Using the Bible to Facilitate Treatment of Religious Obsessions in Obsessive Compulsive Disorder

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The professional literature shows that obsessive-compulsive disorder (OCD) is not caused by religion; thus, clinicians’ removal of religion or religious literature (i.e., the Bible) from the therapeutic process in the name of symptom reduction is unnecessary and may result in lack of engagement in treatment or dropout in religious clients. Cognitive behavioral therapy (CBT) is efficacious for the treatment of OCD, but many Christian denominations are wary of psychological interventions due to fears that their beliefs will not be respected. Given the efficacy of evidenced-based approaches to reduce symptom severity, the centrality of the Bible in the lives of many Christian clients, and the current divergence between evidence-based approaches and pastoral care, specific ways the Bible can be incorporated into the therapeutic process is needed as a means of connecting with this population. This article explores the incorporation of the Bible into the evidence-based therapeutic process surrounding the treatment of scrupulosity OCD.

Obsessive-Compulsive Disorder (OCD) is a severe condition that is often comorbid with anxiety and mood disorders (i.e., 75.8% of those with OCD also meet diagnostic criteria for an anxiety disorder, and 63.3% meet criteria for a mood disorder; Ruscio, et al., 2010). The preoccupations and rituals associated with the disorder exceed developmental norms and are both distressing and functionally impairing to the individual (APA, 2013).

The treatment of OCD centers on the individual’s idiosyncratic core fear(s), which drives an elaborate system of thoughts, behaviors, and often increasingly dysregulated affect. Williams and colleagues (2013) describe four symptom-dimensions or subtypes of OCD that include contamination/cleaning, doubt about harm/checking, symmetry/ordering, and unacceptable thoughts/mental rituals. “Unacceptable thoughts/mental rituals” include religious obsessions (Siev et al., 2011) and is sometimes called Religious Scrupulosity; using both evidence-based treatments and the Bible for treatment is the subject of this paper.

The clinical presentation of OCD involves recurrent obsessions and/or compulsions, and nearly all persons who meet diagnostic criteria will manifest both obsessions and compulsions (Leonard & Riemann, 2012; Williams et al., 2011). The obsessions or compulsions are time consuming (i.e., require more than one hour a day), cause clinically significant distress to the individual, or inhibit social, vocational, or other important areas of daily functioning (APA, 2013). OCD is conceptualized as highly ritualized behaviors (compulsions) whose function is to regulate the extreme distress associated with intrusive images or ideas (obsessions). The irony of the OCD-construct in general, and of the compulsive rituals in particular, is that the compulsive rituals whose function stands to regulate obsession-related distress become less effective as the OCD increases in severity; the compulsive rituals actually perpetuate emotion dysregulation associated with obsession-related distress.

One clinician helpfully noted that double checking an alarm clock or locking the car and immediately lifting the door-handle are both healthy and very common practices and are also examples of subclinical obsessive-compulsive behavior (McMinn & Campbell, 2007).
difference between subclinical symptoms and symptom-sets which together meet the diagnostic criteria for a clinical disorder include distress and impairment (APA, 2013).

How does Religion Relate to OCD?

The professional literature explicates religious scrupulosity (RS-OCD), as a type of obsessive-compulsive symptomatology subsumed under unacceptable/taboo thoughts. These thoughts (i.e., obsessions) are not necessarily characterized as unacceptable or taboo by broader society, although thoughts regarding sexual contact with a child indeed are; such intrusive thoughts are by diagnostic definition extremely distressing to individuals meeting the criteria for this type of OCD. In light of the individual’s rigid and scrupulously religious mental constructs, obsessions involving a perceived violation of a Scriptural mandate/teaching or immoral behavior are extremely distressing to Christian individuals with the disorder and are rooted in a rigid and unrelenting, albeit less conscious, standard of perfection or need for absolute certainty. Such intrusive and distressing thoughts (i.e., obsessions) are regulated by compulsive rituals, such as mental actions/neutralizing, avoidant behaviors, repeated prayers, reassurance seeking, and confessions.

While it is true that OCD does not discriminate between male and female—although the disorder demonstrates a higher frequency in females after childhood (Ruscio, et al., 2010)—or ethnic groups (Williams, Chapman, Simms, & Tellawi, 2017), it is also true that some researchers have detected a correlation between religious affiliation and the clinical presentation of certain types of OCD, namely RS-OCD (Gonsalvez et al., 2010; Huppert et al., 2007; Raphael, et al., 1996). The detected correlation does not show that religion causes OCD, merely that one’s religious affiliation and experience can influence the core fear(s) and corresponding obsessions which develop in people with OCD (Gordon & Clark, 2005). In fact, Witzig and Pollard (2013) examined a homogeneous sample of fundamental Protestant Christians and did not find a positive relationship between scrupulosity and religious fundamentalism. Still, several studies have suggested that clinically insignificant scrupulosity and RS-OCD are related to certain conceptualizations of God (i.e., punitive) and these God-concepts are related to religions (specifically, denominations within the Christian religion) which are particularly “works” or practice-oriented (e.g., following religious rules and Scriptural guidelines are emphasized). That is, religious constructs which require individuals to follow strict regulations (i.e., 613 laws of the Torah) in order to avoid divine retribution are the sorts of constructs that seem to influence OCD toward scrupulosity (Huppert et al., 2007). A similar study, which divided participants into three groups, Catholics, Protestants, and non-religious, found that the Catholic participants reported higher levels of obsessive-compulsive symptoms, although some not of clinical significance. Thus, obsessive-compulsive symptom-presentation was related to obsessive or absolutistic beliefs and obsessive beliefs were related to doctrine that emphasized sin, hell, and a punitive God (Gonzálvez, et. al., 2010). Thus, religions which are heavily practice-oriented influenced individuals predisposed to obsessive-compulsive tendencies toward clinically insignificant scrupulosity and RS-OCD.

Research pertaining to the etiology of OCD is ongoing, but available data point to genetic and developmental/environmental causes as important risk factors (Nestadt, Grados, & Samuels, 2010). For example, direct descendants (i.e., first degree relatives) of individuals with OCD are two times more likely to develop the disorder than the direct descendant of individuals without OCD (Lenane, et al., 1990; Riddle, et al., 1990). That is, OCD is largely hereditary. Further, recent research favors the notion that the pathogenesis of the disorder is more associated with genetics than with environment (Cath et al., 2008), although environmental factors relate to onset.

Historically, an array of therapeutic approaches have been employed in the effort to treat very complex and persistent OCD (Fairfax, et. al, 2014; Lam & Steketee, 2001). Still, significant progress has been made toward the goal of effective treatment, and the professional literature has come to point ever-more narrowly in the direction of a specific form of Cognitive-Behavioral Therapy (CBT) known as Exposure and Ritual Prevention (Ex/RP). The data reveal that a standardized treatment of Ex/RP is significantly more effective in reducing the clinical significance of OCD-symptoms than some other treatment
modalities (NICE, 2006). The data also show that Ex/RP was superior in treatment-efficacy to pharmacotherapy (i.e., clomipramine; Foa et al., 2005). Unlike clients treated with pharmacotherapy alone, most Ex/RP clients demonstrated ability to maintain their therapeutic gains over time (Hiss et al., 1994; Williams, Davis, Powers, & Weissflog, 2014). In certain clinical circumstances, however, the combined treatment of pharmacotherapy and Ex/RP may be advantageous, especially in pediatric cases (Franklin & Simpson, 2005). Additionally, Ex/RP has been successfully supplemented with third-wave CBT approaches, including Acceptance and Commitment Therapy (ACT), mindfulness, and Functional Analytic Psychotherapy (FAP; Fairfax, 2008; Patel et al., 2007; Twohig et al., 2010; Wetterneck et al., 2016).

One limitation associated with Ex/RP, however, is that exposures are often perceived as too threatening (Franklin & Simpson, 2005). That is, an intended piece of Ex/RP is repeated exposure to anxiety producing people, objects, or images, thereby promoting the reduction in associated anxiety over time. Additionally, ritual prevention may be seen as “too risky” or aversive for the client to attempt.

The research illustrates that while exposures (i.e., controlled contact with fear-producing persons, objects, or images) alone produce some therapeutic effect in the treatment of OCD, and while ritual prevention (i.e., the absence of fear-regulating behaviors) alone also produces some therapeutic effect, the combination of the two single-component treatments is superior at both posttreatment and follow up (Foa et al., 1984). Since the 1980’s, research has strongly supported the efficacy of two types of exposures: in vivo and imaginal exposures. There has been some disagreement as to whether the inclusion of imaginal exposure is essential for maximal therapeutic efficacy. But some studies have pointed in the direction of both in vivo and imaginal exposures being necessary for maximum durability of positive treatment results (Foa et al., 1980). Imaginal exposure appears to be particularly important for those suffering with unacceptable/taboo thoughts (Williams et al., 2013).

The clinical presentation of OCD tends to involve more than a maladaptive set of rituals working to regulate intense anxiety. Images or ideas (i.e., obsessions) are in the first place anxiety producing in light of their connection to the individual’s core belief (i.e., “I deserve punishment” or “I fear punishment.”) Individuals suffering from religious scrupulosity tend to maintain heavily ritualized behaviors (i.e., compulsions), which sustain their “I’m-actually-OK” (syntonic) view of self. Beneath the seemingly indefensible wall of rituals, excuses, and defensiveness is a very different (dystonic) view of self. That self believes that it needs the OCD to survive.

That is to say, the professional literature shows that a connection exists between certain OCD symptoms and shame, not only in general terms, but in terms of severity (Singh et al., 2016). Changes in shame are related to changes in symptom severity (Fergus et al., 2010). And the presence of OCD is related to lower self-esteem, the avoidance of people and interpersonal activities, a lack of intimacy in relationships, and the likelihood of hiding the truth of obsessions for fear of rejection (Newth & Rachman, 2001). Thus, Wetterneck and Hart (2012), suggest that interpersonal difficulties may be targeted in the treatment of OCD and that unwanted or unacceptable views of self may contribute to obsessive compulsive tendencies.

The Religiosity Gap

According to recent analysis, approximately 2.2 billion people in the world today identify as Christian, a global percentage of 31.50%, making Christianity the world’s largest religion at the time of this publication. Many religious people are mistrustful of mental health professionals and avoid the process of psychotherapy because they fear that secular therapists will misunderstand or attempt to undermine their beliefs (Richards et al., 2004). This posture is rooted in a decades-long history of modern psychology in which many psychologists and psychological theorists have been non-Christian thinkers, some even antagonistic toward the faith.

This divide was further widened with the publication of Jay Adams’ (1970) Competent to Counsel. Adams espoused a counseling view that rejected the contributions of modern psychology and instead directed Christians to counsel in strict accordance with the Bible. Although Adams is no longer a central voice for the movement now known as Biblical
Counseling, there remains an unmistakable antagonism between Biblical Counseling and so-called “secular psychology.” This recent and relatively brief history has resulted in tension between the two groups.

Like any cultural group, Christian clients have unique needs for mental health care, and they respond best to sensitive support for their worldview (Himle, Chatters, Taylor, & Nguyen, 2013). The same ethical considerations necessary in other cross-cultural issues should be utilized in work with such clients. One of the most effective means of working productively with such individuals is to incorporate their faith into the treatment process. Thus, important tasks of developing and improving therapeutic rapport with religious clients, particularly with Christian clients, are demonstrating regard for their God-centered worldview and validating their establishment of biblically-oriented therapeutic goals.

Having explicated the literature regarding the societal presence, diagnosis, and treatment of OCD, the topic emerges of the Bible and OCD, or the Bible and treatment. Treatment-seeking Christians may wonder if the Bible speaks to human emotion and psychopathology (OCD in particular) and whether the Bible should be included in the treatment of psychological problems, even if only by Christian clinicians or for clients who prefer the Bible’s input. Such questions are among those often posed by religiously scrupulous clients.

Any such discussion should begin with a few words of orientation. First, according to conservative Christian thought, the Bible is God’s authoritative and inerrant Self-revelation. Furthermore, the Bible is eternal and true because God is eternal and true (Psalm 119). Thus, questioning the correctness of the Bible would be considered unacceptable and should be avoided. Another way to put that is that the Bible is about God and God is the Hero of every story. In the Bible, God is revealing God’s self to God’s people both for their good and for God’s glory. Next, the Bible is a sophisticated piece of literature. Among the many things that means is that there is a right way to read (i.e., interpret) the Bible and many wrong ways. The rule of thumb here is simple. If the reader of the Bible is the determiner of intended meaning (instead of the author himself possessing the right to define the intended meaning), then communication from the author to the reader is impossible (Stein, 2011). The Bible is an ancient text, originally written in three different languages, with images, themes, symbols, and typologies. Last, the Bible is not a book about psychotherapy.

It is noteworthy, to begin, that little empirical data is extant in the professional literature pertaining to how to use the Bible in the psychotherapeutic process. Johnson and Jones (2000) put forth a text explaining five views on how theology and biblical teaching might be incorporated into psychological practice and conceptualization. Jones and Butman (1991) published a helpful work describing how biblical teaching and a Christian worldview meshes with today’s psychotherapeutic ideals. McMinn and Campbell (2007) provided an Integrative Psychotherapy which serves to approach clinical work with a decidedly Christian worldview and to practice psychotherapy with the eternal in mind. None, however, reports and explicates data that pertain specifically to the use of the Bible in psychopathological treatment. The lack of available empirical data highlights that we have not identified the specific ways in which the therapeutic process is impacted for adherents when the Bible is incorporated into it. A gap remains in the literature, then, as to the specific ways in which the Bible can be incorporated into the process. Future research should explore how the process is shaped by inclusion of the Bible, and what the resultant treatment effects are.

At the present time, as evidenced by the absence of relevant empirical data, little research has been conducted to determine the efficacy of the Bible’s therapeutic involvement in specific and structured ways in treating identifiable problems. On the other hand, omitting religion (i.e., the Bible) from the therapeutic process, particularly when clients request interventions which are biblical or which incorporates the Bible into the process, is also an ethical matter. Clients have a right to shape their treatment (ACA, 2014). The ethical tension, then, is about centering the treatment plan on the client’s identified goals and ensuring that the specific techniques used in the therapeutic process have been shown to do what they are intended to do.

As above, there is no data that expressly connects religion with the etiology of psychological illness, including, in this case, OCD; thus, there is no need for clinicians to feel the need to
exclude the Bible from psychological treatment in the name of therapeutic progress. Conversely, research does show that those with RS-OCD do not respond as well to traditional Ex/RP when compared to those with other symptoms presentations (Williams, et al., 2014). In regards to this finding, it was hypothesized that clients may be less trusting of exposure-based treatment for fear of disrespecting their faith, potentially influencing treatment adherence. Indeed, it may be difficult for a client and/or therapist to distinguish between acceptable versus excessive moral thoughts or behavior, posing difficulty with developing and implementing the exposure hierarchy. Thus, there is a need to better assist therapists in how to use religiously appropriate interventions to help those with RS-OCD. To that end, the remainder of this article is expressly focused on what the Bible does and does not say about the therapeutic process and how the Bible might be incorporated into the process for Christians with OCD in a way that is in keeping with the structure of empirically supported or evidence-based treatment.

Psychotherapy and the Bible

One of the areas of clear overlap between theology and psychology is that of human suffering, specifically that of human emotionality. That is, human suffering is an area to which both the Bible and psychological theory and practice speak. Furthermore, there is good reason to interpret the Text of the Bible to view the experience and expression of honest emotion as natural to the human condition (i.e., the Psalms). That is, whether suffering is ultimately the result of sin (as Genesis 3 and following teach) or simply the result of biopsychosocial processes (as research demonstrates), emotional processing is viewed as normative and therefore can be assumed to be helpful and healthy. It is nevertheless the tendency of some Christians to condemn emotional experience and expression as, as it were, the “fruit of the flesh.”

There is ample reason, however, to view the experience and expression of honest emotion as natural to the human condition, and this is illustrated in the Bible. Again and again, the Psalms describe the expression of deep emotion as normative for spiritual health. “My tears have been my food day and night…” (Psalm 42:3); “I am worn out calling for help…My eyes fail looking for my God” (Psalm 69:3); “My soul is overwhelmed to the point of death” (Matthew 26:38; the words of Jesus at Gethsemane); “I am overwhelmed with troubles and my life draws near to death. I am counted among those who go down to the pit; I am like one without strength” (Psalm 88:3-4); “Many bulls surround me; strong bulls of Bashan encircle me” (Psalm 22:12); “Be merciful to me, LORD, for I am in distress; my eyes grow weak with sorrow, my soul and body with grief…Terror is on every side” (Psalm 31:9,13).

Indeed, the Bible is replete with references to human emotion. Many of the above references are examples of God’s people praying in the throes of suffering. Two of the abiding messages in these passages are that God’s people are weak and in need of Him, and the LORD is strong and in need of nothing. In fact, the primary avenue for worship in the Psalms is the expression of deep and honest emotion (i.e., the recognition of one’s own weakness in the face of suffering) in relationship to the unrivaled power and faithfulness of God. One of the ways Jesus Christ affirmed the Psalms as God’s Words was by quoting from the Psalms, just as He did from the Torah and the Prophets (i.e., all of the Old Testament). But emotion in the Bible is not limited to the Old Testament. A full range of emotion is portrayed—not just so-called “positive ones”—in the New Testament as well.

To cut to the heart of this question, Does the Bible equate the experience and expression of emotion with sin? Clients can consider the account of Christ in the Garden of Gethsemane. Although the following suggestion may be controversial in some circles, the exploration of the biblical narrative as it relates to Jesus’ prayer prior to His arrest clearly illustrates His emotionality in the face of “this cup” of God’s wrath (Matthew 26:37-39; Luke 22:42) to be poured out upon Him during His crucifixion. As Jesus is praying, “Father…take this cup from me; yet not my will, but yours be done” (Luke 22:42, New International Version), and as the Text describes Jesus’ intense somatic response (Luke 22:44) to the anticipation of the crucifixion, Jesus Himself describes His emotional experience as “overwhelmed to the point of death” (Matthew 26:38); any empathic listener will be immediately attentive to the heaviness of emotion in the voice of Christ. Jesus was “in anguish” (Luke 22:44). Much ink
has been spilt, and time wasted, over the motivation behind Jesus’ prayer in Gethsemane. Was Jesus changing His mind, no longer so sure about His role in redemption? Was Jesus afraid of torture? What was happening for Him in those moments? Taken in context, and taking into account Jesus’ explicit reference to “this cup,” it seems appropriate to interpret Jesus’ motivation and anguish in direct relationship to the holiness of God, the sin of mankind, and the ferocious cost of God’s forgiveness of guilty sinners (i.e., the doctrine that God, in Jesus, sacrificed Himself in the place of guilty sinners so that sinners might be righteously forgiven by God). In this context, with these theological parameters in view, and keeping the intent of the Text in mind, it is appropriate to identify Jesus as having had an honest human and emotional reaction to the terrifying, forthcoming crucifixion.

If Jesus can be shown to have experienced and expressed emotion, including even negative emotions like fear or “anguish” (Matthew 26:36-46; Luke 22:39-46), sadness (John 11), or fatigue (Matthew 8:23-27; Mark 8:23-27), or anger (Matthew 21:12-17; John 2:13-22), then using what logic would His followers argue that the experience of emotion in their lives is sin? If fear or anxiety in particular, and emotion in general, are to be considered sin, then it logically follows that Jesus died a Sinner, and the theological ramifications of such a view are catastrophic to the Christian faith. As was demonstrated amply above, the experience and expression of emotion is normative to the human condition. Jesus’ experience of emotion was not sinful, and neither is that of His followers. Negative emotions are not wrong.

But what does the emotionality of the heroes of the Bible have to do with the treatment of OCD? Mindfulness, a non-judgmental openness to—and acceptance of—one’s thoughts, emotions, and somatic experiences in the present moment, has been linked with effective symptom-reduction in individuals with OCD (Fairfax et al., 2014; Vøllestad et al., 2012) and is a useful posture for the facilitation of Ex/RP. The objection RS-OCD clients often have to Mindfulness, though, is that “to have a morally questionable thought” they think “is to sin.” This, as mentioned above, is a spiritualized variety of thought-action fusion (Cougle et al., 2013; Shafran, Thordarson, & Rachman, 1996). Religiously scrupulous clients might be more prone to believe that the intent of passages like 2 Corinthians 10:5 (i.e., “Take captive every thought to make it obedient to Christ,” NIV) is that people, most of all Christian people, must have total control over what thoughts pop into their heads. Indeed, the issue for the religiously scrupulous is not “What do I do with a morally questionable thought once I think it?” The mind of the religiously scrupulous gravitates toward the issue of, and is distressed by, personal uncertainty (Fergus & Rowatt, 2014). The issue instead is, “Since I had a morally questionable thought, and since I might have more of them in the future, it must mean that I am a bad person, and that I might get punished.” That is, people—not only religiously scrupulous people—tend to think that they have total control over what thoughts come into their minds. While they do have some control over what thoughts stay in their minds, people have quite limited control over spontaneous thought experiences (Rachman, 1997). Further, the focus of 2 Corinthians 10:5 is not spontaneous thought experiences but “speculations” and “every lofty thing raised against the knowledge of God” (NASB). This passage teaches that thought-life is an integral part of spiritual-life, and with that in mind, we ought to be very intentional regarding the things about which we think. This is clearly the point of Philippians 4:8: “Whatever is right, whatever is pure, whatever is lovely, whatever is admirable—if anything is excellent or praiseworthy—think about such things.” To state the obvious, in the context of Scripture, the things which are right, pure, lovely, and admirable are things which reflect the character, glory, and truthfulness of God as revealed in His Word. The writer’s intent here has little do with spontaneous thought experiences. His message is “See to it that your mind is engaged in and occupied by truth, the sort of biblically revealed truth which will shape your understanding of the present moment.” He communicated a similar directive to Timothy: “Watch your life and doctrine closely…” (1 Timothy 4:16; NIV). Jesus clearly taught that thoughts shape behavior (Matthew 5:27-28), and His disciples defined true discipleship explicitly in terms which include feelings of the heart (1 John 4:20; i.e., rumination). In modern times, this idea was explicated by Beck’s Cognitive Model in terms of the inextricable link between thoughts, feelings, and behaviors (Beck et al., 1979). Scripture is clear
that positive ruminations can be healthy for the soul, but the reverse can also be true.

Fortunately for the religiously scrupulous, the message of the Bible is not, “Get your head on straight, or else.” The point of emphasis in the present context is that these passages do not refer to spontaneous thought experiences; they refer to the intentional habits of our thought-life. What a person does with the thoughts which enter his mind is a matter distinct from the material intrinsic to spontaneous thought experiences. This is the point at which the Bible and Ex/RP relate to the purpose of OCD-treatment.

Before expounding this point of relationship between Ex/RP and the biblical message, the point should be made that neither the authors nor the below discussion seek to equate psychopathology to sin. Various types of dysfunction (i.e., psychopathology) may well be the result of bad choices but should not themselves be overspiritualized (John 16:33). Nevertheless, the religiously scrupulous client may well view intrusive thoughts and ruminations, anxiety, and perhaps her underlying core beliefs as evidence that she is bad (i.e., sinful). The clinician, while not endorsing the view that the client is “bad,” may helpfully endorse the notion that she is “sinful.” That is, clinicians may ultimately achieve therapeutic progress with RS-OCD clients (who identify themselves as sinful) by agreeing with their assessment. For if one is a sinner (and the obsessions of the RS-OCD client assures her that she is), then it only makes sense that she will sin. This logical progression is in keeping with the biblical literature, which states that all people have sin (1 John 1:8,10). But it is one that is also likely to achieve therapeutic progress for RS-OCD clients who are resisting the notion of “agree[ing] with the OCD” (Foa et al., 1998).

Scrupulosity is obsessed with thorough rightness as it relates to morality and religion. The incorporation of the Bible into the therapeutic process squarely challenges religious scrupulosity. Clients who are resistant to the Ex/RP process, and many religiously scrupulous clients are, may benefit from a gentle challenge: “This continuous denial of the notion that you probably are homosexual and that you probably will act on that desire soon—isn’t that ultimately a denial of your nature as a sinner and your need for God?” (Williams, Slimowicz, Tellawi, & Wetterneck, 2014) The notion that the religiously scrupulous person has no need for God is oxymoronic. Such a discussion brings that fact to the foreground, causing the function of the client’s compulsions (i.e., to protect him from his core fear) to become clear. That is, his syntonic and dystonic ego states converge upon him, forging further possibility for acceptance-based interventions.

In this sense, Mindfulness, Ex/RP, and the message of the Bible point in the same general direction. To be mindful of one’s thoughts (i.e., “I think I might be homosexual”) is to “know my transgressions, and [to keep] my sin...always before me.” (Psalm 51:3, NIV). To keep “my sin always before me is to acknowledge that I probably will sin again” (Ex/RP exposure statement) and to acknowledge that “I will probably sin again is to see more clearly my ongoing need for God” (the Gospel message). Thus, the Bible can be ethically and productively incorporated into the therapeutic process in such a way that is both deferential to the message of the Bible and helpful to the evidence-based process.

But how is directing clients to agree with intrusive and obsessive thoughts (i.e., “I think I might be homosexual”) and dystonic core beliefs therapeutically advantageous and how is that spiritually helpful? The idiosyncratic obsessions and feared outcomes which clients “prevent” with elaborate sets of compulsions often do not happen, even when they actively resist giving into their compulsions. Continued exposure to this dynamic eventually weakens the association between their obsessions and intense anxiety (Abramowitz, Foa, & Franklin, 2003).

But Acceptance-Based Interventions are also congruent with the teachings of the Bible as was explicated above. Some RS-OCD clients may object saying, “To embrace sin is to contradict the Bible.” As Paul asks, “Shall we go on sinning?...May it never be!” (Romans 6:1). Or, “Whatever is right, whatever is pure, whatever is lovely, whatever is admirable—if anything is excellent or praiseworthy—think about [these] things” (Philippians 4:8). Given the many biblical references to resisting temptation, why would a biblical counseling treatment direct clients to “agree with” intrusive and unwanted thoughts?
This question highlights the point emphasized above. There is at least some distinction between sin and psychopathology. The research shows that clients with OCD (whether experiencing intrusive thoughts regarding same-sex attraction or pedophilia or harm to others) merely experience intrusive (and quite unwanted) thoughts. One of the differences between a pedophile and a person suffering from OCD with intrusive pedophilia-related thoughts is that the latter is deeply alarmed by his or her thoughts and has developed an elaborate set of compulsions (including mental acts) to resist thinking such thoughts and exhibiting such behaviors. That is not to say that the OCD-client does not sin, nor is it to say that the pedophile is not psychologically ill, but the clear difference between the two is both intent and subsequent behavior (Bruce, Ching, & Williams, 2018).

Thus, to return to the previous question, agreeing with the obsessions (i.e., “I probably am a pedophile”), and coupling such exposure statements with the resistance of compulsions, has been repeatedly shown to be efficacious for treatment of anxiety disorders, most notably OCD. That is to say, Ex/RP does not appreciably increase the likelihood of feared outcomes.

Biblical passages, then, which might be used by RS-OCD clients to combat and resist the therapeutic process are precisely the ones which might be used to defend it (i.e., 2 Corinthians 5:10; Philippians 4:8). “To have homosexual thoughts is to do homosexual acts,” one such client might reason. After responding empathically, being sure to hear and reflect the client’s concern, the biblically oriented Ex/RP therapist might highlight the fact that, “It sounds like you’re concerned about where a treatment-approach like this is going. It feels kind of counterintuitive. But my sense is that you’re here in the first place precisely because you are having thoughts that are really alarming to you, and no matter what, you can’t get them to stop.” For clients with RS-OCD, agreeing with intrusive and distressing thoughts is the most effective way to take every thought captive (2 Corinthians 10:5). The demonstrable reality is that clinical practice, in this case Ex/RP, does not contradict biblical teaching. The treatment for OCD with religiously scrupulous clients can be a process that is both evidence-based and biblically grounded.

**Common Presentations in Christian RS-OCD Clients**

Compulsions in clients with RS-OCD frequently include the pursuit of reassurance from clergy (Huppert & Siev, 2010). The corresponding obsessions focus on the consequences of perceived sin (Huppert, Siev, & Kushner, 2007). The reassurance focuses on whether a certain thought is equivalent to sin and whether God will forgive it. “Will He condemn me to hell for my sin?” These questions are among those that form obsessive thoughts in the minds of Christian clients with RS-OCD, and clergy who entertain compulsive behaviors (i.e., provide direct reassurance) only facilitate the cycle of RS-OCD (Huppert & Siev, 2010). As was established above, the idea of a Christian client who has no need for the grace of God is oxymoronic (e.g., Luke 5:32). Clergy and clinicians alike can use the presuppositions behind obsessions as a means of facing fears and resisting compulsions.

One client sought out professional counseling after having worked with one of his pastors for some time, but with little in the way of symptom reduction. Upon presenting for treatment, the client was quite careful to identify the type of counseling he sought as “Christian” and “biblical.” As Ex/RP proceeded, the client repeatedly objected that “accepting the thoughts non-judgmentally will only increase the likelihood that I will act on them,” and inquired “How is this biblical?” After a number of such conversations spanning over the course of approximately six sessions and walking through the passages and arguments presented in this paper, it became clear that the objections and inquiries were far less about Ex/RP and far more about the pursuit of reassurance and the consequences of perceived sin (i.e., thought-action fusion). In subsequent sessions, the frequency of—and distress associated with—his intrusive thoughts began to decrease. The decrease in the client’s symptom severity was directly related to his resistance of compulsive behaviors and agreement with the obsessive (intrusive) thoughts. Ultimately, the most effective means of “taking every thought captive” for RS-OCD clients is doing the counterintuitive but evidence-based work of Ex/RP.

Another frequent compulsion associated with RS-OCD is compulsive prayer. Bonchek and Greenburg (2009) successfully modified
Ex/RP in order to treat compulsive praying within the religious-OCD population and did so by recording the prayers, noting where clients were repeating or having long pauses in their prayers, and then practice refraining from the repetitions and pauses to the best of their ability. Obsessive thoughts motivating compulsive prayer are various. This may take the form of, “Prayers as confessions can cancel negative (i.e., sinful) thoughts, and therefore should be compulsively done with the experience of every sinful thought.” “This,” of course, “is biblical,” the RS-OCD will undoubtedly reason (1 John 1:9). The trouble is that

**Table 1**

_The application of Scripture to the Ex/RP process_

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</table>
| 2 Corinthians 10:5  
"take captive every thought to make it obedient to Christ" (NIV) | Resisting obsessions is the best way to take thoughts captive. | Resisting obsessions only strengthens them; agreeing with obsessions weakens them. Thus, 2 Corinthians 10:5, to which many RS-OCD clients will gravitate, only bolsters the Ex/RP argument. The context of Philippians 4:8 is about habitual thinking or pondering, not spontaneous thought experience (i.e., thoughts which "pop" into one's mind despite the distress they cause). In other words, Paul is not referring to the clinical presentation of RS-OCD, chastising those who seek treatment for intrusive thoughts. Paul's intent is to expound his directive to "stand firm" (4:1). |
| Philippians 4:8  
"whatever is true, whatever is noble, whatever is right, whatever is pure, whatever is lovely, whatever is admirable—if anything is excellent or praiseworthy—think about such things" (NIV) | I cannot agree with the OCD (and embrace the Ex/RP process) when the Bible tells me to think about good things. | Anxiety is sin. Perhaps even emotionality is sin. Emotions are fickle, therefore I should not pay attention to them. |
| Philippians 4:6  
"Do not be anxious about anything" (NIV) | Therefore, we should look only to [God's] divine power as specifically revealed through His Word for help in "life and godliness" in relationship to our problems. | Emotional experience is a God-given part of the human condition. To label emotion, including negative emotion, as sin is to identify Jesus as having sinned throughout His adult life, including the night He was betrayed. Emotional regulation, including the reduction of clinically significant anxiety, is the goal of therapeutic interventions. Neither this passage nor the rest of Scripture equate psychopathology in general and OCD in particular with an absence of godliness. Further, the granting of God's "divine power" to us does not necessitate the instant and complete disappearance of all problems. Such a philosophy is commonly called the Prosperity Gospel—a quite un biblical message. |
| 2 Peter 1:3  
"His divine power has granted to us everything pertaining to life and godliness" (NASB) | I can't use exposure statements (i.e., agree with the OCD) when the Bible tells me to "walk by the Spirit" and to "not gratify the desires of the flesh." | The operative phrase here is "desires of the flesh." For those with RS-OCD, intrusive thoughts are rooted in core fears of the flesh. Ex/RP is not treating the desires of the flesh, but the clinically significant anxiety that one has or will gratify the desires of the flesh and the compulsive rituals one performs to avoid doing so. |
| Galatians 5:16  
"...walk by the Spirit, and you will not gratify the desires of the flesh" (NIV) | | |
both the previous verse and the following verse highlight that, “If we say that we have no sin...the truth is not in us” (1:8), and “we make [God] a liar and His word is not in us” (1:10, NASB). Further, preoccupation with the formality of prayer (i.e., that prayers are prayed with purity, correct intent, and perfect word-annunciation; Huppert & Siev, 2010) betrays the self-focus (not the God-focus) of this lofty spiritual act. Jesus, in fact, rejected the habit of praying in order to be “seen [or approved] by [people],” including the person doing the praying. A parallel rejection was that prayer-form should be “meaningless[ly] repetitious” incorporating the use of “many words” (Matthew 6:5-7). The provision of Jesus’ Lord’s Prayer (Matthew 6:9-13), particularly given the context, is not a certain set of words that must be rightly, purely, and legally articulated in order to be received by the Hearer. On the contrary, the wrong way to pray is the way that centers on the one uttering the prayer rather than on the One hearing it. The irony of compulsive prayer, then, is that the entire construct is centered on the formality and correctness of the prayer and the one conducting the act. Thus, clients with RS-OCD can agree with the OCD here, too. “I’m probably not doing it right, and God knows that.”

It would be tempting to forbid prayer for the RS-OCD client as a means of ritual prevention, and it would certainly help to reduce the OCD symptoms, objectively speaking. But because prayer is central to Christian life, such a requirement could potentially result in loss of rapport and even dropout if the client believes that the treatment is interfering with his relationship with God (for example, clients may believe they are violating Thessalonians 5:17, which says “pray without ceasing” [NASB]). One remedy we have found for this dilemma is to forbid all prayers except prayers of thanksgiving during treatment. This therapeutic alternative is both effective for the treatment of compulsive prayer (as a component of OCD), and acceptable to OCD-clients who are committed to their religious practice. That is, although prayer is a central part of Christian practice, the resistance of compulsive behavior (i.e., compulsive prayer) is a central part of Ex/RP, and both can be accomplished. Table 1 shows additional examples of how the Bible can be applied to CBT for OCD.

**Conclusion**

Ex/RP is an evidence-based therapeutic intervention which has been specifically and repeatedly identified as an effective treatment for OCD, and the teachings of the Bible are not incongruent with the treatment-principles of Ex/RP. The purpose of this article has been to demonstrate the specific ways in which the Bible can be usefully incorporated into the process of treating psychopathological symptoms. It is clear, however, that the lack of empirical data extant in the professional literature reduces the incorporation of the Bible into evidence-based approaches associated with symptom-reduction. It is the sincere hope of these authors that, in the best interest of Bible-believing sufferers, future study will be devoted to incorporating the Bible into the treatment-process of specific diagnoses and corresponding therapeutic interventions, including the reduction of OCD symptoms and anxiety.

**References**


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