

Can Christianity Cure
OBSESSIVE-
COMPULSIVE
DISORDER?

A Psychiatrist Explores
the Role of Faith in Treatment

IAN OSBORN, MD



Brazos Press
Grand Rapids, Michigan

Ian Osborn, MD,

Can Christianity Cure Obsessive-Compulsive Disorder?: A Psychiatrist Explores the Role of Faith in Treatment,
Brazos Press, a division of Baker Publishing Group, © 2008. Used by permission.

Introduction

There are four main ideas in this book, the fruits of my search for evidence of a Christian cure for obsessions and compulsions. They speak to a complicated relationship between obsessive-compulsive disorder and Christianity, a reciprocal relationship of sorts. Christian teachings can, it appears, both trigger OCD and cure it. The disorder itself, on the other hand, through its effect on certain believers, has played a hidden role in the shaping of Christian doctrine.

The most important idea is this: that three of the greatest luminaries in the history of the Christian religion—Martin Luther, John Bunyan, and Saint Thérèse of Lisieux—all appear to have suffered from severe cases of what is now called obsessive-compulsive disorder, and all found the same way to overcome it through centering their lives on a single magnificent Christian truth.

The psychological struggles of Luther, Bunyan, and Thérèse form the core of this book, chapters 3, 4, and 5. Providentially, these three individuals were not only religious geniuses, but also literary geniuses. Their stories are gripping. I hope that

Christians who suffer from obsessive-compulsive disorder—my primary audience—will find it reassuring to read them. I hope these readers will recognize that their symptoms are nothing to be ashamed of when they discover that obsessions and compulsions appear to have affected some of God’s favorite saints. Further, the reader who is tired from years of fighting obsessions and compulsions will find here the possibility of a cure based not on human effort, but rather on trust in God’s merciful love. Chapter 8 presents a summary and analysis of this cure. Chapter 9, perhaps of most practical help to the Christian with active OCD symptoms, suggests a hands-on approach to applying it.

The book’s second idea is that the cure arrived at by Luther, Bunyan, and Thérèse finds strong support in contemporary psychological research. Over the last three decades, psychologists have made immense strides in understanding obsessive-compulsive disorder. They have discovered certain attitudes and behaviors that make obsessional fears worse, and others that relieve them. Chapters 6, 7, and 8 summarize this modern understanding of OCD and its treatment and demonstrate that the cure of Luther, Bunyan, and Thérèse rests on therapeutic principles. It can even be viewed as a form of cognitive-behavioral therapy. These chapters may be especially useful to ministers, priests, and Christian counselors in the everyday conduct of therapy with OCD sufferers: offering direction in which Christian truths to emphasize, what to suggest that a patient pray for, and whether to encourage an individual to strongly reject an obviously sinful thought.

The third major idea, presented in chapter 2, is based on a broader historical observation. It seems clear from surviving evidence that an epidemic of clinical obsessive-compulsive disorder struck the West during that great flowering of individualism known as the Renaissance, and that it was in large part triggered by the emphasis placed on new Christian teachings that arose at that time. One of the lessons of this discovery

is that Christians must always be cautious in how they apply the truths of their faith. Psychiatry has been slow to recognize any link between culture and mental disorder. The onslaught of obsessive-compulsive disorder that occurred during the Renaissance speaks to connections not yet fully explored between radical cultural change, new psychological stresses, the development of new religious practices, and the occurrence of particular mental disorders.

The fourth main idea of the book is treated in the epilogue. Theologians agree that the greatness of Luther, Bunyan, and Thérèse rests on the fact that through their writings and teachings, they brought Christianity back to a foundational truth of our faith that is often neglected: We can put absolute trust in the mercy of God, if only we turn to him in faith. In psychological terms, Luther, Bunyan, and Thérèse were driven to embrace this truth by their tormenting obsessions and compulsions. Can it not be argued, then, that OCD is more than just a disorder? Indeed, it can serve as a catalyst for great accomplishments.

Religion and Psychotherapy

The majority of psychiatrists and psychologists practicing in the present day object to the use of religious beliefs as a means of furthering psychotherapy.¹ To them, religion and psychotherapy simply don't mix. Since mixing the two is exactly what this book advocates, it is important to take a minute to examine this bias.

Essentially, it began with Sigmund Freud, the most famous psychiatrist of the twentieth century and the first great psychotherapist. Freud's goal was to develop a psychological treatment for mental disorders that was firmly rooted in scientific principles. To this end, he developed his famous treatment, psychoanalysis, in which the psychoanalyst's task is to help his patient put emergent psychological conflicts into a fully

rational framework. To Freud, religious beliefs were merely fantasies, “wishful illusions.”² His dim view of religion reflected the rationalism of Enlightenment thought, which held that the function of the mind was to process sensory information, and make sense of it in such a way as to allow the events of the world to be more predictable. In other words, the healthy mind was supposed to function something in the manner of a scientist, producing testable theories that were based on observation. Religious and spiritual beliefs could be of no use to such a mind, since they deal with the unseen rather than the seen, and are not empirically provable.

Psychoanalysis dominated psychiatry in America and parts of Europe for half a century. Not surprisingly, it usually had the direct effect of “curing” people from their religious beliefs. As the noted analyst Otto Fenichel explained in 1941, “Repeatedly I have seen that with the analysis of the sexual anxieties and with the maturing of the personality, the attachment to religion has ended.”³

Though Freud’s influence waned in the second half of the twentieth century, newer forms of therapy continued to incorporate the idea that psychological problems could be cured only if the sufferer came to a more scientific understanding of them. As recently as 1983, Albert Ellis, perhaps the most influential psychotherapist since Freud, could write that “devout belief and religiosity distinctly contribute to and in some ways are equal to mental or emotional disturbance [while] unbelief, skepticism, and thoroughgoing atheism not only abet but are practically synonymous with mental health.”⁴ All unscientific hypotheses, according to Ellis, are harmful when adopted as strong personal beliefs. At least through the 1980s, psychiatrists and psychologists, most of whom were nonreligious themselves, widely believed that religious and spiritual beliefs were a cause of mental illness, but never a cure.

In the last decade of the twentieth century, a rapprochement of sorts finally began between psychiatry and religion. First,

two widely reported national studies concluded that attendance at the spiritually based program Alcoholics Anonymous was the single most important factor in recovery from alcoholism.⁵ Then, as researchers began to consider the role of religious belief more widely, more than a hundred studies reported rather convincing evidence that strong religious and spiritual beliefs are associated with a decreased incidence of a diverse group of problems ranging from depression and anxiety to violent outbursts and delinquency.⁶

The rationalist idea that the mind functions by gathering data to make the world predictable has also been questioned. In his 2001 book *Religion Explained*,⁷ Washington University's Pascal Boyer cites studies demonstrating that when presented with a choice between an explanation that makes an event more rationally understandable and an explanation that makes it less so, people just as frequently choose the latter. The mind seems to have no natural bias toward finding rational explanations, he concludes, and furthermore a person is no happier or more well adjusted when it does so. What is important to the mind, according to evolutionary psychologists such as Boyer, is what works in a Darwinian sense, what works to help people survive. Religious ideas may be what works best.

Not surprisingly, there has been a surge of public interest in spiritual methods of therapy. National newspaper and magazine articles describe the healing properties of New Age philosophies, meditation techniques, and traditional Eastern and Western religious practices. A small but growing number of therapists now incorporate religious and spiritual practices into more conventional therapy. A 1999 poll, for instance, indicated that 15 percent of psychiatrists are willing to engage their patients in prayer.⁸ Others incorporate the popular spiritual ideas advanced by New Age leaders such as Andrew Weil and Deepak Chopra.

One overarching problem, however, is that studies thus far have not pinpointed either how spiritual approaches work

to foster mental health or under what circumstances they should be used. One can be left with the impression that prayer, scripture reading, Buddhist meditation, yoga, and a raft of other approaches are equally therapeutic for anything that ails anybody.

This book deals in particulars. It describes how one specific foundational Christian belief can be used to treat one widespread psychiatric problem of the present day—obsessive-compulsive disorder—through its application within guidelines of modern cognitive-behavioral therapy. It also demonstrates how certain exaggerations and misinterpretations of basic Christian ideas can make obsessive-compulsive disorder worse.

What about religious individuals who are not Christian—can they make use of these insights? I believe they can, although this book does not cover that territory. The great monotheistic religions, including Judaism and Islam, all share a view of an all-powerful God in whom one can put complete trust. It is nothing but this capacity for trust that Luther, Bunyan, and Thérèse used to cure their OCD.

Christian Therapy and OCD

At first glance, obsessive-compulsive disorder might seem to be the least likely of all mental disorders to benefit from any sort of religious psychotherapy or counseling. Since rituals of various types (e.g., repeated prayers) play a prominent role in both religion and OCD, many psychiatrists and psychologists have assumed that encouraging obsessionals to be more religious could be dangerous. It would be like encouraging an alcoholic to spend more time in bars.

Freud argued this point strongly. He believed in an essential equivalence between religious rituals and clinical compulsions. Going further, the great psychoanalyst actually contended that religion was itself a form of obsessive-compulsive disorder. He

proposed that just as obsessions and compulsions represented the neurotic remnants of an individual's childhood conflicts, religious beliefs and rituals were the pathological vestiges of society's growing pains. Thus, he could ultimately conclude that the religious convictions of billions of people constituted one great "universal obsessional neurosis."⁹

Subsequent researchers, however, have failed to find any direct connection. Studies published in the *Journal of the American Academy of Child and Adolescent Psychiatry* in the 1980s, for instance, demonstrated that superstitious and religious behaviors are observed no more often in young OCD sufferers than in the general population; and, further, that how often a child performs normal rituals, such as the use of lucky numbers or certain bedtime stories, has no relationship to the development of clinical obsessions and compulsions. Noted researcher Judith Rapoport of the National Institute of Mental Health, reviewing research in this area, has concluded that the phenomena of clinical compulsions and religious rituals are "quite discontinuous."¹⁰

Although Freud was mistaken in suggesting an essential equivalence between religion and obsessive-compulsive disorder, he was correct in recognizing that religious teachings sometimes lead to the development of obsessions and compulsions. How does this happen? Cross-cultural studies reveal that the content of a person's obsessions depends on the society in which the person is raised. Reports from Israel, Saudi Arabia, and Bahrain reveal that in highly religious societies, obsessions most commonly involve religious concerns. In more secular cultures such as America and Western Europe, on the other hand, contamination obsessions are the type most commonly seen.

Experts now agree that clinical obsessions tend to deal with whatever ideas are potentially most fearful to an individual. Thus, obsessions of filth and contamination, so common among OCD sufferers in the present day, were relatively rare before the

germ theory of disease became accepted in the 1800s. We can say that religion is a cause of obsessive-compulsive disorder, but only in the limited sense that it is often the substrate for the disorder.

Defining Clinical OCD

Obsessive-compulsive disorder is a specific psychiatric syndrome that is narrowly defined. It is important to be clear about its exact definition, because the research cited in this book, as well as the tentative conclusions drawn about the role of religion in its cause and treatment, do not necessarily apply to other similar disorders.

In one sense, diagnosing the disorder is simple. It requires the presence of only two symptoms. In practical terms:

OCD is present when a person suffers from obsessions and compulsions, and they cause significant distress or disability.

The difficulty arises in recognizing these two symptoms. Unfortunately, the terms *obsession* and *compulsion* are somewhat confusing. They have come to be used popularly in such a loose manner that their original psychiatric meanings have been all but lost. The term *obsession*, for instance, is often employed for what is more accurately termed a preoccupation, such as a coach's "obsession" with winning. *Compulsion*, on the other hand, is used to indicate anything done to excess, like compulsively eating sweets. The two terms put together, "obsessive-compulsive," commonly describe an individual who is unusually perfectionistic, time-conscious, and nervously driven to succeed. None of these meanings, astonishingly, has much to do with clinical OCD.

The unique and distinct nature of clinical obsessions was recognized early on. In the nineteenth century, when psychiatry was first emerging as a medical specialty, the German

psychiatrist Karl Westphal provided an excellent definition that has not since been surpassed:

Obsessions are thoughts which come to the foreground of consciousness in spite of and contrary to the will of the patient, and which he is unable to suppress although he recognizes them as abnormal and not characteristic of himself.¹¹

The current, authoritative *Diagnostic and Statistical Manual of American Psychiatry* (DSM-IV-R, see Appendix A) provides a more lengthy but similar definition. Both Westphal and the manual stress four important qualities that set apart the ideas, images, and urges that are clinical obsessions from other kinds of thoughts.

Obsessions, first of all, are *intrusive* thoughts. They pop into the mind abruptly, interrupting the normal flow. They are also *recurrent*. They keep on coming back again and again, in exactly the same form. Obsessions are *unwanted*: they are gate-crashers, intruders in the night, and as a result, a person fights to get rid of them. Here, the clinical meaning of the term stays close to its Latin root, *obsidere*, meaning to besiege, as an army would attack a city for the purpose of forcing surrender. Lastly, obsessions are recognized as *inappropriate*. Given a chance to sit back and reflect for a minute, the individual just can't figure out why the tormenting thought would ever have occurred in the first place.

Clinical compulsions, the other half of the equation, are purely secondary phenomena, acts performed solely to put right a tormenting thought. An obsession strikes, anxiety mounts, and a repetitive act provides a temporary way out. For our purposes,

Compulsions are repetitive acts that are clearly excessive, performed solely in order to lessen the anxiety caused by an obsession.

Compulsions may be either physical behaviors, such as checking or asking for reassurance, or purely mental acts, such as

conjuring up a pleasant image or repeating a phrase over and over in one's mind. Unfortunately, all compulsions share one basic quality: although they provide short-term respite from obsessions, in the long run they only make obsessions worse. Obsessions, in turn, make compulsions worse. It becomes a vicious cycle.

Sir Aubrey Lewis, considered by many the greatest English psychiatrist of the twentieth century, observed in 1935 that most cases of obsessive-compulsive disorder involve one of four fearful themes: filth, harm, lust, or blasphemy.¹² In Western cultures, where filth is the most common theme, obsessions typically involve the idea that one's hands have become contaminated. Often there are accompanying distressing images of germs or dirt. Usually, the response to such obsessions is compulsive washing. Not uncommonly, reassurance about possible contamination is endlessly requested from family members and medical professionals.

Almost as common is the theme of violent harm, which covers a wide range of obsessions and compulsions. One individual suffers the vivid image of being injured in an assault and must check her door again and again to assure safety. Another person is struck by the idea of his house catching fire, so he runs through his house, checking to make sure that the furnace, stove, light switches, and appliances are all turned off. Another has the fear while driving her car that she may have unknowingly struck someone. She repeatedly turns around and checks to make sure there has been no accident.

Tormenting lustful or sexual thoughts are less frequently seen. In my practice as a student health psychiatrist, these often involve homosexuality—not authentic homosexual desires, but rather sudden, completely unwanted images occurring in people who have no actual homosexual inclinations.

The religious theme, studies suggest, is relatively uncommon today in Western cultures, occurring in less than 10 percent of cases. In my practice, however, I see them more frequently,

perhaps because I practice in a rural area where people tend to be very religious. Most commonly the patients I see suffer from either intrusive blasphemous statements, such as “f__ you, Jesus,” or the more general idea that one is simply displeasing God. Frequent among Protestants is the obsessional fear of having committed the unforgivable sin of blasphemy against the Spirit (Matt. 12:31). Among Catholics, a time-honored and still common obsessive thought is that one has failed to confess all one’s sins. The compulsions performed to ward off religious obsessions usually involve repeated prayers, Bible reading, and reassurance seeking. The middle chapters of this book will provide a plenitude of examples.

When I was in training, the overall incidence of obsessive-compulsive disorder was thought to be extremely low. The figure most commonly quoted was a minuscule one-twentieth of 1 percent of the adult population. What was not appreciated, however, was how adept OCD sufferers are at keeping their disorder hidden. In 1983, when the National Institutes of Health announced the findings of the first large-scale study on the incidence of mental health disorders in the U.S. population, the results took mental health professionals completely by surprise: OCD was found to occur in 1.9 to 3.3 percent of the population.¹³ The experts had been off by more than 4,000 percent in their estimate of the incidence of this disorder.

Yet even that oft-quoted figure is probably too low. The criteria used for the diagnosis of obsessive-compulsive disorder in the 1983 survey, called the Diagnostic Interview Schedule, were very strict. Individuals were said to suffer from OCD only if they had taken medication or sought a physician’s help. More recent surveys that include all individuals who suffer significant distress as a result of obsessions and compulsions suggest a considerably higher incidence. A study from Zurich, Switzerland, for instance, concluded that 5.5 percent of people have suffered from such symptoms by age thirty. A reasonable estimate is that 5 to 10 percent of people suffer from at least

a mild case of obsessive-compulsive disorder at some time during their lives.

It is not generally appreciated that the overall incidence of specific psychiatric disorders varies throughout history. Cases of hysteria, such as the sudden onset of blindness for purely psychological reasons, were rather common in the 1800s and a favorite topic in the writings of Freud. We see them rarely now. Obsessive-compulsive disorder became an epidemic in the Renaissance, as will be explained in the next chapter. Here the reader will find that, at first glance, Freud's gloomy assessment of the relationship of Christianity and OCD appears to be borne out.

Renaissance Anxieties

The term *Renaissance* is used in a broad sense to describe the era in Western Europe between the years of 1300 and 1600, when medieval civilization gave way to modern ways of thinking. Literally, it means “new birth.” As noted by historian Basil Oldham, “The Renaissance marks a break in the world’s history such as cannot elsewhere be equaled.”¹ Among the new developments were unparalleled scientific and geographical discoveries, and revolutionary trends in literature, architecture, and the fine arts.

The greatest change of all, many believe, took place at a psychological level: in a person’s sense of self. The distinguished Renaissance expert Jacob Burckhardt wrote in 1860 that the central development of the era was “the emergence of individualism.”² Modern historians continue to echo this idea. Agnes Heller, writing in 1967, observes that the hallmark of the Renaissance was “an ever more individualistic outlook, sense of values, and way of behaving.”³ As a *New York Times Magazine* celebration of the “Me Millennium” phrased it:

A thousand years ago, when the earth was reassuringly flat and the universe revolved around it, the ordinary person had no last name, let alone any claim to individualism. The self was subordinated to church and king. Then came the Renaissance explosion of scientific discovery and humanist insight and, as both cause and effect, the rise of individual self-consciousness. All at once, it seemed, Man had replaced God at the center of earthly life.⁴

In the Middle Ages, people had felt incapable of influencing most of what mattered in their lives. The air was infested with spirits directing events. The stars and clouds were guided by angels. Lifelong roles were foreordained in heaven, assigned in childhood, and lived out in earth's stagnant feudal system in a sort of timeless blur. It was only with the rise of individualism that the average person—or, at least the average adult male—began to believe that he could determine his own destiny. As never before, new vistas opened for the individual.

There was also, however, a significant downside to this sense of empowerment. The new focus on the self introduced a new dimension of concern. The feeling of increased ability meant magnified responsibility. More opportunities to succeed meant more chances to flounder. The door was opened to a new plague of worries centered on the uncertainties of self-determination.

Renaissance Christians, it appears, seldom questioned the major tenets of their faith. For many, the concern that overshadowed all others was whether one would reside eventually in heaven or in hell. Yet the church in this revolutionary era sometimes proved a source of anxiety more than of consolation. The reason can be traced to the fact that official Christianity—that is, the Roman Catholic church—actively promoted the Renaissance ideal of self-determination and empowerment of the individual.

It has been argued, in fact, that the driving force behind the Renaissance was the church's scholastic movement, which put

a new emphasis on the importance of mankind's use of reason. Before that movement, people did not have to think much about their relationship with God; all church members in good standing could feel secure that they would live eternally in heaven after death. In scholasticism's wake, however, each Christian was expected to closely examine where he or she stood. The responsibility for attaining eternal life was placed to a greater degree than ever before on the shoulders of the individual. As historian Thomas Tentler observed in his 1977 book, *Sin and Confession on the Eve of the Reformation*,

The fundamental assumption became that the average Christian can know and weigh his sins, because the church teaches [that] rational man is free and responsible, and he can apply this teaching to his life.⁵

Early in the Renaissance, a new intellectual discipline arose in the Catholic church, its task was to clarify the nature and gravity of the sins for which a person should be held responsible. Moral theology came to assume a central role in the teachings of Catholicism, and as time passed, moral theologians put ever greater burdens on the faithful. While prior to the Renaissance there were only three sins that would inevitably cause a person to lose salvation (murder, adultery, and idolatry), by its end there were literally hundreds. In the area of sexual behavior alone, thirteen different types of sinful acts were defined and categorized, and the seriousness of each was further broken down according to the degree of genuine contrition that was felt by the sinner.

The assumption of personal responsibility for this whole range of new concerns ushered in the era of the guilty conscience. "The concentration on the individual [led to] a preoccupation with sin," notes historian John Mahoney. "As moral theology concerned itself increasingly with the darker side of human existence, it increased men's moral apprehension and sense of guilt."⁶

Modern Catholic writers fully recognize the church's excesses during this period. As noted by leading moral theologian Ladislav Orsy of Georgetown University, author of *The Evolving Church and the Sacrament of Penance*,

With the Renaissance came an inflation of mortal sins to an excess that today we recognize as absurd . . . the Christian conscience was invaded by an exaggerated theology of sin . . . hell became a greater menace for the Christian community than it ever was in the gospel. Damnation became a close threat hanging over the people.⁷

Epidemics of Psychopathies

Especially in the later stages of the era, the overburdened conscience of the Renaissance caused an onslaught of psychiatric illnesses. Psychiatrist Gregory Zilboorg in his widely cited textbook *History of Medical Psychology*, observes that “the number of the mentally ill reached alarming proportions” causing entire “epidemics of psychopathies.”⁸

One epidemic took the form of what we now label as anorexia nervosa, a psychiatric disorder manifested in a refusal to eat. In his popular 1985 book, *Holy Anorexia*,⁹ Rudolph Bell points out that self-starvation was commonplace among nuns in the Renaissance, and concludes that approximately half fasted to the detriment of their health. In some cases, at least, starvation appears to have been brought on primarily by overwhelming religious anxiety and guilt.

Major depression also appears to have become unusually widespread in the late Renaissance. This disorder is diagnosed when a person shows a severely depressed mood, a loss of interest and motivation, and withdraws from usual activities. In *Elizabethan Malady*, Lawrence Babb analyzes references to melancholy in diverse literary works, finding that while they are almost nonexistent in the early Renaissance, by the 1600s

they are a principal theme in prose, drama, and biography. Babb concludes that the late Renaissance was characterized by “an epidemic of melancholy.” The poet John Donne, who offered sonnets to the “Holy Sadness of the Soul,” provided a vivid description of this malady, which he himself knew well: “God has seen fit to give us the dregs of misery, an extraordinary sadness, a predominant melancholy, a faintness of heart, a cheerlessness, a joylessness of spirit.”¹⁰

Two other epidemics of psychopathology sprang up in the Renaissance that shared close similarities. Both were characterized by tormenting anxiety. Both involved intrusive, tormenting thoughts that a person could not dismiss from the mind. Both involved senseless and repetitive acts performed to allay the anxiety that was caused by the tormenting thoughts. These two epidemics were viewed as separate problems by Renaissance observers, probably because they were presumed to have differing causes: one being traceable to the weakness of the individual, and the other to attacks from Satan. Present-day psychiatrists, however, have no difficulty recognizing the more severe forms of both as manifestations of one illness: obsessive-compulsive disorder.

Obsessing about Minor Sins: Scrupulosity

The word *scruple* is derived from the Latin *scrupulum*, meaning a tiny pebble. In the present day, “scrupulous” often connotes outstanding moral integrity. In past centuries, however, the meaning was different. In the Renaissance, a moral connotation took hold: a scruple was a minute concern that needlessly upset a delicate conscience. *Scrupulous* described certain people who were tortured by nagging feelings that they might have committed a sinful act. In more difficult cases, these individuals would be driven to compulsively seek reassurance from others that they had not actually sinned.

Historians of the Catholic church suggest that severe cases of scruples were relatively rare before the thirteenth century.¹¹ By the end of the Renaissance, however, scrupulosity had become a virtual epidemic: mild cases were considered normal, and large numbers of guilt-ridden Christians suffered desperately. The advent of scrupulosity mirrored new developments in the Catholic rite of confession.

In this important sacrament, a believer confides his sins to a priest who, acting on behalf of God, absolves the sinner of responsibility. The priest typically prescribes a penance, an act of self-sacrifice such as a fast, that the individual must perform to atone for sins committed. Confession had always played a role in Christianity, providing a means of restoring individuals who had committed serious sins back into the body of the faithful. In the early centuries, however, confession was made openly, in public, and reserved for sins that seriously damaged the fabric of the community. In the seventh century, Irish monks introduced the practice of private confession and encouraged the revealing of lesser sins. Still, there was no formal obligation to confess, and most laypeople didn't, at least until their deathbed. This situation changed dramatically in the year 1215.

It was then, at the church's famous Fourth Lateran Council, that Pope Innocent III proclaimed that all Christians should confess their sins to a priest on a regular basis. In short order, confession was elevated from a legal matter between the individual and the church to a sacrament, or sacred rite. By the end of the thirteenth century, confession of sins was considered divinely instituted, obligatory, and necessary for the remission of sins.

The idea of regular confession was in line with the new ideals that stressed empowerment of the individual. The pope, reasonably enough, wanted to ensure that each person could avail himself or herself of the opportunity to receive forgiveness of sins. In the early centuries of regular confession, however,

the result proved disastrous for many. The reason for this was the way that confession was carried out.

Too often it turned into an outright interrogation—a search for sin even where none was apparent. The confessor, who was likened to a physician, needed to minutely explore the extent of disease in a person’s soul. He was to conduct a detailed inquiry into the nooks and shadows of an individual’s conscience. Surviving “penitential manuals,” handbooks instructing priests on how to carry out confession, provide a detailed description of the process. Usually, an inquiry into the presence of one of the seven deadly sins was the starting point.

One manual entitled “On the Confession of Masturbation” illustrates the audacious style of confession that was encouraged by some writers. When addressing a young, healthy man, the priest was to ask a series of specific questions about sexuality, such as: “Friend, do you remember when you were young, about ten or twelve years old, that your penis ever stood erect? Did you touch or rub your penis? For how long?”¹²

The goal of such confessions was to provoke an acute sense of fear over the possible loss of salvation. Indeed, William of Auvergne, author of a well-known thirteenth-century guide, wrote that in the conduct of confession there was “nothing to fear but the lack of fear.”¹³ As confession took shape primarily as an inquisition, many confessions, as noted by Tentler, “led to psychological and spiritual disaster.”¹⁴ People of tender conscience were driven to agonizing states of anxiety over minor sins that they may have committed.

An example of an individual who suffered briefly from severe scruples was Ignatius of Loyola (1495–1556), the towering Catholic saint who led the Counter-Reformation and founded the teaching order known as the Jesuits. Ignatius’s scruples began in his early thirties, immediately after he had abandoned a promising magisterial career, given up all his earthly possessions, and become a wandering monk. In his autobiography the saint describes the malady that overtook him.

Although I made confession, there still remained some things which I thought I had not confessed. After confessing, my scruples returned, each time becoming more minute, so that I became quite upset. Although I knew that these scruples were doing me much harm and that it would be good to be rid of them, I could not shake them off.¹⁵

Ignatius makes clear the misery, and even suicidal tendencies, that can result from a such a case. “No trial would have been too great for me to bear, if I thought there was any hope of finding help,” he writes, adding, “While these thoughts were tormenting me, I was frequently seized with the temptation to throw myself into a pit.”¹⁶

It is worth noting how Ignatius carefully analyzed his fearful thoughts. He divided scruples into two groups. “Common scruples” involved incorrect assumptions about church teachings that could be easily corrected. Ignatius provides this example: “I accidentally step on a cross made by straws, and form the erroneous judgment that I have sinned.” A second and more serious form of scruples was different. In these cases, the scruple had an alien quality. “The thought that I have sinned comes from without,” Ignatius writes. Furthermore, these more serious scruples were disturbingly repetitive, and frustratingly difficult to shake off. “I have the thought that I have sinned, while on the other hand, there is the thought that I have not sinned. In all this I feel disturbed.”¹⁷

In this insightful analysis Ignatius defined, perhaps for the first time in history, the core elements of what is called today a clinical obsession and differentiated an obsession from what we would call a common worry.

Horrible Thoughts of Blasphemy

The second epidemic of obsessional thoughts that occurred during the Renaissance took the form of blasphemous ideas,

urges, and images. While scruples entailed exaggerated fear over having committed a sin that others would recognize as minor, these blasphemous thoughts seemed so vile that no one would deny their wickedness. As with scruples, there were mild cases that caused little disruption of people's lives. Other cases, however, caused agonizing torment and provoked severe compulsions such as endlessly repeated prayers and acts of faith.

Occasional reports of monks who suffered from "abominable thoughts and words against God" date back to the early centuries of the church. In the seventh century Saint John Climacus described a monk who was cruelly tormented for twenty years by "horrible thoughts of blasphemy," which he rejected through the use of contrary acts such as "fasts, watchings, and great austerities."¹⁸ Such cases, however, were rare and seemingly confined to members of religious orders. In the Renaissance, the problem of horrible thoughts became a common malady.

Again, the shift appears traceable to changes in Catholic doctrine. In this case, the trigger appears to have been the judgment of moral theologians that entertaining a thought can be just as sinful as performing an act. Having the idea to stab another person, for example, could be as grave a sin as actually committing the crime. Moral theologians justified this conclusion by quoting from the Bible. On one occasion, for instance, Jesus stressed the harsh verdict that would fall on those who entertained thoughts of murder (Matt. 5:21). This interpretation, however, represented a radical departure from what had previously been taught. In earlier times only acts, and not thoughts, were matters for official church inquiry and discipline. When the church made the thinking of certain thoughts a mortal sin, it opened the door to a plague of obsessional fears.

Theologians wrote volumes on the criteria for distinguishing which thoughts were potentially sinful, as well as on the specific conditions under which the thinking of them actually constituted a sin. Basically, any thought against God or another person was a

cause for serious concern. The threshold of culpability, in theory, came to be whether a person consented to the thought's presence. A passing idea, in other words, was not necessarily a cause for alarm; but if an individual let certain thoughts remain in his or her mind, then he or she was guilty of a serious transgression. Renaissance Christians, therefore, were instructed to do everything in their power to immediately dismiss from their minds any thoughts of a potentially sinful nature. Thomas à Kempis's *Imitation of Christ*, next to the Bible the most popular Christian book of the Renaissance, reflects this counsel.

The enemy suggests many evil thoughts. . . . Say to him, "Away, unclean spirit! Shame miserable creature! You are but filth to bring such things to my ears! . . . I would rather die and suffer all torture than consent to you! Be still! Be silent!"¹⁹

If one assumes the Christian perspective of the age, this advice seems perfectly reasonable for most situations, such as when an individual has a genuine urge to hurt someone. In other instances, however, such advice can be catastrophic. Suppose a young mother becomes aware of a passing idea to stab her beloved child. It is now known that such strange and repugnant ideas are commonplace. Most people readily dismiss them as mental rubbish. To a Renaissance Christian of tender conscience, however, such a thought assumes an extreme significance. In view of the teachings of her church, she must fight the thought with all her might or risk losing eternal life. Unfortunately, the very fighting of the thought only makes it come back stronger. The result is that the thought becomes a clinical obsession, and the ensuing battle in the mind produces gut-wrenching agony.

An outstanding example of an individual affected by severe obsessional thoughts of this nature is that of the famous Renaissance nun Saint Jane de Chantal. Widowed and wealthy at twenty-nine, she fought off suitors and finally renounced her worldly position to become a full-time religious. A woman

of great intelligence and astonishing energy, over the course of her long life she founded her own religious order, the nuns known as The Visitation, and established more than eighty chapter-houses. Even as she was accomplishing many great deeds, however, she was hounded by obsessions. Jane writes,

My mind is sometimes, often indeed, a bewildering confusion of darkness, powerlessness, thoughts, rebellions, doubts, disapprovals, and endless miseries. When the evil is at its height no respite comes to me, and so inexpressible is the pain that I know not what I would not do to rid myself of it. . . . The torment is inexplicable, yet it does not interfere with my application to other things, nor hinder me from writing or transacting business.²⁰

Jane attempted to rid her mind of her torment by occupying herself with holy meditations. “I compel myself to make acts of union and of adoration,” she writes. Some of her holy acts undoubtedly represented what would now be termed clinical compulsions.

Her mental agonies never relented. “I don’t know what I would not do and suffer to be rid of this torture,” she writes at age sixty-five. Finally, Jane asked to be relieved as mother superior of her convent. “My soul is in such a miserable and wretched condition,” she explained to her sisters. “Should not I be in the hands of a good mother who will guide me in this state of moral abjection and of most painful blindness?” Her request to step down was rejected. Everyone agreed that, in spite of her tormenting anxieties, she was a marvelous mother superior.

How the Church Dealt with Scruples and Blasphemous Thoughts

In the case of scruples, priests quickly identified the epidemic on their hands: to their dismay, it was manifest openly in their

confessionals. The most esteemed French priest of the 1300s, Jean Gerson, to whom *Imitation of Christ* is sometimes attributed, described the problems created by the scrupulous, both for the individual confessing and for the priest confessor:

It is impossible for them to be sufficiently contrite for their sins. They always have a scruple that they have not yet properly confessed. They exhaust themselves and their confessors with repeated confessions, especially of light and unimportant sins.²¹

Sometimes, the scrupulous were treated with no compassion at all. According to the official teachings of the church, scrupulous confessing could be considered a spiritual vice, because it indicated a lack of confidence in both God and the priest hearing confession. Saint Antoninus of Florence advised confessors, “As to those who want to confess too often, assign a certain time to hear them; do not make yourself available to them for other conversations; and always use not soft but harsh and severe words with them.”²² It is not difficult to imagine the effect of such words on sensitive, overanxious Renaissance Christians.

Fortunately, it appears that most often priests did treat the scrupulous gently, recognizing that they were in the grips of a sickness rather than a vice. Gerson emphasized a compassionate approach. In confession, he suggested, the priest should attempt to remove the excessive guilt that people feel for their minor sins by reminding them that “God does not demand anything beyond man’s power.”²³ The fourteenth-century Dominican theologian Johannes von Dambach wrote with great wisdom that in the case of the scrupulous, the priest should always provide “simple mercy” and encourage the penitent to “hope trustingly in the Lord.”²⁴

Some priests, courageously, openly criticized the church for its extreme hairsplitting on the nature of sin. Von Dambach, for instance, complained, “If a scrupulous man were to confess all those things that have been written for confessions, he well

might need to keep a confessor in his purse!”²⁵ As time passed, compassionate treatment of the scrupulous became the rule.

The treatment of those people who suffered from blasphemous thoughts was different. Often it depended largely on whether the affected individual was a full-time religious (a priest or nun) or a lay parishioner. In the religious life, a person was expected to face severe spiritual trials. Saint Thomas Aquinas, the great thirteenth-century thinker who set the theological course of the Renaissance, declared that to become a priest or nun represented “a second baptism, a restoration of the sinner to a complete state of innocence.”²⁶ In order to achieve this new start, however, the individual had to undergo a furious battle with the powers of hell. It was generally acknowledged that those who were most dear to God were most tested. In the case of priests and nuns, therefore, horrible blasphemous thoughts were an expected attack by the devil. Monastics who suffered from blasphemous thoughts were most often treated with compassion.

The unfortunate laypeople who suffered from such thoughts, however, were usually not treated so sympathetically. Sometimes they were even accused of being witches. It is clear from both civil and church records that the presence of horrible thoughts was often taken as a sign of demonic possession. In a case recorded in Kent, England, in 1584, justice of the peace Reginald Scott writes of a woman brought before him on charges of witchery. Mrs. Davie, “a good wife,” admitted to having evil thoughts to harm her family. The prosecutors wanted her executed. Scott ruled, however, that “she hurt no one except, by her imagination, herself. . . . No one in his right wits would believe her.”²⁷ Many who suffered from horrible thoughts, however, were not so fortunate in those who judged them.

It was the latter part of the Renaissance that witnessed the height of Christian intolerance and bigotry. The Inquisition held absolute power, witch-hunting was commonplace, and

people accused of being satanic were often burned at the stake. In *Mystical Bedlam*, Michael MacDonald points out that “few of the people who thought they were possessed by the devil suffered from insanity or displayed spectacular symptoms. Most of them complained of anxiety, religious fears, and evil thoughts.”²⁸ There is no telling how many individuals with what we now recognize as OCD suffered terrible fates.

It is possible that these twin epidemics—of scruples and of horrible thoughts—represented history’s first widespread occurrence of obsessive-compulsive disorder. These epidemics also had a telling effect on the lives and contributions of a small group of highly influential individuals—people who changed the shape of Christian belief, even the course of history, in finding a specific Christian cure for their disorder.