

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

On the Nature and Treatment of Scrupulosity

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ABSTRACT

Obsessive-compulsive disorder (OCD) focused on religious themes, also known as scrupulosity, is a relatively common but poorly understood form of this disorder. It also presents unique challenges to the therapist who must negotiate the procedures of exposure and response prevention while respecting the patient's religious beliefs and practices. Garcia (2008) describes the successful treatment of Bridget, a 21-year-old woman with scrupulosity, using cognitive-behavioral therapy. Following resolution of her OCD symptoms, a second treatment phase targeted several more interpersonal problems using an integrated cognitive-behavioral and psychodynamic approach. This commentary reviews the nature of religion in OCD, the utility of functional analysis and case formulation, issues in the delivery of cognitive and behavioral techniques in OCD, working with religious compulsions, and the integration of cognitive-behavior therapy (CBT) and psychodynamic approaches in the second phase of Bridget's treatment.

Keywords: obsessive-compulsive disorder; exposure and response prevention; cognitive-behavioral therapy; scrupulosity

It was a pleasure to read Hector Garcia's (2008) thoughtful case study of Bridget, a 21-year-old woman with obsessive-compulsive disorder (OCD). The successful use of exposure and response prevention (ERP) for scrupulosity is a tall order for a second-year doctoral student conducting cognitive-behavioral therapy (CBT) for the first time. Following the use of proven exposure-based CBT strategies, Bridget's OCD symptoms were reduced to normative levels, thus freeing her and the therapist to explore issues of a more interpersonal nature using a less structured psychotherapeutic approach. This case study makes a valuable contribution to the

OCD treatment literature for several reasons, not the least of which is its uniquely detailed description of the phenomenology of scrupulosity. Garcia's (2008) depiction of his own experience working with this form of OCD is likewise illuminating.

While randomized controlled trials are essential in identifying *which* treatments work, they are less useful in describing *how* to implement them in an optimal fashion. Thus, the observation that ERP is the treatment of choice for OCD (e.g., Foa et al., 2005) does not by itself arm the clinician with an understanding of the subtleties of conducting a functional analysis, formulating a treatment plan, or implementing exposure practices. Such knowledge occupies the intersection between the science and art of psychotherapy, and *Pragmatic Case Studies in Psychotherapy* represents an ideal forum for critically reviewing issues involved in the idiographic application of nomothetically-derived treatments. It is interesting to observe that while many clinicians agree on which treatment works, opinions often quickly diverge as to how that treatment should be applied. A brief sampling of potentially controversial issues from the present case study might include: (a) the utility of relaxation training in CBT for OCD, (b) how to incorporate cognitive therapy techniques into this treatment, and (c) whether to use imaginal or in vivo exposure for tackling an exposure hierarchy item. The case of Bridget provides ample opportunities to examine the theoretical and technical issues that arise while conducting ERP for OCD, the discussion of which comprises the majority of this commentary.

To help place Bridget's unique symptoms in context, the present article begins by reviewing the nature of religious symptoms in OCD. We then comment on the cognitive-behavioral conceptual model and treatment plan used to guide to Bridget's therapy. A detailed analysis of how Bridget's CBT was conducted follows, with an emphasis on the nuts and bolts of delivering procedures derived from careful functional analysis of the relationship between obsessions and compulsions. Finally, we discuss the second phase of treatment and contrast the integrated treatment Bridget received with continued use of a more structured CBT approach. While we do our best to reference the scientific literature to justify the positions described below, a hefty portion of this commentary reflects our perspective on the "art" of psychotherapy and its application to Bridget's presenting problems.

THE NATURE OF SCRUPULOSITY

Religion and OCD

OCD is a heterogeneous condition in which the clinical presentation typically involves themes of contamination, hoarding, harming others, symmetry, or unacceptable thoughts (Abramowitz, Franklin, Schwartz, & Furr, 2003; McKay et al., 2004). One of the more interesting presentations of OCD is scrupulosity, in which obsessions and compulsions center on religious themes. Individuals with this form of OCD may have obsessions of having committed sacrilegious acts (e.g., blasphemous or "impure" thoughts or behaviors) and often engage in religious rituals taken to the extreme (e.g., excessive prayer or confession) to neutralize their obsessional distress and seek atonement from God for their perceived transgressions.

Scrupulosity is a relatively common feature of OCD. Religion was the fifth most common obsessional theme in the DSM-IV field trial for OCD (Foa et al., 1995), with roughly

6% of individuals reporting it as a primary obsession. Religious obsessions occur in approximately 25% of adolescents and adults with this disorder (Antony, Dowie, & Swinson, 1998). Not surprisingly, religious obsessions and compulsions are especially common among highly religious individuals with OCD (Steketee, Quay, & White, 1991). Catholicism and Protestantism in particular have been linked to OCD-related concerns such as the fear of God, the fear of sin, thought-action fusion, and beliefs about the importance of thoughts (Abramowitz, Deacon, Woods, & Tolin, 2004; Abramowitz, Huppert, Cohen, Tolin, & Cahill, 2002; Nelson, Abramowitz, Whiteside, & Deacon, 2006; Sica, Novara, & Sanavio, 2002; Siev & Cohen, 2007). Scrupulosity appears most likely to emerge in individuals whose religious beliefs emphasize the moral significance of value-laden thoughts and behaviors. For example, Abramowitz (2001) described a patient who believed that laughing at a tasteless joke or drinking alcohol would damn him to hell.

It is important to note, as did Garcia (2008), that the association between religiosity and scrupulosity does not prove that religion causes OCD. Indeed, such a causal inference is unsustainable given that the vast majority of religious individuals do not suffer from OCD. This observation is interesting in light of the fact that certain religious doctrines, such as the Christian precept that having an adulterous thought is the moral equivalent to adultery, would seem to cultivate the very cognitive biases (e.g., thought action-fusion) believed to lead to the development of OCD (OCCWG, 1997, 2001). Occasional concerns about whether one has committed a sin are not unusual among individuals whose religious beliefs emphasize the importance of moral purity in thought and deed. Obviously, such concerns are insufficient for the development of OCD in most individuals, even in the context of a theology emphasizing the potentially catastrophic consequences of sin.

A Cognitive-Behavioral Model of Scrupulosity.

If concerns about sin and its consequences are common, why do so few people develop scrupulosity? A cognitive-behavioral perspective predicts that scrupulous individuals are distinguished from their peers by the content of their beliefs and behavioral responses to religious concerns. Specifically, individuals who appraise perceived sins as overly significant (e.g., as courting God's disfavor and risking eternal damnation) will experience anxiety which in turn motivates efforts to alleviate distress and prevent catastrophe from occurring. A related cognitive bias may prompt scrupulous individuals to appraise relatively innocuous acts, such as laughing at a raunchy joke, as damnation-risking sins. For such persons, healthy participation in standard religious rituals, such as attending weekly church services, may be insufficient to reduce obsessional fear, neutralize the "badness" of their sins, or placate an angry God. As a result, more frequent and compulsive engagement in religious rituals ensues, of which there are many to choose from in denominations like Catholicism (e.g., confession, prayer, the rosary, signing the cross). Because these rituals are negatively reinforced by the reduction in distress they engender, they become the primary strategy for coping with obsessional fear. Unfortunately, religious compulsions paradoxically serve to increase preoccupation with sin by providing a continual reminder of one's moral failings, strengthening excessive engagement in unnecessary religious rituals, and interfering with the habituation to thoughts about sin that would have otherwise taken place in the absence of ritualizing. They also prevent recognition that feared

catastrophes would have not occurred in the absence of ritualizing. Lastly, they can impair the ability to practice one's religion in a healthy, non-toxic manner.

Bridget's OCD symptoms fit nicely in the context of a cognitive-behavioral formulation based on that proposed by Salkovskis (1985; 1999). Her attempts at age 14 to prevent her father's death via religious rituals such as praying and signing the cross illustrate the early presence of both magical thinking and inflated responsibility for preventing harm to others. When these behaviors failed to avert his untimely death, her conclusion that she could have ritualistically prevented it likely strengthened her perceived responsibility for preventing others from being harmed to a pathological level. In religious terms, Bridget appeared to believe the following: (a) she literally had the power to prevent disaster through performing religious rituals, (b) her father's death demonstrated that she would need to "try harder" while ritualizing in the future to prevent disaster, and (c) she was morally responsible for failing to save her father's life.

In the context of these pre-existing beliefs, Bridget's obsessional fear of failing to prevent harm to others broadened to include situations in which the risk of harm was remote (e.g., inadvertently poisoning restaurant customers, burning the house down by failing to turn off the gas stove) as well as those less connected to herself (e.g., the fate of patients in ambulances passing by on the road). In the morality domain, sexual encounters with her boyfriend evoked obsessional concerns about sin ("going against God and Jesus"). Bridget's attempts to cope with her obsessional fear included excessive engagement in religious rituals such as prayer, crossing herself, kneeling, and looking at the sky toward God. An additional cluster of safety-seeking behaviors focused on checking to see whether potential danger was imminent, whether or not she had harmed others (acts of commission), and whether or not she had failed to prevent others from being harmed (acts of omission). While Bridget's compulsions included a wide variety of topographically distinct overt and covert acts, they collectively served to maintain her OCD by preventing the disconfirmation of her maladaptive beliefs about danger, immorality, and responsibility. At the point when she presented for treatment, Bridget was trapped in a vicious cycle wherein her habitual strategies for coping with anxiety and preventing disaster paradoxically exacerbated the very concerns she attempted to neutralize. In summary, her experience was consistent with Salkovskis's (1999) observation that "obsessional problems are a result of sensitive individuals *trying too hard* to be certain that they have not caused harm" (p. S34).

CONSTRUCTING A CASE FORMULATION OF BRIDGET'S OCD

The first step in any CBT protocol is the development of an idiosyncratic case formulation. Through the use of functional analysis, the clinician attempts to understand the cognitions and triggers that set the stage for obsessional fear as well as the safety-seeking strategies used to neutralize anxiety and thwart disaster. It is common for CBT treatment manuals for OCD (e.g., Kozak & Foa, 1998) to devote the first few sessions to detailed assessment of fear-evoking thoughts, feared external situations, feared consequences of not ritualizing, avoidance behavior, and neutralization strategies. More cognitively-oriented manuals (e.g., Freeston & Ladouceur, 1997) also emphasize the assessment of OCD-related beliefs such as misappraisals of intrusive thoughts, heightened responsibility for preventing harm to others, and thought-action fusion. The end result of this assessment is the formulation of a cognitive-

behavioral case conceptualization that serves as a roadmap for the implementation of individually-tailored treatment procedures. Insufficient attention to this critical phase risks the delivery of treatment that is inefficient, ineffective, or both.

In the present case study, the therapist assessed a multitude of religious and checking rituals, as well as anxiety-evoking situations with themes of immorality and the responsibility to prevent others from being harmed. Just as important as the recording of fear cues and compulsions, however, is the establishment of the functional association between them. Why does a cough from the patient's brother evoke anxiety? What is the function of praying when an ambulance passes by? Why does the patient secretly cross herself in the midst of sexual foreplay? How does crossing oneself prevent another from being harmed? Does the failure to act to prevent another from being harmed constitute a sin, and how might God punish it? By obtaining answers to these questions, the clinician may infer the general beliefs and assumptions (e.g., "I am responsible for preventing harm to those around me") that are considered the proximal causal factor in OCD. This is no trivial task, as the identification of such beliefs is a requirement for constructing an accurate case formulation and developing exposure practices that specifically target the patient's idiosyncratic beliefs.

While many of the beliefs underlying Bridget's OCD symptoms were adequately addressed in this study, we were left with the impression that the clinician's functional analysis could have been more focused and systematic. Examples of topics that might have received more attention include Bridget's beliefs about the acceptability of sexual contact (especially non-intercourse) to God and the mechanism via which religious rituals prevent disaster from befalling others. Further analysis of these topics may have revealed additional clinically relevant beliefs, such as those regarding the catastrophic consequences of displeasing God and God's interest in constantly intervening in the minutiae of her daily life. The use of empirically-based cognitive measures such as the Obsessive Beliefs Questionnaire (OCCWG, 2001), Interpretation of Intrusions Inventory (OCCWG, 2003), Thought-Action Fusion Scale (Shafran, Thordarson, & Rachman, 1996), Responsibility Attitude Scale (Salkovskis et al., 2000), and the Penn Inventory of Scrupulosity (Abramowitz et al., 2002) would have also aided the case formulation process.

In the present case study, the process of functional assessment was likely dictated by the treatment manual used by the clinician. In our experience, manuals typically emphasize a detailed assessment of the separate domains of the patient's OCD symptoms, such as obsessive thoughts, avoidance, rituals, etc. The additional step of tying these phenomena together into an idiosyncratic case formulation that emphasizes the functional relationship between general beliefs, obsessions, misappraisals, and neutralization strategies is rarely prescribed in treatment protocols. In contrast, this task is often regarded as necessary and critical in theory-based (i.e., non-manualized) CBT approaches (e.g., Eifert, 1996; Persons, 1989). We believe that the present case study provides several examples of how a more thorough case formulation would have resulted in therapeutically beneficial modifications to the treatment protocol used with Bridget. Our subsequent discussion of these issues should be considered alongside two caveats: (a) initial research suggests that the case formulation approach is no more effective than manualized CBT at the group level (Persons, Roberts, Zalecki, Brechwald, 2006), and (b) given Bridget's excellent response to CBT it is unlikely that our proposed modifications would have led to a

substantially better outcome. However, we suspect that a theory-driven approach would have been considerably more *efficient* than the CBT protocol employed in this study.

WHICH PROCEDURES SHOULD BE USED IN CBT FOR OCD?

As a novice CBT therapist working with a difficult clinical problem under the supervision of a CBT expert and co-author of an OCD treatment manual (McGinn & Sanderson, 1999), it was exceedingly reasonable for Garcia (2008) to have followed this manual in a step-by-step manner with Bridget. As such, some of the critiques below about the procedures used in her treatment speak more to the manual itself than the therapist's clinical judgment. Overall, Garcia's use of exposure and response prevention (ERP) in the treatment of Bridget's OCD symptoms was prudent, as ERP is considered the gold standard treatment for OCD (Abramowitz, 2006). ERP is more powerful than the most well-established pharmacotherapy for OCD (Foa et al., 2005) and is the most effective psychotherapy, with 70% of individuals showing significant improvement and roughly 40% showing complete recovery (Eddy, Dutra, Bradley, & Westen, 2004). This treatment entails prolonged exposure to anxiety provoking situations, thoughts, or other stimuli in tandem with prevention of a response (i.e., compulsion) that functions to reduce this anxiety and to prevent the occurrence of a feared outcome. Foa and Kozak (1986) argued that ERP reduces anxiety by activating cognitive fear networks and providing information that is incompatible with them. From this perspective, ERP is a learning process through which patients acquire corrective information that disconfirms their pathological beliefs. For example, the observation that prolonged contact with germs does not result in the acquisition of a deadly disease would be expected to correct mistaken beliefs about the dangerousness of germs and the consequences of failing to engage in compulsive hand washing.

While protocols including half a dozen distinct procedures are commonly used in the treatment of other anxiety disorders, most OCD treatment manuals mandate beginning ERP early in treatment (e.g., by the third session in Abramowitz, Foa, & Franklin, 2003) and do not include other CBT techniques. In the present case study, ERP was not implemented until 10 sessions had been devoted largely to relaxation training and cognitive restructuring. In our clinical experience, it is not unusual for OCD patients to *complete* a successful course of therapy in 10 sessions. As such, this is a rather striking period of time to spend before implementing the most active therapeutic ingredient in CBT. As detailed below, the scientific literature does not support the incremental benefit of augmenting CBT for OCD with either relaxation training or cognitive therapy. This position is further strengthened by the modest benefits Bridget derived from these procedures. We suspect that Bridget's treatment in Phase 1 could have been substantially shortened without reducing its overall effectiveness.

Relaxation Training

While stress undoubtedly exacerbates OCD symptoms, the therapeutic benefit of including relaxation training in CBT for OCD is dubious. Meta-analytic reviews indicate that relaxation is less effective than ERP (Abramowitz, 1997; van Balkom et al., 1994), and most studies employing this intervention have used it as a placebo treatment. We are aware of no evidence that relaxation enhances the effectiveness of ERP. There are also theoretical reasons to discourage the practice of combining relaxation with exposure. Teaching patients to use

relaxation as a coping strategy for anxiety symptoms may inadvertently send the message that anxiety is intolerable and should be avoided. This message contrasts sharply with that of exposure in which the patient is intended to learn that the anxiety response naturally decreases over time without the need to engage in coping strategies or safety-seeking behaviors.

In Bridget's case, relaxation was used for the purpose of general stress management rather than as a triage response to anxiety symptoms. This approach thankfully avoids the potential contradictions involved in the simultaneous use of exposure and relaxation. While relaxation was thus unlikely to interfere with ERP, there also seems to be little reason to expect it to enhance the effects of CBT. Relaxation training does not address the problematic cognitions and behaviors that maintain OCD. Moreover, relaxation can have an iatrogenic effect for OCD patients who experience frequent, difficult to control intrusive thoughts during periods of mental rest. Bridget's "paradoxical" response of becoming more anxious during autogenic training is therefore not particularly surprising and illustrates the difficulties inherent in employing relaxation techniques before obsessions and compulsions have been reduced with ERP.

Cognitive Restructuring

Growing emphasis on the cognitive aspects of OCD over the past few decades has spurred efforts to improve CBT for OCD with the use of cognitive therapy techniques (Clark, 2004). It has become a common practice for clinicians to conduct stand-alone cognitive therapy prior to beginning behavioral interventions. A related modification to standard ERP is to confront feared stimuli via brief "behavioral experiments" designed to test pathological beliefs rather than through the use of prolonged exposures that continue until the patient has habituated. Despite the clear face validity of these techniques for a disorder characterized by obviously pathological and modifiable beliefs, cognitive interventions appear to offer little advantage over ERP alone (Abramowitz, Taylor, & McKay, 2005). To illustrate, a series of clinical trials conducted at the University of British Columbia indicate no advantage of cognitive therapy involving behavioral experiments over a version of ERP in which therapists were prohibited from discussing their patients' beliefs (McLean et al., 2001; Whittal, Thordarson, & McLean, 2005). An especially interesting finding from these studies is that changes in OCD-related beliefs (e.g., heightened responsibility, misappraisal of intrusive thoughts) were equivalent in cognitive therapy and ERP. The observation that formal discussion of pathological beliefs is unnecessary for their modification demonstrates an important lesson about the powerful corrective information produced by exposure alone.

Bridget's response to cognitive restructuring illustrates two potential pitfalls of using this technique with OCD patients. First, as Garcia (2008) observed, the practice of developing rational responses to maladaptive cognitions can lead to their ritualistic use as an anxiety management strategy, effectively producing the net effect of adding one more compulsion to the patient's repertoire. Second, patients may experience difficulty with the process of recording fear-evoking thoughts and responses to them. For some individuals, the physical act of writing an automatic thought (e.g., "I might drown my infant") is so anxiety provoking that it is avoided or even refused. For other patients like Bridget, the tasks of examining the evidence and generating rational responses may be undertaken in a perfectionistic and compulsive manner. These potential hazards do not apply to all patients with OCD, and the creative therapist might be able

to find ways of circumventing them when they arise. However, given the efficacy of ERP alone, there appears to be little reason to do so.

The observation that cognitive therapy is not more effective than ERP does not negate the value of cognitive interventions in CBT. In fact, discussions of risk, probability, and uncertainty during exposure are often recommended in ERP treatment manuals (e.g., Kozak & Foa, 1998). The informal use of cognitive restructuring encourages patients to attend to what is being learned from exposure in order to increase the salience of the corrective information provided by ERP. In the present case study, numerous comments from the author demonstrate an appreciation for the importance of cognitive change following exposure. Taking this a step further, we recommend that therapists routinely ask their patients to identify feared predictions prior to exposure practices and process the outcome afterwards with respect to the accuracy of the feared predictions. Two studies with claustrophobic participants indicate that doing so enhances the efficacy of exposure therapy (Kamphuis & Telch, 2000; Telch, Valentiner, Ilai, Petrucci, & Hehmsoth, 2000). Unfortunately, the value of informal cognitive techniques embedded within ERP has not been tested to date.

ISSUES IN THE CONDUCT OF BRIDGET'S EXPOSURE AND RESPONSE PREVENTION

In total, 17 sessions during Phase 1 were devoted to ERP, a figure which roughly approximates the average number of total therapy sessions in most CBT protocols for OCD. Bridget appeared to respond quickly and substantially to this treatment. Garcia's (2008) description of this phase of CBT reflects a level of creativity and thoughtfulness that is exceptional for a neophyte exposure therapist. This section of the present case study is particularly interesting owing to the in depth description of the ERP process and the issues it illustrates about the art of conducting exposure therapy. We elaborate on three such issues below: (a) choosing whether to conduct imaginal exposure or in vivo exposure, (b) what degree of exposure is sufficient to adequately disconfirm an irrational belief, and (c) how to separate religious rituals from healthy religious practices in scrupulous patients.

Imaginal vs. In Vivo Exposure

Most of Bridget's exposures took place in imagination rather than in naturalistic settings. Antony and Swinson (2000) recommend use of imaginal exposure for situations the patient is initially unwilling to face in real life, those that may be dangerous or unethical (e.g., leaving a gas stove on for several hours), and circumstances that are difficult or impossible to practice frequently (e.g., sexual contact with Bridget's out-of-state boyfriend). Imaginal exposure is also ideal for confronting feared stimuli in the form of mental events such as thoughts, urges, or images. In Bridget's case, Garcia (2008) employed imaginal exposure to target her fear of ambulances, blasphemous language, her brother's death, checking stoves and locks, and sexual situations. In most instances, she habituated to exposure items within a few sessions. No doubt the lengths the therapist went to ensure richly detailed exposure scenarios, as well as his practice of audiotaping them and assigning listening to them as homework, facilitated this good result.

Because in vivo exposure is generally more effective than imaginal exposure, we usually attempt to conduct exposures in the “real world” unless it is not safe or feasible to do so. Even in cases where the feared stimulus is a mental event, there are often environmental contexts in which experiencing the mental event is especially anxiety-provoking. To ensure generalization of learning from exposure in imagination to the real world, following imaginal exposure with in vivo exposure to the same feared stimulus is advisable. Bridget’s case provides several illustrative examples.

First, in vivo exposure to ambulances could have been conducted outside the entrance to a busy hospital emergency room. This exposure might have been especially fear- and responsibility-inducing because of the increased salience of the victims (i.e., watching them being unloaded and transported into the hospital vs. simply imagining them as the ambulance passes by on the road). Second, exposures to her brother’s health and safety could have been conducted at home in his presence regardless of whether or not he was coughing, leaving town, or otherwise “at risk” (see below for an elaboration). Third, Bridget’s checking concerns (stoves, locks, chemicals at work) provide a concrete example of the value of following imaginal exposure with in vivo exposure. Prolonged exposure to the imagined worst-case scenario of failing to check the gas stove produced little effect, whereas in vivo exposure to not checking the stove produced rapid reductions in her concerns about burning the house down.

Optimal Dose of Exposure

An important issue for the ERP therapist to consider is determining what degree of exposure is optimal to bring about the full disconfirmation of the patient’s irrational beliefs. Is simply observing the consequences of not ritualizing sufficient? In our clinic, we routinely follow up initial exposures by “pushing the envelope” with the goal of more fully disconfirming our patients’ irrational beliefs. To illustrate, consider Bridget’s heightened responsibility for preventing harm from coming to her brother. A functional analysis would likely have revealed the belief that “my rituals can prevent my brother from being harmed,” which is a specific form of the more general notion “my rituals directly affect what happens to other people.” It is possible that Bridget’s exposures to not ritualizing in the presence of her brother were insufficient to disprove this general notion. A simple question posed to the patient would have tested this possibility: “Would you be willing to purposely wish for your brother to get into a car accident?”

Abramowitz, Franklin, and Cahill (2003) described asking a patient with a similar form of thought-action fusion to conduct a brief experiment in which she looked out the window and purposely thought about cars crashing and pedestrians being struck. We suggest that such an experiment would have been a useful addition to the exposure tasks assigned to Bridget. Following a more general experiment such as that described above, Bridget could have worked her way up to imagining or even wishing for harm coming to her brother, preventing all forms of ritualizing, and observing the results. While such an experiment would have undoubtedly been extremely frightening, it might also have provided a uniquely powerful dose of corrective information for her pathologically heightened responsibility. Why waste energy on ritualizing to prevent others from being harmed if one’s thoughts and rituals have no effect whatsoever on what happens to other people?

Increasing the dose of exposure never entails placing the patient at an unacceptably high risk for harm. ERP does not involve exposure to situations that are objectively hazardous, such as leaving a gas stove turned on for a prolonged period of time. Garcia's (2008) initial conundrum about how to proceed with targeting Bridget's stove checking likely resulted from an incomplete functional analysis. Bridget was quite correct in thinking that a running gas stove could cause a catastrophic fire, and thus it was not surprising that imaginal exposure to her house burning down did not eliminate her urges to check the stove. Where she erred was in believing that she needed to repeatedly check that the stove was turned off in order to prevent such a disaster. This formulation naturally points toward exposures targeting the feared consequences of not checking the stove rather than those associated with leaving the stove on. As expected, once Bridget conducted in vivo exposures to not checking the stove and locks her fear of these stimuli quickly dissipated. As noted above, careful attention to tailoring ERP to what the patient needs to learn, rather than simply exposing the patient to a feared stimulus, often yields a quicker and more robust clinical response.

Prayer and Response Prevention

Lastly, the issue of prayer and ritual prevention deserves special mention in the treatment of patients with scrupulosity. Garcia (2008) noted that prayer is a near-universal feature of religion that often conveys beneficial emotional effects, and as such the wholesale elimination of prayer in the religious patient is no more a therapeutic goal than is the permanent elimination of hand washing and showering for the contamination-fearful patient. On the other hand, the prevention of *ritualistic prayer* during ERP may be necessary for patients to benefit from this treatment. The task for therapist and patient is to distinguish healthy from unhealthy praying, and to develop rules for what constitutes acceptable use of prayer during the course of ERP.

Bridget's case illustrates the difficulties inherent in setting limits on the scrupulous patient's prayer during ERP. While the difference between healthy and OCD-like prayer was clearly understood by the patient, nearly all of her prayers appeared at least somewhat anxiety-driven. Garcia (2008) noted that, "most of the time the motivation for Bridget's praying was strongly in the direction of anxiety-reduction and in response to intrusive thoughts" (p. 14). At times, Bridget even had difficulty understanding that what she perceived as healthy prayer was in fact anxiety-driven and ritualistic. Thus, prayer in this case served the same anxiety-reducing, disaster-preventing function as any other compulsion. Why then was prayer allowed to continue throughout treatment when all other functionally equivalent acts, including religious rituals (e.g., signing the cross), were prevented?

The decision to allow the patient to continue to pray throughout ERP, albeit it at a restricted level of 15 minutes per day, is clearly consistent with the author's philosophical views about respecting the "intrinsic human right" to pray and exercise one's religion. The mutually agreed upon rules for acceptable praying mirror the common practice of setting showering, hand-washing, and checking limits with other types of OCD patients. However, there is an important difference between these behaviors: *some* cleaning and checking is objectively necessary to prevent negative consequences (e.g., disease, theft), whereas prayer is not. The most likely feared outcome of not praying during ERP is religious in nature. If patients express concern about the religious implications of not praying, consultation with a trusted clergy member who

understands the nature and treatment of scrupulosity is recommended. In his seminal book on scrupulosity, Ciarrocchi (1995) noted that clergy members may give scrupulous patients permission to visualize sinful thoughts and refrain from engaging in religious rituals in response to them. In the context of such permission, ERP may proceed without the potential complication of an officially sanctioned compulsion in the form of ritualistic prayer.

We recognize the potentially controversial nature of this suggestion and do not advocate the prevention of prayer as a general rule with scrupulous patients. Garcia's (2008) suggestion to gauge what normal praying is for someone of the patient's religious affiliation, and to restrict the patient to this form and amount of prayer during ERP, is a sensible heuristic. However, for individuals like Bridget who appear unable to pray in a non-pathological manner that does not interfere with learning during exposures, the therapist might consider the temporary suspension of prayer along with all other anxiety-driven religious rituals during some or all of ERP. Obviously, the decision to advocate such a strategy needs to be balanced by its potentially deleterious effects on the therapeutic relationship. For those patients who are unwilling to refrain from ritualistic prayer during ERP, the therapist may decide to involve a clergy member or to drop the issue entirely and hope for the best. In any case, it is critical that both patient and therapist understand that the temporary prevention of religious rituals during ERP does not represent an attempt to rob the patient of his or her religion. In fact, the goal is just the opposite: to empower patients to eventually practice their religion in a healthy, fulfilling, and non-anxious manner.

CRITIQUE OF BRIDGET'S TREATMENT IN PHASE 2

Although the emphasis of our commentary concerns the nature and treatment of scrupulosity, we take the opportunity in this section to comment on Bridget's therapy in Phase 2 (sessions 28 to 79). In the context of taking a graduate class on psychoanalytic therapy, Garcia (2008) elected to change course and adopt a hybrid CBT/psychodynamic approach to treating Bridget's pressured speech and relationship problems. This approach was described as most consistent with an "assimilative integration" model in which therapy is firmly rooted in CBT but allows for meaningful consideration of psychodynamic theory and techniques. Garcia (2008) explained that this method allowed for "artful flexibility in pace, tempo, and timing, which lent itself better to the emotional valence of understanding of interventions, while maintaining the precision and instrumentality of CBT" (p. 7). From our perspective, this method also led to approximately 1.5 years and 50 sessions worth of therapy that produced less tangible improvement than what occurred with half as many sessions of CBT in Phase 1.

Reflecting a psychodynamic influence, treatment in Phase 2 was largely unstructured and permitted the patient to discuss topics of her choosing. A detailed functional assessment of the two targeted problems was not conducted. At least one target, pressured speech, was not adequately understood by either therapist or patient for more than a year. No specific goals were set, nor was there systematic assessment of the patient's progress with regard to her targeted problems. Sessions proceeded without an agenda and jumped from topic to topic. No contract was made for a specific number or range of sessions. It is unclear how either the therapist or the patient would ascertain when therapy was no longer needed, and treatment was instead terminated when the patient eventually ran out of time.

Our reading of the present case study does not lend strong support to Garcia's (2008) claim having a "primary conceptual grounding" in CBT during Phase 2. Many of the most salient characteristics of CBT (e.g., conducting a case formulation, establishing an individualized treatment plan, setting goals, assessing progress) were absent. As a result, our overall impression of Bridget's second phase of treatment is that it was primarily supportive/psychodynamic with occasional use of cognitive therapy techniques such as identifying maladaptive beliefs and discussing their possible origins and effects on her behavior. There were several practical consequences of this approach. First, the patient's pressured speech was (not surprisingly) exacerbated by the lack of structure during therapy sessions. Second, important realizations about the psychological processes underlying her targeted problems did not emerge until well into the 1.5-year duration of this phase. Third, the patient did indeed experience improvement in key areas, such as less pressured speech, increased insight into patterns of relationship conflicts, and increased self-efficacy for not seeking reassurance from future boyfriends. However, these improvements generally occurred after many months of therapy, and treatment had to be terminated before the patient could make significant progress on grieving her father's death. This is particularly unfortunate as this latter issue may have been one of the most important tasks to address in this phase of treatment.

Garcia (2008) noted that Bridget's Phase 2 problems were caused by the "same cognitive and emotional dynamics that had led her to have obsessions and compulsions" (p. 4). Given the doubtful role of heightened responsibility, thought-action fusion, and fear of sin in causing pressured speech and boyfriend problems, a more thoughtful functional analysis seems warranted. Indeed, when Garcia eventually devoted more attention to identifying the cognitive and behavioral factors driving Bridget's two identified problems, progress was quick to follow. Unfortunately, this did not occur until more than 40 sessions had transpired in each case. Using our 20/20 hindsight vision, we suspect that had Garcia engaged in a focused effort to conceptualize and treat these problems from the beginning Bridget would have arrived at the same (or better) outcome in much less time than it took to complete Phase 2.

Of course, it may have been difficult to accomplish this within the constraints of integrating the CBT and psychodynamic approaches. While Garcia (2008) provided several face valid reasons for emphasizing psychodynamic therapy in Phase 2, no doubt the most influential factor was the prospect of learning a new therapy from a different supervisor. While there is nothing wrong with this motive per se, it must always be considered alongside the clinical needs of the patient. When employing a treatment that was selected for training purposes rather than in accordance with empirical support or clinical judgment, students and supervisors should carefully specify treatment goals, monitor progress toward them, and change course when it becomes apparent that the therapy is not progressing in an adequately effective or efficient manner.

CONCLUSION

Garcia's (2008) case study represents an interesting and valuable contribution to the psychotherapy literature. Scrupulosity is a poorly understood form of OCD and therapists interested in treating this problem would do well to familiarize themselves with the procedural, technical, and interpersonal issues illustrated by his case report. While dealing with religious

issues in psychotherapy can be stressful for many therapists, scrupulosity forces the therapist to confront them in a specific and uniquely demanding manner. Striking a balance between the prohibition of harmful religious rituals and respecting healthy religious practices is likewise difficult to negotiate. Garcia's outstanding description of these issues is among the best we've ever seen.

In our commentary we addressed the nature of religious symptoms in OCD, constructing an individualized case formulation and treatment plan using functional analysis, the questionable value of relaxation training and cognitive restructuring in ERP, technical and theoretical issues in the conduct of ERP, and the integration of CBT and psychodynamic approaches for treating Bridget's interpersonal problems in Phase 2. While we have offered a variety of suggestions for how to maximize or improve upon the specific procedures used with Bridget, there is much to like about Garcia's treatment approach and the benefits Bridget derived from it. It is our hope that this issue of *Pragmatic Case Studies in Psychotherapy* stimulates further research on the nature and treatment of scrupulosity.

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