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Response to Commentaries on Targeting Catholic Rituals as Symptoms of Obsessive Compulsive Disorder: A Cognitive-Behavioral and Psychodynamic, Assimilative Integrationist Approach

Meaning and Pragmatism in OCD Treatment

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ABSTRACT

This response to the commentaries of Mandala (2008) and of Deacon and Nelson (2008) focuses on the utility of treatments nested within different theoretical schools of thought. Here I concentrate on the use of self as clinical tool, and the need to define variables and concepts in treatment so that they can be methodically utilized. I also choose to focus on the use of functional analysis to sharpen the accuracy of exposure treatment, and on the relative value of the use of cognitive therapy in obsessive-compulsive disorder (OCD) treatment. Finally, I describe a 5-year follow-up conversation with Bridget along with Bridget's repeat of standardized ratings to illustrate the struggle in differentiating scrupulosity and religious observance as it is experienced by the scrupulous OCD patient.

Keywords: cognitive-behavioral therapy; obsessive-compulsive disorder; Catholic rituals; scrupulosity; psychodynamic therapy; assimilative integration

RESPONSE TO MANDALA COMMENTARY

I have always, in theory, agreed with the contention of psychodynamically-oriented practitioners and scholars that there are therapeutic gains realized in exploratory therapy not immediately detected by measurement tools common to ESTs. Moreover, the stated goals and focus of treatment vary considerably across modalities, a notion that Mandala beautifully captures in his metaphor comparing the nets used by commercial fisherman and biologists and their abilities to contain different organisms. This metaphor vividly portrays his view that, "psychological theories, and their corresponding therapeutic systems, are very much theoretical 'nets.' They allow one to capture and study certain phenomena; but, because of their specificity, they miss, or render invisible, other phenomena" (Mandala, 2008, p. 55). This is a point well-taken. I would add that given the confluence of mental health issues as they present in treatment,

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each uniquely complex, it is important that practitioners focus on the pragmatic and not limit their effectiveness by the constraints of their theoretical groundings.

Mandala mentions the differences in clinical phenomena in the context of describing how I "switched nets" in the middle of treatment, ultimately to study and treat other areas of Bridget's life. The thrust of that switch involved focusing on more deliberate use of the therapeutic relationship as a clinical tool, a "net" that psychodynamic thinkers often argue better contains particular therapeutic gains — in essence, a better emotional grasp of one's interpersonal world and one's sense of self within it.

There is something uniquely restorative about the therapeutic relationship. Clearly we evolved as social animals. By our best estimation, nature's "purpose" for our emotional breadth as humans seems to be geared toward negotiating effective social interaction**.** Not surprisingly, a healthy social environment is in most cases a requisite ingredient for an emotionally healthy individual. For this reason, one could argue that the therapeutic relationship *itself* is what initiates positive change in a therapy patient. This point alone, however, which echoes across the psychodynamic literature, seems a bit too unformulated. One is left wondering what it is about the relationship exactly that makes change and how it works. Within a discussion about choosing therapeutic techniques, Mandala offers**,** "As Irving Yalom (1980) noted, the healing component of therapy may actually transcend technique" (p. 60). This is reminiscent of a message I received during my internship at the Department of Veterans Affairs at Lyons, New Jersey. My supervisor, a psychodynamically-oriented practitioner herself, told me that, "It doesn't matter what you do — it's who you are with someone that makes that person better".

Metaphorically speaking, I valued this message a great deal. I interpreted this to mean that when authenticity and caring are communicated from therapist to patient, there is strong, positive therapeutic value. This notion is not new. Many scholars have written about non-specific factors in treatment, including the nature of the therapist-client relationship, often referred to as *the therapeutic alliance* (e.g., Beutler, 2002; Horvath & Symonds, 1991; Messer & Wampold, 2002; Patterson,1984), a full discussion of which is beyond the scope of this paper. Nevertheless, I caution that this point is not to be taken too literally. Surrendering to an idea of phenomena as irreducible or unknowable unnecessarily precludes the sort of healthy questioning that has allowed psychological science to move forward, pushing beyond the idiosyncrasies of personal belief to create clinical tools that produce measurable change. Even so, within the therapy relationship an enormous amount of learning takes place, perhaps in manner similar to what social learning theorists have argued since Gabriel Tarde's work in 1912, through emulating behavior and conceptual understanding. These are two of the most basic devices used when one person learns from another, and also happen to be the essential domains of cognitive-behavioral therapy.

As scholars, practitioners, theorists, and researchers we have a responsibility to continue to operationalize all that we can, to further refine our understanding of what those factors viewed as "invisible" or "transcendent" or "non-specific" are, and to put to practical use what we identify. Many of the curative aspects of psychodynamic therapy — such as exploring the client's early learning history, the client's behavioral patterns within relationships, and how the client's relationship with the therapist may be part of an overarching pattern of thoughts and

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behaviors — are open to operationalization. My contention is that these aspects can be more efficiently addressed in a cognitive-behavioral therapy based format, and that we should continue to further *reverse engineer* the machinery of the therapeutic relationship. This starts by generating important questions: Does the therapist provide new and corrective information about trust, intimacy, support, or reliability? Are there behaviors that prevent a person from gaining these things beyond the therapist's doors? Most importantly, in accordance with the basic notion of pragmatic psychology, can the products of that operationalization be organized into an efficient and focused treatment strategy? The best I have seen in this regard is Jeffrey Young's Schema-Focused Therapy (Young, Klosko, & Weishaar, 2003).

As I waded thru the second phase of treatment with Bridget — the more psychodynamic phase — I felt a need for more targeted treatment strategies. This portion was much less goal-oriented, and perhaps therefore less efficient than I would have in retrospect preferred. There were aspects of Bridget's personality that seriously impeded learning within a minimally structured environment, namely her tendency to ramble and perseverate. These factors were probably clinically significant and therefore mistakenly left formally undiagnosed. If I had stuck closer to the structure of a cognitive-behavior therapy or Schema Focused Therapy format, and had constructed a more rigorous case formulation with specific goals and means to measure outcome, I suspect the therapy in the second phase would have gone more smoothly, and that gains would have been made more quickly, as noted by Deacon and Nelson.

Nevertheless, I do wish to offer a reframe of some of the theoretical notions described above, particularly as Mandala's focus on the genuineness of the therapeutic relationship is appreciably an important and powerful factor in any therapy. First, I argue that *some* healing components *out of many* transcend technique, and therefore should be utilized. Second, it *does* matter what you do, as well as who you are with a patient. Any therapy should be delivered with some degree of genuineness and the use of self, and no therapeutic modality has cornered the market on that quality as it is delivered thru different treatments. Perhaps the psychodynamic literature can help practitioners to understand and develop this quality more fully, without necessitating the use of psychodynamic therapy per se to comport oneself with genuineness and measured affection. I feel the genuineness of my relationship with Bridget helped nurture the trust required both to perform exposure therapy and to foray into an entirely different area of treatment, two tasks requiring a great deal of confidence. Mandala captures this process and describes its importance well and with a great deal of sensitivity.

RESPONSE TO DEACON AND NELSON COMMENTARY

The Idiosyncratic Nature of Treating OCD

In critically evaluating the effectiveness of the therapeutic techniques outlined in this paper, Deacon and Nelson (2008) bring focus to an important feature of OCD — the idiosyncratic nature of obsessional beliefs and the special attention these require. Deacon and Nelson recommend constructing detailed case formulations to guide the techniques used in treatment, which themselves often necessitate creative implementation. This is important. The idiosyncratic nature of clinical sequelae in general I believe is one of the essential reasons to

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establish a registry of scholarly, systematic case-studies in journals such as this one, *Pragmatic Case Studies in Psychotherapy.*

Deacon and Nelson (2008) describe a technique whereby the dose of exposure is increased, in essence, by more directly targeting the beliefs generating the complex of OCD symptoms. In my case of Bridget, to more effectively address the distorted cognition, "my rituals directly affect what happens to other people," I asked Bridget, "Would you be willing to purposely wish for your brother to get into a car accident?" I found this a very useful strategy. One reason is related to a problem often encountered in performing imaginal (as opposed to *in vivo*) exposure whereby the imagined stimulus sometimes does not generate enough anxiety to facilitate habituation. Increasing the anxiety quotient, or "pushing the envelope" as the Deacon and Nelson say, is one way to circumvent this problem, by more directly accessing what Foa and Kozak (1986) have described as the "fear structure."

Pushing the envelope is done across exposure treatments. In PTSD treatment, for instance, when performing imaginal exposure to intrusive memories of traumatic experiences, patients are instructed to retell their traumatic memories using increased sensory and emotional detail, and to do so in the present tense — i.e., in the place of "*On that day three years ago*, I *turned* and the mortar *exploded* next to me and I *saw* my friend *get* killed," using "I *turn* and a mortar *explodes* next to me and I *see* my friend *getting* killed." I used a similar technique when attempting to simulate Bridget's blasphemous conversations with friends. An early effort to use milder blaspheming, the actual words that prompted her compulsions in real life, was not realistic enough to access the fear structure in the abstraction of the therapy office. Only after we pushed the envelope by making the simulated blaspheming more intensely sordid did any habituation take place. In short, wishing for an imagined catastrophe, as the Deacon and Nelson prescribe, is a good way to increase arousal — a necessary component for exposure therapy — and helps make more robust the learning we presume underlies that habituation. For Bridget, the lesson may have gone something like this: "Even when I go so far as to actually *wish* that my brother would get sick and die, I see that my thoughts have no effect on the safety of my family."

Deacon and Nelson suggest that the way to arrive at specific interventions such as this is through a detailed case formulation. This is very important in view of the convergence of irrational predictions, feared thoughts, feared situations, avoidance behaviors, and neutralization strategies, all comprising OCD, and all of which Deacon and Nelson recommend including in the formulation (2008, p. 42). Within this, they suggest a more formalized functional analysis establishing the relationship between feared cues and compulsions. This helps to arrive at valuable cognitive material for use in targeting irrational beliefs thru exposure, and to test feared predictions, for example, "I am responsible for preventing harm to those around me" (2008, p. 43). Though these thoughts are generated and challenged in the cognitive portion of therapy, documenting these in a functional analysis guides the implementation of exposure work, which, as the Deacon and Nelson noted, is applied in an idiosyncratic fashion. They also offer a number of established measures in aiding this procedure, which seem to facilitate the process. I did not use these measures in my case formulation, but doing so would likely have made the course of therapy more efficient. For some exposure items, the measures might have helped to distinguish the relative therapeutic values of exposing the patient to feared stimuli alone versus exposure that seeks to challenge the patient's irrational beliefs.

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Cognitive Interventions

Deacon and Nelson (2008) argue that there seems "little reason" to overcome some of, as they describe, "the pitfalls" of using cognitive therapy (p. 45) in OCD treatment, though they actually end up listing several reasons. One, in constructing their case formulations, they assess for material squarely within the domain of cognitive therapy, such as "fear evoking thoughts" and "feared consequences of not ritualizing" (p. 47). Also, they note that "discussions of risk, probability, and uncertainty during exposure are often recommended in ERP treatment manuals. The informal use of cognitive restructuring encourages patients to attend to what is being learned from exposure in order to increase the salience of the corrective information provided by ERP" (p. 46). Toward this end, they also note asking their patients to identify feared predictions before exposure, then to re-rate the accuracy of their feared predictions after exposure (p. 46).

The use or disuse of cognitive therapy deserves further elaboration, and I would like to add several other possible uses. Researchers' selectivity in deciding who participates in treatment outcome studies, in which many therapy manuals and theory-based treatments are rooted, may exclude those with comorbid psychiatric problems or other issues affecting OCD sequelae — such as depression, personality or eating disorders, interpersonal problems, marital distress, bereavement, to name a few of potentially hundreds. In reality, patients seeking OCD treatment in the general population may present with a more complex clinical picture. This is where the value of retaining cognitive therapy is realized. Some of the issues listed above will likely require an independent course of cognitive-behavior therapy, while others will not. As a result, one reason to retain cognitive therapy is to ensure, in lieu of an outside referral, that treatment is as comprehensive as possible within one's area of specialization. Sometimes this may involve simultaneously treating OCD, using cognitive and behavioral interventions, and, for example, treating interpersonal problems or mild depression using cognitive interventions, particularly if those problems are related in some way to maintaining OCD symptoms.

I believe the same is true for relaxation training. Deacon and Nelson (2008) argue, citing research conducted largely in experimental environments that are far more controlled than clinical settings, that relaxation training has not been shown effective in treating OCD, stating, once again, that "there also seems to be little reason to expect it to enhance the effects of CBT" (p. 45). The research that Deacon and Nelson cite, however, treats relaxation training largely as a placebo control group, not as an adjunct to CBT (Abramowitz, 1997; van Balkom et al., 1994). There is no question that relaxation training as a stand-alone treatment for OCD is dubious. However, in natural settings where the clinical problems may be much more complex and interdependent, there are other reasons to consider using multiple techniques — with relaxation, the most obvious of these, for helping a patient manage problematic stress. This I believe is within the purview of responsible treatment irrespective of the overall measurable effect on reducing OCD symptoms. Leaving a patient without basic stress management skills at the end of treatment seems incomplete, or at worst ethically questionable, particularly given the prevalence of difficulty managing stress across psychiatric disorders and the contribution of stress to the course, severity, and ability to cope with symptoms.

Deacon and Nelson go on to describe how teaching patients relaxation skills may send a message that "anxiety is intolerable and should be avoided" (p. 12). But these interventions

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should not be discarded for this reason. Psychotherapy clients are highly likely to have difficulty managing stress in the main. Not teaching a psychotherapy client a means to manage stress out of fear that these techniques would be misused is akin to sending the message that because one has OCD, managing stress is always avoidance and therefore should be avoided. This is precisely where cognitive methods, as well as basic psychoeducation, are important—to aid in differentiating healthy stress relief, not directly contingent to OCD symptoms per se, from stress reduction used as a neutralization strategy. At five years follow, Bridget reported being much better able to manage the stress of her daily life.

Deacon and Nelson offer similar notes of caution related to the use of cognitive therapy, arguing that "the physical act of writing an automatic thought (e.g., 'I might drown my infant') is so anxiety provoking that it is avoided or even refused" (p. 45). Again, I believe this sends what may be a misguided message, and one that appears to contradict their prior recommendations. Cognitive therapy — more specifically, writing down an intrusive thought such as "I might drown my infant" — does not seem nearly as likely to elicit treatment rejection or dropout as instructing a patient, who is horrified by the thought that she may cause harm to her brother by not praying for him, to actually wish that he would contract an illness and die (which, as I noted, I find a valuable strategy in the context described above). It is important to recognize that treating anxiety employs a particularly counterintuitive strategy, especially when compared to the treatment of other psychiatric disorders. To treat depression, for example, we don't use techniques that instruct a patient to perform more depressing activities. Nor do we treat psychosis by an intervention that at the outset makes a psychosis sufferer's delusions more entrenched or his/her hallucinations more vivid. However, the most effective treatments for anxiety involve initially asking the patient to experience increased anxiety through exposure, with, of course, the understanding that in most circumstances habituation to the feared stimulus is quickly realized, and corrective information is gained about what once was feared.

Given this peculiarity of anxiety treatment, and more specifically, the fact that OCD sufferers are sometimes horrified by their own intrusive thought content, being conscientious about factors influencing treatment refusal or dropout is especially important. This I believe is a point on which Deacon and Nelson agree with me. However I disagree with their contention about the specific role of cognitive therapy in influencing dropout, particularly when compared to the "fear factor" of exposure therapy. In fact, this is the very point at which cognitive interventions may have unique application. For especially intense beliefs generating a great deal of anxiety throughout the course of treatment, perhaps to the extent that treatment is refused, cognitive therapy can be employed to challenge a patient's faulty cognitions before re-initiating exposure therapy -- for example, from the case with Bridget, my use of the thought, "Actually wishing my brother's death may make his harm even more likely than not praying for him." Likewise, this can be done even with the seemingly less daunting thought of, "Writing down a thought means that I will do it". Interestingly, while Deacon and Nelson downplay the utility of cognitive therapy for this purpose within the context of their current argument, they argue this in another paper, saying, "Nevertheless, we speculate that some CT techniques have relevance for facilitating E&RP in cases of scrupulosity" (Nelson, Abramowitz, Whiteside, & Deacon, 2006, p. 1083). This is the manner in which cognitive therapy was used with Bridget and this is how she agreed to perform some of the exposure exercises that she was initially very reluctant to perform.

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The rationale described by McGinn and Sanderson (1999) in their manual for using cognitive methods is to address secondary automatic thoughts (p. 11). Primary dysfunctional thoughts or images, such as Bridget's imagining her brother dying from a disease, are believed to precede secondary thoughts such as, "I am a bad person for imagining my brother dying." Addressing these thoughts through cognitive restructuring, according to Deacon and Nelson, helps reduce anxiety regarding the obsessions themselves, which leads to a decline in the occurrence of the obsessions. In this vein, cognitive techniques are also useful to correct secondary thoughts generating comorbid depression, low self esteem, and irrational guilt, and such therapy may also put into perspective the nature of exposure therapy. Thus, the supplementation of exposure therapy with cognitive techniques can be useful in helping to avoid treatment rejection or dropout based on obsessional fears, e.g., "I am a bad person for wishing that my brother would get sick and die, therefore doing this treatment is wrong".

That said, in my paper I did voice a note of caution related to the use of cognitive therapy — that cognitive restructuring could be used in an obsessive manner. Bridget appeared to do this by repeating in the same paragraph several times, for instance, "It's just magnification" and by completing at first excessively long cognitive worksheets. Though this remains an issue to contend with in OCD treatment, when I followed up with Bridget five years later she sheepishly admitted to me that she only completed these exercises on the campus bus on the way to session, in an effort to be compliant with treatment, and that she felt repeating herself was related to being pressed for time and not knowing what to write, but wanting to conform to her notions of a good therapy patient. This fit with my initial impression of her efforts to be somewhat over-compliant with therapy.

In fact, ironically, at 5-year follow-up (see below) Bridget found the cognitive portion of therapy the most valuable, despite my reservations. She commented that she has used cognitive techniques fairly extensively across her daily life, with problems both related and unrelated to her OCD symptoms. She notes that while some of her symptoms have returned (an issue I discuss at greater length below), the cognitive techniques learned in therapy have helped mitigate them. Her comments are as follows:

> I've used [cognitive therapy] if someone says something that upsets me. I learned to teach myself to pay attention to my reactions, and what does [the situation] mean to me, the way I interact with people. … I use it to cope with life stressors like bills. If my bills are adding up and I get stressed and start catastrophizing, I ask myself, "Is there really any reason that I should respond this way." And my worry about my family, like the question, "What if someone dies?" It's no more realistic today than it was yesterday and I can see this now. Now sometimes I'll pray more in these situations, but I catch myself, and I stop myself. Even if I can't stop myself in that moment, I do eventually because I know it's not real, it's not an accurate measure of reality. … It changed the pattern in the way I deal with the world in a really good way.

BRIDGET'S OWN VIEW AND SCRUPULOSITY

I was fortunate to have the opportunity to reestablish contact with Bridget, and to share with her the paper on which these commentaries are based. Below I relay much of the conversation I had with Bridget verbatim. I feel this helps to *render visible*, to borrow from

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Mandala, the vicissitudes of her struggle in a more personal, phenomenologically cohesive way, and to illustrate the manner in which filtering away OCD from religious beliefs can be a difficult but ultimately invaluable intervention when presented with a scrupulous OCD patient in clinical practice.

Bridget described to me how her symptoms had increased over the years. She found reading the paper extremely useful to review with her current therapist, and she stated that reading of her treatment success stood to counteract her current symptoms. In other words, because her OCD symptoms crept in so stealthily across time, concealing themselves alongside her shifting religious beliefs, she hardly noticed how much they had increased. She stated that, "For a long time I didn't even worry about OCD".

Bridget summarized her response to treatment as follows: For nearly three years she was notably free from OCD symptoms. Then, in the summer of 2006, she began living and working as a bartender in a New Jersey beach town. The setting lent itself to a more carefree lifestyle and for the larger part of the summer she allowed herself to enjoy her freedom as a 25-year-old, young and attractive woman. She described bar-hopping with her friends, dancing with men at nightclubs, drinking alcohol and staying out late — behaviors not uncommon for someone in her demographic. However, after a time, the guilt crept in, and she began to question the morality of her way of life. Upon reflection, she said that this guilt led to a string of behaviors eventually resulting in a return of many of her previous OCD symptoms, stemming from difficulty reconciling her religious views with her personal desires.

In apparent attempts to quell the guilt about her lifestyle, she began listening to Christian radio. Because she disagreed with many of the views espoused on these programs, she began reading the Bible for substantiation. She told me that she read with much more scrutiny than she ever had before. Upon pouring over scripture and verse, looking for answers to the questions of religious morality, she began to detect punctures in the relatively untroubled world she had constructed for herself. Bridget commented that for years up to this point, she had frequently consulted with members of the clergy. Many of the responses she received failed to mitigate the obsessional urgency underlying her search for religious counsel. With regard to her conflicts, mostly about her sexual desires, one priest responded plainly, "There are differences between thought and behavior," which Bridget at first accepted but later, by the time she began listening to Christian radio, rejected outright. Another priest, she reported, "didn't focus on Hell, but said that it's better emotionally to wait for marriage. …He never told me I was going to hell if I had sex." Another female chaplain stated that, "It's really hard but worth it," citing her own premarital sexual urges and success in resisting them. Perhaps as a function of her perfectionism, Bridget was unable to relinquish herself from the opposing draws of her religion and her desires. Soon, she found herself obsessing about religious issues nearly to the same extent as when she first presented to treatment five years ago, although her compulsions were much less severe. Bridget agreed to complete a YBOCS which is shown below:

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	Week 1	Week 27	5 year followup
YBOCS			
Obsessions	8	4	7
Compulsions	10	2	5

Concretizing even more my view that a case like Bridget necessitates a structured, CBT-oriented treatment, Bridget has been in psychodynamic therapy since her termination with me five years ago, and throughout the time of the re-emergence of her OCD symptoms. Most of her symptoms are concerned with scrupulosity. Though she has not returned to pre-treatment baseline, she did endorse significant obsessive symptoms necessitating another course of CBT treatment.

Bridget outlined several instances in which she rejected the views heard by various religious sources in her search for the *right* answers. For instance, she mentioned rejecting the views espoused on Christian radio because she knew that they were "not true," which led to scouring over Bible passages to discover the true rules regarding premarital intercourse, sin, and the differences between thought and actions. She also talked about why she rejected the advice from the priest who suggested that thought and action are separate spheres of morality: "A priest says thoughts are different than actions, then you read in the Bible that thoughts are the same as action," citing a passage in the book of Matthew, chapter five. However, she also noted other contradictions within the Bible itself on many issues. She further stated that she no longer sees herself as Catholic because the Catholic religion "is so inaccurate."

I pointed out to Bridget that the tenor of her seeking out precise answers, and being dissatisfied with whatever information she gleaned from the various sources listed above, had a distinctly OCD flavor, particularly of compulsive checking and perfectionism. I pointed out that the worship of most people is not consumed in this way, and that she runs the risk of getting lost in the letter of the law, thus bypassing the real meaning and peace that religion imparts to the religious. She agreed, if somewhat hesitantly.

In our conversation, I attempted to determine the viability of using the various methods I described in my case study (Garcia, 2008), and by Deacon and Nelson (2008), particularly the suspension of prayer. I asked her to imagine her reaction if I had asked her to discontinue all prayer in the service of treatment. Her reaction illustrates both the challenges and delicacy of this as a clinical intervention, and also the internal conflict this produces in a patient:

> I don't think I would have been able to do it. I think maybe it would have lessened my anxiety though. It would have been better if someone told me not to, because then it wouldn't be my fault. … That is if I could do it. ...But I don't think that I could. … I probably would have done it [prayed] and not told you.

Bridget seemed to truly appreciate the reason for suspending prayer through the course of treatment, apart from her doubts. We further discussed the choice made in exposure treatment to

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allow prayer by differentiating between healthy and unhealthy prayer, which was also something she had tried to do on her own for years, both before and after treatment. She noted her difficulties:

> I don't know how much of it is religion, or how much of it is OCD. It's very confusing in my life. And praying seems to be an instant gratification with OCD. I sometimes stop praying when I feel that it's OCD and not prayer. But religion says you're supposed to pray for anything and everything at all times of the day, to keep that line of communication open. It says to "Pray to God for all things." When you have OCD, that's a license to drive yourself crazy!

The conversation continued and Bridget reported that she greatly appreciated having someone to help challenge her beliefs and thinking on these issues, because, as noted above, she was often tormented by uncertainty. To help sort this out further, I asked her about premarital intercourse — in particular, what she felt would happen to her if she were to have it. Bridget began to further identify the inconsistencies in the set of rules and moral assumptions she has arranged for herself. She noted that:

> Human beings are too imperfect for one thing to ruin you. God planned things so that we are inherently sinful. …That said, that seems to go against the way I do things [referring to her ruminating about sin], doesn't it?

Deacon and Nelson (2008) describe OCD sufferers as, "Specifically, individuals who appraise perceived sins as overly significant (e.g., as courting God's disfavor and risking eternal damnation) will experience anxiety which in turn motivates efforts to alleviate distress and prevent catastrophe from occurring" (p.41). With this in mind, I asked Bridget, "What do you fear then? Is it damnation? God's disapproval? Gods punishment?" She appeared to give very serious consideration to this question, and actually decided that the nature of her fears was not so much religious, as they were related to OCD and perfectionism.

> I think it has to do with my own knowledge that I can't be good, not that God is going to punish me. Because if I sin, *I* know that I'm a bad person and that I have nothing to hide behind. It's not that God would know — *I* would know. OCD is so sneaky, the overt things are so easy — the covert things catch you by surprise. You're so insecure about your own decisions. When God is the authority, it gives you the excuse to be OCD-ish, because it's someone else telling you to pray. Then there's a whole paragraph in the Bible about anxiety and that you're not supposed to have it. … Really, if I stopped praying, my fear is that I wouldn't know what to do with myself.

I suggested to Bridget the notion that God wouldn't want her to be coerced into prayer by her own OCD-driven anxiety. And that perhaps stopping prayer for the purposes of an exposure regimen would reduce the anxiety associated with prayer so that she could then decide, free from anxiety, if prayer is something she really wants in her life, as a function of religion and not OCD. I pointed out that her fears around not praying were not religious in nature; they were, "I wouldn't know what to do with myself" and "If I sinned I would be a bad person," both of which are OCD-related. Bridget, being someone who by her nature strives for self-understanding, agreed to this upon thoughtful consideration. It struck me how powerfully she tried to avoid being a "bad person" or, an *unscrupulous* person, so much so that she felt better off if someone

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else were to instruct her to perform certain behaviors she deems morally wrong. For scrupulous patients, deliberately taking on this blame can prove excellent leverage — in other words, "Since I am asking you to do the exposure to test a prediction, it will be my fault (or sin, or moral misdeed) not yours"— so long as the patient doesn't start ritualistically praying for the clinician's sins in turn.

Looking back on my treatment with Bridget, I find myself questioning and in some instances regretting choices that I made, despite the treatment having gone quite well. Bridget's religious practices were much more infused with OCD that I had originally detected. Nonetheless, I suspect that altering some of the interventions would have resulted in a more enduring treatment response over time. Certainly, by the end of the conversation outlined above, Bridget expressed strong conviction of the value of suspending prayer for the reasons discussed, and spontaneously announced that she would try — despite her doubts — to stop praying for one month as a self experiment. She also agreed to a cognitive-behavior therapy referral in her area upon termination of her psychodynamic therapy.

FINAL REMARKS

Bridget's case illuminates the internal struggle of OCD sufferers plagued with the notion that they will commit an act so immoral, so tainting to their very persona, that they will be greatly punished, perhaps even with eternal damnation. In considering this case, these commentaries illustrate some of the technical, ethical and philosophical dilemmas a clinician faces in the service of his/her client. In particular, the consideration of religious faith and practice within OCD raises questions that require careful inquiry into the relationship between faith and scrupulosity. Undoubtedly, most religious individuals do not dart back and forth between contradicting scriptures, terminally entrapped in conflict between them. Many cleave a winding and selective path through scripture to highlight for themselves those edicts that are personally meaningful and life-enhancing. Scrupulous patients such as Bridget are often unable to distinguish between thoughtful religious questioning and the tangles of obsessional theology, and in their equivocation forgo psychologically healthy prescripts within the Bible, as one example of a religious text. (The topic of how scrupulosity may manifest differently among patients of different faiths remains an interesting one, open to further inquiry.) Consider a verse from the book of Matthew:

> [25] Therefore I tell you, do not worry about your life, what you will eat or drink; or about your body, what you will wear. Is not life more important than food, and the body more important than clothes? ... Can any one of you by worrying add a single hour to your life? (International Bible Society, 2005).

In concluding, it seems timely to note how science fueled by intellectual drive and compassion has forged tools to relieve the suffering of individuals like Bridget, and diligently continues to make inroads. I offer my thanks to forums such as *Pragmatic Case Studies in Psychotherapy* and to the practitioners and scholars who direct their energies towards preserving science as an active and open enterprise, and who strive to steer their craft toward improvement and accountability. What better endeavor than to work in the world of the mind, which continues to be a vast frontier for discovery.

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