Karl D. Lehman, M.D. Charlotte E.T. Lehman, M.Div.

Obsessive Compulsive Disorder (OCD) and Immanuel Approach Emotional Healing: General Comments and Frequently Asked Questions

I have gotten a steady stream of questions about obsessive compulsive disorder (OCD) over the past ten years, and I'm finally getting around to compiling my informal e-mail consultations into an essay. This essay summarizes some of my general thoughts, and also the answers to frequently asked questions. This essay is *not* a comprehensive discussion of obsessive compulsive disorder, but rather focuses on issues especially relevant to using the Immanuel Approach in the treatment of OCD.

Obsessive compulsive disorder involves *both* biological brain phenomena *and* non-physical mind/spirit phenomena: As discussed in detail in our "Mind and Brain: Separate but Integrated" essay, there are many different factors that can contribute to mental health problems, with some of these factors being primarily biological-brain phenomena, some of these factors involving an intimate interweaving of brain-biology and mind/spirit phenomena, and some of these factors being primarily mind/spirit phenomena. In my experience, ***every*** mental health problem I have ever encountered has involved a combination of *both* mind/spirit phenomena *and* biological-brain phenomena. Even in situations where mind/spirit issues are clearly the most important contributing factors, biological-brain factors, such as genetic predispositions, developmental effects on the biological brain, and environmental effects on the biological brain always contribute, *determining how the mind/spirit issues will be expressed* in the overall clinical pictures of specific mental illnesses. For example, a person might have traumatic experiences resulting in memory anchored lies along the lines of "I'm dirty, and my dirtiness makes me bad." One combination of genetic, developmental, and environmental biological brain factors will combine with these memory anchored lies to result in the overall clinical picture of depression, whereas a different combination of genetic, developmental, and environmental biological brain factors, *interacting with these same traumas and lies*, will result in the overall clinical picture of obsessive compulsive disorder.

My perception is that most (all?) cases of OCD are a combination of 1.) Genetic vulnerability, so that the persons brain is predisposed to respond to environmental stress, psychological trauma, and demonic oppression with the clinical picture of OCD; 2.) Psychological trauma; and 3.) Demonic spirits taking advantage of the first two, like bacteria infecting a wound, and exacerbating the whole picture.

Genetic predisposition to OCD: As also explained in "Mind and Brain: Separate but Integrated," there is a HUGE collection of data proving some degree of genetic contribution to most mental health problems. For OCD, this research includes case-control family pattern studies, studies comparing fraternal vs identical twins, studies comparing twins reared apart vs twins reared together, adoption studies, gene mapping association studies, and other molecular genetics research. One of the strongest studies – a twin study with more than 10,000 twin pairs – found that obsessive compulsive symptoms are influenced by both genetic factors

(approximately 55%) and unique environmental factors (approximately 45%).[1] Taken together, this research clearly indicates a genetic predisposition factor for obsessive compulsive disorder.[2]

Note that the evidence for genetic factors contributing to mental health problems is *NOT* just family patterns that could be explained by psychological and/or spiritual phenomena being passed down in families.[3] A thorough discussion of this research is beyond the scope of this essay, but I would like to briefly summarize an especially compelling and easy to understand component of the medical research provided by a specific kind of twin study. The results I would like to summarize here come from twin studies that work with sets of twins that have been reared together, and then compares the concordance rate in fraternal twins with the concordance rate in identical twins. The two key points in these studies are 1) both the fraternal and identical twins have shared very similar intrauterine and family environments; and 2) the identical twins have *exactly the same genetic blueprint*, whereas fraternal twins share genes in the same way siblings do. Under these conditions, if a particular illness is *completely genetic*, identical twins will be concordant (both twins either having the illness or not having the illness) *100%* of the time because their genes are *100%* identical, whereas fraternal twins will be concordant at the same percentage as *non-twin siblings* (50%). In contrast, if a particular illness is *completely the result of environmental factors*, there will be *no difference between identical twins and fraternal twins*. And if an illness is *partially genetic* and *partially environmental* – that is, there is a genetic predisposition/vulnerability, but some kind of environmental factor causes the underlying vulnerability to manifest as actual disease – then identical twins will be concordant at a greater percentage than fraternal twins, but at a percentage less than 100%. With OCD, Monozygotic (MZ) twins have been shown to have a concordance rate for OCD as high as 70% to 80%, compared with 22% to 47% among dizygotic (DZ) twins.[4]

To my assessment, this evidence proves that genetics-based biological brain factors *contribute* to obsessive compulsive disorder. To keep this in perspective, remember that *every* twin study

---

[1] Hudziak, J.J., et al. "Genetic and Environmental Contributions to the Child Behavioral Checklist Obsessive-Compulsive Scale." *Arch Gen Psychiatry*, Vol 61, June 2004, pp 608-616 (quote: pg 608).

[2] Hudziak, J.J., et al. "Genetic and Environmental Contributions to the Child Behavioral Checklist Obsessive-Compulsive Scale." *Arch Gen Psychiatry*, Vol 61, June 2004, pp 608-616 (quote: pg 609).

[3] A number of current books discuss this extensive evidence. See, for example, Mellon, Charles David. *The Genetic Basis of Abnormal Human Behavior*. (Genetics Heritage Press), 1997. Another good source is the introductory sections on genetics, and then the genetics section within the discussion of each mental illness in Kaplan, H.I., Kaplan, Virginia A. (Eds.) *Kaplan and Sadock's Comprehensive Textbook of Psychiatry, 8th edition*, (Baltimore, MD: Lippincott Williams & Wilkins), 2004. For a good general discussion of genetics and mental illnesses, and an understandable explanation of the different kinds of research examining genetic contribution to mental illnesses, see Faraone, Stephen V., Tsuang, Ming T., Tsuang, Debby W. *Genetics of Mental Disorders: A Guide for Students, Clinicians, and Researchers*. (New York, NY: Guilford Press), 1999.

[4] Inouye E. "Similar and dissimilar manifestations of obsessive-compulsive neurosis in monozygotic twins." *Am J Psychiatry.* 1965;21:1171-1175, and Carey G, Gottesman II. "Twin and family studies of anxiety, phobia, and obsessive-compulsive disorder." In: Klein D, Rabkin, J, eds. *Anxiety: New Research and Changing Concepts.* (New York, NY: Raven Press), 1981, 117-136, both as cited in Hudziak, J.J., et al. "Genetic and Environmental Contributions to the Child Behavioral Checklist Obsessive-Compulsive Scale." *Arch Gen Psychiatry*, Vol 61, June 2004, pp 608-616.

with OCD has also found identical twin concordance rates *less than 100%*, which proves that the obsessive compulsive disorder is not *completely* determined by genetic factors.

OCD biological brain abnormalities and a false dichotomy: Many rigorous research studies show that people with obsessive compulsive disorder have abnormalities in their biological brains – their SPECT scans are abnormal in a way that is consistent in those with OCD, and they have serotonin imbalances that are consistent in those with OCD. Furthermore, these abnormalities can be corrected with medication, *and the symptoms of OCD steadily decrease as the biological brain abnormalities are corrected*. These striking data points lead many to mistakenly conclude that if OCD is a medical illness, caused by brain chemistry imbalances, and effectively treated with medications that correct the brain chemistry imbalances, then it must not be a psychological problem, caused by traumatic memories, and corrected by therapy that resolves the psychological trauma. This mistaken conclusion is based on the logically erroneous *false dichotomy* that a mental illness must be *either* a medical illness, caused by brain chemistry abnormalities and treated with medications that correct the brain chemistry imbalances, *or* a psychological problem caused by traumatic memories and corrected by therapy that resolves the psychological trauma.

As discussed at length in the "Mind and Brain: Separate but Integrated" essay, carefully documented case studies and fascinating research demonstrate an amazing, intimate interaction between measurable biological problems in the physical brain and psychological problems in the non-physical mind. The very short summary is that psychological trauma appears to be able to cause clinical mental illnesses, such as major depression and OCD, *including the associated brain chemistry imbalances and abnormal SPECT scans*. Furthermore, carefully documented case studies demonstrate that resolving underlying psychological trauma consistently produces resolution of the associated mental illnesses, and fascinating research demonstrates that *the abnormal SPECT scans and brain chemistry imbalances associated with OCD also resolve as psychotherapy reduces the distorted thoughts and emotions associated with OCD*.

If you are having trouble with the "either medical illness caused by brain abnormalities or psychological problem caused by traumatic memories" false dichotomy, see the "Mind and Brain, Separate but Integrated" essay for a much more detailed discussion of this issue.[5]

Psychological trauma contribution to OCD: As discussed at length in "Mind and Brain: Separate but Integrated," psychological trauma is the primary contributing factor for many mental health problems, and my perception is that this is true for at least most cases of OCD. Genetic predisposition can make the person more vulnerable to trauma, and predispose him to develop the specific clinical picture of OCD in response to psychological trauma, but he will not develop OCD unless unresolved trauma provides an underlying root. Every case of OCD that I have seen personally has involved someone trying to avoid a specific package of unresolved traumatic implicit memory and the associated painful emotions. The immediate focus has always been triggers in the present that *appeared* to be the true cause of their unpleasant emotions, and they would engage in frantic obsessions and compulsions in attempts to avoid/manage the associated negative emotions; however, there has always been underlying traumatic implicit memory that was the real source of the OCD. Note: to the person with OCD, it will usually (always?) *feel* overwhelmingly, compellingly, one-hundred percent true that their

[5] Also, note that we can fall into similar *false* dichotomies between medical vs spiritual and psychological vs spiritual.

painful emotions are being cause by the triggers in the present;[6] but if they can get past this tenacious illusion and work on the underlying trauma, they will be thrilled to discover that the same triggers in the present no longer cause trouble once the traumatic memories have been resolved.

As additional data, I will include an excerpt from a recent e-mail from Dr. Wilder regarding obsessive compulsive disorder:

> "Every case of OCD that I have seen personally involved someone who was avoiding a specific feeling that was triggered by implicit memory and current events. So, let us say that someone felt helpless because their mother has cancer. They can do nothing about the cancer so they do not think about it. However, when they think about getting sick from germs they feel helpless too but this they can do something about so they wash their hands. It is much easier to think about the "screen" issue of germs and then wash your hands than it is to think about the "trigger issue" of mother's cancer. So, when the feelings come up about being helpless with the loss of mother to cancer the mind goes instead to the easier problem that feels the same way, and begins thinking about germs and then washing hands.[7]

Spiritual harassment/oppression contributing to OCD: My observation is that, in at least some cases of OCD, demonic spirits take advantage of the psychological trauma and genetic vulnerability, and exacerbate the overall clinical picture. This is much like bacteria that take advantage of any place where your skin has been damaged. Usually your skin provides a very effective defense against bacterial infection, but when your skin gets injured, bacterial infect the wound and exacerbate the problem.

Obsessive compulsive disorder can be resolved with emotional healing: In the section on obsessive compulsive disorder and psychological trauma, above, I comment that every case of OCD in my personal clinical experience has been energized by underlying traumatic memories. The good news implication from this observation is that most (all?) cases of OCD can therefore be resolved with emotional healing – when the underlying traumatic memories that energize the problem are resolved, the tormenting obsessions and compulsions collapse! A colleague of ours, Dr. Ed Smith, has had especially good results with using Theophostic in the treatment of OCD. He has worked with people who had full blown, clinical obsessive compulsive disorder (my diagnosis, based on his detailed description), who have experienced complete, lasting resolution of their obsessive compulsive symptoms after only a handful of sessions. They found key traumatic memories, that exactly matched the negative thoughts and emotions associated with their OCD, and then experienced immediate and complete freedom when these traumatic memories were resolved.

Unfortunately, in my personal clinical experience working with OCD has been slow and difficult because the people had lots of resistance to going to the memories, but I still think most (all?) cases of OCD can be resolved if the underlying trauma is addressed. Furthermore, I have not

---

[6] For a detailed discussion of why we focus so tenaciously on triggers in the present, and why it feels so compellingly true that they are the true source and origin of painful thoughts and emotions that are really coming from underlying traumatic memories, see Karl D. Lehman, *Outsmarting Yourself: Catching Your Past Invading the Present, and What to Do about It* (Libertyville, IL: This Joy Books!, 2011), chapters one through five.

[7] E. James Wilder, personal e-mail correspondence, July 2011.

worked with OCD since developing the Immanuel approach; and my expectation is that the Immanuel approach emphasis on connecting with Jesus, from the very beginning of the session, will help with the fear and capacity problems that have been a big part of the difficulties in the OCD related sessions I have facilitated.

Obsessive compulsive disorder and psychiatric medication: Extensive research reveals that a variety of psychiatric medications can be effective in moderating the symptoms of obsessive-compulsive disorder. However, research also reveals that this management of symptoms with medication does not resolved the underlying issues. For example, a 1998 review of the literature on medication discontinuation found that for patients who respond to SSRI[8] treatment for OCD, up to 80% relapse when the medication is withdrawn.[9] My personal clinical experience with treatment of people with OCD is very consistent with this research – both that medications can help manage the symptoms, and that the symptoms eventually return when the medication is stopped, unless the underlying issues are resolved. Except that my experience is that 100% eventually relapse, if you wait long enough for them to encounter triggers that sufficiently reactivate the underlying issues.

As discussed in the "Mind and Brain: Separate but Integrated" essay, a very appropriate place for medication is to manage symptoms that would otherwise be disabling, so that the person can continue to function (e.g., care for his family, maintain employment) while he is working to resolve the underlying trauma. For additional discussion regarding the appropriate place for psychiatric medication in the treatment of obsessive compulsive disorder, see also "Depression & Immanuel Approach Emotional Healing: General Comments and Frequently Asked Questions." (Most of the principles discussed with respect to medication and depression will also apply to the use of medication for OCD.)

Many people who are considering the use of psychiatric medication for OCD ask, specifically, "Will medication help or hinder my emotional healing work?" This important question is discussed at length in "Depression & Immanuel Approach Emotional Healing: General Comments and Frequently Asked Questions," and, again, most of the principles discussed with respect to medication and depression will also apply to the use of medication for OCD.

Other treatment options, such as cognitive behavioral therapy (CBT) and exposure – response prevention (ERP): My assessment is that a combination of cognitive behavioral therapy and exposure – response prevention can be very good for symptom control, when the person is able to do it. It does *not* resolve the roots, but, as with appropriate medication, it can be very helpful in managing symptoms that would otherwise be disabling, and this can enable the person to continue functioning while he does the emotional healing work to address the underlying issues.

Also, I have read case studies of people who were using CBT/ERP for symptom control, but as they used CBT/ERP to dismantle their OCD thoughts and behavior, they discovered that the OCD thoughts and behavior were part of psychological defenses that were covering underlying trauma. So CBT/ERP can actually be part of the overall emotional healing plan. As the person

---

[8] SSRIs, or selective serotonin re-uptake inhibitors, are a family of medications that include Prozac, Zoloft, Paxil, and Lexapro.

[9] Ravizza L, Maina G, Bogetto F, Albert U, Barzega G, Bellino S. "Long-term treatment of obsessive-compulsive disorder." *CNS Drugs.* 1998; 10:247-255.

uses CBT/ERP to dismantle the OCD defense system, the underlying memories will come forward, and this can certainly be helpful as part of finding and resolving the traumatic memory roots.

Some people have trouble with being able to use exposure and response prevention, due to unbearable negative emotions. My perception with respect to these situations is that the underlying memories start to come forward as the person begins to use exposure and response prevention,[10] and the person stops because he is unable to handle the increasingly intense negative thoughts and emotions.

There are a number of good books that present exposure and response prevention as an intervention that can be used as a self help tool by lay persons. From what I understand, research indicates that many lay people have been able to use these tools as a valuable part of symptom management. See, for example, Edna B. Foa, *Stop Obsessing: How to Overcome Obsessions and Compulsions*, (New York, NY: Bantam Books) 1991; and Baer, Lee. *Getting Control: Overcoming Your Obsessions and Compulsions*, (New York, NY: Penguin Books) 1992. (I'm sure there are also more recent books, but these are the two I am most familiar with.)

Miscellaneous thoughts:

Looking for "the answer": A sneaky part of OCD is that the person often perceives that there is information that will resolve the problem – if they can just find the right explanation/answer, it will finally settle their obsessive doubts and fears. And they focus their energy on looking and looking and looking for this answer. I have never seen this work, and perceive that it's actually part of the OCD. The only way I have ever seen people resolve OCD is with emotional healing work to address the underlying trauma.

Intense focus on details of the session: Focusing on the specifics of the session can often be part of the OCD defenses. For example, the person receiving ministry may be intensely bothered by the ticking of the clock, by the particular pattern of lighting in the office, or by noise from outside the office, and feel that these problems need to be addressed "so that I can concentrate." Sometimes these external stimuli are specific triggers that are stirring up underlying memories, but they can also be used as distractions and/or ways to avoid/decrease emotional intensity. They can sometimes lead to important information if followed. Have the person focus on the problem/concern/complaint, but do not "fix" it. This will help the emotional intensity increase and/or lead directly to a specific clue.

[10] Note that the intense negative emotions and thoughts from the memory usually come forward before memory for the actual autobiographical story, and the person often stops before he recognizes that the emotions and thoughts he is experiencing are from memory.