Obsessive Compulsive Disorder and Religious Scrupulosity

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Goals for the day

- Explore important understandings related to mental health.
- Learn about the experience of obsessive-compulsive disorder.
- Learn about therapies for treating individuals who live with OCD.
- Consider religious scrupulosity and Christ-oriented counseling for this experience.
- Provide opportunity for discussion and interaction.

Objectives: At the completion of this day participants will have had opportunity to:

- Consider personal shaping experiences related to mental health.
- Explore several important concepts related to mental health.
- Review the experience of OCD and religious scrupulosity.
- Explore ways of treating OCD
- Consider the application of Christ-centered methods for managing religious scrupulosity.
- Engage in discussion related to OCD and religious scrupulosity.

Session 1 – Important Concepts Related to Mental Health

Session 2 – What is it Like to Struggle with the Experience of OCD?

Session 3 – How do we counsel those with OCD?

Session 4 – Religious Scrupulosity and Christ-centered Helps

Session 1 – Important Concepts Related to Mental Health

Common Legitimate Concerns About Mental Health

- Acceptance of mental health categories may remove personal responsibility.
- Acceptance of mental health categories may legitimize sin.
- Consideration of mental health categories may negate faith.
- How do I know if my mental health is okay?
- I'm scared that I have a mental illness.
- I don't want to depend on a substance -I want to depend on Jesus.
- Maybe medication will change my personality?
- Concerns about secular psychology and Freud
- Maybe this is caused by demonic activity and not a mental health concern.

Common Unhelpful Responses

- Mental Illness does not exist.
- The mind does not exist.
- The mind cannot be broken.
- Taking mental health medications is participating in witchcraft or at least a lack of faith.
- All you really need is to read more Scripture.
- All you really need to solve your problem is a concordance.

Important Understandings About Mental Health

- The mind can be broken. The Noetic impact of the fall
  - Both in structure, and in the way it processes.
  - Both in the neurology, and in the way of thinking

- Our basic problem is both our sin and our suffering.
  We must consider the person's suffering but not lose sight of their heart in the middle of the suffering.

- Religious ecstasy
  - We have the power of the Holy Spirit and all the heavenly resources so we should pray and read our Bible and obey and overcome any problem.
  - God does heal sometimes miraculously, but he doesn't always.
  - We do believe in the power of God; however, we also recognize that most of our lives will be spent "waiting for Jesus to come."

- Diagnostic labels
  Helpful in communicating what an experience might be like
  Possibly stigmatizing and possibly excusing

- Consider how we arrive at our conclusions.
  - Randomized controlled studies vs anecdotal evidence vs placebo.
  - Randomized controlled studies consider what is generally true for the population as a whole.
  - Anecdotal evidence may be only true for one person.

- Demonology
  - Unhelpful if depersonalization of sin – The devil can easily become the focus.
  - Sometimes God choses to heal through prayer of renunciation.
  - However, we must be careful to understand that most of life is lived in the mode of faith, repentance, obedience, and trust.

- Medicating Normal
  - Anti-depressants have only shown to be helpful beyond placebo in the severely depressed, not in the mild or moderately depressed.
  - There is a place for mediation used wisely.

- Important to know the person in front of you.
  - Idiographic vs nomothetic norms

- Is medication witchcraft?
  - Be sure to not misinterpret scripture.

    Example: Pharmakeia. Strong's Greek G5331 Revelations 18:23 used to demonize both pesticides and psychotropic medications.

- Psychology proper vs psychology as a worldview
  - Differentiate between psychology proper and psychology as an institution or group of people with a particular worldview.
  - Psychology = study of the mind
  - A psychologist is someone who spends time thinking about human regularities.
  - Worldview = a comprehensive way of seeing the world from a particular perspective

- Mental health definitions

  World Health Organization
  Mental Health Fact sheet no. 220.
  "Mental health is a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community. It is an integral component of health and well-being that underpins our individual and collective abilities to make decisions, build relationships and shape the world we live in. Mental health is a basic human right. And it is crucial to personal, community and socio-economic development.

Mental health is more than the absence of mental disorders. It exists on a complex continuum, which is experienced differently from one person to the next, with varying degrees of difficulty and distress and potentially very different social and clinical outcomes.

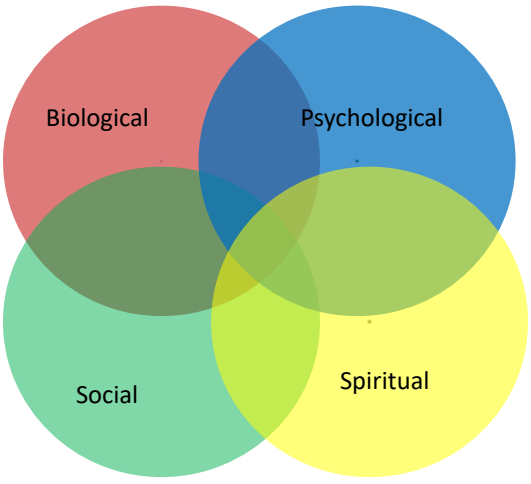
Mental health conditions include mental disorders and psychosocial disabilities as well as other mental states associated with significant distress, impairment in functioning, or risk of self-harm. People with mental health conditions are more likely to experience lower levels of mental well-being, but this is not always or necessarily the case."

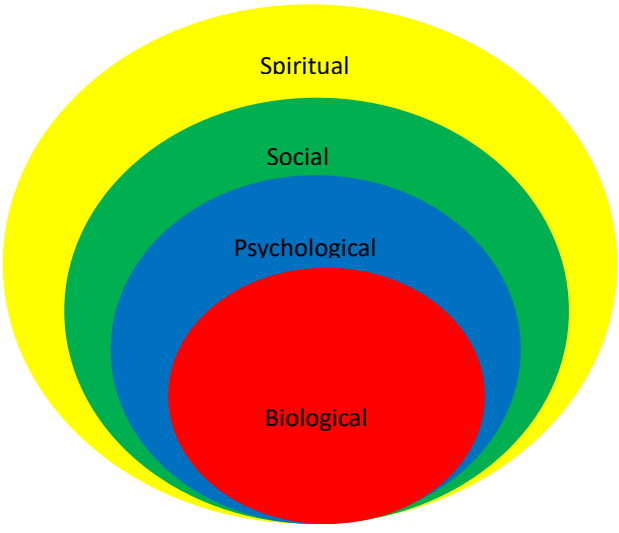
(Mental Health Fact sheet no. 220. Geneva, Switzerland: World Health Organization. Retrieved from https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response)

- We are interpreters – we make meaning out of our experiences.
  - Our observation of human regularities must be interpreted in light of who and what Jesus Christ is doing in the world. Psychology must support our faith.
  - "The Blind Men and the Elephant" by John Godfrey Saxe
- What is the hermeneutic by which you must interpret anything you hear today?
  - Luke 24:13. Beginning with himself and Moses he expounded unto them in all the Scriptures the things concerning himself.
  - We must interpret not only the Scripture but also our life events in terms of faith in the finished work of Jesus Christ and what He wants to do today.

Conclusions

1. People are complex – We need to stay curious.
   - We need a holistic approach that considers all aspects of the person.
   - Biological, Psychological, Social, and Spiritual





- When we find healing in one particular way, physically through medication or exercise, spiritually through fasting and prayer or exorcism, socially through improved relationships, psychologically through talking with someone, it is easy to expect that that experience should help everyone else.

2. Humility – We are made in the image of God, but we know so little compared to what there is to know

3. Living relationally under the direction of the Holy Spirit
   - Given all that we've stated above, what does it look like in the particulars to move in faith toward Christ?

   - **Attempts to define the nature of who we are as people that do away with complexity are generally motivated by an attempt to find rest, security, and even salvation, apart from relationship with the person of Jesus Christ.**

   - We must be able to hold contradictory truths in the same hands and in wrestling with these truths come to a humble rest in relationship with Jesus Christ.

   - We must do whatever we do in faith with an eye on building the kingdom of heaven.

Session 2 – What is it Like to Struggle with the Experience of OCD?

DSM-V criteria

A. Presence of obsessions, compulsions, or both:

   1. Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress.

   2. The individual attempts to ignore or suppress these thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion).

   Compulsions are defined by (1) and (2):

   1. Repetitive behaviors (for example, handwashing, ordering, checking) or mental acts, (example, praying, counting, repeating words, silently) that the individual feels driven to perform in response to an obsession, or according to rules that must be applied rigidly.

   2. The behaviors or mental acts are aimed at preventing, or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way, with what they are designed to neutralize or prevent, or they are clearly excessive.

B. The obsessions or compulsions are time-consuming (example, take more than 1 hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The obsessive-compulsive symptoms are not attributable to the physiological effects of a substance.

D. The disturbance is not better explained by the symptoms of another mental disorder, such as excessive worries, generalized anxiety disorder…

Prevalence

- 1-2% of the population. Typical age of onset is 19.5 years, 25% starting by the age of 14. Females are affected at a slightly higher rate than males in adulthood, males more commonly affected in childhood.

Age of Development

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Development of Disorder

- If untreated typically chronic with waxing and waning symptoms throughout life. Without treatment 80% of individuals who do not get treatment will still have symptoms after 40 years.
- Onset in childhood or adolescence can lead to a lifetime of OCD. However, 40% of individuals with onset in early childhood or adolescence may experience remission by early adulthood.

Risk and Prognostic Factors

- Temperamental: Greater internalizing of symptoms, higher negative emotionality, behavioral inhibition in childhood trauma
- Environmental: physical and sexual abuse in childhood, other stressful or traumatic events have been associated with increased risk for developing OCD.
- Certain ethics, values, and beliefs can have a contributing effect, but parents do not cause OCD. For example, accommodation may reinforce re-assurance seeking, if you don't know what to do, or a family that is extremely fastidious may intensify the symptoms of OCD, but you can't cause OCD by poor parenting.

Genetic and Physiological

- There is a genetic component to OCD. If you have a family member or a relative, who has OCD, you have a higher chance of having it yourself maybe about twice as likely. If your relative had onset of the disorder in childhood this risk factor increases by about 10 times.

Cultural Components

- Occurs across the world though expression is different due to cultural factors.

Personality Characteristics That Play into OCD

- Upright, moral, high standards, fearful, introspective, depressive, risk averse, tendency to avoid harm, lack of interest in novelty, great need for approval from others, **excessive personal responsibility for others**, fearfulness, introversion, perfectionistic, punctual aloof, inflexible, **over importance of thoughts**, intolerance for uncertainty.
- An inflated sense of personal responsibility, a deep-seated automatic tendency to feel accountable for anything bad that might happen. (Osborn 1998, pg 59)

Neurobiological Etiology for the Disorder

- A genetic predisposition to a neurological etiology, probably involving the neurotransmitter serotonin.
- Anecdotal
    - When brain trauma occurred
    - When the basal ganglia are damaged, OCD symptoms sometimes occur.
- Serotonin abnormalities due to studies showing that people who use the medication improve over placebo, (Osborn 1998, pg 182)

- **Stress and sleep, impact OCD. Capacity to manage obsessions decrease when tired.**
- Take away: There is significant evidence for a neurobiological basis sufficient to allow us to think - "This is something that my brain is making me experience that is not really who I am."

- How does a Christian worldview make sense of this kind of an understanding? My body can make me very uncomfortable, but it can't make me sin, and Christ's death on the cross is sufficient for both my sin and my suffering.

Obsessions and Compulsions

- What is an Obsession?
  - An obsession is an intrusive thought. It is recurrent. It is unwanted, and it is inappropriate.

- An obsession
  - Maybe I didn't tell the truth.
  - Maybe I'll pick up a germ and give a sickness to a family member and they will get sick and die.
  - Maybe I will abuse my son or daughter.
  - Maybe my heart had a sinful motive.
  - Maybe I didn't turn off the stove and the house will burn down.

- What is a Compulsion?
  - A compulsion: A repetitive behavior or thought engaged in for the purpose of lowering anxiety.

- A compulsion
  - I must say a prayer.
  - I must wash my hands every time I touch a germ so that I'm not responsible for the death of a family member.
  - I must mentally recount every minute of the last hour so that I can prove I did not abuse my child.
  - I must ask forgiveness to cover the possibility of a sinful motive.
  - I must count to 10 while looking at the stove so that I can be sure the stove is off so that the house doesn't burn down.

- Demand for Certainty

- Reassurance seeking

- Typical stories
  - A person who brushes his teeth until his gums bleed and his teeth fall out because he is worried he will get cavities if he doesn't brush.
  - A man who washes his hands until they bleed.
  - A woman who counts over and over again for 30 minutes before going to bed because she needs to convince herself that the door is locked the light switch is out or the stove is not left on.
  - The lady who repeatedly askes church members for forgiveness because she is worried she may have slighted them.
  - The man who fears he is a sexual predator even though he has never engaged in any sexually inappropriate behavior.
  - The person who believes he has committed the unpardonable sin and will go to hell because he is unable to stop curse words from going through his mind.
  - The young woman who cannot put the clean towels in the drawer because it takes too much time to make sure each item is properly folded.

- Common assessments used in diagnosis
  - Padua -See Osborn, 1998
  - Yale Brown Obsessive Compulsive Scale

Session 3 – How do we counsel those with OCD?

- Common Treatment Forms:
  - Cognitive Behavioral Therapy, CBT
  - Acceptance and Commitment Therapy, ACT
  - Medication management of symptoms

Medication

- See your doctor and do not take this info as directive for medication use.
- Typically, SSRI such as: fluvoxamine (Luvox), Sertraline (Zoloft), fluoxetine (Prozac) paroxetine (Paxil), citalopram (Celexa).
- Impact serotonin in the brain. Can help with depression that often accompanies OCD. Can help the person to be able to better control their thoughts and learn new patterns of thinking. Take the edge off of the intensity of OCD. Makes resisting the urges easier.
- Generally, should see improvement within 8-12 weeks, but may take up to 6 months. 60% see some improvement with first try. Fewer than 20% will see improvement with medication alone. Medication with CBT most effective. 20% see no improvement with first medication.
- Common side effects of SSRI: nervousness, insomnia, restlessness nausea and diarrhea. Most go away as body gets used to the medication. Side effects prior to therapeutic dose. Non addictive. Slow discontinuation with doctors' recommendation. Example Reduce 25% then wait several months and lower again.
- Sometimes addition of benzodiazepine: clonazepam (Klonopin) Lorazepam (Ativan) Use with care -addictive. Better PRN instead of daily.
- Antipsychotics olanzapine (Zyprexa) orap (Pimozide) risperidone (Risperdal)
- Medication: Typically, SSRI, sometimes anti-psychotic. May need to experiment with different types of SSRI and may need to start low dose and slowly increase. Manage side effects with prescriber.
- Some patients will be on medication for the rest of their life, some will come off medication. Some will utilize during times of stress but do all with the direction of a doctor.
- I like to be a minimalist here but recognize that many people with OCD will benefit from medication management of symptoms. Try counseling first to see if progress can be made. If symptoms are impacting daily functioning in significant way, consider evaluation for medication management of symptoms.

Counseling/Therapy Session

- What other factors could be playing into what is going on for the person? I am assessing what is going on for the person. Is this actually OCD?
    - For example, what else is going on with the person's life that might need to be taken care of? Are there social concerns, biological concerns, spiritual concerns that could be impacting the individual.

- When working with OCD it sometimes takes a few sessions to discover what is going on.
    - Begin to hear the person's story to identify obsessions and compulsions, then psychoeducation around OCD.

- Self-calming techniques:
    - Safe place: utilize the 5 senses, to go to a safe space psychologically.
    - Coping skills, rate the anxiety, body scan, deep muscle relaxation, deep breathing, talk back to anxiety/OCD, calming scripture, calming prayer, rate the anxiety again, now shift attention to what is in front of me.

- What is a ritual? A set of compulsive behaviors or mental processes engaged in for the purpose of lowering anxiety.

    Examples
    - Washing your hands in a particular manner. I must soap each finger in order 6 times.
    - Shower routine, I must wash my shoulder, arm, hand, and face in that order while counting to 10 on each one.
    - When a curse word comes into my mind, I must say "Jesus forgive me" 3 times or I can't feel like I meant it.
    - I must check that each door of the house is locked at nighttime walking in the same way around the house 4 times or I can't be sure that each door is locked.

- What is re-assurance seeking? Pulling another person into my compulsions for the purpose of lowering anxiety

    Examples
    - Do you think that I need to go and confess…to….
    - Are you sure my motives were pure when I read the Bible yesterday in family devotions.
    - Can you please say it this way…so that I can be sure I'm okay.
    - Please let me tell you what I did for the last half hour so that I can be sure I didn't go kill the neighbor.

- Scripts
  - An obsessional story that keeps being triggered over and over again. For example, I walk into Home Depot and the greeter smiles and says, “Hello!” I smile back and noticing the good feeling of this human interaction, suddenly think, “Oh dear, I liked that which probably means I’m gay.” Images and urges to go hug the man flood my mind. “See I do like him too much.”

  - Scripts may also be a positive way of responding to an obsession. For example, “I may or may not pick up a germ, and pass an illness to my family, but I am going to see how anxious I can make myself because germs are not my biggest problem right now.”

- Avoidance: Behaviors and thoughts that are avoided because they will create an obsession

  Examples
  - Saying “maybe” instead of giving a definitive answer.
  - Not putting laundry in the drawer or not showering or not leaving the house because those activities trigger an obsession that then leads to a fight with a compulsion.

- ERP – Exposure Response Prevention. Works by process of habituation. Why don’t you hear the highway noise?
  - Exposure. Intentionally placing yourself in the situation that causes the anxiety.
  - Imaginal exposure. Imagine thoughts that evoke anxiety.
  - Go hunting for anxiety. Write words down that cause the distress and say them over and over again.
  - Create a recording of the dreaded outcome and listen to it on a recording over and over again. Write a story in the first person of the dreaded outcome and listen to it over and over again.
  - Do exposures at a planned time in the day. Other times the person is to use distraction, dismissal, to try to train the mind to put away or ignore what seem like important urges obsessions. Use learned coping skills.
  - Generally, the anxiety will lower in less than an hour.
  - Osborn states that 20-30 hours of exposure and response prevention is typically sufficient to result in habituation.
  - For example, touching a toilet seat and not washing hands for two hours. Intentionally putting your sandwich on the floor then eating it. Kissing the bottom of your shoe after you walk down the street or use the restroom.

- Intentionally stating a script. I may or may not be responsible for causing harm to said person, but I am not going to do xyz compulsion because I want to feel the anxiety and beat OCD.

- Habituation -responding less strongly over time. How people learn to sleep in NY city.
- Externalization -locate anxiety in the body. Give it a name "Fred" is on my shoulder. Shana Nicely made a puppet with knitting needles.
- Learn to be present with the thought, feel the anxiety in your body, rate it 1-10, see if you can maintain a high level of anxiety, until it begins to decrease.
- Hierarchy of obsessions and associated compulsions. Then work on them little by little.
- Differentiate between Content and Uncertainty
- Remind self that obsessions are not a reflection of one's true character.
- Exposure to harm obsessions

  "In case of harm, obsessions, the OCD sufferer must be taught, and remind it again, and again, that obsessions are not part of one's basic personality. They have no bearing on who a person "really is." Intrusive, violent thoughts are normal for the human race. Overly responsible, guilt prone OCDers are the least likely people to ever act on them. The OCD sufferer must strive continually to keep a rational perspective and a therapeutic distance from these most gut wrenching of obsessions." (Osborn,1998, pg 83)

- Coping skills utilized by Osborn groups. (Osborne, 1998)

  1. Ignore obsessions. I can have this thought and still be okay. Maintain the thought instead of resisting it. OCD can make this very difficult. So, use humor. That is a silly thought, but it's no big deal. Static on the radio, a suitor who won't take "no" for an answer.

  2. Rational argument
     a. My fears never come true.
     b. Just because this feels real doesn't mean it is.
     c. I want to overcome OCD. I have to feel this anxiety as intensely as I can.
     d. This is just a silly stupid thought like a brain burp.
     e. I'm not going to let this thought win.
     f. All I have to do is try my best and then move on
     g. No one else has to act like this.
     h. If it feels like OCD, it's probably not real.
     i. I've done what's reasonable, I'm not going to do anymore.

  3. That's not me! It's OCD.
     a. The thought I'm having is not me at all it's just a neurochemical problem in my brain. My brain doesn't like to process fears.

b. Poor Fred, poor OCD, should I give you a tissue I'm sorry to be mean to you. It's OK if you have to cry, OCD.

4. Take control stand up to OCD.
    a. Say to yourself, I'm not going to let OCD ruin my day.
    b. I'm going to make a plan, and I am going to follow through and not let my OCD thoughts interfere.

5. Whatever happens, happens! I'm going to do the opposite of my compulsion and whatever happens happens!

6. Remember, the stories of other people with OCD.

7. Trust in God.
   My trust in God is bigger than my obsessions and compulsions. Osborn quotes a 14th century prayer from *The Imitation of Christ:* "My Lord and God, do not abandon me; remember, my need, for many evil thoughts, and horrid fears trouble my mind, and terrify my soul. How shall I pass through them unhurt? How should I break their power over me? You have said, "I will go before you. I will open the gates of the prison." Do, oh, Lord, as you have said, and let your coming put to flight all wicked thoughts." (Osborn, 1998, pg. 129)

8. Limit or post pone a ritual.

9. Lead an active life.

10. Except OCD is a chronic disorder
    Many people with moderate to severe OCD will struggle with some level of symptoms, are their life, but the symptoms don't need to rule their life, and can generally be managed. Excepting this reality can be a significant step of growth in the process of therapy.

OCD and the Family

- Warning, signs in children:
    - Large blocks of time spent alone in the bedroom or bathroom.
    - Excessive time to perform simple tasks.
    - Too much excessive concern over minor details.
    - In flexibility and excessive lateness around deadlines.
    - Strong, emotional outbursts in relation to trivial matters.
    - Avoidance of certain activities
    - A need for constant reassurance and other reassurance seeking behaviors.

The following is from (Van Noppen et al, 2006) *OCD Foundation, Learning to Live with OCD*

Family Interventions

- Possibly family group therapy
- Families tend to error in one of two ways, participating in the family members rituals and compulsions, or becoming upset and angered by them.

- Goal: agreement to stop giving reassurance, stop participating in rituals. Care. Explaining that we are going to slowly stop engaging in rituals. I will tell you are okay one time and then you need to deal with this yourself. What coping skill are you going to use? Validate the struggle, explain care, help to identify the obsession, name the compulsion, and then redirect toward a coping skill.

- Collaborative
    - Provide resources for the individual to watch listen to
    - Encourage
    - Seek professional support.
    - Refuse to get involved with the OCD cycle, no reassurance giving, no checking, no avoidance.
    - Learn to recognize the signals.
    - Modify expectations during stressful times.
    - Measure progress according to the person's level of functioning.
    - Don't make day to day comparisons.
    - Recognize "small" improvements.
    - Create supportive home environment.
    - Keep communication clear and simple.
    - Set limits but be sensitive to person's mood.
    - Keep family routines normal.
    - Use humor.
    - Support medication regime.
    - Prioritize family time for other members.
    - Be flexible.

Understand that the counseling process is recursive in OCD. We do a lot of the same things over and over again until the individual is able to recognize obsessions and compulsions on their own and design their own exposures. When one compulsion is conquered the anxiety frequently moves to another compulsion until the person is able to recognize the process that is happening in the mind apart from the content of the obsession.

Session 4 – Religious Scrupulosity and Christ-centered Helps

- Religious Scrupulosity
  - A form of OCD in which the OCD attaches itself to themes related to faith.

- Excessive religious behavior, pathological doubt, hyper-morality, worry about sin.
  - Did I commit the unpardonable sin?
  - Did I pray enough today?
  - Did I fast enough today?
  - Was I sincere when I made my commitment to Jesus?
  - Did I really mean it when I asked forgiveness from that person?
  - Do I need to confess the motives of my heart?
  - What if I need to think about my past to make sure all my sins are confessed?
  - What if I stand up in church and start cursing?
  - What if I'm not really a Christian?

- Religious Scrupulosity typical stories
  - If I don't fast, pray, read my Bible, witness, several hours a day I am not sincere and my faith, and I will not be a good enough Christian to get into heaven.
  - What if my faith is not sincere?
  - What if my confession was not genuine?
  - I can't go to church because I might stand up on a Sunday morning and start cursing the pastor or shouting curse words.
  - I have these horrible thoughts in my head. How can I be a Christian when I have these terrible thoughts and urges to sin in really horrible ways. After all the Bible says by your fruits, you shall know them…
  - One time the thought went through my head, "I think the Holy Spirit might be the devil. So clearly, I've committed the unpardonable sin."
  - Terrible images of possible sins going through a person's mind that they don't want to be having, cause guilt.

- It is like the conscience is making me feel guilty when it should not be, and no amount of confession or behavioral change brings lasting relief.

- Why so much OCD in the Plain Community? Similar to other religious communities with performance tendencies.
  - Put together Swiss German precision, focus on piety, encouragement to holy living, and the personality factors that play into OCD and you have a fertile soil for OCD to develop.

- Use wisdom designing exposures to troubling thoughts like curse words, sexual content, blasphemy.
  - Use hierarchy and work on less troubling thoughts.
  - Use exposure that sounds like hit and miss engine, **shit**, shit, shits, shit, **shit** shit shit shit, assuming that curse words are an obsession.

- Sexual content, have the person notice the content and not flee from it. Be present and then turn mind to something else.

- Differentiate between and addictive process that is arousing and the distressing function of seeing images that are aversive.

- Differentiating between conscience, Holy Spirit, and OCD
  - Peace following repentance vs continued condemnation.
  - Learning to lean on community and family for hopeful direction, and not reassurance seeking.
  - There is a repentance that leads to death and a repentance that leads to life. 2 Corinthians 7:10 “for godly sorrow, worketh repentance to salvation, not to be repented of; but the sorrow of the world worketh death.
  - Noticing how the obsessive process looks, thinks, feels, and sounds in the brain and differentiating this, with practice, from the direction of the conscience or Holy Spirit
  - Does my response lead to hope? Is this a compulsion that will lead to another obsession or is this an act, behavior, or thought that will result in hope and freedom?

- ERP and ACT handout by Dr. Ted Witzig

- How to read Scripture
  - What scripture verses are particularly helpful? Ephesians chapter 1-3
  - People with religious scrupulosity tend to interpret scripture with an eye toward personal responsibility rather than trust in the sufficiency of Jesus. Point this out and work on shifting this focus.
  - At some level the belief that we are good enough or okay is dishonest. Scrupulosity knows this and capitalizes on it.
  - The reality is that if we actually were in God’s nearer presence we would shrivel up, except for the presence of Jesus. The holiness of God is so holy that we can't stand in its presence.

- How to pray
    - Are your prayers God centered or man centered?
    - Are they active engagement of faith or are they simply another compulsion to lower anxiety?

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Resources you may want to download or explore online

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Learning to Live with OCD -PDF by Barbara L. Van Noppen, PHD, et. Al., 6th Edition 2006, Obsessive Compulsive Foundation. Retrieved from: https://accounseling.org/wp-content/uploads/2018/04/Learning_to_Live_with_OCD_-_VAN_NOPPEN.pdf

Videos by Dr. Ted Witzig. - Scrupulosity.org
https://accounseling.org/mentalhealth/ocd/ocd-and-scrupulosity-videos/

Coach: Jaimi M. Eckert. - Scrupulosity.com

International OCD Foundation - https://iocdf.org/

OCD workbooks on back table

Working with Personality Disorders

DR. CHUCK JANTZI, PsyD

1 **Personality Disorders**

- A persistent pattern of emotions, cognitions and behavior that results in enduring emotional distress for the person affected and/or for others and may cause difficulties with work and relationships.

2 **An Overview Personality Disorders**

- 10 specific personality disorders
- 3 clusters (A, B, and C)
- Chronic, developmental, and relatively inflexible
- Helpers Reactions

3 **Borderline Personality Disorder**

- A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
  (1) frantic efforts to avoid real or imagined abandonment.
  Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.
  (2) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
  (3) identity disturbance: markedly and persistently unstable self-image or sense of self
  (4) impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, Substance Abuse, reckless driving, binge eating). (Note: Do not include suicidal or self mutilating behavior covered in criterion 5.)
  (5) recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
  (6) affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
  (7) chronic feelings of emptiness
  (8) inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)
  (9) transient, stress-related paranoid ideation or severe dissociative symptoms

4 **Red Glass Effects**

- Have decreased cognitive performance
- Have less oxygen available for critical brain functions
- Tend to over generalize
- Respond with defensive action
- Perceive small stressors as worse than they actually are
- Are easily aggravated
- Will struggle to get along with others
- Cannot perform at your best

5 **Clear Glass Effects**

- Are intrinsically motivated
- Have improved cognitive functioning (i.e. rational, creative thought)
- Are willing to do difficult things
- Are willing to take risks
- Think deeply about issues developing creative solutions
- Collaborate productively
- Are engaged
- Perform at higher levels

6 **Walking with those struggling with BPD or traits**

- Protecting yourself and avoid being split from others
- An unmovable pillar
- Preventing burnout
- The battle stage of gaining trust
- The medication question
- Skill development
- Relearning/learning relationship skills
- Emotional management
- Distress tolerance
- What about the relationship with God?

7 Narcissistic Personality Disorder

- A pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
  1. has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements)
  2. is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love
  3. believes that he or she is "special" and unique and can only be understood by, or should associate with, other special or high-status people (or institutions)
  4. requires excessive admiration
  5. has a sense of entitlement, i.e., unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations
  6. is interpersonally exploitative, i.e., takes advantage of others to achieve his or her own ends
  7. lacks empathy: is unwilling to recognize or identify with the feelings and needs of others
  8. is often envious of others or believes that others are envious of him or her
  9. shows arrogant, haughty behaviors or attitudes

8 Walking with those struggling with NPD

- Assessing the person's ability to take ownership of their role in problematic patterns
- Developing trust and the ability to speak into their life
- The medication question
- Teach how to develop emotional and relationship skills
- Boundary development
- Accepting feedback
- Empathy development
- Learning to listen
- Distress tolerance
- Expressing and learning to recognizing the feelings of others
- What about the relationship with God?

9 **Walking with those who are impacted by those struggling with NPD**

- Don't over function
- Don't take things personally
- Set boundaries to protect yourself
- Learn to negotiate
- Develop a close circle of friends and supporters

Toxic Shame: Causes and Cures

Michael Hochstetler, MA, LMFT

What is shame?

Shame comes in many forms

Shame has many faces, and manifests in a thousand ways. It ranges from a mild feeling of embarrassment to intense self-loathing. Shame is a natural emotion, but one that can become destructive and unhealthy.

Healthy versus unhealthy shame

Healthy shame is being aware of how we impact others or having a working conscience. Healthy shame motivates improvement. Unhealthy or toxic shame is destructive and non-redemptive. This workshop addresses the latter, and the word "shame" will be used here to refer to the unhealthy kind.

Definitions

Unhealthy shame is the feeling of being unworthy, defective or unacceptable. It is often triggered by perceived judgment, criticism or rejection. Brene Brown says that "shame is basically the fear of being unlovable." The chronically shamed believe and feel the worst about themselves. They are terrified of being exposed and work hard to hide unacceptable parts of themselves.

Thoughts, feelings and behaviors:

Thoughts: self-accusing thoughts, self-critical thoughts, negative self-talk, etc.
Feelings: embarrassment, rejection, humiliation, inadequacy, worthlessness, fear of exposure, etc.
Behavior: avoiding shame-inducing situations, hiding from people, self and God, pushing oneself to be perfect, overperforming, acting defensively

The experience of shame

While thoughts and actions are involved, shame is primarily a matter of *experience*. Patricia DeYoung described it this way. "It's feeling like a failure. It's feeling exposed as inferior or deficient—or as ugly, dirty and disgusting. Shame includes awkward self-consciousness, blushing embarrassment, and searing humiliation…So many words, and yet they can't capture the essence of shame, because the experience of shame is fundamentally non-verbal and visceral."

Triggers

People can feel shame because of many things: appearance, personality, a mental condition, family, past behavior, imperfections, etc.

Shame versus guilt

Guilt is a feeling associated with action. Shame is deeper, and more personal in nature. "We feel guilty for what we do. We feel shame for what we are." (Lewis Smeades)

Shame versus pride

Shame is sometimes confused with pride. Pride says, "If my reputation suffers, people will no longer think I'm the best." Shame says, "If my reputations suffers, people will think I'm the worst."

How does shame impact us?

Shame wounds the conscience

The chronically shamed often feel bad because of things that are not morally wrong. They even feel bad because of things that are good!

Shame invites defensiveness

It is frightening to move toward the light when darkness offers to cover our flaws. “The wish to relieve guilt may motivate a confession, but the wish to avoid the humiliation of shame may prevent it.” (Paul Ekman)

Shame undermines connection

Shame creates a powerful impulse to hide (Genesis 3:8). This blocks emotions and creates a barrier with loved ones. One cannot hide from oneself and connect with others at the same time. Brain processes involved in interpersonal connection are disrupted by shame. The number one prerequisite for connection is emotional safety, which shame corrodes.

Shame undermines growth

It is very difficult to grow, heal or change without feeling confident and secure. Toxic shame is destructive of confidence and security. It also makes it hard to face growth areas, as these trigger self-consciousness and defensiveness. “Shame corrodes the very part of us that believes we are capable of change (Brene Brown).”

Shame and mental health

Shame is a primary driver of addiction, especially sexual addiction. Many turn to sexual behavior to dull the pain of childhood shame. This brings more shame, setting up a vicious cycle that keeps people stuck in unwanted behaviors.

Shame often fuels anxiety and depression. Some anxious individuals are triggered by shame-inducing experiences or the fear of reliving past ones. Unhealthy shame also feeds the negative self-perceptions that depression thrives on.

Destructive behaviors such as cutting or binging and purging are ways of managing intense feelings of distress, including shame.

"Acting out" versus "acting in"

Some express shame outwardly through things like cutting, addictive behavior, anger, etc. ("acting out"). It is easy to focus on the behavior of such a person and miss the hurt and shame beneath the behavior. Some deal with shame internally through negative self-talk, anxious rumination or suppressing feelings ("acting in"). It is easy to assume these people are ok because they are quiet or well-behaved.

Shame and relationships

Hidden shame may explain much perplexing church conflict and marital dysfunction. When people shut down or become aggressive during an argument, it may be because feelings of worthlessness, rejection or humiliation have been activated.

The spiritual impact of shame

Many Christians do not feel close to God. Suppressed feelings can contribute to this. It is hard to be close to anyone—including God—when we are disconnected from ourselves. Many believers struggle to put away false guilt or to find assurance of salvation. This may be because the root of the problem for them is not guilt per se, but shame.

What causes shame?

Many causes

Like most emotional struggles, toxic shame has multiple causes. It rarely stems from a single root. Contributing factors can include the following:

Shaming experiences

Many people have been shamed, humiliated or put down as children, leaving them permanently sensitive to criticism, rejection or disapproval.

Shaming environments

Some families foster a culture of shame, something that can occur in subtle ways. This can include angry, controlling or perfectionistic parenting. Culture can also play a role. Religious subcultures that overemphasize performance, outward appearance and conformity can unintentionally foster shame.

Abuse

Chronic shame is often traceable to abuse, whether verbal, physical, sexual or spiritual. This is especially true of sexual abuse, which can leave survivors feeling ugly, dirty, worthless or degraded. “When you’re abused,” Patricia DeYoung says, “you can’t help feeling that you deserve it.”

Emotional malnourishment

Sometimes shame is the result of what did *not* happen. Shame is the opposite of confidence, security and resilience. These are learned through emotionally meaningful connection between a young child and caregivers. Children who missed these experiences can enter adulthood lacking the ability to work through their insecurities.

How do we heal from shame?

Vulnerability

It has been said that shame "needs light and air" to heal. Being vulnerable with trustworthy loved ones strikes at the root of shame. Through vulnerability we learn that we can be known—and still loved.

Connection

Knowing others and being known, experiencing relational intimacy with loved ones and with God brings healing from shame. Adult relationships, while no substitute for childhood bonding experiences, can be reparative.

Accepting feelings

Suppressing feelings of shame paradoxically strengthens shame. Many people feel shame about shame! While we don't want to accept the destructive impact associated with shame, it is healing to tolerate the related emotions. Viewing our feelings self-compassionately is also healing.

Changing beliefs

Recognizing, examining and reworking shame-based beliefs is very helpful. Such beliefs can include "I am worthless or unlovable," "I must perform perfectly to be accepted," or "I must hide from others to survive." Trying to suppress such thoughts is not helpful. It is helpful to notice them, question them, pray over them and identify positive, biblical truths to replace them with.

Emotionally honest prayer

Bringing our deepest feelings to God—including the "ugly" ones—leads to an experience of being known intimately by God and still loved. Scripture gives us ample invitation to pray with raw honesty. God already knows how we are feeling, after all!

How do we help the chronically shamed?

What isn't helpful

The Don'ts:
-Do not add to their shame
-Do not rescue
-Do not react
-Do not avoid

What is helpful

The Dos:
-relate with calm and confidence
-demonstrate caring
-help them face their feelings
-meet them where they are
-offer new perspectives

PACE:

Playfulness, Acceptance, Curiosity, Empathy (Daniel Hughes)

Conclusion: what the gospel tells us about shame

The story of Jesus is a story about shame from start to finish. Jesus risked rejection, humiliation, misunderstanding and loss of reputation by becoming human, taking a servant's role, violating the taboos of his time—and ultimately by going to the cross. Jesus demonstrated that the love of God is more powerful than human rejection, more valuable than human approval. The Christ who touched lepers, honored outcasts and broke bread with stigmatized sinners is the same One who reaches out to the marginalized and rejected today, offering dignity, worth and the love of God to those made in his image.

Resources

Brown, Brene. "Listening to Shame." (Ted Talk)

https://www.youtube.com/watch?v=psN1DORYYV0

Brown, Brene. "The Power of Vulnerability." (Ted Talk)

https://www.youtube.com/watch?v=iCvmsMzlF7o

DeYoung, Patricia. *Understanding and Treating Chronic Shame*

Hughes, Daniel. *Attachment Focused Family Therapy*

Laaser, Mark. *Healing the Wounds of Sexual Addiction*

Schmitt, Abraham. *Brilliant Idiot: an Autobiography of a Dyslexic*

Thompson, Curt. *The Soul of Shame*

Welch, Ed. *Shame Interrupted: How God Lifts the Pain of Worthlessness and Rejection*

Wilson, Sandra. *Released from Shame: Moving Beyond the Pain of the Past*