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KEEPING THE FAITH: HOW TO ETHICALLY AND COMPETENTLY TREAT RELIGIOUS SCRUPULOSITY

Presented by:

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SHARE

Where have you experienced client resistance?
(question #1 on the padlet)

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LEARNING OBJECTIVES

1. Gain greater awareness in recognizing your own mindset and bias when treating religious scrupulosity.

2. Learn to develop an effective treatment plan that includes clerical collaboration and respectful exposure planning.

3. Learn to integrate healthy faith practice into the scrupulosity treatment plan.

CLINICAL GUIDANCE

By the numbers

- Clients need & want their religion or spirituality incorporated
- Most clinicians do not have training and are quite different from their clients

Competence Vs. Proficiency

Sixteen Spiritual and Religious Competencies

Faith Sensitive Clinical Pointers for OCD

Justin K. Hughes, MA, LPC

SRBPS (SPIRITUAL AND RELIGIOUS BELIEF AND PRACTICE)

IMPORTANCE TO CLIENTS

SRBP	Stats (U.S.)
Belief in God or higher power (Pew, 2023)	88%
Participate in a religious community	About half
Base life on religion	75%
Desire to address in therapy	Most
Prefers a therapist with religious values	Most
SRBPs very important	Most

(Vieten and Scammell, 2015)

R/S = Religion/Spirituality

SBRPs = Spiritual and Religious Beliefs and Practices

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PSYCHOLOGY'S RELATION TO SRBPS

COMPARISON

Clinical practice (psychologists)	Stats (U.S.)
Discussing with SRBPs with patients	30%
Personally believe in God	66%
Base life on religion	35%
Amount Psychiatrists personally identify with a religion, compared to other doctors (Reuters, 2007)	Least

(Vieten and Scammell, 2015)

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Competence

"...refers to the basic attitudes, knowledge, and skills clinicians should possess to conduct effective therapy."

Proficiency

"...refers to a high degree of expertise or skill." (Vieten and Scammell, 2015, pg. XIII)

- **Competence is a requirement for licensed mental health professionals.**
- **Proficiency will be needed for some interventions. Some challenges to both therapists and clients arise when these two merge.**
- **Directions to grow in; NOT accomplish once and for all.**

Sixteen Spiritual & Religious Competencies for Clinicians

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Knowledge

- Many diverse forms of R/S exist; explore what is important to clients
- Be able to describe how R/S are distinct and interconnected constructs.
- Experiences may be consistent with R/S but difficult to separate from pathological symptoms
- SRBPs change over the life span
- Be aware of internal and external supports with R/S and be able to understand from research which practices may support well-being or recovery
- Identify SRBPs with potential negative impact to health
- Recognize legal or ethical issues around R/S that can arise

Attitudes

- Show empathy, respect, and appreciate clients from diverse backgrounds--R/S OR secular
- R/S are viewed as an important factor of human diversity
- Be aware of one's own SRBPs and background influence practice and attitudes

Skills

- Provide effective therapy with those from diverse affiliations, backgrounds, or levels of participation in them
- Inquire about SBRPs and background
- Explore and help clients access their SRBP related resources and supports
- Identify R/S problems and refer when necessary
- Stay up to date on research and developments concerning R/S and continue assessment into own competency
- Recognize limits of competence, qualifications, and responses--then to pursue consultation, seek further training/education, or refer out as necessary

R/S = Religion/Spirituality SBRPs = Spiritual and Religious Beliefs and Practices

Summarized from Vieten, C., & Scammell, S. (2015). Spiritual and religious competencies in clinical practice: Guidelines for psychotherapists and Mental Health Professionals. New Harbinger Publications, Inc.

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FAITH SENSITIVE CLINICAL POINTERS FOR OCD

Rapport
&
Willingness

Diversity
&
Direction

Regular
Assessment

Differentiate

Clergy
Collaboration

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RAPPORT & WILLINGNESS

- You need to have trust in your team and support (therapists, clergy, etc.). You also need to believe in what you are doing. Mental health is tricky like that--if you aren't willing, regardless of your actions, you'll simply reinforce fear. This is why recovery can't be forced, and possibly why interventions aren't really used in OCD treatment compared with things like addiction.
- Bottom line: Willingness and readiness are essential to effective ERP. No willingness? No effective ERP.
- If you struggle with scrupulosity:
    - Not only is it more common to doubt the actual need for exercises and the possibility of violating faith, but it is all the more important to tap into a person's overall beliefs and purpose.

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REGULAR ASSESSMENT

- Slow down to get there faster. Identify actual beliefs and values
- When in doubt, work with values and willingness
- Get objective. Be “crisp” in what you are trying to practice from a faith standpoint. OCD loves play off general discomfort and “feeling bad”
- Track whether you can stick to your exposures and whether or not you are able to eliminate compulsions. Watch out for “sneaky” assessment by basing success on feelings. Hopefully you will have already defined what you will stick with and not.

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DIFFERENTIATE

- Working diversely with Faith and Spiritual concerns is NOT saying that it's "all the same"
- Objectively identify what is ERP and what is faith practice.
  - If you can't state what you're doing in ERP terms, it's probably not ERP
  - If you can't state clearly what a belief is, it's probably not a belief.

DIVERSITY & DIRECTION

- Practices will need to be diverse not just from person to person but across the lifespan.
- Diversity is “the state of being diverse; variety” (Oxford).
    - Once you differentiate values from obsessions, you can then practice with flexibility, appreciating your uniqueness and sameness.
- Specificity on diversity provides direction.
    - For example, Christians with a sensitive conscience who honor it are being faithful to God. In fact, it might even be applied differently at different times and not be compulsive (e.g., fasting leading up to Christ's crucifixion).
- Appreciate the steps you are taking as both part of a larger picture and personal to you. You have to take them. No one else can walk the same plan.
- Work with commitments you make (ACT is helpful here)

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Section References:

- *Becka A. Alper, M. R. (2023, December 7). 2. spiritual beliefs. Pew Research Center. https://www.pewresearch.org/religion/2023/12/07/spiritual-beliefs/*
- Cashwell, C. S., & Young, J. S. (2020). *Integrating spirituality and religion into counseling: A guide to competent practice*. American Counseling Association.
- Gill, C. S., & Freund, R. R. (Eds.). (2018). *Spirituality and religion in counseling competency-based strategies for ethical practice*. Taylor & Francis.
- *Kahle, P. A., & Robbins, J. M. (2004). The power of spirituality in therapy: Integrating spiritual and religious beliefs in mental health practice. Haworth Pastoral Press.*
- *Psychiatrists least religious of U.S. doctors: Study | reuters. (n.d.). https://www.reuters.com/article/us-psychiatrists-religion/psychiatrists-least-religious-of-u-s-doctors-study-idUSN0228386620070903/*
- *Vieten, C., & Scammell, S. (2015). Spiritual and religious competencies in clinical practice: Guidelines for psychotherapists and Mental Health Professionals. New Harbinger Publications, Inc.*
- *Vieten, C., Scammell, S., Pierce, A., Pilato, R., Ammondson, I., Pargament, K. I., & Lukoff, D. (2016). Competencies for psychologists in the domains of religion and spirituality. Spirituality in Clinical Practice, 3(2), 92–114. Based on Vieten et al. (2016) Competency Keys*

IOCDF Articles for further reading:

- *https://iocdf.org/faith-ocd/mental-health-providers/principles-of-effective-and-religiously-sensitive-exposures/*
- *https://iocdf.org/faith-ocd/mental-health-providers/how-to-ethically-integrate-faith-and-spirituality-into-therapy/*
- *https://iocdf.org/faith-ocd/mental-health-providers/implementing-specific-religious-traditions-into-a-treatment-plan/*
- *https://iocdf.org/faith-ocd/mental-health-providers/grasping-religious-spiritual-traditions-sensitively/*

AWARENESS:
RECOGNIZING YOUR MINDSET & BIAS

Implicit Bias: attitudes or stereotypes that affect our understanding, actions, and decisions.

- Unintentional
- Automatic
- Outside of Awareness
- Shaped by experiences, background, etc

Mubeena Mirza

HISTORICAL EXAMPLES OF BIAS IN MENTAL HEALTH

Racial Bias:

Drapetomania

Gender Bias:

Hysteria

Sexual Orientation Bias:

Homosexuality as a mental health disorder

Socioeconomic Bias:

Institution-alization

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CASE EXAMPLE

INTAKE

You receive a call for a consultation with a potential new client. The caller is a man desperate for his wife to get help. “My wife is distraught. She is so distracted by these rituals that she cannot even make our family dinner anymore! Can you please help her get back to the woman I married?” You speak with his wife, and although she is very quiet, it is clear that she has OCD and that you can help her. You schedule a session with her.

CASE EXAMPLE

ASSESSMENT

In the first session, a woman enters the room fully covered from head to toe. She identifies as Muslim, wearing a hijab and loose clothing. She has difficulty articulating herself, and her voice is barely audible. During the intake, as you conceptualize her obsessions and compulsions, she mentions and exhibits the following:

- Repeatedly adjusting her headscarf
- Mumbling words in Arabic after discussing blasphemy
- She reports repetition during prayer
- She reports asking her husband and religious leaders for reassurance

Mubeena Mirza

CASE EXAMPLE

TREATMENT

After multiple sessions and significant improvement, your client has reduced many compulsions, including repetition during prayer and seeking reassurance from her partner. She is now visibly less anxious and has shown increased mental flexibility around her religious practice. During a session, you notice that she continues to adjust her scarf, so you bring it up. She acknowledges it as a compulsive behavior and agrees to do an exposure for it. You suggest that she walk outside daily for 5 minutes, exposing part of her hair. She becomes quickly anxious, which you interpret as ERP gold. She insists that showing her hair is sinful and refuses. You explain that in order to progress in treatment, she needs to engage in this exposure.

SHARE

Reflecting on our biases (questions #2-5 on the padlet)

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ACTIVITY:
REFLECTING ON OUR BIASES

- What are some implicit biases that came up for you during intake and assessment?
- How do my views on faith influence my conceptualization of this case?
- How might my culture, race, and socioeconomic background influence the way I treat this client?
- How did I respond to the client? Which aspects of treatment were affected by my response? How do I repair?

WHERE DO WE GO FROM HERE?

Case Consultation/ Supervision

Curiosity with Client

Awareness and Humility

Education

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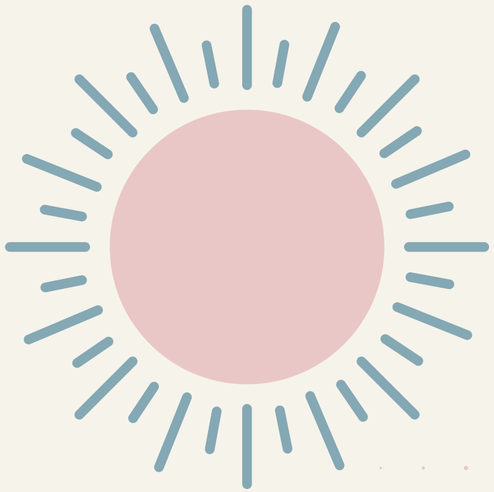
UNDERSTANDING THE FAITH

- For many, faith is one of the most significant things in their life (which makes it an easy target for OCD)
- Diversity of faith traditions and experiences for culturally responsive treatment
- Faith can be a strong value for recovery



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CONNECTIONS BETWEEN FAITH & TREATMENT

CASE EXAMPLES ACROSS RELIGIOUS/SPIRITUAL TRADITIONS

ERP does not oppose your faith. Rather, it helps you return to a healthy, value-driven version of your faith. You can actually become more connected to the Divine and your faith practices.

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EMBRACING UNCERTAINTY

- The embrace of uncertainty required as a part of OCD treatments can be compared to the beauty of uncertainty required for faith in the Divine.
- This is the same faith that Henri Nouwen described as “an adventure in the unknown, an adventure in which we learn to trust in the goodness of God.”
- Treatment for OCD takes having faith to a whole new level, as individuals must come to terms with the fact that no level of reassurance will yield certainty, but rather that radical faith can lead to freedom from the disorder and value-driven life.

Henri Nouwen, The Inner Voice of Love: A Journey Through Anguish to Freedom (New York: Image Books Doubleday, 1996), 60.

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DISCLAIMER

The line between appropriate exposures and religious law is not black and white. While religious laws exist and are important, the specific line between religious law and exposure differs across denominations, sects, communities, and individuals. Consultation with faith leaders and patient with regard to what crosses the line for their unique case is imperative!*

***Suggestions are not a one-size-fits all approach**

Caitlin Claggett Woods & Emily Bailey

ADDITIONAL CONSIDERATIONS WHEN DETERMINING IF AN EXPOSURE IS APPROPRIATE/BREAKS RELIGIOUS LAW

- Discomfort versus Disrespect
- 80/20 Rule of Thumb based on patient's faith community versus tradition as a whole

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WHERE'S THE LINE BETWEEN EXPOSURE & RELIGIOUS LAW?

"Why don't you want to do this exposure?"

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WHERE'S THE LINE BETWEEN EXPOSURE & RELIGIOUS LAW?

"This is something you need to do to get better"

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POTENTIALLY OFFENSIVE AND UNETHICAL EXPOSURES

Catholic:

-Using a Ouija board or holding a seance
-Dropping a communion wafer on the floor
-Masturbating

Orthodox Judaism:

-Eating a cheeseburger
-Turning on electricity during Shabbat
-Eating without making a blessing

Islam:

-Drinking alcohol
-Publicly denying the existence of Allah
-Prostrating to an idol

All: Desecrating sacred objects or texts

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POTENTIALLY OFFENSIVE AND UNETHICAL EXPOSURES

Risks to treatment and the therapy relationship

If you don’t know, don’t assume

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INTERDISCIPLINARY COLLABORATION WITH CLERGY





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INTERDISCIPLINARY COLLABORATION WITH CLERGY

Offering a role:

- **Explaining/exploring the scope of the faith tradition**
- **Motivation through meaning**
- **Acceptance rather than accommodation**
- **Assistance determining where and how religious practices can be restricted during treatment**

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RESTRICTING RELIGIOUS PRACTICES DURING TREATMENT: A DISCUSSION

Identify - what is required and what is recommended?

Required:

Attending mass
Observing Shabbat
Salat

Recommended:

Bowing to the altar
Covering hair
Using a prayer rug

A point on religious requirements - identify exemptions granted due to illness or extenuating circumstances

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HEALTHY PRAYER AND RECOVERY

What does it mean to have faith in God, faith in treatment, and faith in ourselves?

How can prayer for strength be used as a value during treatment?

How do affirmation and hope differ from reassurance?

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HEALTHY PRAYER & RECOVERY

Let me give my permission (accept) for life to be as I find it (as life is, was, or may be) even though I may not approve of what I find. I have wisdom to see what would be good to change, willingness to act, willingness to follow through...and the gratitude for the opportunity to try to live my life as best I can.

I. Nieuwsma, J., Walser, R. & Hayes, S. (Eds.). (2016). ACT for Clergy and Pastoral Counselors: Using Acceptance and Commitment Therapy to Bridge Psychological and Spiritual Care. Oakland, CA: Context Press.

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HEALTHY PRAYER & RECOVERY

God, please give me the strength to lean into discomfort and sit with uncertainty. It feels hard and scary, but I know that you are walking alongside me. Please give me the courage to use my tools as I offer myself compassion and truly live into my treatment, always moving towards the beautiful life you have created for me. Amen.

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WHO IS GOD?

What is God like?

What does God want for us?

Which God are you serving?

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DOES GOD WANT YOU TO HAVE OCD?

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SHARE

How far do you go in an exposure? How do we remain client-centered and culturally responsive? How do you navigate this nuance? (questions #6 on the padlet)

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