SODP Learning Collaborative on Patient AI Use: Clinical Case #1

1. Patient Demographics

Name	Ashton B.
Age	17 years
Gender	Male
Diagnosis	Obsessive Compulsive Disorder

2. Presenting Complaint & Background

Ashton was first referred to a child psychologist for psychological assessment at age 15 following reports from school staff of increased anxiety, difficulty concentrating, and periodic withdrawal from classroom activities. His parents had also noted ritualistic behaviours at home, including frequent inspection of his skin and repeated requests for reassurance about his physical health.

Clinical assessment identified a specific pattern of health anxiety OCD centered on fears of developing skin cancer. This was understood in the context of a significant family history:

- Ashton's father was diagnosed and treated for skin cancer when Ashton was approximately 10 years old, a period during which Ashton witnessed his father's medical treatment and experienced significant distress.

At the initial presentation, Ashton described intrusive thoughts as:

"What if that mark is cancer? I need to check before it's too late."

He engaged in frequent self-examination of his skin, sought reassurance from his parents multiple times daily, and was spending approximately 3 hours per day engaged in skin-checking behaviours.

3. Treatment History & Progress

Ashton commenced individual therapy (ERP-based CBT) at age 15. Treatment goals focused on:

- Psychoeducation about OCD, health anxiety, and the maintenance cycle of reassurance-seeking.
- Developing a collaborative list to rank triggers, avoided situations, and intrusive thoughts from least to most distressing, and linking each to the skin-checking and reassurance-seeking compulsion behaviours (ERP hierarchy targeting).
- Building tolerance for uncertainty (cannot know for certain whether a mark is cancerous).

Over the course of the first year in treatment, Ashton demonstrated meaningful and consistent improvement. He and his parents reported a significant reduction in daily checking behaviours, he was engaging more confidently in school, and he described feeling increasingly capable of fighting back against intrusive thoughts rather than acting on them. Therapeutic homework practiced collaboratively with his parents at home was a notable contributor to this progress.

4. Recent Regression

Ashton is now 17 years old prior to the current review. Over the two months, Ashton's child psychologist observed a notable regression in his progress. Specifically:

- Increased distress around intrusive thoughts about skin cancer.
- Reduced capacity to tolerate uncertainty without seeking reassurance.
- Return of frequent reassurance-seeking behaviours with parents.
- Decreased confidence in his ability to sit with intrusive thoughts.

When explored in session, Ashton eventually disclosed that over the past two months he had been regularly uploading photographs of skin marks to AI, asking whether they appeared cancerous. He had been doing this in private, without the knowledge of his parents or clinician. Ashton mentioned that he knew it was wrong and felt guilty for asking AI behind his parents' back, but admitted that he also felt ashamed for relying on AI in general. In discussion with his clinician, Ashton was adamant that he did not think of the AI as anything more than a useful tool ("...like a google search"). When asked if he thought of AI as a "friend" by the clinician, Ashton reacted negatively and said he "wasn't stupid."

Ashton described that AI had consistently provided responses suggesting his marks were not obviously concerning, which offered him temporary relief. However, he also noted that the relief was short-lived, that he found himself using AI repeatedly, and that new marks would trigger new episodes of checking.

5. Discussion Questions for the Collaborative

The following questions are offered to guide collaborative discussion:

1	How do we conceptualize AI-mediated reassurance-seeking within and outside existing OCD frameworks? Is it functionally equivalent to traditional reassurance-seeking, or do the features of an LLM (such as constant availability) potentially produce clinically meaningful differences?
2	Does the quality or content of the AI response matter therapeutically, or is the act of checking itself the problem regardless of what the AI says?
3	The AI responses in the transcript are clinically measured and medically reasonable. How might safety-aligned LLMs still play into pathological tendencies? How does the question of AI safety change when considering overlapping or contradictory psychiatric vulnerabilities?

4	Ashton did not identify his AI use as a compulsion prior to the session. How should clinicians be routinely screening for AI use as part of therapy sessions? How would you approach this discussion without creating stigma that acts as a barrier to disclosure?
5	Beyond obsessive compulsive disorder, how can the reliance on AI heighten other symptoms of psychiatric disorders (such as GAD)? Give an example.
6	What is one key lesson from this case that may change how you approach your clinical practice or patient sessions?