed some participants to reflect more openly:

It was important for me to exchange ideas... without fear, without being criticized... (P4)

Empathy and emotional attunement were also highlighted:

I want to be able to express myself freely... I want him to be on the same wavelength as me. (P6)

Finally, trust in the therapist's competence and reliability helped participants feel secure in the process:

I need reliable data... Here, the element of trust comes into play... I can get it from you. (P8)

Seeing the person in front of you as competent... seeing that their words resonate with you.

(P5)

## DISCUSSION

This study aimed to identify the interventions and therapeutic factors that individuals diagnosed with religious obsessive-compulsive disorder found beneficial in psychotherapy and to understand how these were experienced. Existing literature shows that in religious OCD (alongside sexual OCD), which is one of the subtypes of OCD, the benefits derived from traditional therapeutic methods may be lower compared to other OCD subtypes (Abramowitz et al., 2003; Alonso et al., 2001; Ferrão et al., 2006; Mataix-Cols et al., 2002; Rufer et al., 2005). Possible reasons for this include the fact that religious obsessions are less amenable to disconfirming evidence, therapists are not perceived as authorities in religious matters (Steketee et al., 2011), difficulties in integrating exposure-based interventions into religious OCD treatment (Huppert & Siev, 2010), and challenges in differentiating between faith and obsessive thoughts (Toprak, 2024). In this context, understanding which elements and mechanisms patients with religious OCD benefit from in psychotherapy is of critical importance both for clinical practice and for enhancing treatment adherence.

The findings of this qualitative study revealed that participants' perceptions of benefit were primarily concentrated around the personal and professional characteristics of the therapist. The main factors identified were the therapist's religiosity, mastery of religious knowledge and its use when appropriate, mastery and application of scientific psychological knowledge, the integrative use of both domains, and the therapist's attitudes and approach toward the patient.

Participants emphasized that religiosity was not limited to the therapist's knowledge of religion; instead, being perceived as personally religious was important in terms of trust, understanding and value congruence. According to participants, the therapist's religiosity met their need for religious knowledge, made them feel understood, created a safe therapeutic space and strengthened the therapeutic alliance. Literature similarly indicates that therapists' attitudes toward religion significantly influence the therapy process (Shafranske & Malony, 1990) and that religious clients may feel threatened about their values when working with secular therapists (Greenidge & Baker, 2012). The findings show that religious clients perceived their alliance as stronger when the therapist was religious. This parallels the findings of Prout et al. (2021), who reported that value congruence reinforces the therapeutic alliance. The openness and acceptance of therapists toward religious and cultural issues allow clients to express religious content more openly (Judd, 2019). Conversely, failure to understand or respect clients' faith may weaken the alliance (Whitwell & Barker, 1980). In this respect, the natural empathic stance of a religious therapist may strengthen the client's motivation and trust, thereby reinforcing the alliance.

In terms of understanding the client, it is acknowledged that not every therapist can fully grasp the religious background of their client (Walker et al., 2004). In religious OCD, where symptoms revolve around religious themes, clients expect therapists to understand their beliefs and demonstrate sensitivity to them (Bergin & Jensen, 1990; Cinnirella & Loewenthal, 1999; Macmin & Foskett, 2004; Sloan et al., 1999). The literature highlights that religious therapists may be important in understanding religious clients (Ağilkaya Şahin, 2024; Walker et al., 2004). The findings of this study are consistent with this view: participants, particularly those with faith-based disorders such as religious OCD, expected therapists not only to be knowledgeable about the subject but also to value religion as much as they did. Clients who had previously experienced secular therapy where religious/cultural sensitivity was lacking expressed that working with a religious therapist more clearly met their needs for trust and empathy. This suggests that clients who encounter insensitivity in religious/cultural matters may become more attuned to issues of value congruence and trust.

Another important factor from which clients with religious OCD benefited was the therapist's mastery of religious knowledge and the appropriate integration of this knowledge into therapy. According to participants' accounts, this competence provided benefits in five main areas: (1) meeting the client's need to be understood, (2) establishing a relationship of trust, (3) reducing psychological tension through religious knowledge integration, (4) benefiting from religious figures, texts and terminology and (5) referring to religious authorities when necessary. This finding aligns with literature demonstrating that integrating religious elements into psychotherapy enhances motivation, engagement and the sense of being understood and accepted (Markova & Sandal, 2016; Slewa-Younan et al., 2017). Similarly, Reich et al. (2024) reported that integrating religious practices and beliefs into therapy supported psychological balance and increased the effectiveness of therapy for distressed individuals. This resonates with the present study's finding that integrating religious knowledge into interventions reduced psychological tension.

Likewise, religious narratives have been reported to strengthen hope in the therapeutic process (Shafraanske, 2024) and to be perceived as helpful by clients (Martinez et al., 2007). The involvement of religious leaders or authorities in therapy has also been suggested to aid in differentiating between faith and obsessive thoughts, particularly in the context of religious OCD (Hepworth et al., 2010; Nelson et al., 2006). Indeed, Nelson et al. (2006) emphasized that the confirmatory role of religious authorities in clarifying that "thought is not the same as action" could meaningfully contribute to the therapeutic process. Similarly, the case study presented by Özçelik and Toprak (2025) demonstrated that involving a religious authority in the therapeutic process led to marked improvements in psychological symptoms by helping the client clarify their values. The inclusion of a religious authority figure in the therapeutic process serves as a strategic extension of collaborative empiricism, a cornerstone of cognitive behavioural therapy (CBT). By incorporating an authority figure, the intervention provides 'expert evidence' that facilitates cognitive restructuring of dysfunctional religious appraisals related to OCD. Consequently, the authority figure acts as a credible source of information that helps the patient re-evaluate their obsessions as symptoms of an illness rather than spiritual failings, thereby reducing the perceived threat and neutralizing the need for compulsions.

Another theme from which participants benefited was the therapist's mastery of scientific psychological knowledge and its use in appropriate contexts. It is well known that therapist expertise is a critical determinant of therapy outcomes (Sperry, 2015). Therefore, mastery and effective application of psychological knowledge are key factors in enhancing expected therapeutic benefit. Three forms of intervention were particularly emphasized in participant accounts: normalization, formulation and psycho-education and cognitive interventions.

In normalization, clients were informed that others experienced similar symptoms, and intrusive thoughts were reframed as part of the natural functioning of the human mind. This approach enabled clients to reinterpret obsessional content as a non-threatening and normal cognitive process. These findings are consistent with Freeston et al. (1997) and Salkovskis (2007), who reported that normalizing intrusive thoughts reduces cognitive burden in OCD.

In terms of formulation and psycho-education, participants found it beneficial when the cyclical structure of OCD was presented schematically. Psycho-education is a core component of the CBT protocol for OCD and provides patients, families, or caregivers with knowledge about the nature of the disorder and coping strategies (Brady et al., 2017; Kavak et al., 2019; Motlová et al., 2017; Whittal & McLean, 1999). The current finding is in line with Donker et al. (2009), who reported that psycho-education may reduce the incidence of mental disorders and support recovery.

Cognitive interventions were also found to increase participants' cognitive flexibility and reduce intolerance of uncertainty. Intolerance of uncertainty refers to the tendency to perceive uncertain situations as harmful, dangerous, or unjust (Boswell et al., 2013; Buhr & Dugas, 2009; Carleton, 2012; Dugas et al., 1997; Gentes & Ruscio, 2011). Literature indicates that cognitive interventions may reduce OCD symptoms by increasing tolerance of uncertainty (Overton & Menzies, 2005; Wilhelm et al., 2015).

The findings of this study demonstrated that participants emphasized the therapist's mastery of religious and scientific psychotherapeutic knowledge. Similarly, the literature reports that integrating competence in religious and spiritual issues into psychotherapy strengthens the therapeutic alliance, especially among highly religious individuals (Aten & Leach, 2009; Currier et al., 2022; Hook et al., 2010), increases clients' sense of trust and acceptance (Captari et al., 2018) and facilitates treatment adherence (Hathaway et al., 2022). Competence in both domains increases the therapist's religious-cultural sensitivity, allowing for interventions aligned with clients' values, which in turn supports treatment success in sensitive areas such as religious OCD. This dual competence also contributed to clients' perception of the therapist as a “two-winged” authority. According to participants, experts with only religious knowledge may neglect the psychological dimension, while therapists with only scientific knowledge may overlook the religious dimension, leading to unmet needs. Mastery of both domains, however, enabled the holistic fulfilment of both faith-based and psychotherapeutic requirements.

Finally, participants highlighted the therapist's attitudes and approach toward the patient as a significant theme. Listening without judgement or blame, adopting an empathic stance and building a trusting relationship were described as among the most valuable aspects of the therapeutic process. This approach allowed clients to freely express religious cognitive content, facilitating the open discussion of these issues in therapy.

Empathy refers to understanding an individual not from one's perspective but from the client's frame of reference, or indirectly experiencing their thoughts, emotions and perceptions (American Psychological Association, n.d.). Research indicates that empathy is one of the strongest predictors of therapeutic progress (Constantino et al., 2008; Norcross & Lambert, 2011; Norcross & Wampold, 2011; Sandage & Worthington Jr., 2010). Liaquat et al. (2025) similarly reported that clients' perception of high empathy was associated with improvements in depression and anxiety scores. The findings of the present study are consistent with these results; empathy was associated with positive mental health outcomes and was evaluated by clients as one of the most beneficial aspects of therapy (Corrigan & Schmidt, 1983; Monica, 1981).

As an extension of empathic attitudes, discussing religious cognitive content in therapy allowed religious themes to enter the therapeutic agenda. Literature also emphasizes that addressing religion in psychotherapy may reduce symptoms (Paukert et al., 2009). This is considered possible only within a trusting relationship, with trust being a critical prerequisite for an effective therapeutic alliance (Norcross & Wampold, 2011; Tryon & Winograd, 2011). Bae Brandtzæg et al. (2021) similarly reported that the perceived benefit from therapy was significantly influenced by the degree of trust clients had in their therapist.

The qualitative method employed in this study enabled an in-depth exploration of the “how” and “why” dimensions of the research questions, thereby providing a comprehensive understanding of experiences, phenomena and context. This approach makes it possible to investigate questions that cannot be measured quantitatively or reduced to numerical data, thereby enriching knowledge and conceptual understanding by exploring how social phenomena manifest in everyday life (Cleland, 2017; Finn et al., 2022).

However, this qualitative study has some limitations. First, the fact that the researcher was also the therapist of some participants constitutes an important limitation. This may have increased participants' tendency to emphasize positive experiences or led to reticence, affecting the data's depth and objectivity. In addition, the study was conducted with a small sample, which limits the generalizability of the findings; the results are specific to the particular group of individuals who participated and cannot be directly generalized to a broader population. Furthermore, while gender distribution (one woman, eight men) was recorded, data on racial/ethnic identification, cultural/geographic background beyond being from Turkey and measures of income, education, or socioeconomic status were not collected. This constitutes an additional limitation, as the absence of these demographic details restricts the contextual interpretation of the findings. By nature, qualitative data are open to interpretation, and the subjective perspective of the researcher may play a role in shaping the findings. Future research could overcome these limitations by including larger and more diverse samples, employing different methodologies,

conducting longitudinal studies, or ensuring that different individuals fulfil the roles of therapist and researcher. Moreover, an important consideration in interpreting the findings of this study concerns the distinction between participants who completed therapy and those who dropped out. As indicated in [Table 1](#), four participants discontinued therapy before completion. While some of these participants reported benefiting from the therapeutic process, their statements may reflect reassurance-seeking—a well-documented feature of obsessive-compulsive disorder—rather than sustained therapeutic change. In OCD, particularly in scrupulosity, individuals may experience temporary relief through perceived confirmation or religious reassurance, which can be misinterpreted as improvement. Therefore, it is possible that some accounts of “benefit” reported in this study represent short-term alleviation of distress rather than genuine recovery. This distinction should be taken into account when evaluating the findings, as the experiences of dropout participants may differ qualitatively from those who completed therapy. Another limitation concerns the predominantly male composition of the sample. This imbalance may have influenced not only how therapeutic factors were experienced, but also the types and expression of religious obsessions reported by participants. The themes identified in this study may therefore reflect a more limited range of symptom presentations. In particular, certain concerns or forms of religious preoccupation may be underrepresented, which in turn may have affected the prominence of specific therapeutic elements. Accordingly, the findings should be interpreted with caution, as a more gender-balanced sample might reveal different patterns of both symptom experience and perceived therapeutic benefit.

## CONCLUSION

As a result, the findings demonstrated that patients benefited from the therapist's religiosity, mastery of religious knowledge and its appropriate use when necessary, expertise in scientific psychological knowledge, and, most importantly, the integration of both religious and scientific knowledge simultaneously. Furthermore, the therapist's non-judgemental, sincere and empathic approach and the therapeutic trust established between client and therapist were also identified as contributing factors to treatment benefits. These results demonstrate that, in the treatment of religious OCD, addressing the therapist's cultural and religious sensitivity together with scientific competence in an integrated manner—particularly through the incorporation of religious knowledge and practices into the therapeutic process—is critically important. Specifically, combined scientific and religious knowledge (“dual-wing” approach) plays a central role in maximizing therapeutic benefit.

## AUTHOR CONTRIBUTIONS

**Taha Burak Toprak:** Conceptualization; investigation; writing – original draft; methodology; formal analysis; writing – review and editing; validation; visualization; data curation.

## ACKNOWLEDGEMENTS

I would like to thank Umut Muhammed Kaymakçı, Yakup Işık and Hanne Nur Özçelik for their valuable contributions, particularly for providing feedback on language and editorial revisions.

Declaration of generative AI and AI-assisted technologies in the writing process: During the preparation of this manuscript, ChatGPT, Scite.ai and DeepL were used to assist with language refinement, literature searching and translation. The author critically reviewed and verified all content to ensure accuracy and integrity.

## FUNDING INFORMATION

This study received no specific funding from funding agencies or sectors.

## CONFLICT OF INTEREST STATEMENT

The author reported no conflicts of interest related to this article.

## DATA AVAILABILITY STATEMENT

Data supporting the findings of this study are available from the corresponding author upon reasonable request.

## ORCID

Taba Burak Toprak  <https://orcid.org/0000-0001-7958-4181>

## REFERENCES

- Abramowitz, J. S. (2006). The psychological treatment of obsessive–compulsive disorder. *Canadian Journal of Psychiatry*, *51*(7), 407–416. <https://doi.org/10.1177/070674370605100702>
- Abramowitz, J. S., & Hellberg, S. N. (2020). ‘Scrupulosity’, in *advanced casebook of obsessive-compulsive and related disorders* (pp. 71–87). Academic Press. <https://doi.org/10.1016/B978-0-12-816563-8.00005-X>
- Abramowitz, J. S., & Jacoby, R. J. (2014). Scrupulosity: A cognitive–behavioral analysis and implications for treatment. *Journal of Obsessive-Compulsive and Related Disorders*, *3*(2), 140–149. <https://doi.org/10.1016/j.jocrd.2013.12.007>
- Abramowitz, J. S., Franklin, M. E., & Foa, E. B. (2002). Empirical status of cognitive-behavioral therapy for obsessive-compulsive disorder: A meta-analytic review. *Romanian Journal of Cognitive and Behavioral Psychotherapies*, *2*(2), 89–104.
- Abramowitz, J. S., Franklin, M. E., Schwartz, S. A., & Furr, J. M. (2003). Symptom presentation and outcome of cognitive-behavioral therapy for obsessive-compulsive disorder. *Journal of Consulting and Clinical Psychology*, *71*(6), 1049–1057. <https://doi.org/10.1037/0022-006X.71.6.1049>
- Ağlıkaya Şahin, Z. (2024). *Psikoloji ve Psikoterapide Din* (2nd ed.). Çamlıca Yayınları.
- Akuchekian, S. H., Almasi, A., Maracy, M. R., & Jamshidian, Z. (2011). Effect of religious cognitive-behavior therapy on religious content obsessive-compulsive disorder. *Procedia – Social and Behavioral Sciences*, *30*, 1647–1651. <https://doi.org/10.1016/j.sbspro.2011.10.319>
- Almasi, A., Akuchekian, S. H., & Maracy, M. R. (2013). Religious cognitive–behavior therapy (RCBT) on marital satisfaction OCD patients. *Procedia – Social and Behavioral Sciences*, *84*, 504–508. <https://doi.org/10.1016/j.sbspro.2013.06.593>
- Alonso, P., Menchon, J. M., Pifarre, J., Mataix-Cols, D., Torres, L., Salgado, P., & Vallejo, J. (2001). Long-term follow-up and predictors of clinical outcome in obsessive-compulsive patients treated with serotonin reuptake inhibitors and behavioral therapy. *Journal of Clinical Psychiatry*, *62*(7), 535–544. <https://doi.org/10.4088/jcp.v62n07a06>
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Publishing.
- American Psychological Association. (n.d.). Empathy. In *APA dictionary of psychology*. Retrieved 19 August 2025, from <https://dictionary.apa.org/empathy>
- Aouchekian, S., Karimi, R., Najafi, M., Shafiee, K., Maracy, M., & Almasi, A. (2017). Effect of religious cognitive behavioral therapy on religious obsessive-compulsive disorder (3 and 6 months follow-up). *Advanced Biomedical Research*, *6*, 158. [https://doi.org/10.4103/abr.abr\\_115\\_16](https://doi.org/10.4103/abr.abr_115_16)
- Aten, J. D., & Leach, M. M. (2009). A primer on spirituality and mental health. In J. D. Aten & M. M. Leach (Eds.), *Spirituality and the therapeutic process: A comprehensive resource from intake to termination* (pp. 9–24). American Psychological Association. <https://doi.org/10.1037/11853-001>
- Bae Brandtzæg, P. B., Skjive, M., Kristoffer Dysthe, K. K., & Følstad, A. (2021). When the social becomes non-human: Young people's perception of social support in chatbots. In *Proceedings of the 2021 CHI conference on human factors in computing systems* (pp. 1–13). Association for Computing Machinery. <https://doi.org/10.1145/3411764.3445318>
- Bergin, A. E., & Jensen, J. P. (1990). ‘Religiosity of psychotherapists: A national survey’, *psychotherapy: Theory, Research, Practice, Training*, *27*(1), 3–10.
- Beşiroğlu, L., Karaca, S., & Keskin, İ. (2014). Scrupulosity and obsessive compulsive disorder: The cognitive perspective in Islamic sources. *Journal of Religion and Health*, *53*(1), 3–12. <https://doi.org/10.1007/s10943-012-9588-7>
- Boswell, J. F., Thompson-Hollands, J., Farchione, T. J., & Barlow, D. H. (2013). Intolerance of uncertainty: A common factor in the treatment of emotional disorders. *Journal of Clinical Psychology*, *69*(6), 630–645. <https://doi.org/10.1002/jclp.21965>
- Brady, P., Kangas, M., & McGill, K. (2017). ‘Family matters’: A systematic review of the evidence for family psychoeducation for major depressive disorder. *Journal of Marital and Family Therapy*, *43*(2), 245–263. <https://doi.org/10.1111/jmft.12204>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. <https://doi.org/10.1191/1478088706qp063oa>
- Buchholz, J. L., Abramowitz, J. S., Riemann, B. C., Reuman, L., Blakey, S. M., Leonard, R. C., & Thompson, K. A. (2019). Scrupulosity, religious affiliation and symptom presentation in obsessive compulsive disorder. *Behavioural and Cognitive Psychotherapy*, *47*(4), 478–492. <https://doi.org/10.1017/S1352465818000711>
- Buhr, K., & Dugas, M. J. (2009). The role of fear of anxiety and intolerance of uncertainty in worry: An experimental manipulation. *Behaviour Research and Therapy*, *47*(3), 215–223. <https://doi.org/10.1016/j.brat.2008.12.004>
- Captari, L. E., Hook, J. N., Hoyt, W., Davis, D. E., McElroy-Heltzel, S. E., & Worthington, E. L., Jr. (2018). Integrating clients’ religion and spirituality within psychotherapy: A comprehensive meta-analysis. *Journal of Clinical Psychology*, *74*(11), 1938–1951. <https://doi.org/10.1002/jclp.22681>

- Carleton, R. N. (2012). The intolerance of uncertainty construct in the context of anxiety disorders: Theoretical and practical perspectives. *Expert Review of Neurotherapeutics*, 12(8), 937–947. <https://doi.org/10.1586/ern.12.82>
- Carpenter, J. K., Andrews, L. A., Witcraft, S. M., Powers, M. B., Smits, J. A. J., & Hofmann, S. G. (2018). Cognitive behavioral therapy for anxiety and related disorders: A meta-analysis of randomized placebo-controlled trials. *Depression and Anxiety*, 35(6), 502–514. <https://doi.org/10.1002/da.22728>
- Cinnirella, M., & Loewenthal, K. M. (1999). Religious and ethnic group influences on beliefs about mental illness: A qualitative interview study. *British Journal of Medical Psychology*, 72(4), 505–524. <https://doi.org/10.1348/000711299160202>
- Cleland, J. (2017). The qualitative orientation in medical education research. *Korean Journal of Medical Education*, 29(2), 61–71. <https://doi.org/10.3946/kjme.2017.53>
- Constantino, M. J., Marnell, M. E., Haile, A. J., Kanther-Sista, S. N., Wolman, K., Zappert, L., & Arnow, B. A. (2008). 'Integrative cognitive therapy for depression: A randomized pilot comparison', *psychotherapy: Theory, Research, Practice, Training*, 45(2), 122–134. <https://doi.org/10.1037/0033-3204.45.2.122>
- Corrigan, J. D., & Schmidt, L. D. (1983). Development and validation of revisions in the counselor rating form. *Journal of Counseling Psychology*, 30(1), 64–75. <https://doi.org/10.1037/0022-0167.30.1.64>
- Creswell, J. W. (2011). *Educational research: Planning, conducting, and evaluating quantitative and qualitative research*. Pearson.
- Creswell, J. W., & Poth, C. N. (2016). *Qualitative inquiry and research design: Choosing among five approaches*. Sage Publications.
- Currier, J. M., Stevens, L. T., Hinkel, H. M., Davis, E. B., & Park, C. L. (2022). Understanding religious attachment among Christians seeking spiritually integrated psychotherapies: A mixed methods study. *Journal of Clinical Psychology*, 78(5), 758–771. <https://doi.org/10.1002/jclp.23258>
- Deacon, B., & Nelson, E. A. (2008). 'On the nature and treatment of scrupulosity', *pragmatic case studies. Psychotherapy*, 4(2), 39–53. <https://doi.org/10.14713/pcsp.v4i2.932>
- Dehaghi, A. A., Dolatshahi, B., Tareman, F., Pourshahbaz, A., & Ansari, H. (2022). Acceptance and commitment therapy with Islamic aspects as a treatment for scrupulosity in a case study. *Journal of Organizational Behavior Research*, 7(2), 95–108. <https://doi.org/10.51847/Fa3ED8HrzB>
- Donker, T., Griffiths, K. M., Cuijpers, P., & Christensen, H. (2009). Psychoeducation for depression, anxiety and psychological distress: A meta-analysis. *BMC Medicine*, 7(1), 79. <https://doi.org/10.1186/1741-7015-7-79>
- Dugas, M. J., Freeston, M. H., & Ladouceur, R. (1997). Intolerance of uncertainty and problem orientation in worry. *Cognitive Therapy and Research*, 21(6), 593–606. <https://doi.org/10.1023/A:1021890322153>
- Eddy, K. T., Dutra, L., Bradley, R., & Westen, D. (2004). A multidimensional meta-analysis of psychotherapy and pharmacotherapy for obsessive-compulsive disorder. *Clinical Psychology Review*, 24(8), 1011–1030. <https://doi.org/10.1016/j.cpr.2004.08.004>
- Ferrão, Y. A., Shavitt, R. G., Bedin, N. R., de Mathis, M. E., Carlos Lopes, A., Fontenelle, L. F., Torres, A. R., & Miguel, E. C. (2006). Clinical features associated to refractory obsessive-compulsive disorder. *Journal of Affective Disorders*, 94(1–3), 199–209. <https://doi.org/10.1016/j.jad.2006.04.019>
- Finn, G. M., Dueñas, A. N., Kehoe, A., & Brown, M. E. L. (2022). A novice's guide to qualitative health professions education research. *Clinical and Experimental Dermatology*, 47(12), 2090–2095. <https://doi.org/10.1111/ced.15381>
- Foa, E. B., Steketee, G., Grayson, J. B., Turner, R. M., & Latimer, P. R. (1984). Deliberate exposure and blocking of obsessive-compulsive rituals: Immediate and long-term effects. *Behavior Therapy*, 15(5), 450–472. [https://doi.org/10.1016/S0005-7894\(84\)80049-0](https://doi.org/10.1016/S0005-7894(84)80049-0)
- Freeston, M. H., Ladouceur, R., Gagnon, F., Thibodeau, N., Rhéaume, J., Letarte, H., & Bujold, A. (1997). Cognitive-behavioral treatment of obsessive thoughts: A controlled study. *Journal of Consulting and Clinical Psychology*, 65(3), 405–413. <https://doi.org/10.1037/0022-006X.65.3.405>
- Gava, I., Barbui, C., Aguglia, E., Carlino, D., Churchill, R., De Vanna, M., & McGuire, H. (2007). Psychological treatments versus treatment as usual for obsessive compulsive disorder (OCD). *Cochrane Database of Systematic Reviews*, 2007(2), CD005333. <https://doi.org/10.1002/14651858.CD005333.pub2>
- Gentes, E. L., & Ruscio, A. M. (2011). A meta-analysis of the relation of intolerance of uncertainty to symptoms of generalized anxiety disorder, major depressive disorder, and obsessive-compulsive disorder. *Clinical Psychology Review*, 31(6), 923–933. <https://doi.org/10.1016/j.cpr.2011.05.001>
- Greenidge, S., & Baker, M. (2012). Why do committed Christian clients seek counselling with Christian therapists? *Counselling Psychology Quarterly*, 25(3), 211–222. <https://doi.org/10.1080/09515070.2012.673273>
- Hatch, J. A. (2023). *Doing qualitative research in education settings*. State University of New York Press.
- Hathaway, D. B., e Oliveira, F. H. D. O., Mirhom, M., Moreira-Almeida, A., Fung, W. L. A., & Peteet, J. R. (2022). Teaching spiritual and religious competencies to psychiatry residents: A scoping and systematic review. *Academic Medicine*, 97(2), 300–310. <https://doi.org/10.1097/ACM.0000000000000417>
- Hepworth, M., Simonds, L. M., & Marsh, R. (2010). Catholic priests' conceptualisation of scrupulosity: A grounded theory analysis. *Mental Health, Religion and Culture*, 13(1), 1–16. <https://doi.org/10.1080/13674670903092177>
- Hirschtritt, M. E., Bloch, M. H., & Mathews, C. A. (2017). Obsessive-compulsive disorder: Advances in diagnosis and treatment. *JAMA*, 317(13), 1358–1367. <https://doi.org/10.1001/jama.2017.2200>
- Hook, J. N., Worthington, E. L., Jr., Davis, D. E., Jennings, D. J., Gartner, A. L., & Hook, J. P. (2010). Empirically supported religious and spiritual therapies. *Journal of Clinical Psychology*, 66(1), 46–72. <https://doi.org/10.1002/jclp.20626>

- Huppert, J. D., & Siev, J. (2010). Treating scrupulosity in religious individuals using cognitive-behavioral therapy. *Cognitive and Behavioral Practice, 17*(4), 382–392. <https://doi.org/10.1016/j.cbpra.2009.07.003>
- Judd, K. (2019). Doctrinal dialogues: Factors influencing client willingness to discuss religious beliefs. *Mental Health, Religion and Culture, 22*(7), 711–723. <https://doi.org/10.1080/13674676.2019.1639649>
- Kavak, F., Yılmaz, E., Okanlı, A., & Aslanoglu, E. (2019). The effect of psychoeducation given to psychiatry nurses on level of knowledge, attitudes, and practices regarding physical restraint: A randomized controlled study. *Perspectives in Psychiatric Care, 55*(4), 743–751. <https://doi.org/10.1111/ppc.12429>
- Koran, L. M., Hanna, G. L., Hollander, E., Nestadt, G., Simpson, H. B., & American Psychiatric Association. (2007). Practice guideline for the treatment of patients with obsessive-compulsive disorder. *The American Journal of Psychiatry, 164*(7 Suppl), 5–53.
- Liaquat, R., Waqas, A., Qadeer, T., Malik, A., Atif, N., Sikander, S., Wang, D., & Rahman, A. (2025). Exploring the delivery of empathic care in task-shared settings: A psychometric study in rural Pakistan. *Global Mental Health, 12*, e15. <https://doi.org/10.1017/gmh.2025.4>
- Macmin, L., & Foskett, J. (2004). “Don't be afraid to tell.” The spiritual and religious experience of mental health service users in Somerset. *Mental Health, Religion and Culture, 7*(1), 23–40. <https://doi.org/10.1080/13674670310001602508>
- Markova, V., & Sandal, G. M. (2016). Lay explanatory models of depression and preferred coping strategies among Somali refugees in Norway: A mixed-method study. *Frontiers in Psychology, 7*, 1435. <https://doi.org/10.3389/fpsyg.2016.01435>
- Martinez, J. S., Smith, T. B., & Barlow, S. H. (2007). Spiritual interventions in psychotherapy: Evaluations by highly religious clients. *Journal of Clinical Psychology, 63*(10), 943–960. <https://doi.org/10.1002/jclp.20399>
- Mataix-Cols, D., Marks, I. M., Greist, J. H., Kobak, K. A., & Baer, L. (2002). Obsessive-compulsive symptom dimensions as predictors of compliance with and response to behaviour therapy: Results from a controlled trial. *Psychotherapy and Psychosomatics, 71*(5), 255–262. <https://doi.org/10.1159/000064812>
- Merriam, S. B., & Grenier, R. S. (Eds.). (2019). *Qualitative research in practice: Examples for discussion and analysis*. John Wiley & Sons.
- Monica, E. L. L. (1981). Construct validity of an empathy instrument. *Research in Nursing & Health, 4*(4), 389–400. <https://doi.org/10.1002/nur.4770040406>
- Motlová, L. B., Balon, R., Beresin, E. V., Brenner, A. M., Coverdale, J. H., Guerrero, A. P. S., Louie, A. K., & Roberts, L. W. (2017). Psychoeducation as an opportunity for patients, psychiatrists, and psychiatric educators: Why do we ignore it? *Academic Psychiatry, 41*(4), 447–451. <https://doi.org/10.1007/s40596-017-0728-y>
- National Institute for Health and Clinical Excellence. (2006). *Obsessive-compulsive disorder: Core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder*. The British Psychological Society & The Royal College of Psychiatrists.
- Nelson, E. A., Abramowitz, J. S., Whiteside, S. P., & Deacon, B. J. (2006). Scrupulosity in patients with obsessive-compulsive disorder: Relationship to clinical and cognitive phenomena. *Journal of Anxiety Disorders, 20*(8), 1071–1086. <https://doi.org/10.1016/j.janxdis.2006.02.001>
- Norcross, J. C., & Lambert, M. J. (2011). Psychotherapy relationships that work II. *Psychotherapy, 48*(1), 4–8. <https://doi.org/10.1037/a0022180>
- Norcross, J. C., & Wampold, B. E. (2011). Evidence-based therapy relationships: Research conclusions and clinical practices. *Psychotherapy, 48*(1), 98–102. <https://doi.org/10.1037/a0022161>
- Öst, L. G., Enebrink, P., Finnes, A., Ghaderi, A., Havnen, A., Kvale, G., Salomonsson, S., & Wergeland, G. J. (2022). Cognitive behavior therapy for obsessive-compulsive disorder in routine clinical care: A systematic review and meta-analysis. *Behaviour Research and Therapy, 159*, 104170. <https://doi.org/10.1016/j.brat.2022.104170>
- Öst, L. G., Havnen, A., Hansen, B., & Kvale, G. (2014). Cognitive behavioral treatments of obsessive-compulsive disorder: A systematic review and meta-analysis of studies published 1993–2014. *Clinical Psychology Review, 40*, 156–169. <https://doi.org/10.1016/j.cpr.2015.06.003>
- Overton, S. M., & Menzies, R. G. (2005). Cognitive change during treatment of compulsive checking. *Behaviour Change, 22*(3), 172–184. <https://doi.org/10.1375/bech.2005.22.3.172>
- Özçelik, H. N., & Toprak, T. B. (2025). “In search of truth?” integrating religious consultation into CBT to address ambivalence: A case study. *Clinical Case Studies, 24*(5), 315–332. <https://doi.org/10.1177/15346501251369115>
- Pallanti, S., & Quercioli, L. (2006). Treatment-refractory obsessive-compulsive disorder: Methodological issues, operational definitions and therapeutic lines. *Progress in Neuro-Psychopharmacology and Biological Psychiatry, 30*(3), 400–412. <https://doi.org/10.1016/j.pnpbp.2005.11.028>
- Paukert, A. L., Phillips, L. L., Cully, J. A., Loboprabhu, S. M., Lomax, J. W., & Stanley, M. A. (2009). Integration of religion into cognitive-behavioral therapy for geriatric anxiety and depression. *Journal of Psychiatric Practice, 15*(2), 103–112. <https://doi.org/10.1097/01.pra.0000348363.88676.4d>
- Prout, T. A., Magaldi, D., Kim, E. E., & Cha, J. (2021). Christian therapists and their clients. *Spirituality in Clinical Practice, 8*(1), 1–15.
- Rasmussen, S. A., & Eisen, J. L. (1997). Treatment strategies for chronic and refractory obsessive-compulsive disorder. *The Journal of Clinical Psychiatry, 58*(Suppl 13), 9–13.
- Reich, M., Jarvis, G. E., & Whitley, R. (2024). Examining recovery and mental health service satisfaction among young immigrant Muslim women with mental distress in Quebec. *BMC Psychiatry, 24*(1), 483. <https://doi.org/10.1186/s12888-024-05940-8>

- Reid, J. E., Laws, K. R., Drummond, L., Vismara, M., Grancini, B., Mpavaenda, D., & Fineberg, N. A. (2021). Cognitive behavioural therapy with exposure and response prevention in the treatment of obsessive-compulsive disorder: A systematic review and meta-analysis of randomised controlled trials. *Comprehensive Psychiatry*, *106*, 152223. <https://doi.org/10.1016/j.comppsych.2021.152223>
- Reis, A., Westhoff, M., Quintarelli, H., & Hofmann, S. G. (2024). Mindfulness as a therapeutic option for obsessive-compulsive disorder. *Expert Review of Neurotherapeutics*, *24*(8), 735–741. <https://doi.org/10.1080/14737175.2024.2365945>
- Rosa-Alcázar, A. I., Sánchez-Meca, J., Gómez-Conesa, A., & Marín-Martínez, F. (2008). Psychological treatment of obsessive-compulsive disorder: A meta-analysis. *Clinical Psychology Review*, *28*(8), 1310–1325. <https://doi.org/10.1016/j.cpr.2008.07.001>
- Rufer, M., Grothusen, A., Maß, R., Peter, H., & Hand, I. (2005). Temporal stability of symptom dimensions in adult patients with obsessive-compulsive disorder. *Journal of Affective Disorders*, *88*(1), 99–102. <https://doi.org/10.1016/j.jad.2005.06.003>
- Salkovskis, P. M. (2007). Psychological treatment of obsessive-compulsive disorder. *Psychiatry*, *6*(6), 229–233. <https://doi.org/10.1016/j.mppsy.2007.03.008>
- Sandage, S., & Worthington, E. L., Jr. (2010). Comparison of two group interventions to promote forgiveness: Empathy as a mediator of change. *Journal of Mental Health Counseling*, *32*(1), 35–57.
- Sandelowski, M., & Barroso, J. (2002). Finding the findings in qualitative studies. *Journal of Nursing Scholarship*, *34*(3), 213–219. <https://doi.org/10.1111/j.1547-5069>
- Shafraanske, E. P. (2024). Religion and spirituality in psychotherapy: A personal bedrock of faith. *Spirituality in Clinical Practice*, *11*(1), 48–54. <https://doi.org/10.1037/scp0000359>
- Shafraanske, E. P., & Malony, H. N. (1990). 'Clinical psychologists' religious and spiritual orientations and their practice of psychotherapy'. *psychotherapy: Theory, Research, Practice, Training*, *27*(1), 72–78.
- Slewa-Younan, S., Yaser, A., Guajardo, M. G. U., Mannan, H., Smith, C. A., & Mond, J. M. (2017). The mental health and help-seeking behavior of afghan refugees in Australia. *International Journal of Mental Health Systems*, *11*(1), 49. <https://doi.org/10.1186/s13033-017-0157-z>
- Sloan, R. P., Bagiella, E., & Powell, T. (1999). Religion, spirituality, and medicine. *The Lancet*, *353*(9153), 664–667.
- Sokolowski, R. (2000). *Introduction to phenomenology*. Cambridge University Press.
- Sperry, L. (2015). Does clinician expertise make a difference in spiritually oriented psychotherapy? *Spirituality in Clinical Practice*, *2*(4), 241–244. <https://doi.org/10.1037/scp0000089>
- Stein, D. J., Costa, D. L. C., Lochner, C., Miguel, E. C., Reddy, Y. C. J., Shavitt, R. G., van den Heuvel, O. A., & Simpson, H. B. (2019). Obsessive-compulsive disorder. *Nature Reviews Disease Primers*, *5*, 52. <https://doi.org/10.1038/s41572-019-0102-3>
- Steketee, G., Siev, J., Fama, J. M., Keshaviah, A., Chosak, A., & Wilhelm, S. (2011). Predictors of treatment outcome in modular cognitive therapy for obsessive-compulsive disorder. *Depression and Anxiety*, *28*(4), 333–341. <https://doi.org/10.1002/da.20785>
- Strom, N. I., Soda, T., Mathews, C. A., & Davis, L. K. (2021). A dimensional perspective on the genetics of obsessive-compulsive disorder. *Translational Psychiatry*, *11*(1), 401. <https://doi.org/10.1038/s41398-021-01519-z>
- Toprak, T. B. (2018). *An attempt for an alternative approach for the structure of humans and its applications: İbn'u nafs*. World Congress of Psychotherapy.
- Toprak, T. B. (2022). *Dini içerikli psiko-egitim eklemlenmiş bilişsel davranışçı grup psikoterapisinin dini içerikli obsesyon ve kompulsyonları olan hastalardaki etkililiği [Effectiveness of religious psycho-education integrated cognitive behavioral group therapy in the treatment of the patients with religious obsessions and compulsions]* (Publication No. 719272). Master's thesis. Hasan Kalyoncu University.
- Toprak, T. B. (2024). Rethinking cognitive psycho-education—4T model—In the psychotherapy of religious obsessive-compulsive disorder: Report of three resistant cases. *Spiritual Psychology and Counseling*, *9*(1), 75–105. <https://doi.org/10.37898/spiritualpc.1319545>
- Tryon, G. S., & Winograd, G. (2011). Evidence-based psychotherapy relationships: Goal consensus and collaboration. *Psychotherapy*, *48*(1), 50–57.
- Turner, D. W. (2010). Qualitative interview design: A practical guide for novice investigators. *The Qualitative Report*, *15*(3), 754–760. <https://doi.org/10.46743/2160-3715/2010.1178>
- Walker, D. F., Gorsuch, R. L., & Tan, S. Y. (2004). Therapists' integration of religion and spirituality in counseling: A meta-analysis. *Counseling and Values*, *49*(1), 69–80. <https://doi.org/10.1002/j.2161-007X.2004.tb00254.x>
- Whittal, M. L., & McLean, P. D. (1999). CBT for OCD: The rationale, protocol, and challenges. *Cognitive and Behavioral Practice*, *6*(4), 383–396. [https://doi.org/10.1016/S1077-7229\(99\)80057-1](https://doi.org/10.1016/S1077-7229(99)80057-1)
- Whitwell, F. D., & Barker, M. G. (1980). "Possession" in psychiatric patients in Britain. *British Journal of Medical Psychology*, *53*(4), 287–295. <https://doi.org/10.1111/j.2044-8341.1980.tb02554.x>
- Wilhelm, S., Berman, N. C., Keshaviah, A., Schwartz, R. A., & Steketee, G. (2015). Mechanisms of change in cognitive therapy for obsessive-compulsive disorder: Role of maladaptive beliefs and schemas. *Behaviour Research and Therapy*, *65*, 5–10. <https://doi.org/10.1016/j.brat.2014.12.006>
- Yağar, F., & Dökme, S. (2018). Niteliksel araştırmaların planlanması: araştırma soruları, örneklem seçimi, geçerlik ve güvenilirlik [Planning qualitative research: Research questions, sample selection, validity and reliability]. *Gazi Sağlık Bilimleri Dergisi*, *3*(3), 1–9.
- Zai, G., Barta, C., Cath, D., Eapen, V., Geller, D., & Grünblatt, E. (2019). New insights and perspectives on the genetics of obsessive-compulsive disorder. *Psychiatric Genetics*, *29*(5), 142–151. <https://doi.org/10.1097/YPG.0000000000000230>

**How to cite this article:** Toprak, T. B. (2026). Effective factors in the psychotherapy of religious obsessive-compulsive disorder: A qualitative study. *British Journal of Clinical Psychology*, 00, 1–21. <https://doi.org/10.1111/bjc.70060>

## APPENDIX A

### Semi-structured interview questions

1. How would you describe your overall therapy process?
2. What were your expectations from psychotherapy at the beginning?
3. Do you think you benefited from therapy? In which areas?
4. What do you attribute this benefit to? (e.g., therapist's approach, techniques used, your own efforts)
5. Were there any points during therapy where you thought, "It would have been better if this had been different"?
6. Did you experience any situations in the process that felt challenging, blocking, or ineffective?
7. In this context, what elements do you think would have made your psychotherapy more effective and beneficial?