Obsessions and Compulsions: Breaking Free of the Tyranny

Michael R. Emlet

Have you ever had a thought that you found difficult to push from your mind? Have you ever just gone to bed and asked yourself, "Did I lock the front door?" You're 99.9% sure that you did, but that last shred of lingering doubt causes you to get up and go downstairs and check, just to be sure. You find that, indeed, you did lock the door and so you trudge back to bed and quickly fall asleep, forgetting the incident. No problem.

I would venture to say that this is a common and normal experience. But have you or anyone you know struggled in more far-reaching ways as described below?

- After checking the door once, you lie awake in bed and wonder, "Did I absolutely make certain that the door was locked?" You fight the building anxiety, but eventually succumb, checking the lock again. In fact, you unbolt and rebolt several times in order to be sure. And yet, it is not enough. Lying in your bed a bit later, the doubt begins to grow, and the cycle of checking and rechecking continues until you fall asleep out of sheer exhaustion at three o'clock in the morning.
- You worry that the floors and other household surfaces are not clean enough to prevent contamination of your children. So, although you know your fear is irrational, you spend hours a day cleaning the surfaces of your house with Clorox.
- You have stopped driving out of fear that you may hit and kill someone (although you admit that your driving record is untarnished and your driving skills are above reproach).
- You are a CPA who inadvertently makes a mistake while preparing a client's income tax return. You rectify the situation when your mistake is discovered, but now you are wracked with doubts about your abilities. Each tax return takes longer and longer to prepare as you ever more meticulously pour over every line again and again.
- You stop going to church because of an overwhelming fear that you will yell something blasphemous during the sermon.
- Your seven year old son develops an increasingly complex bedtime routine that includes the presence and correct position of a certain number of stuffed animals and other toys, checking and rechecking the locks on the windows a certain number of times, flipping the light switches on and off a set number of times, and a series of standard questions he asks and standard responses to be given by you the parent. Any deviation from this routine leads to a prolonged and violent temper tantrum.
- You seemingly are unable to throw away old magazines and newspapers and they begin to

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accumulate in piles around the house. Eventually you do not throw out any piece of paper, no matter how small.

While these problems may seem extreme, there are in fact many people, perhaps as much as 3% of the U.S. population, who struggle in this manner, to either a greater or lesser extent. What is the cause of such a struggle? Is this principally a spiritual issue? Is it primarily a sin issue? Or is it principally a body issue in which a particular portion of your brain circuitry continues to fire in an endless loop, compelling you to carry out certain behaviors? These are some of the questions that must be answered if we as biblical counselors are to be equipped to minister wisely and compassionately to those who struggle in this manner.

The purpose of this article will be to describe the experience/struggle of what has been named Obsessive Compulsive Disorder (hereafter "OCD"),[1] to discuss the potential causes for such a struggle, and then to suggest a biblical approach that does justice to the person as a body/soul duplex.[2] Hopefully you will gain a greater sense of clarity about how to approach either your own struggle with OCD or such a struggle in another's life.

OCD Described

The essential features of OCD include recurrent obsessions and/or compulsions that are severe enough to be time consuming or to cause marked distress or significant impairment in the person's daily routine.[3]

Obsessions are "persistent ideas, thoughts, impulses, or images that are experienced as intrusive and inappropriate that cause marked anxiety or distress."[4] More simply put, obsessions are "sticky thoughts"—thoughts that individuals can't seem to get out of their minds. These ideas, thoughts, impulses, or images are not simply excessive worries about actual, current real-life problems (e.g., concerns about finances, work or school). The individual with such an obsession experiences anxiety and attempts to suppress such thoughts or impulses or to "neutralize" them with some other thought or action (i.e., a compulsion). It is important to realize that the person with an obsession is distressed by its presence; it is an *unwanted* intrusion into his/her thought life.

Common obsessions include the following:

- Repeated thoughts about contamination. This fear of contamination is the most common obsession.
- Repeated doubts (e.g., wondering whether or not you have hit someone while driving or wondering if you turned off the iron).
- A need to have things in a particular order or a need to do a task "just right."[5]
- Aggressive or horrific impulses (e.g., to hurt one's child or to shout an obscenity in church).
- Sexual imagery (e.g., a recurrent pornographic image).
- An irrational and persistent fear of developing a serious life-threatening illness.

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[1] I realize that using the term Obsessive-Compulsive *Disorder* is loaded with certain presuppositions about its cause—i.e. the term *disorder* suggests a purely biological cause. While I fundamentally disagree with that hypothesis because it ignores the spiritual aspect of our personhood, for the sake of simplicity I will abbreviate this struggle as "OCD" for the remainder of the article. However, one could make an argument for the use of more purely descriptive language as a shorthand for this problem, such as obsessive thoughts and compulsive behaviors ("OTCB"). Such terminology comes less freighted with presuppositions about etiology. An even more descriptive phrase might be: "intrusive broken-record thoughts and ring-in-the-nose behaviors"—the "brrn" experience! All said, we need to carefully consider what our language communicates and realize that the term, "disorder," is not neutral in its connotation.

[2] For a more lengthy background to my overall approach to problems having definite or possible physical components, please see "Understanding the Influences on the Human Heart," *Journal of Biblical Counseling* 20, no. 2 (Winter, 2002), p. 47-52.

[3] The description that follows is based upon the American Psychiatric Association [hereafter APA], *Diagnostic and Statistical Manual of Mental Disorders,* (Washington, DC: American Psychiatric Association, 2000), 4th ed., text revision, 456-463. As mentioned above, while I disagree with the unspoken premise that all the problems described in the DSM have a purely somatic cause, the detailed description, as given in the DSM, can help biblical counselors understand the scope and severity of the counselee's struggle, as well as to facilitate communication with others who are seeking to help the counselee.

[4] APA, p. 457.

[5] This may manifest itself as "obsessional slowness." That is, the counselee may take an inordinate amount of time to complete even simple tasks, because he/she is obsessed with completing the routine exactly right. See Michele Tortora Pato and Joseph Zohar, *Current Treatments of Obsessive-Compulsive Disorder,* (Washington, DC: American Psychiatric Publishing, Inc., 2001), p. 6.

Compulsions are "repetitive behaviors or mental acts, the goal of which is to prevent or reduce anxiety or distress."[6] The person does not carry out these behaviors or thought processes to gain pleasure. Rather, they feel driven to perform the compulsion to reduce the distressing anxiety that accompanies an obsession. So, someone having a contamination obsession might wash his hands thirty times a day. Someone with intrusive and unwanted aggressive impulses might count to twenty forward and backward for each aggressive thought. Compulsions are clearly excessive or are not connected in a realistic way with what they are designed to neutralize or prevent.

Common compulsions include the following:

- Repetitive behaviors (checking, washing and cleaning, requesting or demanding assurances, ordering and arranging, doing and undoing certain tasks in an exact sequence).
- Mental acts (counting, repeating words silently).
- Hoarding.

The DSM description helps us acknowledge the reality of this group of suffering people and gives shape to the kind of data-gathering questions that might be helpful to elucidate the extent and severity of our counselee's struggle. At the same time we must remember that the description does not, in and of itself, explain *why* someone would struggle with obsessive thoughts and compulsive behaviors. To begin to answer that, we need a review of biblical anthropology that will give us the foundation for a biblically rooted counseling approach.

What Causes OCD?
Brief Review of Biblical Anthropology

The biblical view of the person affirms "inner" and "outer" aspects to our constitution, which function together as a unity to live before God and others. We live, spirit and body, before the living God and others, either in obedience or disobedience. One common designation that Scripture uses to describe the inner aspect of a human being is the word "heart."[7] The heart, both in the Old and New Testaments, refers to the basic inner disposition of the person who either lives in covenant obedience or in covenant disobedience before God. The term expresses the reality that at our core we are all worshippers of *something,* either of the Creator (obedience) or of created things (disobedience), as emphasized in Romans 1.

God has designed us to express the worship mandate of our hearts in a tangible, "flesh and blood" context. Any thoughts we have, any emotions we feel, and any behaviors we carry out (all of which originate in the heart and are expressions of our worship),[8] must happen in a bodily context. That bodily context in various states of health or disease makes *either* obedience or disobedience easier. While our bodies ultimately do not have the "final say" in whether our thoughts, emotions, and actions honor or dishonor God,[9] the Scriptures do not ignore the real and often profound influences/pressures of bodily weaknesses and limitations that test the response of our hearts in these three areas.[10]

In bringing wise counsel to bear on the lives of those who struggle with OCD, we want to differentiate between potential bodily pressures and the active responses of the heart.

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[6] APA, p. 457.

[7] See Deut. 6:5; Josh. 22:5; 1 Sam. 13:14; 1 Sam. 16:7; 1 Chron. 28:9; Ps. 14:1 (and many other psalms); Prov. 4:23; Prov. 27:19; Jer. 24:7; Matt. 5:8; and Matt. 6:21; The Bible also uses other terms to capture this inner aspect of human beings, including spirit, soul, mind, will, conscience, hidden self, and inner nature (see Ezek. 11:19; Matt. 10:28; Col. 1:21; John 7:17; Heb. 8:10; Rom. 2:15; 1 Pet. 3:4; and 2 Cor. 4:16.

[8] See Gen. 6:5; Deut. 8:5; Prov. 2:10; Eph. 1:18; Eph. 4:18; Heb. 4:12 (thoughts); Gen. 6:6; Lev. 19:17; Prov. 13:12; Prov. 14:13; Prov. 24:17 (emotions); Ex. 25:2; Luke 6:45; Eph. 6:6 (actions).

[9] This discussion is not meant to suggest an ultimate dualism in which one part of us sins or obeys (the heart) while one part of us passively carries out the desire for sin or obedience (the body). When we disobey or obey, we do it heart and body. Yet, nowhere does Scripture suggest that the genesis for obedience or sin lies within the bodily aspect of our personhood. That moral initiation is the domain of the heart.

[10] Here's a simple example: if I tend toward anger/irritability after several poor nights of sleep, the answer is not simply to examine and overcome the heart-based roots of my anger (which I should do), *but also* to get some sleep! I'm still responsible for my actions, but my approach includes addressing the bodily weakness as well (the physical "treatment" of sleep). But most ministry situations are not so simple or clear-cut!

We will likely have the tendency to "overweight" one or the other, leading to unbalanced counsel that either addresses issues of faith/obedience/disobedience exclusively (the domain of the heart) or addresses bodily issues exclusively. To avoid these extremes we must ask, "What are the potential body (brain)-based influences/pressures and what are the potential heart (worship) issues in someone struggling with OCD?"[11]

Potential Brain Based Influences

Familial and genetic studies of OCD have shown a higher incidence rate among identical twins rather than fraternal twins, suggesting that some predisposition to obsessional behavior might be inherited.[12] While no definite conclusions can be drawn, it should at least put on our radar screens the possibility that a person is born with certain bodily predispositions to struggle in this manner. Right away, that possibility should increase our level of compassion. After all, how many times have we observed the suffering in another person's life and asked ourselves the question, "How would *I* respond if faced with that particular life provocation?" Exactly!

In addition, the world wide influenza epidemic of the early 1900's provided some of the first evidence that obsessive-compulsive symptoms might be mediated by specific regions of the brain. Some patients developed not only Parkinson's like symptoms (muscle tremors, slowed movement), but also psychiatric symptoms including obsessive-compulsive behaviors. Autopsies showed damage in the basal ganglia, a set of structures deep within the brain.[13] OCD has also been described to occur following head trauma.

One of the more compelling reasons to grapple with the biological or bodily factors that may influence the development of OCD is the sudden onset of OCD behaviors in children associated with a strep throat. Treatment with antibiotics not only resolves the strep throat but also usually terminates the OCD behaviors as well.

These examples suggest that perhaps there are subtypes of OCD that are more biologically weighted and we must take that possibility into consideration, just as we would acknowledge that there are certain medical conditions that can precipitate depression, such as a low functioning thyroid.

In addition, "live action" brain scans such as PET scans or functional MRIs show the functional neuroanatomy in OCD. There seems to be an over-activity in the basal ganglia and frontal regions of the brain of a person struggling with OCD compared to a normal person. This hyperactivity in the brain decreases with treatment.[14]

Many researchers hypothesize that the neurotransmitter serotonin is involved in OCD. This hypothesis has been both generated and supported by the use of medications such as Zoloft[15] for OCD symptoms. While altered neurochemicals (serotonin and others) may indeed be part of the "bodily pressure" in OCD, there is no current way to prove this as "the ultimate cause." Why? Because of the unity of the heart and body there will always be at the very least, biological *correlation:* a visible, measurable (more or less) connection between the spirit and the body. The brain scans reveal this correlation, but they cannot confirm body → behavior causation (i.e. that changes in the brain are the cause of obsessive thinking and ritualistic compulsions.) While altered neurochemicals and neuroanatomic circuitry might predate and pressure us to respond in certain ways, it is equally possible that the state of our hearts—our thoughts and beliefs about God, ourselves, and the world around us—may

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11 Because of space considerations, I am not going to address in any depth interpersonal influences (e.g. the role of family upbringing) or societal-cultural influences, both of which may impact the development of this struggle, and are worth exploring in order for our counsel to be biblically robust as possible.

12 American Psychiatric Association, *The American Psychiatric Textbook of Psychiatry,* 3rd ed. (Washington, DC: American Psychiatric Press), p. 603.

13 The basal ganglia mediate several phenomena including movement, cognition, and emotion.

14 Interestingly, the changes occur whether or not treatment is with medication or counseling.

15 Zoloft is part of a family of medications called "selective serotonin reuptake inhibitors" (SSRIs), which are hypothesized to affect the levels of serotonin in different regions of the brain.

influence and change the levels of neurochemicals in our brains.[16]

Current (secular) psychiatric thought sees the body/brain as the final common pathway for the disordered thinking and behavior that comprise the diagnostic criteria for OCD. Because psychiatry's anthropology is monistic—we consist of one material substance—the cause of the person's dysfunction must ultimately be assigned to body/brain. In other words, disordered neural circuitry in the brain is the culprit in OCD, even if it is acknowledged that the environment plays a role in modifying what happens at the level of neurons.[17]

Potential Heart Issues

While it is important to consider the potential bodily pressures in this struggle (and at the very least the bodily correlations with the heart), it is absolutely critical to address the potential underlying dynamics of the heart that could lead to the experience of OCD. Did you ever wonder why someone struggles with anxiety in a more general way whereas someone else might struggle with OCD? Why is the former person's anxiety "reality-based" (e.g., worries about losing a job, caring for an elderly parent, etc.) and why is the latter person's anxiety less "reality-based" (e.g., worries that I might pick up my infant son and throw him through the window)? And why does the latter person respond to this anxiety with ritualistic, compulsive behavior? In part, the answer to that question can be traced to the motivational dynamics of the human heart. We are purposeful creatures made in the image of our God and are not merely robots responding to neurochemical events in our brains. We want, we desire, we hope, we yearn, we fear, we believe, we trust. Therefore, it is imperative to examine the spiritual dynamic behind OCD if such a person is to have hope for real and lasting change. As helpful as bodily symptom reduction is, the ultimate goal is a person who is forsaking the sinful inclinations of his/her heart, is embracing the transforming hope of the gospel, and who is growing in tangible ways to love God and others.

Having said this, what are some potential spiritual (heart) issues that may generate this struggle? Remember, not every person will have all of the following, but this overview should help to identify some the major motivational themes in OCD.

- **Need for Certainty.** One of the major themes in OCD is the need for certainty. Other ways

It is absolutely critical to address the potential underlying dynamics of the heart that could lead to the experience of OCD.

[16] Although secular models assume primary biological causation, one of the most successful secular treatments for OCD (a cognitive-behavioral model) is based upon the reverse assumption; i.e., I can change the pattern of my brain chemistries by first changing my thinking. Jeffrey Schwartz's book *Brain Lock* is representative of this popular approach. While a cognitive-behavioral model rightly sees the need for change at the level of thoughts and behavior, it does not do justice to the more fundamental God-ward aspect of our lives, which is the very wellspring of those thoughts and behaviors.

[17] Current thinking in psychiatry is trying to create a synthesis between "nature vs. nurture." A recent proposal that attempts to combine the social and biological determinants of behavior is provided by Eric Kandel, "A New Intellectual Framework for Psychiatry," *American Journal of Psychiatry* 155, no. 4 (April 1998), 457-469. Kandel proposes the following: (1) "All mental processes, even the most complex psychological processes, derive from operations of the brain." (2) "Genes and their protein products are important determinants of the pattern of interconnections between neurons in the brain and the details of their functioning." (3) "Altered genes do not, by themselves, explain all the variance of a given major mental illness. Social or developmental factors also contribute very importantly." (4) "Alterations in gene expression induced by learning give rise to changes in patterns of neuronal connections." (5) "Insofar as psychotherapy or counseling is effective and produces long-term changes in behavior, it presumably does so through learning, by producing changes in gene expression that alter the strength of synaptic connections and structural changes that alter the anatomical pattern of interconnections between nerve cells of the brain." At the end of the day, however, Kandel is saying that nature and nurture *both* find their final common pathway biologically. This kind of "soft" biological determinism is also espoused by Peter Kramer in his influential book, *Listening to Prozac.*

of describing this might be an inability to live with uncertainty, the need for total assurance, the quest for exhaustive and certain knowledge. OCD has been described as "the doubting disease." People with OCD characteristically "doubt" what they see with their own eyes is true. And so, there is an attempt to control the environment (e.g., the checking ritual) in order to erase doubt and to be certain.

- **Demand for Control or Mastery.** Thus, the need for certainty is allied with the demand for control or mastery. Ironically, their attempt to control their anxiety "bites back." They are mastered by their own struggle to gain certainty and control. For some, this standard of absolute certainty brings doubts about their salvation and even undermines their ability to speak (e.g., "How do I know that what I just said was accurate and true? Better to keep silent than to risk saying something that is not absolutely, certainly true"). And so, these strugglers live in a Humean nightmare[18], having no absolute grounding for truth.
- **Need for Order.** Another facet of this demand for certainty or control may be a perceived need for order. This is not merely a preference for neatness but a demand for exactness, order, and symmetry, which catapults them into a never-ending organizing and arranging of their world. There's something about order that communicates, "All is well."
- **Expectation of Perfection.** A related and common theme is the expectation of perfection. Other ways of describing this would be the desire to be or do things "just right," the fear of being wrong, or perhaps a "fear of unrighteousness."[19] The focus here is on the "works" orientation, the pressure to do everything "right." This particular heart dynamic may be especially active with regard to people who struggle with aggressive or horrific impulses. They cannot deal with the fact that this thought entered their mind. "How could I think such a thing? Could I really do it? It's outrageous to think I could do such a thing. But what if I did?…" This hypersensitivity and the ensuing guilt and anxiety lead to a self-oriented mad scramble to overcome and neutralize the thought by some compensatory thought or behavior (the compulsion). "I can make things right; I can pay for this sin by doing this ritual, etc." OCD has an "it's all up to me" mentality, but the problem is, the performance (whether it be checking or ordering or whatever ritualistic behavior occurs) is never enough. There is always yet another hoop to jump through. In a sense, the compulsions are tangible "works." There is the false belief that "If I just do this one thing, my conscience will be clear and my anxiety will leave." Somehow, it seems "safer" to live by a self-imposed ritual than to face the disturbing thought head-on.
- **Guilt.** The issue of perfectionism is closely tied to another common theme in OCD, namely guilt. When I speak of guilt, I am mainly referring to the obsessions that center on the fear of doing (or having done) something horrifically bad. Some secular OCD experts think a critical factor in the development of obsessions is "an inflated sense of personal responsibility, a deep-seated, automatic tendency to feel accountable for anything bad that might happen."[20] But is this real guilt for real sin or is it guilt arising from *potential* sin? Is it not the latter?
- **Self-atonement.** But their *experience* of guilt is real and it moves them into self-atonement. In a sense, one aspect of OCD involves people trying to atone for their own (imagined) sins through their "neutralizing" compulsions. What follows is a cycle of self-righteousness and despair. The neutralizing effect of the completed compulsion lasts only for a short while (the self-righteous phase). This is replaced by a renewed obsession and its attendant anxiety and self-loathing (despair). The compulsion ("sacrifice") is made to atone

[18] The empiricist philosopher David Hume believed that the only knowledge we could gain about our world comes through our senses. Ultimately, however, this leads to a radical skepticism about the possibility of true certainty because his approach cannot explain what lies behind our sensory experiences to give them coherent meaning.

[19] Interestingly, one pastoral counselor has described OCD as a "phobia about sin." Robert Collie, *Journal of Pastoral Care* 51, no. 3, (Fall 1997), p. 294.

[20] Ian Osborn, *Tormenting Thoughts and Secret Rituals* (New York: Dell Publishing, 1998), p. 59.

for their obsession ("sin"). It is really a cultic, ritualistic system that they are creating, which bypasses the final sacrifice of Christ, and therefore, can offer no lasting hope.

- **Fear of Man.** Finally, one other dynamic often resident in the heart of an OCD struggler is fear of man. "What will others think?" is often a refrain that plays in their minds. This can be expressed as excessive ruminations about conversations and replaying personal interactions over and over again. Sometimes the fear of making a mistake before the eyes of others (related to preceding theme of perfectionism) will lead to increasing tentativeness in making decisions, answering questions, offering opinions. Once again, this ironically backfires, and their desire to "do right" before others leads to a self-focus that ends up disregarding the needs and concerns of others.

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Ministry Approach for OCD

1. Remember Your Biblical Anthropology

OCD, as with all psychiatric problems (really, as with all human problems!), sits at the intersection of the physical and spiritual.[21] Therefore, as I noted above, we must be sensitive to both aspects of our personhood in order to have a balanced approach. As body-spirit duplexes, the Scriptures address us as *both* sufferers and sinners. If there is indeed a biological "cause" (in the sense of applying pressure to the inner man), remember that there is always a spiritual receptivity or an active conscience in a believer. At the same time we must do justice to the bodily context if we are to minister the whole gospel to the whole person.[22]

2. Enter into Their Struggle

Make sure that you have engaged with their story. If you don't, your words, however wise, will not strike a chord. It may be helpful to remember your own transient experiences with obsessions/compulsions. Doing so serves two purposes: It may give you window, however small, into the force of their struggle. And it can be a part of "normalizing the abnormal," that is, giving them hope that their struggle is not an isolated, unintelligible, and shameful experience.

3. Identify and Address Heart Issues Biblically

First, remember that not all doubt is sin! It is certainly not sinful to have the mere thought, "Have I locked the door?" and to respond by checking it. In fact, doing so may be an expression of a godly desire to protect family and property. The issue is more clearly a sinful struggle when that desire to be certain becomes a screaming, demanding tyrant that erupts in anxiety and disrupts the God-ward and others-centered focus that the Scriptures would have for us.

Similarly, the transient experience of a

[21] Edward T. Welch, *Blame it on the Brain?* (Phillipsburg, NJ: P & R, 1998), 107.

[22] Remember that even the Bible is God's redemptive truth contextualized to God's people in specific situations in space and time. Likewise biblical counselors must seek to be fully aware of the situational (bodily, interpersonal, societal-cultural) factors that bear upon a counselee's life if we are to minister truthfully and compassionately. This article focuses on the intersection of the physical influences and heart to "parse" the experience of OCD, but it is critical to understand the broader situational context of someone who manifests obsessive thoughts and behaviors. For example, I want to take seriously potential interpersonal influences that might include controlling, perfectionistic parents; a legalistic church environment; the lack of close friends; or an employer who will not tolerate mistakes. And I want to consider the impact of potential societal-cultural influences including a society where success and performance are expected and rewarded, a post-9/11 general uneasiness regarding security and safety, a culture that sees no benefit to suffering, or a dominant naturalistic, materialist worldview that increasingly views problems of living in biological categories. While none of these influences (nor the multiplicity of other life circumstances we face everyday) make someone "do" OCD, they may contribute in some way to the struggle. This requires biblical counselors to really know the person who sits beside them, in order to most compassionately, truthfully, and creatively contextualize the richness of the Gospel to their lives.

graphic image or impulse may not be sin in and of itself. It may well be *temptation to sin.* How many of us have had such fleeting irrational thoughts, only to lay them aside without further reflection? What I do with that thought is more heart-revealing. Do I nurse and cherish it with pleasure? Do I respond, as in OCD, with displeasure, anxiety, fear, and dread, and engage in a ritualistic, cleansing protocol? These deeper dynamics are the target in OCD.

Realize that the following heart (spiritual) categories are not exhaustive and that there is much overlap between them. In addition some of these heart issues are more clearly associated with one kind of obsession or compulsion and so that what is helpful for one person may be less relevant for another.

- **Need for Certainty.** In one sense, the struggle with OCD raises some valid questions: What *is* the ground of my certainty? How *can* I trust my senses? How *can* I make a decision to act and then rest in that decision? How *can* I be sure of *anything?*

Part of the problem in OCD is the "self-contained" nature of the struggle. My internal logic and reason, even my actual sensory experience, seemingly cannot convince me to ignore my emotion (anxiety) as irrational. Ultimately, the grounding of certainty, of what is true, does not lie within; it comes to us from the outside, from our triune God as He reveals Himself in the Scriptures. Truth, assurance, and certainty are grounded in a covenant-making, promise keeping God. And God's promises are not "naked." They come clothed in the form of a person, the Redeemer, Jesus Christ. "For no matter how many promises God has made, they are 'Yes' in Christ…" (2 Cor. 1:20).

This is much more than a cognitive battle; it's a battle of trust. Do I *trust* that God has revealed enough that I can live with what might be called "faithful" or "functional" certainty (which is not the same thing as possessing 100% exhaustive knowledge)? Or, will I continue to insist the grounding of certainty lies within me, in *my* "seeing?"

This is the problem with assurance issues, particularly assurance of salvation. The solution is not to marshal evidence in my favor (i.e. to build faith in my anemic faith) but to gaze long and hard at the person and character of Christ on whom my faith ultimately rests. It's not the strength of my faith that counts but rather, the One to whom my faith is directed.

If my faith is directed toward Jesus then I am able to act, even if I still have some small measure of doubt. I don't need to be 100% certain to act in faith. Reliance upon Jesus helps to conquer remaining doubt, just as it did for the father whose son Jesus healed (see Mark 9:14-32, especially 9:24).

In reality, even the OCD sufferer lives with "functional certainty" in most areas of his life. I recently asked a counselee struggling with incapacitating doubt why he was able to come into my office and sit down in the chair without a second thought. His response was, "I just knew the chair would hold me." In other words, he implicitly *trusted the character* of the chair without having to check its structure to be sure.

It is a similar trust in the person, character, and work of God that must inform and break the obsession-compulsion connection. In the midst of rising doubt and anxiety, I must relinquish the quest for "certainty" (fueled by the attitude that "seeing is believing"), choosing instead to trust God's oversight of my life (see below). It will bring great struggle in the moment to walk away from the compulsion to check to be sure, but with each resistance fueled by a realization of the multifaceted character and care of God, the drive for certainty becomes less. Similarly, if my doubt is manifested as an unwillingness to answer questions until I can come up with a "100% accurate and truthful answer," I must choose to speak out of love for

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the other person anyhow, believing that God's Spirit is in the process of ever-conforming my thinking to His own and being content that I won't have perfect knowledge of myself in this life.

- **Demand for Control/Mastery.** If the craving for certainty and the inability to live with doubt underlie much obsessional thinking, a quest for control, primarily to quell rising anxiety, manifests itself in compulsive behaviors. And so, to control my anxiety I seek to control/manipulate my environment: "If I bolt and rebolt the door three times, *then* I can be certain." But "shrinking" my world to a manageable area—checking the lock, cleaning the sink, reciting a ritualized prayer—does not calm/control my fear for long. Mastery exists for but a moment. And just as once-snuffed trick birthday candles erupt in flame again and again, so the anxiety returns because the extinguishing power of God's real and loving care is not apprehended in the moment. Freedom begins to come as the OCD sufferer gives up the need to control his anxiety and his world and casts himself upon the grace and providential care of God.

  Psalm 139 is a helpful place to turn because it reminds us of God's complete knowledge of us and His detailed oversight of our lives. It reminds us of the "guardrails of God's providence."[23] Consider the following verses:

  > You know when I sit and when I rise; you perceive my thoughts from afar. You discern my going out and my lying down; you are familiar with all my ways. Before a word is on my tongue you know it completely O Lord. You hem me in—behind and before; you have laid your hand upon me. (v. 2-5)
  >
  > If I rise on the wings of the dawn, if I settle on the far side of the sea, even there your hand will guide me, your right hand will hold me fast. (v. 9-10).
  >
  > All the days ordained for me were written in your book before one of them came to be (v. 16).

  How does the psalmist respond to this realization? "Such knowledge is too wonderful for me" (v. 6). "Your works are wonderful, I know that full well" (v. 14). "How precious to me are your thoughts, O God!" (v.17) Although the psalmist recognizes the complexity of God's world and His oversight, he is content to leave that ultimate control in the hands of his God. In fact, praise erupts! Ultimately I am safe in Him. Safety is not found in my own reasoning process or ritual. I am called to live responsibly before God, but I don't have *ultimate* responsibility or oversight of my life. Other psalms that address this theme include Psalms 104, 121, 127, and 131. Apprehending God's sovereign and loving care over the details of life—my life!!—quells the anxiety and fear that result from the humanly impossible task of mastering and controlling my world.

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- **Desire for a "Black and White" World.** This is closely related to the preceding two points, but needs some elaboration. OCD sufferers want to live in a "black and white" (all or nothing) world. Exhaustive knowledge, complete control, and being certain allow no room for ambiguity. Either I'm sure or I'm not; either I'm in control or I'm not; either I'm right or I'm not. Yet we must admit we live in a "gray" world: God reveals enough knowledge

[23] I am indebted to Jim Petty for the coining of this phrase in his book, *Step by Step,* (Phillipsburg, NJ: P & R, 1999), p. 76.

to live sanely before Him, but He doesn't give us full access to His mind (Cf. Job 38-41). God gives us the ability to choose freely and to act, but we are not able to know and master all the details of our world. God gives us direction in His Word, but many issues are not so clear-cut. This shows the importance of the biblical category of wisdom. It's "safer" to live in a black and white world, because it requires no trust! Trust and wisdom go hand in hand (as Job found out!)

- **Perfectionism, Guilt, and Self-atonement**

Differentiate actual sin from potential sin. For people struggling with OCD, potentiality equals actuality. They react to the "what if" potentiality as though they actually have committed the terrible act that came into their minds. On the one hand, someone with OCD may have an over scrupulous conscience. On the other hand, because the volume of their conscience has been turned up so loud on potential sins (e.g. yelling an obscenity during the sermon), their consciences become hardened to the ways in which they actually do transgress the law of God (e.g. ignoring wife and children in the midst of a complex counting ritual.) At the very least, they are confusing the temptation to sin from actually committing the sin.[24] More seriously, in responding to potential sin matters, they miss the "weightier matters of the law—justice, mercy and faithfulness" (Matt. 23:23-24.)

"*Cheer up, you're worse than you think.*" The fact of the matter is, apart from the sustaining grace of Christ, I am capable of atrocities far worse than have currently entered my mind. Why should I be so surprised by the content of a fleeting thought? Church planter and seminary professor Jack Miller coined the phrase, "Cheer up, you're worse than you think" to undermine the self-righteousness of someone who continues to wallow in their sin—in our case, potential sin—and refuses to grab hold of the righteousness of Christ.[25]

Lay hold of the remedy for real guilt from real sin. This ties the preceding two points together. Forgiveness is available for actual sins, not imagined sins. Christ didn't die for potential sinners; He died for actual sinners whose guilt could only be taken away by His atoning sacrifice. And his sacrifice is enough. His work is not mere temporary "neutralization" of potential evil; it was and is a once for all, permanent overturning and destruction of the worst evil imaginable. This is where the entire book of Hebrews (particularly chapters 8-10) can be immensely helpful for the OCD struggle. As you gaze at the multifaceted character and work of Jesus Christ—His finished work on the Cross, His ongoing high priestly intercession for His people, etc.—the need to self-atone or establish a self-righteousness will diminish.

Self-cleansing, either for the true guilt of real sin or the "false" guilt[26] of imagined sins (in OCD) is never enough. All your penance, all your regrets, all your anxieties, all your sacrifices and compensatory duties are not enough. Only the blood of Christ is enough. And it is that very sacrifice that can embolden you to step into the light to forsake the real

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[24] In fact, you could really argue that the horrific and aggressive impulses are not true temptations in the biblical understanding of the word. While it is true that they are thoughts that could only happen in a fallen context, they don't meet the description offered in James 1:13-15. The person struggling with OCD is *not* enticed by the horrific impulse; rather they are repulsed. The *true temptation* is "Will I trust the sufficiency of Christ's sacrifice for me or will I take action to atone for my own actions (wrongly perceived as sin)?

[25] The other side of the coin is that the mercies of God are far better than you think.

[26] By "false guilt" I don't mean the person does not have a real experience of guilt. I mean, rather, the guilt they feel related to the *content* of the obsession has no basis in reality.

sin: the self-absorption in which an OCD sufferer is caught. Jesus has kept all the important standards. He has done everything that needs to be done and has done it right. Any additional standard we impose saps the vitality from that "restful reality." Let that joyful reality break the need to act out a compulsion and you will find that the guilty grip of your obsession will loosen.

Live as a son/daughter and not as an orphan. The view of God that often accompanies someone struggling with OCD is that of a harsh taskmaster, a capricious deity whose demands are oppressive. A person with OCD often lives under a "film of displeasure." If you are a Christian, your identity is not that of an orphan ("It's all up to me; I can't trust anyone; I must control my life and destiny"). It is that of a son or daughter on whom the Father's favor rests. That brings freedom from the tyranny of performance and perfectionism in the moment.

Two additional comments are needed in regards to addressing these heart issues. First, the road to change with OCD is filled with potholes, ruts, and switchbacks. In other words, anticipate a bumpy country road kind of ride as you tackle these heart themes head on rather than a superhighway to success. Expect progress and regress in overcoming your obsessions and compulsions day to day. At the same time remember, with Luther, "We are not yet what we shall be but we are growing toward it." Never forget that He who has begun—and continues—a good work in you, will carry it on to completion (Phil. 1:6).

Secondly, change happens in a corporate context. Expect and solicit the help, counsel, and prayers of other believers as you do battle with entrenched obsessive/compulsive thoughts and behaviors. Often, those closest to OCD strugglers are frustrated because they have accommodated their friend or family member's obsessive-compulsive cycle in order to avoid the interpersonal conflict that might follow if they were to challenge those behaviors. And yet, mutually agreed upon limits (e.g. "I will only check the locks once for you") and encouragement-in-the-moment (e.g. "I realize that your anxiety is rising over this impulse you have, but let's pray together right now and ask God to give you a clear picture of His complete and faithful care of you") are building blocks in an approach for change that cannot be individualistic. We are indeed our brother's keeper (Gal. 6:1-2).

Identify and Address Potential Body Issues

Concurrent with tackling potential heart issues is the need to consider potential bodily issues. Certainly if a normal child suddenly develops obsessive-compulsive behaviors in conjunction with a sore throat, it would be wise to seek medical help immediately. If indeed a streptococcal infection is present, the antibiotics given will cure the infection while it should at the same time decrease or terminate the OCD behaviors.

But what about in the vast majority of OCD cases, where the onset of the struggle is often insidious and progressive? How much should the potential bodily influences impact our approach? Remember that the content of the obsession (and *perhaps* even its frequency) may not be sin in and of itself, but simply a bodily provocation.[27]

While affirming, as I did above, that the somatic aspect of our constitution (body/brain) is ultimately not the "cause" of sin, we must never underestimate the overwhelming tyranny of the bombarding thoughts these sufferers can face. To be sure, as the counselee addresses the underlying motivational dynamics of this struggle, symptoms (the frequency and severity of the obsessions and compulsions) should decrease.

Notice that for biologically oriented psychiatry, curing the symptom cures the problem. In other words, obsessive-compulsive thoughts and behaviors are thought to stem from a disordered brain as the ultimate cause. Treat the symptoms with medication *or* with cognitive-behavioral therapy (both of which are thought to work by their effect on the brain, both directly and indirectly, respectively) and you have attacked the underlying disorder. Both secular approaches may bring a measure of

[27] However, I believe the more one attempts to deal with the anxiety induced by the obsession in an unbiblical way, the more intrusive and persistent the obsession may become. In that situation, the frequency of the obsession becomes part of the heart dynamic.

symptom relief, sometimes substantial. But our ultimate goal as biblical counselors is more than symptom relief. When we carry out biblical counseling, we are assuming that as the counselee grapples, applies, and is transformed by biblical truth at the heart level, his/her "disordered" brain patterns *will also* change and symptom relief will occur. How could it be otherwise given our biblical anthropology?!

Having said this, there may be a time and place for targeting symptoms in and of themselves, particularly if the person's experience of his OCD is so severe that engagement with the counseling process is functionally prohibited. The decision to use medication is a wisdom issue and must be individualized for each counselee. Although there are biblical guidelines for making such a decision there is not a "one size fits all" approach.[28] We must beware of dichotomous thinking that would uphold *either* the relief of suffering (whether physical or mental) or the benefit of suffering as the "more" biblical. The Scriptures speak positively to both the relief of suffering and the endurance/benefit of suffering. If medication is used we must remember that it is relieving symptoms, nothing more, but nothing less. While that approach *may* be a wise adjunct in certain individuals with severe symptoms, we must never lose sight of the need to investigate the primary underlying heart dynamic that is invariably present in cases of OCD.

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Conclusion

Remember that although it is helpful, even necessary, to differentiate between spiritual issues and bodily weakness in order to wisely counsel, this will not always be easy. We have to acknowledge a certain sense of mystery that remains as we seek to do this task. Accordingly, we must set about this ministry with humility. At the end of the day, we must ask, have we approached the person struggling with OCD as both a sufferer and a sinner, speaking and incarnating the truth and hope of the Gospel in love?

This is by no means the "last word" on a biblical counseling approach to obsessive-compulsive thinking and behavior. I consider it an "early word" and hope that it will be helpful even now and will also initiate additional questions and discussion that will bring further clarity. After all, even our counseling approaches have a "progressive sanctification" aspect to them!

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[28] For a concise discussion of the issues to consider when thinking about medication see Edward T. Welch, *Blame It on the Brain,* (Phillipsburg, NJ: P & R, 1998), 108-109. Potential relief of symptoms with medication, (which is less reliable for OCD than for some other psychiatric problems), must be balanced with potential negative effects of being on medication.