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The Cognitive Behavioural Therapy of an Adolescent with Sexual and Religious Obsessions: A Case Report

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Abstract

Obsessive-compulsive disorder (OCD) is defined as thoughts, images or instincts (obsessions) causing anxiety and behavioural endeavours to reduce this anxiety. OCD can cause a serious deterioration in the family, social and academic functionality of adolescents. Cognitive behavioural therapy (CBT) is recommended as the primary form of treatment in the approach to the treatment of children and adolescents who have been diagnosed with OCD. The CBT intervention on a 17-year-old client, who has been diagnosed with OCD, has been presented in detail in this case report. Clinical interviews based on DSM-5 diagnosis criteria and the Yale-Brown Obsession Compulsion Scale for Children (CY-BOCS) directed at determining the severity of the OCD have been used in order to finalise the diagnosis of OCD. The CY-BOCS score was determined to be 25. The exposure and response prevention intervention, which is known as the principal approach of CBT for OCD, together with pharmacotherapy, were implemented for the sexual and religious obsessions, behavioural neutralisation and avoidance behaviours of the client, under the administration of the case. An improvement was seen in the sexual issues of the client as a result of the exposure and response prevention applied to his sexual obsessions. A significant fall in the obsession and compulsion symptoms and an increase in the daily functions (listening to lectures, socialising) of the client were determined. The CY-BOCS score measured at the end of the consultation sessions was 16. As a result, it has been seen that the joint use of the exposure and response prevention techniques of CBT, together with pharmacotherapy, have reduced the severity of the OCD symptoms and improved the family, social, academic and sexual functionality of the client.

Keywords: Obsessive–compulsive disorder, exposure and response prevention, cognitive behavioural therapy

Öz

Cinsel ve Dini Obsesyonları Olan Bir Ergen Danışanın Bilişsel Davranışçı Terapisi: Olgu Sunum

Obsesif-kompulsif bozukluk (OKB) yoğun bir kaygıya neden olan düşünceler, imajlar veya dürtüler (obsesyonlar) ile bu kaygıyı azaltmayı amaçlayan davranışsal (kompulsiyonlar) çabalar olarak tanımlanır. OKB ergenlerin ailevi, sosyal ve akademik işlevselliğinde ciddi düzeyde bozulmalara yol açabilmektedir. OKB tanısı almış çocuk ve ergen danışanlar için tedavi yaklaşımında ilk sırada Bilişsel Davranışçı Terapi (BDT) önerilmektedir. Bu olgu sunumunda OKB tanısı almış 17 yaşındaki bir danışanın BDT müdahalesi ayrıntılı olarak sunulmuştur. OKB tanısını netleştirmek için DSM-5 tanı kriterleri temelli klinik görüşme ve OKB şiddetini tespit etmeye yönelik Çocuklar için Yale-Brown Obsesyon Kompulsiyon Ölçeği (CY-BOCS) kullanılmıştır. CY-BOCS puanı 25 olarak tespit edilmiştir. Olgunun yönetiminde danışanın cinsel ve dini obsesyonları, davranışsal nötrleme ve kaçınma davranışları için, farmakoterapinin yanında BDT'nin OKB'deki temel yaklaşım tekniği olarak bilinen maruz bırakma-tepki önleme müdahalesi çalışılmıştır. Danışanın cinsel obsesyonlarına uygulanan maruz bırakma ve tepki önleme sonucunda cinsel sorunlarında iyileşme görülmüştür. Danışanın obsesyon ve kompulsiyon belirtilerindeki belirgin bir azalma ve günlük işlevselliğinde artış (ders dinleme, sosyalleşme) belirlenmiştir. Danışma sonucunda ölçülen CY-BOCS puanı 16 olarak belirlenmiştir. Sonuç olarak; BDT'nin maruz bırakma ve tepki önleme teknikleri ile farmakoterapinin birlikte kullanımının OKB'nin belirti şiddetini azalttığı; danışanın ailevi, sosyal, akademik ve cinsel işlevselliğini artırdığı görülmüştür.

Anahtar Kelimeler: Obsesif kompulsif bozukluk, maruz bırakma ve tepki önleme, bilişsel davranışçı terapi

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INTRODUCTION

In the literature, no studies were found in which involuntary thoughts about religious issues and sexual obsessions were discussed together in adolescents diagnosed with obsessive-compulsive disorder (OCD). Obsessive-compulsive disorder are discussed together, could be found in the literature (Storch & Lewin, 2016). OCD is defined as thoughts, images or instincts (obsessions) causing anxiety and behavioral endeavours to reduce this anxiety (Diagnostic and Statistical Manual of Mental Disorders [DSM-5], 2013). The frequency of observing OCD in children and adults is approximately 1–2% (Canals, Hernández-Martínez, Cosi, & Voltas, 2012). The frequency of observing OCD in children and adolescents in Turkey is approximately 1% (Ercan, Bilaç, Özaslan, & Akyol Ardic, 2016). OCD can cause serious disruptions in the social, academic and familial functions of adults (Piacentini & Bergman, 2000). The sexual intrusive thoughts that trigger obsessions and the avoidance or safety behaviors that the individual uses to reduce anxiety, affects the clients' social, academic and family functions negatively (Piacentini, Bergman, Keller, & McCracken, 2003). Whilst these problems exist, there are psychological interventions that could be used in the treatment of these symptoms.

The most commonly used interventions for OCD in the literature are antidepressant drugs and cognitive behavioral therapy (Bolton & Perrin, 2008). The cognitive behavioral therapy technique that is considered to be the gold standard for OCD treatment is exposure and response prevention (Storch, Schneider, Guzick, McKay, & Goodman, 2020). Exposure and response prevention involves reducing the client's rituals or avoidance behaviors, and a gradual, systematic exposure to triggers that evoke the obsessive-compulsive symptoms. This technique consists of exposure to triggers that have an "ordinary" risk level, such as touching objects without washing hands, wearing different or unwashed clothing, and potentially "contaminating" objects. Cognitive Behavioral Therapy (CBT), which includes exposure and response prevention, has achieved high levels of success in treatment of anxiety disorders (Meng et al., 2019; Öst, Riise, Wergeland, Hansen, & Kvale, 2016). CBT is considered to be primary treatment for OCD in children and adolescent (Geller & March, 2012; Jónsson & Hougaard, 2009; March, Frances, Kahn, & Carpenter, 1997; Öst, Havnen, Hansen, & Kvale, 2015). Drug treatment is accepted as the second line of treatment (Geller & March, 2012). Psychoeducation and CBT are important in the treatment of OCD in adolescents (Cazard & Ferreri, 2013). Although experimental studies (Bolton and Perrin, 2008; Riise, Kvale, Öst, Skjold, & Hansen, 2018) that use the exposure and response prevention technique to treat OCD in children are present, the number of the studies are limited (Canals et al., 2012).

Fear of a destructive family event is often at the center of children's obsessions (Geller & March, 2012). The psychosocial stress factors could be a possible trigger for OCD symptoms in children (Lafleur et al., 2011). However, OCD can develop even though there is no apparent trigger. Among the common obsessions; somatic (43%), contamination (39%), violent thoughts (30%), symmetry (26%), religious (9%) and sexual (4%) causes were reported. Similarly, cleaning and washing (52%), repeating (52%), sequencing (43%), checking (35%), counting (22%) and other mental impulses (13%) were specified for compulsions (Borda, Feinstein, Neziroglu, Veccia, & Pérez-Rivera, 2013). When sexual and religious concerns become prominent in adolescents, they are seen to be compatible with the formation stages of OCD symptoms (Geller et al., 2001). The occurrence of OCD at an earlier age in children and adolescents, results with prolonged duration of OCD, increased likelihood of impatient treatment, sexual, religious or hoard obsessions becoming more permanent in the lives of individuals (Geller & March, 2012). In their study on the development of OCD, Geller et al. (2001) found that sexual and religious obsessions were more common in adolescents compared to adults.

Adolescents are faced with problems such as withdrawal from family and social relationships, inability to complete academic tasks because of the sexual and religious obsessions they experience. The obsessions adolescents have in relation to sexual and cultural values makes it difficult for them to express themselves and to seek help. OCD symptoms affect the lives of adolescents and children negatively. Many adolescents suffering from OCD experience difficulty in peer relationships and academic life and participate less in recreational activities than their peers who are not affected by OCD (Coluccia, Ferretti, Fagiolini, & Pozza, 2017). It is believed there are many undiagnosed OCD patients in schools that procrastinate or lack motivation in academic achievement since receiving support is difficult.

In the literature, no studies were found in which involuntary thoughts about religious issues and sexual obsessions

were discussed together in adolescents with OCD. In this case report, sexual and religious obsessions, behavioral neutralization and avoidance behaviors of adolescent OCD client is tried to be reduced with the help of CBT's exposure and response prevention technique and pharmacotherapy.

THE CASE

The client is a 17-year-old male who lives with his parents and two siblings. The client attending the 11th grade in a secondary school applied with complaints of difficulty concentrating, decrease in academic achievement, and impairment in social relations. Previously, he sought the help from three different psychological counselors (counselors) for a short time but left without completing the therapies. At the end of the evaluation, he and his father were told that he might be suffering from OCD according to the DSM-5 criteria, therefore psychiatric support should be sought. The client stated that he has not had any psychiatric complaints previously, he did not think that the condition could be an illness and that he only had problems with academic success. The client showed resistance to receiving a psychiatric. The client was seen once a week for 18 sessions. The effect of the treatment was evaluated by client's self-observation.

The type and severity of the OCD suffered by the client was re-evaluated after the first interview and it was observed that he had sexual issues. When investigated, it was determined that when masturbating, he was unable to complete the masturbation, because of sexual images of religious figures he would stop. The clinical assessment and the severity of the symptoms were measured by CY-BOCS. His CYBOCS score was 25 (severe level); 16 for obsession subscale and 9 for compulsion subscale.

Considering his previous tendencies of dropping out from psychotherapy, priority was given to the areas where the client had issues. The counselling process started with motivational interviews and the establishment of therapeutic communication (Türkçapar, 2018). It was determined that the client had had similar complaints in his previous psychothreapies, but he normalized them by saying "I am a bit neater", rather than "I don't have an obsession with frequent hand washing".

Counselor: Sometimes certain thoughts come into our minds unintentionally, like, "your hands are dirty; they need to be washed". Do other thoughts, similar to these, come into your mind?

Client: There are also other things but I cannot share these with anyone. I'll feel very bad, and I don't even know how to stop this.

Counselor: You are not thinking of these intentionally. They occur all of a sudden, don't they?

Client: But how can they come into my mind without me wanting them to? If they are in my mind, I am responsible for them.

Counselor: How do you feel when they come into your mind?

Client: I feel bad.

Counselor: "We all have such thoughts that come into our minds unintentionally, just like those coming into your mind".

Client: I don't think such bad thoughts would go through anyone's mind.

Counselor: What do you do to feel better when these thoughts disturb you?

Client: I focus on my cellphone for a long time. Then I either get distracted or I pressure myself to think I blow these thoughts up.

Counselor: What happens then?

Counselee: I feel a little better.

Counselor: "I had asked you questions in the first week we've met, and you have said, "they had asked me these questions before". The situation you are experiencing is called OCD. Let me tell you a little bit about this.

The client was given an assignment to record the frequency of his thoughts, the level of anxiety for each thought and what he did to cope with this in order to achieve an awareness and be mindful about his OCD.

In the following session OCD was re-evaluated again this time based on the client's assignment. The OCD rationale of CBT was presented to the client. However, the client did not want to share the content of his obsessions during this session either. During the process of sharing the rationale of OCD, the client said that he may be able share something if he was more relaxed. The dialogue continued as follows:

Client: My anxiety increases when I masturbate.

Counselor: Is this the first time you're telling anyone this?

Client: I talked to my father. He said you could help me.

Counselor: Do you feel anxious when you tell me this?

Client: My anxiety never diminishes!

Counselor: What do you do when you feel more anxious?

Client: I take a bath, wash myself thoroughly. Next day I take a bath again so I can be completely clean.

Counselor: Is it because you feel anxiety again or because you're just not sure?

Client: It is like starting everything from scratch, turning a new page.

Counselor: Do you have bath the next day because you think you are not clean after masturbating?

Client: Yes.

Counselor: How long does it take for you to feel less anxious?

Client: It doesn't take long, and after cleaning I can at least touch my pencil or notebook. If I don't do it then I can't touch anything else because I think the filth will spread everywhere.

Counselor: Did the level of your anxiety decrease when you were telling me about this?

Client: It was high at first but I feel better now.

The downward arrow technique was used during this session hierarchically to determine the hierarchy of the avoidance behaviors that occur when faced with disturbing thoughts, the downward arrow technique was used.

Thoughts*:* Cognitive activities like; attempting to think of starting a moment from scratch by neutralizing, thinking about the people he loves most when religious figures come into his mind, trying to be certain Interviews were continued during the session in order to evaluate the client's cognitions about avoidance behavior.

Behaviors: Behaviors like; squeezing his head between his hands tightly, contracting his muscles, washing his hands frequently, taking a bath after masturbating and taking another bath immediately afterwards, washing his ears and nails more thoroughly, using extra soap.

Avoidance*:* Objects and activities like; avoiding dolls, not masturbating, not touching clothes and items (pens, books, etc.) that are thought to be contaminated with semen, not being able to sit on the sofa in his grandmother's house.

During the session, an in-vivo exposure was performed by having the client touch the school items he believed to be contaminated by semen, this process helped the client see that he could in fact handle the exposure and succeed. Thus, by limiting the client's bathing time, an attempt was made to demonstrate how the thought of "contamination by semen or having sexual intercourse with a religious figure" made his life difficult.

Among the avoidance behaviors included in the exposure list, wearing a blue underwear that he had not worn for about two years, which caused anxiety in 40–70% to the client, was given as an exposure assignment. The client said that he had anxiety but he could do this easily.

The next session was started with the assignment. The client stated that when he wore the blue underwear all his thoughts had come back, his anxiety increased, and that the assignment was as not as easy as he had thought. He said he had thrown the blue underwear in the garbage outside their home in order to ensure it was not washed together with the other laundry and he does not want to wear it again. After wearing the underwear, he threw all of his school items, bought new ones and cleaned the room using wet wipes. He said that he had washed his hands all week long so much so that wounds appeared on his hands. The client's problems with school increased as well. There was not a progress in the recovery process of the client.

The client and his father were informed that he had difficulty managing his anxiety and he needed psychiatric help. The client accepted to have a psychiatric interview. The interview was organized with the psychiatric clinic and carried out with the client. As a result of this evaluation the psychiatrist had begun Selective serotonin reuptake inhibitor (SSRI) (paroxetine) treatment for the client.

When the client came for consultation, he stated that he started to take the medication and had been better that week, also he had experienced less disturbances. The therapeutic communication with the client made it easier for him to express his sexual and religious obsessions. He did not have enough courage to wear (be exposed to) the blue underwear that was given to him as an assignment between the sessions as his anxiety had increased. In this session, it was observed that he was able to manage his anxiety, and with the "downward arrow technique" the formulation was reconstructed so he could perform his avoidance behavior assignments.

Counselor: If you like today, let us try to understand the thoughts that come into your mind when you feel sexual arousal or masturbate and what you don't do because of these. First of all, can you recall the anxiety this blue underwear causes?

Client: Yes, when I'm masturbating I had the thought of having sexual intercourse with well-known male religious figures. I became so anxious that I stopped masturbating without knowing whether I had ejaculated or not. Then, to punish myself I came up with the rule of thinking that I was doing those things in my mind to the people I loved the most (my father). I was trying to neutralize that guilty guilt. I put so much pressure on myself that my stomach began to hurt.

Counselor: What were you saying to yourself at that moment?

Client: I was saying that I was guilty and a sinner.

Counselor: How all of these made you feel?

Client: I got anxious, I thought I was a sinner.

Counselor: What did you do to reduce this anxiety?

Client: Because I masturbated, I took a bath the way I wanted and then wore the blue underwear.

Counselor: In the morning or in the evening?

Client: It was the morning. I came out of the bath since I had to go to school.

Counselor: When did your anxiety increase during the day?

Client: At school I went to the bathroom and I saw a spot on my underwear. I thought about whether it was semen of detergent.

Counselor: Did your anxiety increase?

Client: It is difficult to put this into words. It was as if my heart was going to come out of my mouth.

Counselor: What went through your mind at that moment?

Client: All the things I at touched at school, my clothes, my pen… everything had become dirty!

Counselor: Were you able to go back to class after getting out of the bathroom?

Client: I did but I could not pay attention to the lesson. I could not touch anything. I wanted to go home and take a bath.

Counselor: Can you recall your day?

Client: Generally, I try not to remember. I try to go on without thinking of that moment. When I got home, I didn't want the blue underwear to be washed with the other items. The filth on it could then contaminate everything that it contacts with. I could no longer wear the blue underwear. I took a bath. I thought everything was starting from fresh. I threw away my school objects and I didn't wear the clothes that I wore that day after.

Counselor: Could you wear the blue underwear this week?

Client: I have another blue underwear at home. I do not even know which one I was wearing after I masturbated. But I can wear the other blue undergarment this week.

Counselor: What has changed in relation to wearing the blue underwear?

Client: These thoughts come into my mind unintentionally. Before I used to think that if they were coming into my mind because I wanted them to.

Counselor: What would happen if they came into your mind intentionally?

Client: If thoughts related to religious figures come into my mind and I enjoy it, then it will be very bad.

Counselor: What if they come into your mind and you enjoy it?

Client: If I want these thoughts, then I am a sinner, I'll think that I am guilty.

Counselor: What kind of a person does having these thoughts make you?

Client: It makes me a worse person.

Counselor: Can we become bad just because these thoughts pass through our minds?

Client: Yes, if I were to get sexually aroused thinking about those religious figures and I enjoy it.

Counselor: Can you really enjoy a situation that makes you so anxious?

Client: No.

Counselor: Can we control everything that passes through our mind?

Client: No.

Counselor: What does, "everything that passes through my mind is under my control" means?

Client: I need to be like that so that I won't be a sinner.

Counselor: Can you be a sinner for things that pass through your mind in a situation where you are so conscientious?

Client: Of course, but I won't be like those who have sinned.

Counselor: What did you realize from this interview?

Client: That I cannot control everything that passes through my mind and it is difficult for me to enjoy these thoughts, even if I wanted to.

Counselor: Do the things you do to reduce your anxiety actually help with this?

Client: "The behaviors I perform to neutralize these thoughts don't reduce my anxiety either.

Counselor: These thoughts make your life more difficult. What could you think instead of saying, "I must be responsible for every thought, that is coming into my mind," to make your life easier?"

Client: I guess it is not possible for each thought that comes into my mind to be under my control. For this reason, even if it does come into my mind, I must not try to neutralize it or reduce my anxiety. This may enable me to focus on my lectures and to reduce my anxiety.

Counselor: It's great that you can recognize this. So, which thought would make things different for you instead of, "I must control each thought that comes into my mind?".

Client: "If I don't try to control everything that passes through my mind, my performance in the lectures and my relationships with my friends will improve."

Counselor: Can you wear your blue underwear this week?

Client: I already don't know which blue underwear is contaminated, I can wear it.

Counselor: If you knew, would you wear it?

Client: I don't know, but I can try now.

The stages of exposure and response prevention were determined following this session, and the wearing the blue underwear was planned as an assignment. The client put on his blue underwear and said, "It was not as difficult as I expected, and I did not become anxious at all".

The next session started with the assignment. The client reported that he was able to wear his blue underwear, he was not as anxious as he had expected, and he felt good because he had succeeded. The client said he was able to study because he felt better this week. As he was able to do his assignment, another assignment on the exposure list was planned and assigned in the session this week.

One of the other assignments on the exposure list was seeing and touching a doll. Because the client had masturbated with his sister's dolls before, his anxiety increased every time he saw a doll. The exposure technique was implemented using the doll during the session. The method of the exposure assignment was to keep this doll in his room until the next session and study while the doll was at his desk.

The next session started talking about the assignment. The client reported that he had kept the doll in his room for a week, he stated he still had anxiety but he felt more of guilt. It was determined that the client had felt better this week than the week before the assignment. Since he was able to do his assignment, another assignment in the exposure list was implemented in this session.

Counselor: You haven't been able to masturbate for a long time, or even if you have, at the moment of ejaculation, you stopped because of what was on your mind.

Client: Yes, masturbating is like torture for me now.

Counselor: Your assignment for this week is to masturbate. We will work on that in this session.

Client: I did tell you before, just as I'm about to ejaculate, awful things come to my mind, and I can't stand it.

Counselor: Now, can you explain this process to me step by step so we can understand what's going through your mind."

Client: But I can't bear them coming into my mind.

Counselor: Where do you masturbate?

Client: I do it in the bathroom, just before I take a bath, to ensure it doesn't get on anything.

Counselor: Do you do it in the bathroom to make sure nothing gets contaminated?

Client: Yes.

Counselor: Now I want you to take this pornography magazine. Today, we will work on you masturbating in the toilet, after this session.

Client: I will be very embarrassed. I can't do it outside the bathroom, I can never do it here, and I can't touch my clothes. I can't take this magazine!

Counselor: Your anxiety has increased again, right?

Client: My anxiety is at its peak, I feel even more embarrassed. How can I do it knowing you are here in the office?

Counselor: If you want, we can do the relaxation exercise that we studied before, then continue working on the assignment.

….

Counselor: Now, I want you to take the magazine on the table and look through its pages.

Client: Religious figures are running through my head.

Counselor: Sexual scenes with religious figures?

Client: Yes.

Counselor: What are you saying to yourself?

Client: I say, "Think these things about your father as well".

Counselor: When these thoughts come into your mind, can you just watch them go through your mind without responding to them?

Client: Should I let them pass through my mind?

Counselor: Yes, can you turn the pages without responding to these thoughts?

Client: But these thoughts are still coming into my head.

Counselor: They may do, but can you keep turning the pages?

Client: How can I let myself be at ease when such things are running through my mind!

Counselor: Do you think you do these scenes with your loved ones to punish yourself for thinking about religious figures in a sexual way?

Client: Of course, one should not feel comfortable when experiencing such a thing!

Counselor: Does your anxiety increase or decrease when you blame yourself like this?

Client: Increases more and more!

Counselor: So, how does your anxiety decrease?

Client: Sometimes my anxiety stays at that level for a long time.

Counselor: You are turning the pages. Are religious figures coming into your head?

Client: Yes.

Counselor: Are you able to respond to the thoughts that are coming into your mind while you're talking to me and looking through the pages of the magazine?

Client: No, I am not able to imagine things about my loved ones.

Counselor: Is your anxiety still high?

Client: Not as much as in the first moment.

Counselor: What is the level of your anxiety when you do not respond to these thoughts?

Client: My anxiety is lower now.

Counselor: Think about it, do the sexual scenes with religious figures increase your anxiety or do the sexual scenes with loved ones that you create intentionally in response to them?

Client: The sexual scenes with my loved ones that I create to punish myself increase my anxiety more.

Counselor: What have you noticed about the masturbation process now?

Client: My anxiety increases with the reactions I give to the thoughts going through my mind.

Counselor: So, can you just keep masturbating without responding to the thoughts that come into your mind?

Client: I can, but it's still very difficult.

When evaluating the client's OCD again, it was determined that his CY-BOCS score was 16 (intermediate level) (obsession subscale score 10; compulsion subscale score 6). Other assignments were created and implemented according to the principles of exposure and response prevention. An increase was observed in the family, social and academic functions of the client.

DISCUSSION

There were no studies found in the literature on the sexual and religious content of OCD in adolescents. The exposure and response prevention technique of CBT and pharmacotherapy are presented together in this case report. CBT was used as the primary treatment. However, when the expected change did not occur in the ensuing sessions, psychiatric support was also obtained. When CBT and SSRI are used together, its effectiveness on OCD increases. This impact reduces OCD symptoms by between

20–40% (Pigott and Seay, 1999). A significant decrease in the obsession and compulsion symptoms of the client and an increase in his daily functionality (listening to lectures, socializing) were determined.

The effort of the individual to gain control can be assessed among the primary symptoms of OCD. Repeated controls (returning to the beginning of the action and repeating it until no sexual thoughts about a religious figure comes to mind, saying the same phrase twice because of the thoughts), and washing (washing between the fingers and the ears) can be given as examples.

The client's denial of the diagnosis of OCD at the beginning of the consultation decelerated the therapy process. Progress started following the establishment of a therapeutic relationship with the client in the following sessions. The adolescent considered the thoughts coming into his mind as a loss of control and attempted to prevent these thoughts. It can be seen that the thought "what comes into my mind must be under my control", is one of the misconceptions of OCD that roots from the underlying thought "I am responsible for having this immoral thought; if I am thinking about it, must mean that I enjoy them". Behavioral assignments given to increase the awareness of the client's avoidance behaviors did not cause any progress in the therapy process as they increased his anxiety due to this avoidance behaviors in the assignment. After SSRI support was provided, his anxiety decreased to the required level for a behavioral homework to be assigned. Later, his thoughts (contaminating objects, inability to use objects, taking a bath) were questioned using Socratic questioning, and his evaluations of control were examined as therapy goals. After discussing the level of control for the thoughts passing through his mind, it was ensured that he could do his homework without performing avoidance behaviors. Progress in therapy have been made by behavioral assignments with the help of exposure and response prevention techniques. This case provides evidence that CBT can work with difficult clients (Ung, Ale, & Whiteside, 2016).

As a result; it has been observed that the combined use of CBT exposure and response prevention techniques and SSRI reduces the severity of OCD symptoms and increases functionality in the family, social life and academic fields. It is known in the literature that the combined use of CBT and SSRI is common. However, there are limited number of studies or case reports on sexual and religious figures, which are rarely seen in adolescents. The results of this case report need to be supported by studies with larger samples and control groups.

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