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Scrupulosity: Practical Treatment Considerations Drawn from Clinical and Ecclesiastical Experiences with Latter-day Saint Persons Struggling with Religiously-oriented Obsessive Compulsive Disorder

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Scrupulosity, a religiously-oriented form of obsessive-compulsive disorder (OCD), is both a clinical matter for treatment and can be an ecclesiastical concern for members, therapists, and priesthood leaders of the Church of Jesus Christ of Later-day Saints. Just as some people of all faiths suffer from scrupulosity, Latter-day Saints (LDS) persons are not immune. This article addresses the issues pertaining to scrupulosity and provides practical treatment considerations for working with LDS persons struggling with scrupulosity from both a clinical and ecclesiastical perspective. A treatment approach, including consultation with priesthood leaders, is outlined.
Keywords: Scrupulosity, Obsessive-Compulsive Disorder, Religion, Latter-day Saint, Clinical Treatment

Scrupulosity is emerging as a recognized subtype of Obsessive-Compulsive Disorder (OCD) pertaining to religious-oriented obsessions and compulsions (Abramowitz et al., 2002; Nelson et al., 2006; and Olatunji et al., 2007). Essentially, scrupulosity is a form of obsessive-compulsive disorder, which manifests as religious symptoms. Both scrupulosity and obsessive-compulsive disorder have two features that must be present in order to make an accurate diagnosis; (1) intrusive thoughts (obsessions) and (2) actions to neutralize the intrusive thoughts (compulsions). While many individuals suffering with OCD may experience a wide range of symptoms or issues, such as contamination obsessions, pathologic doubt, need for symmetry, sexual obsessions, and compulsive hand-washing/cleaning among others (see Ciarrochi, 1995 for a complete review of symptoms), people who struggle with scrupulosity primarily manifest their symptoms through religious-based issues

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(though they may exhibit other OCD symptoms, as well). Often scrupulosity is described as "the doubting disease" or "seeing sin where there is none" (Ciarrochi, 1995; Nelson et al. 2006). The symptoms of this disorder are invasive and distressing in the individual's daily functioning and can impair occupational, social, and family relationships.

Often a person exhibiting scrupulosity will first seek help from a religious official believing that the symptoms are a religious-based issue, as opposed to a mental health issue. This is the first obstacle that clinicians face in the treatment of this disorder. Furthermore, religious officials may make the mistake of inadvertently reinforcing the distress and anxiety associated with scrupulosity by viewing the concerns solely through a religious perspective. In addition to this obstacle, people living with scrupulosity are often suspicious of mental health professionals, believing that the clinician is ignorant of their religious beliefs or will attempt to convert them to anti-religious practices. For this reason, appropriate co-consultation between the individual's religious leader and the treating clinician is advisable. This study presents practical treatment considerations to assist therapists, counselors, and other clinicians treating LDS persons who are struggling with scrupulosity based on the research and our clinical experience working with this population.

Literature

Definitions and Symptoms

Scrupulosity has two essential features of diagnostic criteria; "(1) recurrent intrusive thoughts, urges, doubts, or images that, although perceived as senseless, evoke anxiety (obsessions); and (2) repeated urges to perform excessive overt or covert rituals to neutralize the anxiety" (Abramowitz, Deacon, Woods, & Tolin, 2004, p. 70). The religious manifestation of the obsessions and compulsions distinctly identifies scrupulosity from obsessive-compulsive disorder. The obsessions (thoughts), for scrupulosity take form as "persistent doubts and fears about sin, blasphemy, and punishment from God" (Hepworth, Simonds, & Marsh, 2010, p.1). The compulsions (actions), take the form as "excessive religious behavior such as repeated praying and seeking reassurance about religious beliefs" (Hepworth et al., 2010, p.1). In order to meet the criteria for scrupulosity, Ciarrocchi (1995) argues that the individual must experience fear from the obsession and simultaneously attempt to prevent the compulsion.

Ciarrocchi (1995) describes the symptoms of scrupulosity as "seeing sin where there is none," (p. 5). Prominent symptoms of scrupulosity include excessive and inappropriate guilt, worry, and doubt. Although these symptoms are perceived to be related to the individual's religious beliefs, these persons often find no solace in seeking reassurance or guidance from religious officials. This inability to be reassured results in significant impairment in the individual's daily functioning (Hepworth et al., 2010). As stated in Steketee, Quay and White (1991), Rosen suggests that the excessive guilt experienced by the scrupulous person is what perpetuates the compulsive behaviors and fearful obsessions.

Ciarrocchi (1995) illustrates in his book, *The Doubting Disease: Help for Scrupulosity and Religious Compulsions*, how symptoms of scrupulosity are exhibited and perpetuated by fears and anxiety. Ciarrocchi (1995) offers a case example of a symptom theme of causing harm or injury to other people, which is considered a sin. In this example, the obsession is a "nurse [who] worries he will miscalculate medications and injure [the] patient" (Ciarrocchi, 1995, p. 46). The compulsion is the nurse will "check [the] dosage frequently. [Who] eventually gives up nursing" (Ciarrocchi, 1995, p. 46). He continues by explaining that this may be why patients are resistant to sharing these feelings and urges (Ciarrocchi, 1995).

Earliest known cases of scrupulosity are found in early prominent religious reform leaders and founders of religious societies. These cases include Martin Luther, English Puritan writer John Bunyan and Spanish founder of the Jesuits, Ignatius Loyola. Luther's symptoms became evident when he celebrated his first mass in 1517. He feared that an act of omission during the mass would be a sin, even if this was an accidental omission (Cefalu, 2010). Based on early cases, Freud theorized that religion was an "obsessional ritual" and further recognized a similarity between religious rituals and defense mechanisms" (Zoher, Goldman, Calamary, & Mashiah, 2005, p. 858; Ciarrocchi, 1995). Theorists today on the other hand, agree that scrupulosity is a psychological disorder as opposed to Freud's theory of

using religion to escape "unconscious impulses" (Zoher et al., 2005, p. 858).

Distinguishing Between Normal Religious Behavior and Pathological Behavior

A challenge for most clinicians working with scrupulosity is distinguishing the line between "normal" religious behavior and pathological neurosis. The term "normal" is based on the particular religion in which an individual practices, due to the varying amount of beliefs and rituals between religions, denominations, and sects. Some signs distinguishing pathological symptoms from normal behavior include: 1. If the behavior exhibited by the individual exceeds what is required set by religious doctrine, 2. If the behavior is focused on insignificant religious rituals, thus ignoring other important aspects of their religious beliefs, and 3. If the symptoms resemble signs of OCD, for example, compulsions for checking or cleansing (Ciarrocchi, 1995).

Ciarrocchi (1995) argues that symptoms are frequent, intense and last much longer than religious rituals ought to. Similar to OCD features, the scrupulous person imagines a more horrible outcome then it is in reality and resists the obsessions by attempting to neutralize them. The primary distinction between OCD and scruples, is the religious nature of the symptoms and its effects on the cognitive process. The efficacy for treatment of scrupulosity also appears more controversial then treatment for OCD. While OCD treatment methods include behavioral therapy, behavioral therapy alone (without attention to spiritual aspects of belief and behavior) may not be effective treatment for scrupulosity (Ciarrocci, 1995).

Causes of Scrupulosity

The cause of scrupulosity is one of the most controversial topics associated with this disorder. Researchers have examined whether the degree to which the individual believes in a religion is the cause of religious obsessions, or if it is caused by cultural influences. Tek and Ulug (2001) argue scrupulosity is not associated with religiosity, but is simply the manifestation of symptoms. In their study conducted in 2001, Tek and Ulug found no association between the religious practices of the person and the obsessive-compulsive symptoms. Instead of religious practices, Tek and Ulug (2001) believe that it may be the culture that places more emphasis on religion, which contributes to the expressions of these types of religious symptoms.

Yorulmaz, Gencoz, and Woody (2009) and Zohar et al. (2005) agree that religiosity contributes to the symptoms of scrupulosity. Yorulmaz et al. (2009) discovered an association between the level of religiousness and the symptoms experienced by scrupulosity. Zohar et al. (2005), states that although the relationship between the obsessions and compulsions and religiosity is vague, those individuals who practiced religious beliefs and who have strengthened their religious beliefs demonstrate higher obsessive-compulsive behaviors. Sica, Novara, and Sanavio (2002) add that individuals with high devoutness experienced higher levels of obsessions and cognitions then individuals with low levels of devoutness.

Moral thought-action fusion (TAF) is one theory that attempts to explain the source of scrupulosity symptoms. Moral TAF is the association that immoral thoughts are the equivalent to immoral actions. Since scrupulosity exhibits symptoms based on fears of sin and fears of God, moral TAF drives these fears and anxiety further by equating thoughts with behavior (Hepworth et al., 2010). Christian bible passages such as Matthew 5:27-28 (King James version), support this theory stating, "Ye have heard that it was said by them of old time, Thou shalt not commit adultery: But I say unto you, That whosoever looketh on a woman to lust after her hath committed adultery with her already in his heart" (Matthew 5:27-28 KJV). Thus to a scrupulous person, the consequences of immoral thoughts are construed to be the same as the consequences of immoral behavior, and this again perpetuates the anxiety associated with these symptoms (Siev, Chambless, & Huppert, 2010).

One problem with this theory is that it may only applicable to Christian based religions. According to a study conducted by Siev, Chambless, and Huppert (2010), moral TAF is culturally normative to Christian religions, and may not readily apply to religions such as Judaism or Islam. These authors continue to say, moral TAF varies by religion and is inconsistently associated with religious symptoms (Siev et al., 2010).

Obstacles to Treatment of Scrupulosity

Clinicians face several obstacles in identifying and treating patients with scrupulosity. Often, the first contact made by a scrupulous person will be a church leader based on the nature of this disorder (Hepworth et al., 2010). This may be detrimental to the individual, if the church leader is unaware of scrupulosity and fails to refer the church member to a therapist. Another possibility is the clergy member may say something to the scrupulous person to perpetuate the anxiety and fears associated with scrupulosity (Huppert & Siev, 2010).

From the perspective of the scrupulous person, they believe this is a religious issue they are experiencing, not a mental health issue. They also may feel that the therapist does not have sufficient knowledge of their religious beliefs to state whether these behaviors are healthy or if they are obsessions. Scrupulous persons may also feel suspicious of psychotherapists and the mental health field, believing that the therapist is going to try to convert them from their religion (Huppert & Siev, 2010; Hepworth et al., 2010). Due to the fear of being converted from their religious beliefs and their suspicions of the therapist, one study conducted by Greenberg and Shefler (2002) discovered that in general, people with scrupulosity would rather seek medication for the interfering symptoms, than to attempt traditional therapy. Scrupulous people would rather engage in a treatment they believe will not intrude on their religious beliefs and practices (Greenberg & Shefler, 2002).

Latter-day Saints and Scrupulosity

As a religious group and culture, members of the Church of Jesus Christ of Latter-day Saints are not immune from mental health concerns. Despite the research indicating that active, faithful Latter-day Saints (LDS) have significantly lower rates of suicide (Hilton, Fellingham, and Lyon, 2002) and either lower or comparable rates of anxiety, depression, divorce, and other mental illnesses or family problems (Bergin, 1992; Decker & Chatlin, 2000; Judd, 1999), LDS persons may experience mental health concerns like any other group of people. Historically, LDS people were somewhat reticent to seek counseling or therapy for a variety of reasons (Koltko, 1992), however in recent years there has been an increasing openness to seeking treatment for mental health needs. One example of this increased awareness of mental health issues among the LDS population was the publication of the book *Valley of Sorrow* from an emeritus General Authority on the topic of mental illness in the church (Morrison, 2003). Emerging from this increased awareness and acceptance of treatment for mental health and family problems among LDS people has been a small increase in research on the topic of scrupulosity among church members (Twohig & Crosby, 2010; Dehling, Morrison, & Twohig, 2013). These two studies are the only recent studies that could be found on scrupulosity that specifically focuses on treatment efficacy with LDS populations. Dehling, Morrison, and Twohig (2013) recently published their results from using Acceptance and Commitment Therapy (ACT), which is a form of Cognitive-Behavioral Therapy (CBT), with five LDS people struggling with scrupulosity. Their study indicated that use of ACT helped reduce scrupulous-based compulsions by 74% at post-treatment and 80% at the 3-month follow-up. One of the primary reasons they attributed to the success of ACT with this disorder is that ACT causes the individual in treatment to address the symptoms at the meta-cognitive level, thus helping them break out of the anxiety-provoking thought process loop characteristic of scrupulosity. Dehlin et al. (2013) describe ACT in the following:

> ACT for OCD seeks to address the context in which obsessions are experienced through the teaching and practice of such concepts as acceptance of thoughts and feelings, learning to disempower thoughts and feelings by not giving them more significance than they merit, mindfulness, and values-based committed action. These skills are taught through exercises, discus¬sions, and experiential exercises and metaphors in the therapy sessions. Through weekly homework assignments, clients are able to further apply the techniques learned in session to real-life situations and problems. (p. 411)

Practical Treatment Considerations

Expanding the Treatment Approach Options for LDS Persons

The lead author of t this article is currently both an ecclesiastical leader in the church (bishop) and a part-time clinician at LDS Services, in addition to being

a professor of marriage and family therapy. This has granted him a rich opportunity to examine this issue of scrupulosity from both the perspective of a clergyman and a mental health professional. Deriving from these combined experiences, the current treatment approach our team recommends builds upon the previous use of ACT and CBT approaches with individuals suffering from scrupulosity by adding LDS-specific spiritual perspectives, as well. Though Dehlin et al. (2013) recommend avoiding religious content in their use of ACT in order to focus on metacognitive processes, our team's approach sees initial religious and spiritual content discussions in the early phases of treatment as essential for building a therapeutic alliance and establishing a foundation of trust. This may seem counter-intuitive to address spiritual concerns and have doctrinal/spiritual discussions while concomitantly maintaining a goal to help the client engage in a metacognitive break from the religiously-oriented, anxiety-provoking thought process loop, but experience has shown that such spiritual discussions are a necessary precursor to any progress through other interventions. Without establishing this spiritual foundation, the scrupulous are simply too anxious to pursue the metacognitive work of ACT/CBT approaches. Primarily, this addresses the issue of joining or building a relationship of trust with the client at a spiritual level as well as other dimensions of the therapeutic relationship. Once the client is able to trust that the therapist has expertise in religious/spiritual matters (and some authoritative experience in addressing similarly intertwined religious/mental health concerns as a result of one's church service, experience, and professional training), the client suffering from scrupulosity is generally more open to receiving new ideas and suggestions that may assist them. Once the client and therapist have an established relationship that demonstrates respect for the client's faith and a capacity on the part of the therapist to speak intelligently (if not quasi-authoritatively) on religious matters, then the mental health treatment from a psychotherapeutic perspective can commence.

The following steps outline our basic approach to treating scrupulosity:

1. Joining/Building a Relationship of Trust
2. Assessment - Including the Penn Inventory of Scrupulosity (PIOS)
3. Ecclesiastical Consultation
4. Diagnosis (Including Client Acceptance of the Diagnosis) and Treatment Plan
5. Medication Evaluation Referral
6. Spiritual Doctrine Review/Reframes
7. Bibliotherapy–Church/Mormon publications; Ciarrocchi (1995) The Doubting Disease; and Schwartz (1996) Brain Lock among Others
8. ACT/CBT

Joining/Building a Relationship of Trust

Common factors research (Lambert & Barley, 2001; Sprenkle, 2002; Sprenkle, Davis, & Lebow, 2009) indicates how essential establishing a relationship of trust or "joining" (Minuchin, 1974) is to the success of any therapeutic process. With LDS persons suffering from scrupulosity, establishing a strong clinical working relationship is crucial. Because earlier generations of psychologists and other mental health professionals were skeptical, if not antagonistic, towards religion, people of faith were often wary of receiving therapy. They feared their faith would be ridiculed and were concerned the clinician would seek to dissuade them from being faithful to their religious tenants. For the scrupulous believers, their worldview or perspective is fundamentally religious, therefore any attempts to address their difficulties from a secular approach would be suspicious, at best, and sacrilegious, at worst. So it is essential that in the initial sessions of treatment with a faithful believer suffering with scrupulosity that the therapist be extremely "faith-friendly" and can demonstrate that they understand the client's religious views.

Among the LDS who have a history of persecution in the early foundational periods of the church's rise in the 19th century, an "us vs. them" mentality toward "the world" sometimes persists. Thus previous generations of Latter-day Saints were often unwilling to go to a therapist or interpret their problems through a mental health perspective (Kolto, 1992). Although competent therapists, regardless of their religious affiliation, can be helpful in treating LDS OCD sufferers, scrupulosity often requires an LDS therapist—given the high level of religious distrust that a scrupulous client would likely feel towards an non-LDS client—or at least consultation with an LDS therapist on the part

of a non-LDS counselor regarding some of the unique nuances of belief in the LDS faith. Additionally, an LDS person with scrupulosity will likely be wary of even an LDS therapist until the therapist has passed some sort of client-imposed "secret test" (Broderick, 1992) that the therapist is "orthodox" or "faithful" as a Latter-day Saint and not a "Jack-Mormon" whose religious opinions are not to be trusted. Thus some limited self-disclosure may be appropriate (for example, as part of introducing myself—the lead author—to a client struggling with scrupulosity, I include my current calling as a bishop[1] to help ease their concerns about "what kind of Mormon" I am). While this is not necessary with all LDS clients, persons with scrupulosity seem to need that initial assurance they are in "spiritually-safe" hands with their new therapist. Sometimes, as part of their "secret testing" the client will want to discuss doctrine or ask questions about spiritual matters. While the therapist must use one's clinical judgment as to what pieces of information would be useful to explore and which ones are irrelevant tangents, it is important to understand this initial penchant for the scrupulous person to focus on spiritual questions in the early phases of treatment as an attempt to reduce their own anxiety about whether or not they can trust this therapist spiritually, rather than interpreting their questions as the client's incapacity to resist their obsessions and compulsions (as one might conclude if these behaviors continue in the later phases of treatment). Thus joining on a religious and spiritual level is essential at the outset of therapy and ample time (perhaps multiple sessions) should be devoted to this early aspect of therapy. In fact, one of the keys to success we have seen is *patience* in the early phases of treatment. Joining, assessing, consulting, diagnosing, and treatment planning cannot be rushed with the scrupulous client. Their propensity to doubt, obsess, and vacillate (as symptoms of OCD/scrupulosity) determines the necessity of slow, and patient foundation building in these early steps. In supervision, we find that therapists who rush through these early foundational stages have poorer outcomes.

1. I often have to ensure throughout the course of treatment that the client realizes I am not their bishop and that they must address any confessions or authoritative, ecclesiastical-requiring concerns with their bishop who holds the keys of stewardship for them.

Assessment

In addition to the traditional assessments one might use with cases of anxiety (e.g. Outcome Questionnaire, Beck Anxiety Inventory, the State-Trait Anxiety Inventory, Family Assessment Device, and so forth), when working with cases of scrupulosity, the Penn Inventory of Scrupulosity (PIOS) is a requisite assessment tool. Developed by Abramowitz et al. (2002), this 19 item self-report instrument assesses the level of scrupulosity utilizing a Likert scale from 0-4 with zero representing no scrupulous thoughts or behaviors and four representing constantly experiencing scrupulous thoughts or behaviors. Six of the 19 items pertain to "Fears of God" and thirteen items pertain to "Fears of Sin" (Olatunji et al., 2007). Examples of questions in the PIOS include: "Item 1. I worry that I might have dishonest thoughts, Item 2. I fear that I might be an evil person, Item 3. I fear I will act immorally, Item 4. I feel urges to confess sins over and over again, Item 15. I worry I will never have a good relationship with God, Item 16. I feel guilty about immoral thoughts I have had, and Item 17. I worry that God is upset with me" (see Abramowitz et al., 2002). The PIOS has been shown to have high levels of validity and reliability (see Abramowitz et al., 2002; Olatunji et al., 2007).

Ecclesiastical Consultation

Obtaining a release of information for purposes of co-consultation with the LDS person's bishop, branch president, stake president, mission president, or other appropriate priesthood leader is essential. Latter-day Saints have an ecclesiastical structure that emphasizes priesthood keys and specific responsibilities pertaining to revelation, counsel, and accountability for ward members under the priesthood leader's stewardship. Therefore, consulting with the scrupulous client's proper priesthood leader can be a source of reassurance for the client that the therapist is not providing counseling along a course that significantly differs from their priesthood leader. The practice of co-consultation by LDS Family Services and other LDS therapists with priesthood leaders consistently conforms to ethical and legal requirements (e.g. consistently obtaining signed written releases of confidential information from the client prior to co-consultation), and is sound clinical practice that significantly aids the client's treatment prognosis.

Ecclesiastical consultations have demonstrable value in our experience with scrupulous clients. In some cases, educating priesthood leaders (who serve as clergy from the laity and often do not have formal training in counseling or therapy) about mental illness, OCD in general, and scrupulosity in particular, is the first step. Such priesthood leaders may not understand why a member of their congregation is constantly confessing sins they have already addressed previously or just cannot seem to stop focusing on praying "just right." Explaining scrupulosity gives content and context to the priesthood leader so they can lovingly and compassionately counsel the scrupulous person.

Ecclesiastical consultations also serve the valuable purpose of lending credibility or authority to the therapist in the eyes of the client. If the scrupulous person places a high value on doing what is right in the sight of God (often as interpreted by the priesthood leader's perspective in whom the LDS scrupulous person likely has high confidence), then having the therapist and the priesthood leader on the "same page" regarding treatment lends some borrowed trust and credibility from the priesthood leader to the therapist. Essentially, if the therapist can demonstrate that the bishop and the therapist are in agreement, then client compliance on the part of the LDS scrupulous person increases significantly.

Diagnosis (Including Client Acceptance of the Diagnosis) and Treatment Planning

Once the assessments and clinical judgment of the therapist lead him or her to suspect a diagnosis of OCD/scrupulosity, the therapist should work in concert with the client to mutually agree upon the scrupulosity diagnosis. It is crucial to remember that the client will likely have an oscillating waxing and waning in their confidence in the diagnosis of scrupulosity. They have usually interpreted their struggles as *primarily* religiously-based for several years, so accepting a new perspective of their trials and tribulations pertaining to their symptoms as being primarily a mentally-health-based issue with religious nuances will take some time to assimilate and adapt to in their thought process and emotional capacity to accept this shift. Thus their ebb and flow of acceptance and non-acceptance of the diagnosis is understandable and predictable. Given that scrupulosity is often termed "the doubting disease" it is no wonder that doubts about the "correctness" of the diagnosis will also ensue. This undulation between acceptance and non-acceptance of the diagnosis is symptomatic of their overall undulating "ups-and-downs," "back-and-forth" of their anxieties and thought processes in their lives. Both the scripture 1 Kings 18: 21 "How long halt ye between two opinions?" and chapter 8 of C.S. Lewis's (1942/2001) *The Screwtape Letters*, which explains why the up and down undulation pattern in life is normal and common to all (as well as a valuable, purposeful tool God uses in our lives to develop us) can be very helpful at this stage of treatment.

As their confidence, acceptance, and ownership of the diagnosis of scrupulosity is strengthened and emboldened, the therapist then proceeds to develop a mutually agreed upon treatment plan involving medication evaluation, spiritual discussions/reframes, bibliotherapy, CBT, and ACT.

Medication Evaluation Referral

Referral to a competent medical physician (preferably a psychiatrist) for medication evaluation and possible prescription is another key element to treatment success. Research (Bloch et al., 2010; Shin et al., 2014) has shown that anti-depressant medications in the classification of Selective Serotonin Reuptake Inhibitors (SSRIs) generally have positive outcome results for improving the health and functioning of people suffering from OCD. Should a physician choose to prescribe a medication, the therapist's role most often involves medication compliance review.

Spiritual Doctrine Review/Reframes

Therapists must address the spiritual and doctrinal content of the client's concerns and help reframe them to a more positive and helpful perspective. The client's anxiety-based perspective of God may tend to overemphasize fear, strict obedience, vengefulness, and austerity. They may have blasphemous thoughts, inadequate perspectives about sin and righteousness, or feelings and compulsions towards apologizing or confessing sins that were not really sins in the first place (or will not believe they have been forgiven of legitimate sins for which they have truly, fully repented). Additionally, their religiously-oriented obsessions and compulsions may be compounded by other forms of

OCD behaviors, including excessive washing, compulsive gambling, compulsive pornography usage and masturbation, hoarding, or other similar, common compulsive behaviors. Addressing some of the spiritual aspects and reframing/cognitive restructuring along the lines of religious perspectives, may reduce anxiety sufficiently that other treatments may begin to be tried for those associated problems.

In terms of reframing doctrinal understandings while counseling LDS persons with scrupulosity, it has been helpful to emphasize the role of pre-mortal creation and the organization of intelligences into spirit sons and daughters of a loving Heavenly Father who saw value in these unique intelligence and chose to create them into His children. Further, we emphasize that God nurtured, tutored, and developed all of us in the pre-mortal realms. A quote from Pres. George Q. Cannon describing us pre-mortally enjoying God's "presence and His smiles" (see Pace, 2005) is emphasized to reframe God as a loving, smiling God who cares about us individually and is easily pleased with us. Reframing the spiritual perspective from what could best be described in the classic sermon of Jonathan Edwards' (1741) *Sinners in the Hands of an Angry God* (which the person suffering from scrupulosity probably obsesses over and personalizes) to a more loving, benevolent, and merciful Deity as taught in the LDS theology and tradition is thus conceptually linked with "correcting false doctrine" and therefore the scrupulous person is caught in a bind where to continue their unhealthy, self-prosecutorial perspective would be to continue down a path that contains the errors of the Apostasy era. This strategic juxtaposition is a catalyst for their openness to accept more positive and healthy reframes of God and themselves.

Often clients are projecting flaws and problems they experienced with their mortal parents onto God. Vitz's (2000) work regarding the psychology of atheism and faith in God as being linked with one's early childhood experiences with earthly parents is helpful to further counter oppressive notions of a God who carries the capriciousness, austerity, and judgmentalism that may have existed in the client's earthly parentage. In exploring the client's family of origin, we seek to separate their feelings about their parents from their perspective on God. We seek to help them come to see and know God and His love through a clear lens rather than through the cloudy and dark lens that comes from projecting one's earthly parents' characteristics onto Heavenly Father. Once the client is in this position of accepting a more loving and tender view of God (and a Being who desires a compassionate and understanding relationship with the client), further scriptural and doctrinal evidence can be given adding "line upon line, precept upon precept" depending upon the level of resistance the client raises to such doctrinal reframes. Typical examples of scriptures about both God's loving nature and our non-anxious emotional state He seeks from us that are commonly used would be:

- D&C 18:10—"Remember the worth of souls is great in the sight of God;" (emphasis added)
- D&C 112:4—"Let thy heart be of good cheer before my face;"
- D&C 6:36—"Look unto me in every thought; doubt not, fear not."
- Philippians 4:6–7—"Be careful for nothing; but in every thing by prayer and supplication with thanksgiving let your requests be made known unto God. And the peace of God, which passeth all understanding, shall keep your hearts and minds through Christ Jesus." (Also, the footnote in reference to "careful" states that the Greek translation of the phrase suggests "Don't be unduly concerned about anything."
- Jeremiah 29:11–14—"For I know the thoughts that I think toward you, saith the Lord, thoughts of peace, and not of evil, to give you an expected end. Then shall ye call upon me, and ye shall go and pray unto me, and I will hearken unto you. And ye shall seek me, and find me, when ye shall search for me with all your heart. And I will be found of you, saith the Lord."

Bibliotherapy

Clients with scrupulosity are given certain readings to reinforce these new spiritual concepts about a loving God who delights in His children and wants them to have self-worth as He sees worth in them. Elder Glenn L. Pace's "Confidence and Self-Worth" (Ensign, Jan. 2005, p. 32) article is a typical starting reading assignment. Much of the client's scrupulous anxiety stems from their feelings of low self-worth before God. Thus building of self-esteem and confidence is valuable

toward reducing this anxiety that underlies scrupulosity. Using authoritative sources (e.g. scriptures, general conference talks from General Authorities, and publications from Church Magazines) helps aid the process because the scrupulous individual finds these sources credible.

From both an ecclesiastical and a professional position, the lead author generally asks the LDS scrupulous individual who is seeking repentance (in an ecclesiastical role) or help (in a professional role) to read other church-related material that will not exacerbate their condition and will reinforce the new positive spiritual paradigm about a loving God and their personal worth that we are attempting to build. Books such as Wilcox's (2009) *The Continuous Atonement* or Robinson's (1992) *Believing Christ* are extremely useful and powerful with the scrupulous or otherwise discouraged saints. While an impressive and powerful work regarding repentance and forgiveness, Pres. Spencer W. Kimball's (1969) **The Miracle of Forgiveness** (particularly his early chapters) tends to induce greater guilt and therefore is not normally recommended to the scrupulous persons who already have excessive and inordinate spiritual guilt. Such a reading assignment is used for people who are far too comfortable in their sins and need the motivating warning of repentance found in Kimball's (1969) classic work. But the scrupulous are almost always motivated to repent—often they seek repentance when they have not actually sinned. So prescribing such a reading assignment is contraindicated in this instance.

Once the emerging new (more positive, tender, loving, and accepting) spiritual paradigm begins to be tentatively accepted, we will begin to assign some readings specific to OCD and scrupulosity. Two essential books in this regard are Ciarrocchi's (1995) *The Doubting Disease* and Schwartz's (1996) *Brain Lock*.

Ciarrocchi's (1995) is a unique work from the perspective of both an associate professor of pastoral counseling in the Catholic tradition and a clinical psychologist. His very readable text carefully reviews both historical and contemporary examples of scrupulosity, discusses the philosophical and theological teachings of the centuries of religious thought concerning the subject, and then outlines a treatment plan of CBT interventions coupled with religious perspectives that he finds useful in his work. His descriptions of both OCD/scrupulous behavior and of the intricate moral reasoning used in religious writings and teachings over the Christian Era centuries is exceptionally well done. Clients find that this normalizes their experiences to a degree. They also find hope in the understanding that treatment, though new and emerging for scrupulosity, is available and generally effective.

In Schwartz's (1996) book *Brain Lock* and Schwartz and Gladding's (2011) *You Are Not Your Brain*, this leading research psychiatrist on neuroplasticity offers a four-step process for the OCD/scrupulous person to use in response to their obsessions and compulsions: 1. Relabel, 2. Reattribute, 3. Refocus, and 4. Revalue. These steps introduce some of the concepts of cognitive and behavioral restructuring we do with clients in the ACT/CBT phase of treatment.

In one rare instance, a television show, *Monk* (Breckman et al, 2004), was recommended to a client struggling with OCD/scrupulosity. In fact the mother (who was the primary client) and her two sons—literally half of the family—all suffered from this mental illness. They were very unfamiliar with OCD and the mother, in particular, was resistant to any consideration of medications. Sensing their need for some visual understanding of the OCD illness (though admittedly in an extreme format to create humor for the show), I (the lead author) recommended they watch the show *Monk*. I particularly hoped they would see that although the main character (Mr. Monk) suffered with OCD, the illness was actually a unique part of him that made him so good at what he does. Rather than portraying someone with mental illness pejoratively, the show highlighted his positive qualities during his struggle with OCD. I also wanted the family to enjoy some clean humor together that might allow for some of the tension in their relationships to be diffused. After watching the show for a number of weeks, the mother came to a session, thanked me for introducing the show to her family, talked about how much it helped them, and discussed an episode where Mr. Monk had tried an experimental medication and it completely relaxed him to the point of totally changing his behavior in very uncharacteristic ways. Though she knew such a television portrayal was an exaggeration, it helped her ponder over her own situation and she determined she was finally ready to try medications. Eventually, through medication and counseling,

her two sons were able to improve to the point of being able to accept missionary calls and faithfully serve in the mission field. The mother also improved significantly with treatment.

Such exposure to new ideas and possibilities to a person previously lacking of hope can be powerful. Through articles, books, and even television or films, persons struggling with scrupulosity can begin to accept new perspectives that are more positive and healthy.

Cognitive-Behavioral Therapy/Acceptance and Commitment Therapy

Bibliotherapy can be a starting point for treatment sessions. Clients who engage in such readings are given a basic framework of new language and novel ideas to talk about their experiences. This quickly enables the ACT/CBT work to begin in earnest.

Building upon Schwartz's (1996) four-step model, clients are encouraged to discuss their specific scrupulous obsessions and compulsions and then the therapist and client can explore how to relabel, reattribute, refocus, and revalue them.

Helping the client to recognize and relabel the unwanted thoughts, urges, and behaviors as obsessions and compulsions rather than some type of spiritual impression that something is amiss in their life is particularly difficult in a religious culture that consistently emphasizes heeding spiritual promptings as revelation from God. It takes considerable practice and life experience for the average LDS person to distinguish between an actual spiritual prompting, inspiration, or revelation from Heaven and a random thought, emotional impulse, or affective experience common to our mortal experience. But consistent familiarity with legitimate spiritual experiences does bring into one's life a refinement of discernment and a heightened capacity to differentiate between inspiration and emotion. The LDS person with scrupulosity, however, has experiences with religion and spirituality that have further intertwined complex emotional issues with spiritual ones to the point where their ability to judge between the two is severely impaired. It is true they may have heightened anxiety and sensitivity about religious matters and dilemmas of right and wrong, but that does not necessarily equate to greater discernment and clarity about distinguishing between the emotional and spiritual feelings. In fact, the opposite is usually the case. They have so blended their affective issues with spiritual ones that their capacity to differentiate is greatly impaired. Relabeling the unwanted thoughts, urges, and behaviors as OCD rather than revelation actually begins to help them differentiate between the two and actually frees them up to have quite different, legitimate spiritual experiences that are affirming of them and positive. It is the first step to being free to truly come to know God as He really is and establishing a healthy, loving relationship with Him without the murky lens of anxiety impeding. In relabeling, clients are encouraged to identify their false brain messages for what they really are: obsessions and compulsions—not spiritual promptings or warnings that they have sinned or might sin. Identifying their inner emotional experience as their own mental processes frees them to truly experience spiritual experiences later on that are genuine. Relabeling begins the metacognitive process of standing objective to one's self and watch or view one's thoughts and actions from a position of mindful awareness. Schwartz (1996) cites Adam Smith's concept of the "impartial and well-informed spectator" to describe standing "meta" to one's self. This strengthens the LDS scrupulous person's capacity to build healthy discernment. This step often requires patient and persistent practice on the part of the client. Techniques involved with relabeling and expanding the client's metacognitive capacity might include journaling, telling one's obsessions to a tape recorder in the most extreme fashion (e.g. fear of germs—imagine falling in mud) and playing it over and over to the point of boredom, or engaging in useful activity (because passivity is a key component of OCD continuing to plague the individual).

Reattributing these obsessions and compulsions to one's OCD/scrupulosity is the next crucial step. Clients are taught to say to themselves, "It's not me, it's my brain" or "It's not sin, it's my scrupulosity" or other similar refrains. Helping the client attribute their problem to something that is totally "in their head"—a mental process that is a false alarm rather than something to pay attention to—is the goal. Encouraging the client to consider the metaphor that their brain is simply "stuck in gear" and needs some action to get it unstuck helps them prepare to take that necessary action (step 3—refocus) and

eventually dismiss the urge as undeserving of their attention and interest (step 4 —revalue).

Refocusing is the key to helping the client move forward. Just as faith is a "principle of action and power" (*Lectures on Faith* 1:10–13) that affects "both physical and mental" exertions (verse 10), refocusing toward wholesome activities and thoughts unrelated to the obsessions and compulsions takes faith on the part of the scrupulous and will bring the benefits of peace and clarity. As the LDS person with scrupulosity engages in other thoughts and actions and ignores the scrupulous urges, even for as short a period of time as ten to fifteen minutes, they become empowered and become better able to differentiate reality from obsession. Much like the native American story of a boy with two wolves in his heart—a good wolf and a bad wolf —who is taught that whichever wolf will eventually win depends on which wolf the boy chooses to feed, persons struggling with scrupulosity are faced with having to choose to feed one perspective or another. As they erode the OCD based paradigm of obsessions and compulsions, they must "starve" their obsessions and compulsions by "feeding" the thoughts and actions that are healthy. Refocusing gives the client the tools to choose to focus on healthy thoughts and actions.

Revaluing is the final step in Schwartz's (1996) model, and is, in essence, the result of persistent and diligent application of the first three steps. By relabeling, reattributing, and refocusing, the client comes to see the obsessions and compulsions for what they really are—false, deceptive brain messages that are of no value or worth. This enables the client to dismiss them. The unwanted thoughts and behavioral urges will likely continue to come, but the client will be able to quickly dismiss them as of no worth or value over time with consistent effort.

Adding to Schwartz's (1996; Schwartz & Gladding, 2011) model, Ciarrocchi's (1995) approach adds the importance of keeping a record or journal of daily dysfunctional thoughts, feelings, and behaviors along with the power of exposure and response prevention therapy. For example, one client, a young college age man, was consistently ten to fifteen minutes late to sessions. When asked why this was happening, he admitted he was trying to get his prayers "just right" and then that would delay his preparation and travel time. In fact, he had daily struggles with excessive praying as well as daily fears that when he noticed a pretty girl at work he was "lusting" after her. His prayers often involved repenting for looking at her and thinking she was attractive. We explored places in the scriptures where prophets had prayed in a manner that does not fit with the modern LDS format of beginning prayers by addressing Heavenly Father and ending in the name of Christ (e.g., in Alma 31:26 the prophet Alma begins his prayer, "O, how long O Lord . . ." and the ending of his prayer in verse 35 does not even include an "amen"). The client was asked if he felt God had heard and accepted Alma's prayer even though it did not follow the formulaic model of prayer that he (the client) is seeking to rigidly follow. He was then asked to follow the counsel in Philippians 4:6–7 and make his simple, heartfelt prayers of thanksgiving and requests be made "known unto God" in whatever inarticulate manner they may be and then resist the temptation to pray again and again with the promise that if he did so he would find the "peace which passeth all understanding." He might not know or understand why such imperfect prayers work, but he would find peace and the knowledge that they are indeed heard and answered. This exposure to the thing he feared the most coupled with the response prevention of not allowing himself to pray repeatedly was exceptionally helpful to him. Regarding the "repentance" for noticing a pretty girl at work, we carefully discussed the distinction between righteously noticing attractiveness in a potential romantic interest and "mentally undressing" and imagining specific sexual actions with a person. He was encouraged that he was already resisting temptations of lust by avoiding pornography and averting his eyes when scantily clad women were portrayed on television, films, or magazine covers, and so he was to be commended for his efforts to be pure. But in avoiding the righteous attractiveness of a potential dating companion, he was "looking beyond the mark" (see Jacob 4:14) and taking a good thing too far. In modern terms, he was allowing a "strength" to become his "downfall" (Oaks, 1994). He was encouraged to take action and talk to her to develop a friendship. In time, he was encouraged to ask her out on a date. This exposure to the very thing he was afraid of was very helpful because he had to take action and dismiss his former perceptions that held him bound.

Lastly, from Dehlin et al. (2013) we suggest specific, weekly, active homework assignments idiosyncratic to the clients particular concerns. Getting the client to "stay busy" (Schwartz, 1996) and avoid passivity is essential. Whether it is physical exercise, socializing, attending church social events, or engaging in some other meaningful labor or effort, active homework assignments help them to consistently and repetitively refocus and revalue.

Conclusion

LDS persons with scrupulosity experience a great deal of suffering. Fortunately, emerging treatment trends show great promise. The model described in this article builds on the recent trends in ACT/CBT treatment for OCD, but adds several practical treatment considerations. A careful and patient emphasis on joining, assessment, ecclesiastical consultation, diagnosis and treatment planning, medication evaluation, spiritual and doctrinal reframes, bibliotherapy, and ACT/CBT can yield positive clinical outcomes.

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