

The Relationship Between Obsessive-Compulsive Disorder and Religious Faith: Clinical Characteristics and Implications for Treatment

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This paper explores the relationship between religion and obsessive–compulsive disorder (OCD), with particular interest in religion’s possible influence in the development of OCD and its impact on treatment outcome. The paper begins with a review of theoretical and research literatures concerning religious involvement, research evidence linking religious involvement and physical and mental health, and theoretical linkages supporting both positive and negative religious effects on health. Following this, we provide a general overview and description of OCD and information concerning the prevalence and incidence of religiously based OCD. Next, extant research linking religion and OCD is presented. Information relevant to the clinical treatment of OCD with religious content is discussed. Finally, practice implications for clinicians and clergy are provided.

Keywords: religious involvement, religion, spirituality, anxiety, obsessive–compulsive disorder (OCD)

Obsessive–compulsive disorder is a common mental disorder affecting approximately 1.6% of the U.S. population over their lifetime (Kessler, Berglund, Demler, Jin, Merikangas, & Walters, 2005). OCD is somewhat more common among women compared to men (Bland, Orn, & Newman, 1988). This condition is highly comorbid with other psychiatric disorders including major depression, other anxiety disorders, and tic disorders (Attullah, Eisen, & Rasmussen, 2000; Brown Campbell, Lehman,

Grisham, & Mancill, 2001; Mayerovitch et al., 2003; Sasson et al., 1997).

Obsessive–compulsive disorder is an anxiety disorder characterized by two major symptom clusters—obsessions and compulsions. Obsessions are distressing repetitive thoughts, ideas, or impulses that are outside of a person’s voluntary control (*DSM-IV*; American Psychiatric Association [APA], 2000). Common obsessions include: concerns about contamination; fears of harming oneself or others; thoughts of symmetry; somatic concerns; and religious intrusions (Foa, Kozak, Goodman, Hollander, Jenike, & Rasmussen, 1995). Compulsions are defined as repetitive behaviors or mental acts that are performed according to certain rules or in a stereotyped fashion (APA, 2000). Common compulsions include: excessive checking; cleaning and washing; repeating; and mental compulsions (Foa et al., 1995). Sufferers often view their obsessions and compulsions as excessive or unreasonable, at least to some extent, yet they still report significant difficulty controlling the frequency and distress associated with their thoughts and behaviors (Foa et al., 1995). This condition is often chronic and waxes and wanes over an individual’s lifetime (Hollingsworth, Tanguay, Grossman, & Pabst, 1980). Obsessive–compulsive disorder is also associated

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with significant impairment in social and occupational functioning (Andrews, Henderson, & Hall, 2001; Calvocoressi et al., 1995; Leon, Porter, & Weissman, 1995). Common OCD symptoms related to religion include intrusive blasphemous thoughts related to religious themes, compulsive prayer, hypermorality, touching and repeating rituals, repetitive reassurance seeking, and cleaning/washing rituals. The majority of the rituals associated with OCD related to religious content (ROCD) are aimed at atoning for sinful thoughts or actions.

The purpose of this paper is to consider the possible linkages between OCD and religious involvement. Our goal is to examine OCD within the broad context of religion and to understand the ways that OCD may be manifested in this particular domain of experience. The following sections of the paper examine available research linking religion and OCD and discussion of information relevant to the clinical treatment of ROCD. Finally, practice implications for clinicians and clergy are provided.

ROCD

Table 1 presents a summary of studies on the effects of religion and religiosity on OCD.

Denominational Affiliation

There has been considerable interest in the relationship between religious practice and OCD. Much of the early interest in this topic was concerned with whether specific religious or devotional practices are associated with disproportionate of OCD (Steketee, Quay, & White, 1991) and, given this, whether ROCD was prominent within certain denominational groups. Ritualistic practices (e.g., touching, repetitive prayer) common in the Catholic faith, have been hypothesized to be associated with increased rates of OCD among vulnerable persons (Higgins, Pollard, & Merkel, 1992). The available data examining the association between OCD and Catholicism is somewhat mixed with certain clinical studies finding no selective association between the Catholic faith and OCD (Steketee et al., 1991) and others finding a trend favoring Catholicism among outpatients with OCD compared to other diagnoses (Higgins et al., 1992). Perhaps the most definitive study on the topic involved the Epi-

demologic Catchment Area survey (Koenig, Ford, George, Blazer, & Meador, 1993). This study failed to find an association between Catholicism (or any other specific denomination) and OCD. We found interesting that a recent study found that Protestant OCD patients were higher in intrusive negative religious thoughts than patients with no religious affiliation (Nelson, Abramowitz, Whiteside, & Deacon, 2006).

Other religious denominations have been hypothesized in several cross-cultural studies to be particularly associated with ROCD compared to other OCD symptoms. Okasha and colleagues (Okasha, Saad, Khalil, el Dawla, & Hehia, 1994) found that Egyptian and Israeli OCD patients were more likely to report ROCD compared to persons from India and England. The authors speculate that the differential rate of ROCD is likely related to Moslem cultural standards of cleanliness, ritual purity, and sexual prohibition. Other investigators have also found high rates of religious obsessions among persons with OCD who live in predominately Moslem countries compared OCD sufferers in the United states and Western Europe (Tek & Ulug, 2001). Other research has found higher rates of OCD symptoms related to religion among practicing Moslems compared to practicing Christians (Yorulmaz, Gençöz, & Woody, 2009).

Religious Intensity

Beyond denomination, the relationship between the degree of religiosity and obsessive-compulsive symptoms has been examined in several studies. Studies involving clinical samples of OCD patients have found that those with higher levels of religiosity are at increased risk of meeting criteria for OCD (Koenig et al., 1993), having more severe OCD symptoms (Steketee et al., 1991), and endorsing OCD symptoms related to religion (Steketee et al., 1991; Nelson et al., 2006). Higher rates of religious conflict have also been found among OCD sufferers compared to persons with other psychiatric disorders (Higgins et al., 1992). Consistent with this research, two studies found that ultraorthodox Israelis were more likely to endorse OCD symptoms related to religion compared to those who were not ultraorthodox (Greenberg & Witztum, 1994; Greenberg & Shefler, 2002).

Table 1
Summary of Studies on the Effects of Religion and Religiosity on OCD

Author(s)	N	Religion	Diagnostic criteria	OCD measures	Results
Abramowitz et al. (2004)	1005	Protestant (74.8%), Catholic (16.7%), Atheist (8.5%)	—	OBQ, OCI-R	Obsessional symptoms, washing rituals, and OCD-related cognitions were positively correlated with religiosity among Protestant students.
Abramowitz et al. (2002)	197	Jewish (21.3%), Catholic (28.4%), Protestant (20.8%), other (29.5%)	—	MOCI	Scrupulosity was moderately correlated with religiosity. Highly religious Protestants scored higher than less religious participants on the Fear of Sin subscale of the PIOS. Highly religious participants scored higher on the Fear of God subscale of the PIOS than less religious participants; Catholics and Protestants scored higher than Jews and participants of other religions on the Fear of God subscale.
Assarian et al. (2006)	293	—	DSM-IV	Y-BOCS	There was no relationship between religious attitudes and occurrence of OCD.
Greenberg & Shefner (2002)	28	Ultra-orthodox Jew (100%)	ICD-10	—	Patients exhibited three times more religious OCD symptoms than nonreligious symptoms.
Greenberg & Wiztium (1994)	34	Ultra-orthodox Jew (56%), non-ultra-orthodox Jew (44%)	DSM III-R	—	Ultra-orthodox Jews were more likely to present with religious OCD symptoms than non-ultra-orthodox Jews. Most ultra-orthodox Jewish patients had nonreligious OC symptomatology although secular values were not highly regarded by this group.
Hermesh et al. (2003)	66	Jewish (100%)	DSM III-R	Y-BOCS	There was no correlation between religiosity and OCD, religiosity and severity of OCD, and religiosity and presence of religious obsessions (among OCD patients).
Higgins et al. (1992)	451	Catholic (44%), Protestant (36%), Jewish (7%), other (6%)	DSM III-R	DSM III-R	Catholicism was the most common religious affiliation among OCD patients. Higher percentage of OCD patients reported religious conflict than panic disorder and nonanxiety psychiatric patients. (<i>table continues</i>)

Table 1 (continued)

Author(s)	N	Religion	Diagnostic criteria	OCD measures	Results
Koenig et al. (1993)	2969	Pentecostal (4.2%), Conservative Protestant (59%), Mainline Protestant (28%), Catholic (2.7%), other (1.9%), nondenominational (4.3%)	DSM-III	DSM-III	Catholics and other denominations did not differ from each other in rate of OCD. OCD was more common among younger adults who said religion was very important to them, compared with those whom it was only somewhat or not at all important.
Lewis (1994)	139	Christian (100%)	—	S-HOI	Religiosity was positively correlated with obsessional traits.
Lewis & Maltby (1995)	Study 1: 267 Study 2: 167	Christian (100%) Christian (100%)	—	S-HOI S-HOI	A positive attitude towards religion was positively correlated with obsessional personality trait in females only.
Nelson et al. (2006)	71	Catholic (26.8%), Protestant (45.1%), Jewish (4.2%), other religious affiliation (9.7%), other (4.2%)	—	Y-BOCS, OCI-R, PIOS, TAFS, III	Frequency of personal prayer was positively associated with obsessional symptoms for males. Frequency of church attendance, personal prayer, and personal Bible reading were positively associated with obsessional personality traits in females. Protestant patients were higher in scrupulosity than patients with no religious affiliations. Scrupulosity was not related to strength of religious devotion.
Okasha, Saad, Khalil, el Dawla, & Hehbia (1994)	90	Muslim, Christian, Jewish, Hindu	ICD-10	Y-BOCS	Egyptian and Israeli OCD patients were more likely to have religious obsessions, compared to Indian and British OCD patients.
Raphael et al. (1996)	148	Christian, Catholic, Jewish, Muslim, Hindu, Buddhist, other/no religion	DSM III-R	—	A larger proportion of the OCD patients had religious affiliations than the control group.
Sica et al. (2002)	165	Catholic (100%)	—	OBQ, III, PI	Religiosity was positively correlated with obsessional and obsessive-compulsive cognitions.
Steketee et al. (1991)	57	Catholic (58.1%), Protestant (17.5%), Jewish (15.8%), other/no religion (8.6%)	DSM III-R	MOCI, CAC, Y-BOCC	Religiosity was positively correlated with OCD symptoms. OCD patients with religious obsessions were more religious than those who did not report religious obsessions.

Table 1 (continued)

Author(s)	N	Religion	Diagnostic criteria	OCD measures	Results
Tek & Ulug (2001)	45	—	DSM-IV	Y-BOCS, Y-BOCC, MOCI	Patients with religious obsessions were younger than patients without them. High rates of religious obsessions among persons with OCD were found in many Middle Eastern (predominately Moslem) countries compared to rates observed in the United States and Western Europe. Religiosity was not correlated with religious obsessions or compulsions.
Yorulmaz et al. (2009)	219	Muslim (53%), Christian (47%)	—	III, OBQ, TCQ, TAFS, WSBI, PI-WSUR	Muslim sample reported more OCD cognitions and were higher in OCD symptoms than Christian sample. Highly religious people reported more OCD cognitions than low religiosity people.
Zohar et al. (2005)	Study 1: 256	Jewish (100%): secular (62%), traditional (16%), orthodox (14%), ultra-orthodox (8%)	—	MOCI, OTQ	No relationship between religiosity and obsessive-compulsive behavior. People who became more religious were higher on OC measures than those who became less religious.
	Study 2: 61	Jewish (100%): secular (41.1%), traditional (9.8%), orthodox (34.4%), ultra-orthodox (14.8%)	—	MOCI	People who became more religious were higher in OC behavior than those who became less religious.

Note. OBQ, Obsessive Beliefs Questionnaire; OCI-R, Obsessive-Compulsive Inventory-Revised; MOCI, Maudsley Obsessional-Compulsive Inventory; DSM-IV, Diagnostic and Statistical Manual of Mental Disorders, 4th ed.; Y-BOCS, Yale-Brown Obsessive-Compulsive Scale; ICD-10, International Classification of Diseases, 10th ed.; DSM III-R, Diagnostic and Statistical Manual of Mental Disorders, 3rd ed, revised version; DSM III, Diagnostic and Statistical Manual of Mental Disorders, 3rd ed.; S-HOI, Sandler-Hazari Obsessional Inventory; PHOS, Penn Inventory of Scrupulosity; TAFS, Thought-Action Fusion Scale; III, Interpretation of Intrusions Inventory; PI, Padua Inventory; CAC, Compulsive Activity Checklist; Y-BOCC, Yale-Brown Obsessive-Compulsive Checklist; TCQ, Thought Control Questionnaire; WSBI, White Bear Suppression Inventory; PI-WSUR, Padua Inventory-Washington State University Revision; OTQ, Obsessive Thought Checklist.

Similar associations between religiosity and obsessiveness have also been found in nonclinical samples. Lewis and Maltby (1995) found that higher levels of religiosity were associated with higher obsessiveness scores among female adults from the United Kingdom. Males were not found to have a positive association between religiosity and obsessive symptoms. Abramowitz and colleagues (Abramowitz, Huppert, Cohen, Tolin, & Cahill, 2002) also found that highly devout Catholic and Protestant college students reported higher levels of OCD symptoms compared to those with reduced levels of religiosity. However, the association between degree of religiosity and increased OCD symptoms was not found among Jewish students. The degree of religiosity was also found to be a significant predictor of increased obsessions and washing rituals among highly devout Protestant college students compared to moderately religious Protestant and Agnostic/Atheist students (Abramowitz, Deacon, Woods, & Tolin, 2004). Moreover, religiosity was found to be positively correlated with obsessional traits among U.K. college students (Lewis, 1994). Finally, Yorulmaz and colleagues (Yorulmaz et al., 2009) recently found that highly religious people tended to report more OCD cognitions compared to people who were less religious.

The above research notwithstanding, a limited number of studies of religion and OCD exist where high levels religiosity were not associated with increased risk of religious obsessions or compulsions. A nonsignificant relationship between the degree of religiosity and the severity of OCD symptoms has been observed in samples of Israeli Jews (Hermesh, Masser-Kavitzky, & Gross-Isseroff, 2003), American Protestants (Nelson et al., 2006), Turkish Moslems (Tek & Ulug, 2001), and Iranian schoolchildren (Assarian, Biqam, & Asqarnejad, 2006). Although these divergent findings may be attributable in part to measurement and other methodological differences, this research indicates that the relationship between the degree of religiosity and obsessive-compulsive symptoms is a complex one that is open to further cross-cultural study. The complexity in this relationship is highlighted by recent findings indicating that individuals who became more religious over time experienced increased OCD symptoms compared to those

who became less religious (Zohar, Goldman, Calamary, & Mashiah, 2005).

Religious Beliefs

The nature of specific religious beliefs and their relationship to OCD has also been investigated. Raphael, Rani, Bale, and Drummond (1996) found that a larger proportion of OCD patients in their clinical study were religiously affiliated than the non-OCD control group. In contrast, other research suggests that OCD patients were no more likely to be religious than persons with other anxiety disorders or individuals without mental health problems (Hermesh et al., 2003). Nevertheless, Abramowitz and colleagues (Abramowitz et al., 2004) reported that highly devout Protestants were more likely to endorse certain OCD-related cognitions including the belief that thoughts are very important, that they need to be controlled, and that they are responsible for their thoughts. Similarly, Sica and colleagues (Sica, Novara, & Sanvivo, 2002) found that highly religious persons were more likely to report an association between OCD symptoms and high ratings of the importance of thoughts and the need to control thoughts, further suggesting that religious beliefs may influence the nature of OCD symptoms. Clinical impressions suggest that holding the belief that one is responsible for sinful thoughts can lead to efforts to suppress or control one's thinking. Thought suppression, although likely effective in redirecting thinking for many individuals, increases the frequency and intensity of obsessional thinking for persons with OCD (Tolin, Abramowitz, Prezeworski, & Foa, 2002). Additionally, thoughts that are considered to be especially alien to one's true beliefs are particularly likely to intensify obsessions among persons with OCD (Langlois, Freeston, & Ladouceur, 2000).

It is important to note, however, that an association between increased religiosity and certain obsessions and compulsions does not necessarily indicate that being highly devout *leads* to the development of certain OCD symptoms or increased overall OCD symptomatology. Certainly, many persons with OCD may become more devout in response to their OCD symptoms, which might explain, in part, the association between high levels of religiosity and certain obsessive-compulsive problems.

The temporal relationship between high levels of religiosity and ROCD symptoms is of significant interest and ripe for further study.

ROCD Symptoms

Perhaps the most common and impairing OCD problem related to religion involves repetitive blasphemous thoughts which is referred to as scrupulosity or having the "scruples" (Greenberg, Witzum, & Pisante, 1987). Accounts of troubling, unwanted, and intrusive religious thoughts and accompanying compulsive behavior date back to the 16th century (Greenberg et al., 1987). Common themes for these ROCD obsessions include obscenities related to religious figures, thoughts of sexual activities involving a God or other religious entity, or thoughts about joining the devil or other similar figures. Most people who are religious likely occasionally experience similar blasphemous thoughts, are not distressed by them, and are able to redirect them quite easily (Purdon & Clarke, 1993). Clinical impressions suggest that some individuals with OCD also report limited distress associated with their initial blasphemous thoughts only to experience growing distress as their thoughts became more common and explicit. Others may experience severe distress when the thoughts first occur, at least in part because of the belief that having impure thoughts is sinful and that these negative religious thoughts must be controlled.

Specific codes of moral conduct are central features of many religious traditions. For some individuals with ROCD, following a code of moral conduct becomes the focus of their ROCD symptoms. Persons experiencing hypermorality often find themselves consumed with concerns that they may have unwittingly stolen something, said something that was not fully true, put others at risk of injury, or experienced unacceptable thoughts. Often, the focus of the concern is that the individual will be held accountable for these sins, possibly resulting in the loss of their salvation. These concerns commonly motivate sufferers to obsess about potential transgressions. Persons with this form of ROCD often compulsively check to see that they have not done something wrong (e.g., checking to see that they have not stolen something or made a mistake), treat others with the utmost respect and care, seek reassurance from

others to be sure that they have not committed a sin, and/or compulsively pray for forgiveness. As with most OCD subtypes, clinical impressions suggest that the majority of persons experiencing hypermorality have at least some degree of insight that their concerns are excessive or unreasonable yet they remain unable to control their obsessions and related compulsive behaviors.

Persons troubled with blasphemous thoughts and/or other morality concerns often turn to prayer as a route to cope. Clinical impressions suggest that individuals initially report being helped by prayers designed to confess and gain forgiveness from blasphemous intrusions and/or possible moral breaches. Unfortunately, many sufferers soon find that more and more prayer is required to obtain a sense of relief from their concerns. Activities devoted to prayer can involve repeating a prayer(s) until an acceptable number of repetitions is achieved, praying according to exacting standards or rules (e.g., particular cadence or pronunciation pattern), praying until the prayer is completed without intervening blasphemous thoughts, or any combination of these strategies. Individuals with this form of ROCD may often doubt whether they met their prayer standards, even when prayers are performed perfectly, which leads to even more compulsive praying. Additionally, some sufferers repeat their prayers to be certain that they said them sincerely with full focused attention.

Beyond compulsive prayer, some persons with ROCD find themselves consumed with the compulsive need to treat religious books or symbols with excessive care. Religious books, statues, jewelry, and images are sometimes the focus of ritualistic cleaning, straightening, and checking behaviors for persons with ROCD. These routines can last for several hours at a time and are often paired with ritualistic prayers.

When persons with ROCD find themselves unable to quiet the demands of their obsessions, they often begin to seek reassurance from others. Family members, friends, and especially clergy are often consulted in an attempt to soothe anxiety and reduce the need to perform compulsions. These consultations may begin with a simple request for reassurance that salvation has not been lost, but like other rituals, sufferers often require ever more frequent and

exacting reassurance in order to gain relief. For Catholics, many of these reassurance-seeking activities take place in the confessional booth. Over time, most family, friends, and clergy-members begin to question the utility of the repetitive reassurance seeking which introduces a dilemma about whether to continue to provide it. Adding to the dilemma, many persons with ROCD become quite insistent when those who once provided reassurance attempt to discontinue the practice. Often sufferers will plead, find ways to ask a question slightly differently, and/or angrily insist that the trusted person give in to their request. In these circumstances, personal and family relationships are often significantly impacted (Calvocoressi et al., 1995).

Persons with cleaning/washing rituals related to their religious beliefs also commonly experience significant impairment related to their ROCD. These compulsions often involve washing or rinsing to make up for sinful thoughts or actions. Persons with this problem typically report that their body or surfaces in their environment have become contaminated with sinful thoughts/behaviors and that these sins must be washed away. Occasionally, a simple rinse is all that is required but more often excessive washing and cleaning are needed to obtain relief. A second form of washing compulsion related to religion involves excessive attention to religious doctrine regarding cleanliness. Certain religions stress the importance of keeping certain body parts or surfaces especially clean (e.g., practice among certain religions to keep a particular hand clean which may make followers especially vulnerable to religiously motivated washing and cleaning routines). However, none of the faiths that emphasize cleanliness would encourage the extensive compulsive cleaning and washing rituals among their followers that is seen among ROCD sufferers.

Repeating rituals are also commonly associated with ROCD in which sufferers often feel compelled to repeat certain activities when they become associated with a blasphemous thought. Examples of this type of ROCD include getting up and down from a chair, going in and out of a door, or placing and replacing an object. In these cases, most individuals become concerned that the activity has been fouled by a negative religious thought and that this pairing constitutes a sin that needs to be addressed. This concern leads people to repeat the activity until

it is completed without a negative thought. Some sufferers feel compelled to perform several repetitions of the behavior without a negative thought in order to “make-up” for the bad thought. Repeating rituals can also be associated with religious thoughts that are positive in nature. Some persons report having thoughts of religious figures when performing certain behaviors that they believe should not be associated with religious thought. In these circumstances, sufferers may feel compelled to repeat an action such as sitting on the toilet over and over again until they are able to complete it without an accompanying positive religious thought.

Finally, several other possible compulsive behaviors which may relate to ROCD include collecting religious material, as well as touching, tapping, and rubbing compulsions making the number of potential treatment targets for ROCD considerably large.

It is important to note that although the current psychiatric nomenclature (*DSM-IV*; APA, 2000) classifies the above symptoms as examples of obsessive-compulsive or obsessive-compulsive personality disorders, recent theorists suggest that differences in symptom presentation, treatment response, and epidemiology from other forms of OCD may justify the development of a separate diagnostic scheme for scrupulosity (Miller & Hedges, 2008).

These important diagnostic considerations notwithstanding and even with the vast array of potential ROCD target symptoms, the evidenced-based treatments for OCD, namely medication and cognitive-behavioral therapy (CBT; APA, 2007), often yield significant improvement in ROCD symptoms and overall life functioning.

Clinical Treatment Implications

Medications

As with other forms of OCD, serotonin reuptake inhibiting medications (e.g., fluoxetine, sertraline, paroxetine, clomipramine) play an important role in the treatment of ROCD. Several placebo-controlled, double-blind studies of these medications have established their efficacy in the treatment of OCD in general (Abramowitz, 1997). Only one open medication trial of persons with moral or religious scrupu-

losity exists and results indicate significant improvement in eight of 10 subjects given fluoxetine and/or clomipramine (Fallon, Leibowitz, Hollander, & Schneier, 1990). This finding must be interpreted with caution, however, since the study did not involve a placebo control condition making it impossible to determine if the observed outcomes can be attributed to the effects of the medication.

The results of this open trial notwithstanding, it is important to note that some persons with OCD refuse medication, fail to improve with medication, experience limited improvement from selective serotonin receptor inhibitors, and/or experience unacceptable side effects. Given these drawbacks, psychosocial interventions also play an important role in the treatment of OCD. Cognitive-behavioral therapy is the best-tested psychosocial treatment and is recommended in expert consensus guidelines for OCD (APA2007).

Behavioral and Cognitive Therapies

Exposure and response prevention therapy. The primary psychosocial treatment of choice for OCD is CBT (APA, 2007). The central treatment components of CBT for OCD are exposure and response prevention (ERP). The first of these components, exposure therapy, involves real-life or imaginal contact with anxiety evoking stimuli. For example, persons with fears of dirt, germs, or contamination may be asked to handle contaminated surfaces (e.g., door handles, light switches, restroom surfaces) for prolonged periods of time. These exposure exercises for OCD are usually introduced in a graded fashion from easier to more difficult tasks. For example, contamination-related exposure exercises might begin with touching a remote corner of a seldomly touched wall followed by handling progressively more challenging surfaces (e.g., door handles, light switches, toilet surfaces).

Exposure exercises in ROCD often include repetitive exposure to the content of the person's blasphemous obsessive thoughts or religious uncertainties in addition to *in vivo* exposure to minor moral breaches (Abramowitz, 2001; Himle & Thyer, 1989). Exposure to the content of intrusive thoughts (blasphemous thoughts and/or religious uncertainties) can begin with the therapist and patient generating a

list of common blasphemous thoughts or composing a more detailed narrative of a more complex scenario involving negative religious images. No research is available to guide the clinician as to whether to use a list of challenging blasphemous phrases versus a detailed narrative but clinical impressions suggest that the decision can be informed by the nature of the obsessive thoughts. If the obsessions generally involve a group of common intrusive phrases, then conducting exposure to these phrases makes most sense. If the symptom presentation involves one or two detailed concerns, a comprehensive narrative is likely indicated.

Once a decision is made with respect to the type of exposure stimuli, the therapist would typically look for opportunities to make the statements or narrative more challenging. Increasing the difficulty of the naturally occurring obsessional material can be done in order to prepare for spontaneous worsening of the obsessional content during the course of exposure treatment. Even with this preparation, new obsessions typically do develop during a course of exposure therapy, especially at the beginning of treatment. When new obsessions occur, this material can be added to the exposure therapy program. It is important to note that the content of the intrusive religious obsessions are often very challenging with typical content including sexual thoughts related to religious figures, profanity, and thoughts of joining the devil or other similar entities.

Once the list of challenging thoughts (usually about 10–15 thoughts) or detailed narrative is drafted, an audiotape of the thoughts is dictated by the patient (see Himle & Thyer, 1989). The exposure audiotape is then rehearsed several times within the therapy session (typically 1 to 1.5 hours in duration). At the end of each session, homework assignments are given to listen to the audiotape for a similar length of time daily. Exposure exercises of this sort are typically conducted continuously in one sitting. In the author's clinic (J.A.H.), the exposure exercises are usually divided into three 20–30-minute segments within the exposure session with one segment devoted to listening to the audiotape, one segment reading the thoughts aloud, and one segment involving writing out the scenario or phrases over and over again (Himle & Thyer, 1989). Clinical impressions suggest that this method helps patients to attend

to their exposure exercises given that exclusive use of audiotapes can be monotonous, especially later in treatment. Additionally, patients sometimes report that reciting or writing the thoughts can be more challenging than listening to an audiotape.

A second typical exposure exercise in ROCD involves exposure to environmental stimuli that prompt religiously motivated compulsive rituals. The most common of these rituals is compulsive prayer. Although the majority of persons with ROCD perform compulsive prayer rituals triggered by internal stimuli (e.g., intrusive obsessional thoughts), many persons with ROCD also report compulsive prayer triggered by viewing bibles, crosses, churches, and other religious symbols. Conversely, some individuals with ROCD perform compulsive behaviors when they come in contact with stimuli that they judge as religiously inappropriate (e.g., adult book store, a sexually attractive person). Many persons with problems in this area begin to avoid these environmental stimuli in order to limit the frequency and intensity of their negative thoughts and associated need to perform compulsive rituals.

Exposure exercises aimed at these environmental stimuli typically involve placing stimuli in locations that would commonly be encountered in a person's daily routine (e.g., living room, bedroom, automobile, workplace, inside a wallet). Sufferers would be encouraged to look at these symbols throughout the day while attempting to avoid compulsive prayers or other behaviors designed to reduce anxiety. These stimuli are also commonly placed in view when persons with ROCD are undergoing exposure to the content of their negative intrusive thoughts as described above.

Handwashing and cleaning rituals related to ROCD are also treated with exposure therapy. As described above, individuals with this form of ROCD would be asked to handle progressively more challenging contaminated surfaces. As treatment progresses, patients might also be asked to recite negative religious thoughts while confronting various contaminants. It is important to note that washing and cleaning rituals among persons with ROCD may appear to be similar to other OCD patients with contamination obsessions. However, washing performed by persons with ROCD may be designed to

wash away sins rather than washing to avoid getting sick or passing germs to others.

Repeating rituals related to ROCD are also treated with exposure therapy. ROCD sufferers with repeating rituals would typically be asked to repetitively confront activities commonly associated with religiously motivated repeating behaviors (e.g., placing an item down, walking through a door, sitting on a chair) without engaging in neutralizing repeating behavior. For some, negative religious thoughts would also be recited while purposefully confronting these stimuli associated with religiously motivated repeating.

Persons with religiously motivated morality-based rituals are often given exposure assignments aimed at repetitively breaching moral standards. Exercises may include slightly damaging products in a store (e.g., squeezing a peach too firmly, creasing a page in a magazine), taking more than one free brochure, placing a coin shaped piece of metal in an offering plate or donation cup, slightly defacing a page of a religious book, saying something offensive, returning a product after using it slightly, seeking a replacement food in a restaurant after eating a portion of a well prepared food item, throwing out recyclable items, or looking at a pornographic picture. Clearly, there are nearly limitless possible exposure assignments for persons with morality concerns and considerable creativity is often needed in order to arrange exercises that activate anxiety and accompanying obsessions without stretching moral standards too far.

The central theory behind the utility of the exposure therapy posits that repetitive and prolonged exposure to fearful stimuli results in habituation to the conditioned stimuli and a resultant decline in distressing emotions (Marks, 1981; Rachman & Hodgson, 1980). The theory takes the position that prolonged exposure is crucial for habituation to occur. If a person with OCD confronts fearful stimuli but follows the confrontation with the immediate performance of anxiety reducing ritual, habituation cannot occur. Response prevention addresses this issue by encouraging patients to block or delay compulsive rituals after performing exposure exercises in order to allow the discomfort to eventually decline on its own. Exposure and response prevention exercises are

almost always performed in tandem for nearly every type of OCD.

The most common response prevention exercise for persons with ROCD involves blocking compulsive prayers after exposure to challenging religious thoughts or other anxiety triggering environmental stimuli. This goal can be a very challenging one for persons with ROCD since it often involves blocking a mental behavior, namely silent prayer. By definition, most persons with OCD often have substantial difficulty redirecting their thinking.

Clearly, the first step in blocking compulsive prayer involves asking the person with ROCD to avoid prayers for forgiveness and prayers aimed at reducing anxiety associated with exposure to challenging ROCD thoughts or environmental stimuli. Some patients can manage to delay, reduce, or eliminate compulsive prayer quite well, whereas many find it difficult to stop the mental act of prayer. In these cases, individuals are encouraged to modify their prayers in order to make them less effective in reducing anxiety. For example, a person who feels compelled to counter a religious obsession with compulsive prayers in attempt to inform God that they did not actually believe the thoughts, could be asked to modify their prayers to inform God that they did indeed believe the negative thoughts to be true.

Other typical response prevention exercises for persons with ROCD include delaying or eliminating compulsive touching, repeating, washing, and reassurance-seeking behaviors. For persons with morality obsessions, similar response prevention strategies can include blocking attempts to make up for purposeful ethical breaches (e.g., donating extra money, buying damaged products). With each of these varied ritual blocking goals, the best strategy is to attempt to block the ritual altogether as opposed to attempting to delay the ritual after exposure to challenging ROCD stimuli. However, it is clear that some people cannot eliminate their rituals after exposure to challenging stimuli. In these cases, the aim is to delay the ritual as long as possible in order to allow for habituation to occur. After delaying, it is advisable for the individual to modify the ritual to make it imperfect, less repetitious, and shorter in duration. It is also often best that these delayed rituals are immediately followed by an-

other exposure exercise such that further desensitization can occur.

Cognitive therapy. Although exposure and response prevention therapy is the cornerstone of most successful behavioral therapy programs for OCD, cognitive therapy can also be a helpful therapy for OCD (van Oppen et al., 1995; Cottraux et al., 2001; Abramowitz, Franklin, & Foa, 2002). Contemporary cognitive interventions for OCD focus attention on how obsession-related intrusive thoughts are appraised by the individual (Wilhelm & Steketee, 2006; Clark & Beck, 2010). With respect to religious intrusions, if the individual responds to a negative religious related thought by judging it to be ridiculous, nonsensical, and unimportant, they are likely to simply let it pass and go on about their daily business. Alternately, persons with ROCD are likely to respond to religious intrusion with concern and an accompanying desire to drive the thought away or neutralize it with a particular thought or action (Clark & Beck, 2010). The Obsessive Compulsive Cognitions Working Group (1997) has identified six important belief domains related to OCD that correspond to how an individual might respond to unwelcome, intrusive thought.

One important domain related to ROCD is "intolerance of uncertainty," wherein persons with ROCD often have high levels of distress associated with religious ambiguity including uncertainty about whether their prayers have been adequately performed, whether their sins will consign them to hell, and even whether there is a God. Most religious people occasionally consider these uncertainties but for people with ROCD, the uncertainty becomes difficult to tolerate. Often people with ROCD will respond to these uncertainties by compulsively reassuring themselves, seeking reassurance from others, or by trying to avoid thinking about religious ambiguity. Unfortunately, these attempts to neutralize or suppress obsessional concerns only serve to increase the intensity and frequency of the intrusions over time (Najmi, Reese, Fama, Beck, & Wegner, 2010).

A second belief domain with high relevance to ROCD is "overimportance of thoughts." Many persons with ROCD believe that one's thoughts are highly significant and meaningful. This can be especially challenging with religion-related intrusions in cases where individuals have been taught to believe that having

negative religious thoughts is sinful and if not responded to, may compromise one's standing with God. A third belief domain that relates to "overimportance of thoughts" is the "importance of controlling thoughts." People with ROCD who hold this belief exert themselves in an often futile attempt to keep intrusive negative religious thoughts at bay. People in this situation believe that if they were simply strong enough, or devout enough, they could succeed in purifying their thinking or otherwise controlling their intrusions. Persons with ROCD often believe that intrusive thoughts and associated negative events would escalate to unbearable proportions if they did not exert strong efforts to control their obsessional thinking. The drive to control obsessional thinking has been related to the concept of thought-action fusion wherein individuals with OCD often hold the belief that simply thinking of a dreaded event will increase its chances of occurring (Rachman, 1993). This concept comes into play strongly in ROCD when sufferers believe that if they are not successful in controlling certain thoughts (e.g., thoughts of joining the devil in hell, selling one's soul to the devil), the chances of these catastrophes increase.

"Inflated responsibility" is a fourth important belief domain that influences appraisal of intrusive thoughts of a religious nature. Individuals who strongly adhere to this belief are often concerned that if they do not respond to a given obsessional thought, any negative outcomes would be their responsibility. In ROCD, many individuals become concerned that if they do not suppress or somehow make up for an intrusion, something terrible will happen to a loved one, others, or in the world at large and that they would be at fault. Persons in this situation often feel a tremendous burden to attend to and respond to their ROCD-related thoughts.

A final centrally relevant belief domain related to ROCD is "overestimation of threat." Clearly, many people with ROCD believe the ultimate threat is that they will lose their eternal salvation if intrusive thoughts persist and/or if they are not fully successful in making up for them with various mental acts or behavioral countering measures.

Cognitive therapy offers several important strategies for addressing these belief domains. A cognitive therapist working with ROCD sufferer would be likely to begin with a normal-

ization effort that involves educating the patient that uncertainty, especially in the religious domain, is common. The cognitive therapist would then seek to educate the ROCD sufferer regarding the role of faulty appraisals in OCD. The therapist would then proceed to illustrate how neutralizing rituals (e.g., compulsive prayers, excessive reassurance seeking) and thought suppression efforts may initially relieve obsessional concerns but ultimately increase them over the long-term. Once this introduction is complete, the therapist would likely select from a series of cognitive strategies aimed at reducing fear and anxiety associated with religious obsessions.

One important cognitive strategy is referred to as cognitive restructuring. The core of this approach utilizes a Socratic dialogue approach wherein the therapist uses questions to examine the accuracy of the clients thinking (see Beck, 1995). Disputing questions such as "Is there another way of looking at that?", "What is the evidence for that?"; "Is there any evidence that goes against that belief?" are often used to assist the client in countering their irrational ROCD thoughts. The general approach is to create an atmosphere of "collaborative empiricism" wherein the therapist and the client work together as a team to examine the accuracy of the client's beliefs (Beck, 1995). In support of the Socratic dialogue technique, several other related strategies are used to address ROCD intrusions including the cost-benefit analysis (e.g., examining the costs and benefits of seeking certainty in religion-related life domains vs. attempting to gain full certainty), the pie-chart technique (i.e., evaluating the relative responsibility one might have for negative outcomes experienced by others), and the "courtroom" technique (see Wilhelm & Steketee, 2006) which involves using this metaphor to help patients evaluate the quality of the evidence related to a given belief. A central goal of these strategies is to reduce the sense that their religious obsessions are important and need to be attended to. The strategies are not designed to convince patients to abandon their religious concerns but instead to help ROCD sufferers feel less threatened by their religious intrusions.

A second important general cognitive strategy involves seeking an alternative explanation for their intrusions. The cognitive therapist may work to build a healthier, alternative, internal

script to explain their obsessions. Instead of accepting the thought that negative religious obsessions are signals from God that need to be avoided and neutralized, the therapist guides the client in adapting an alternative view that these thoughts are meaningless, unimportant, and common among most religious people. The aim with this approach is that patients will eventually just allow obsessive thoughts to be present in their mind and they will accept the strategy that seeking to control intrusions only increases them. Phrases such as "That is just an OCD thought, I am going to go about my business" can be helpful as sufferers attempt to treat intrusions as if they do not "count."

Response prevention also plays an important role in cognitive therapy for OCD. The primary goal of response prevention in cognitive therapy is not only to reduce and eventually eliminate compulsive rituals, but to also discontinue other more subtle neutralization strategies. For example, a person with ROCD who feels compelled to pray compulsively after an intrusive, blasphemous thought may also attempt other thought control strategies (e.g., forcing away the obsessive thought or seeking reassurance) which would also be targeted for reduction.

Behavioral experimentation, a final important cognitive therapy approach to OCD, also utilizes exposure and response prevention techniques. These behavioral experiments involve confronting obsessional triggers and preventing associated neutralizing behaviors as in traditional ERP treatment. However, in cognitive therapy, the primary goal is to build evidence to dispute faulty appraisals and beliefs related to OCD. For example, a patient with ROCD who believes that having a certain thought might cause a terrible event to occur would be asked to test out the validity of this belief by deliberately producing the intrusive thought while preventing any neutralizing behavior to see if terrible events actually occur. As a second example, behavioral experiments can be helpful for persons who believe that it is critical to exert all efforts to control their thinking. Experimenting with progressively longer exercises wherein the OCD sufferer suspends all efforts to block their intrusive thoughts often leads to a reduction in intrusions instead of the surge in thinking that most patients expect.

Cognitive therapy can also be a helpful method to increase motivation to engage in ex-

posure and response prevention therapy. Certain distorted thoughts such as: "God will be offended and punish me if I do not make-up for my blasphemous thoughts;" or "I must do my rituals or God will send me to hell;" may be particularly amenable to a Socratic approach. A Socratic dialogue between a therapist and a patient with ROCD experiencing these types of thoughts might progress as follows:

Patient: I am afraid to expose myself to my negative religious thoughts because God might get really offended.

Therapist: It sounds like you are concerned that God might not realize that you have OCD and will misinterpret your exposure exercises, is that right?

Patient: Yeah, I am worried that he will send me to hell for reciting all those bad thoughts about Jesus.

Therapist: Do you think that God is aware of what OCD is?

Patient: Sure, He knows everything.

Therapist: Do you think He is better than everyone when it comes to diagnosing an illness?

Patient: Yes, He is better than everyone at everything.

Therapist: Ok, given that this is the case, do you think that God is really likely to misdiagnose you as not having OCD?

Patient: Yeah, I get your point, He knows I have OCD.

Therapist: Ok, since He is the best at diagnosing OCD, do you think He understands that the thoughts are not your fault?

Patient: Ok, that makes sense but what about all this exposure to negative religious thoughts and cutting way back on my prayers . . . don't you think that will offend him?

Therapist: Do you think God is familiar with exposure and response prevention therapy?

Patient: Sure, He knows of everything.

Therapist: Do you think that God is really good at exposure and response prevention therapy compared to me and any other therapist?

Patient: Sure, He is best at everything.

Therapist: So do you think He understands what we are trying to do?

Patient: Yes, I am sure He does.

Therapist: Do you think he gets angry when people use therapeutic techniques to help themselves?

Patient: No.

Therapist: Given that, do you think that He is offended by our efforts to do exposure and response prevention?

Patient: I see your point; it really doesn't make sense that He would be offended.

Another valuable use of Socratic dialogue concerns attempts by the person with ROCD to eliminate all uncertainty related to spiritual concerns. Clinicians can assist patients by reminding them about the futility of seeking perfect assurance that God exists and that their eternal salvation has been achieved. A sample dialogue follows:

Patient: How can I be sure that there is a God?

Therapist: Are you sure of anything in your life?

Patient: Yes, there are some things that I am sure about.

Therapist: What does it take for you to be sure about something?

Patient: Well, when I see something with my own eyes, hear it, or feel it . . . then I am sure.

Therapist: Do you think that God is likely to let you see, hear, or feel him?

Patient: No, it does not seem likely.

Therapist: Do you think that others use similar criteria, like seeing, hearing, or touching in order to be sure about something?

Patient: Yes I do.

Therapist: So do you think that most people are at least somewhat uncertain about spiritual issues too?

Patient: Probably.

Therapist: Does it seem likely that you will someday end up being sure or do you think that you will be like many people and remain somewhat uncertain about spiritual issues?

Patient: Yes, I think I will always have some uncertainty.

Therapist: Given that you probably will always be somewhat uncertain, do you think that it would be best to practice accepting the uncertainty as opposed to trying to drive it away?

Patient: That probably makes sense.

Although cognitive therapy has been shown to be helpful for OCD (van Oppen et al., 1995; Cottraux et al., 2001; Abramowitz et al., 2002), it is important to note that certain cognitive strategies can also be fertile ground for compulsive reassurance seeking. Practitioners conducting cognitive therapy for ROCD must be aware of sufferer's attempts to encourage their thera-

pist to repeat sentences, write down arguments, or to otherwise provide compulsive reassurance about a religious concern. When the cognitive therapist detects compulsive reassurance seeking statements such as "We have already covered that topic," "That question sounds like your OCD talking" or "We need to move on now" can be helpful. Finally, it is important to note that although cognitive therapy has been shown to be effective in treating OCD; empirical support for its value is not as extensive as the body of evidence confirming the value of exposure and response prevention for OCD (Foa, Franklin, & Kozak, 1998). Several clinical researchers support integrating cognitive therapy along with exposure and response prevention for persons with OCD (Purdon & Clark, 2005; Salkovskis & Wahl, 2004).

Practice Implications for Ministers and Religious Counselors

Research has found that there is no difference between psychiatrists and ministers in the type and severity of disorders that they address (Wang, Berglund & Kessler, 2003). As a matter of fact, ministers are more likely than psychiatrists to provide counseling for certain psychiatric disorders such as mood and anxiety disorders (Wang et al., 2003). Ministers and religious counselors often experience a significant dilemma when meeting with a person suffering from OCD related to religion. It is often very difficult to initially detect if a person is presenting for compulsive reassurance in response to an ROCD related obsession or whether they are simply seeking a spiritual consultation. In practice, most clergy are initially likely to respond to a person with ROCD in the same way as any other person seeking help, to provide expert information about scripture, make suggestions for prayer, and/or provide general support and counseling services. However, often within a short time, a person with ROCD begins to behave in several characteristic ways that could provide clues to the spiritual counselor that they are suffering from ROCD. One classic sign of ROCD involves seeking exacting and repetitive feedback about spiritual questions. For example, a person with blasphemous obsessions may ask a clergy about whether having a thought is sinful but when a response is given, the person with ROCD may

ask that the response be repeated, may request extensive examples from scripture to backup the position taken by the religious counselor, or may repeatedly offer slightly different versions of the question in order to gain more reassurance. A minister faced with this situation may initially try to meet demands for greater feedback, but at some point they will likely begin to view the situation as counterproductive.

Once the spiritual advisor notices that he or she is not able to provide relief to the person with religious obsessions, it is difficult to know how to proceed. One method is to suggest yet further spiritual consultations until the obsession is ultimately resolved. This strategy is rarely successful and even if the concern fades, clinical impressions suggest that a replacement concern is likely to emerge. A preferred alternative route may be to let the individual know that they have likely lost perspective and that further review of the issue is not likely to yield a satisfactory resolution. This conversation also provides an excellent opportunity to socialize the individual to the problem of ROCD and its treatment. Ministers and other clergy can also encourage the individual to try to discontinue spiritual consultation related to the issue at hand and instead to accept that religious uncertainty will always be present. For many religions, living with uncertainty but still believing is the essence of religious faith. For people with clinical ROCD, these suggestions may clearly not be enough. In these situations, referral to a well trained mental health professional is likely indicated.

Another important contribution that ministers and religious counselors can make in these situations is to support diagnostic and treatment decisions made by outside practitioners attempting to provide appropriate service to individuals with ROCD. Many persons with ROCD look to their clergy in order to confirm that their problems are psychiatric, not spiritual. Clergy can provide feedback that God does not one day decide to afflict someone with intrusive blasphemous thoughts as a punishment, reminder to increase their religious participation, or as a spiritual message. In addition, it can be very helpful for clergy to endorse the use of exposure and response prevention therapy. Sending the message that God understands and endorses CBT can be very helpful in enhancing adherence to treatment. For some ROCD sufferers,

exposure therapy may be seen as an assault on religion and clergy and therapists can play a very important role by confirming that exposure treatment is in keeping with the God-given right for persons to take measures to improve their lives. In fact, exposure therapy can have a freeing effect, allowing affected individuals to return to a satisfying spiritual life after successful treatment. Additionally, clergy can assist persons with ROCD by supporting the appropriate use of serotonin reuptake inhibiting medications.

Clergy can also provide helpful feedback that God does not expect followers to be morally perfect, or to even strive for perfection. Followers can be reminded that a comprehensive system is in place for gaining forgiveness, which by definition indicates that sins are inevitable and expected. It can also be helpful for clergy to review scripture related to the topic of scrupulosity in order to help sufferers understand that they are not alone. It is important to note that the above suggestions can also carry risk. It is clearly possible that persons with ROCD may begin to seek compulsive reassurance on these and other topics from clergy. It is important for clergy members to provide this sort of feedback one time, resisting the temptation to provide repetitive consultation about these issues. Spiritual consultation with a person suffering from ROCD is best thought of as a method to facilitate adherence to cognitive-behavioral and other therapies rather than as a strategy to reduce obsessions and compulsions in a clinically significant way. It is possible that a person with ROCD may find lasting relief through multiple, creative, and comprehensive spiritual consultations, but clinical experience suggests that extended discussions focused on religious doctrine are rarely helpful.

One special issue related to spiritual counseling and ROCD concerns whether to suggest prayer to ROCD sufferers as a method of gaining relief from their symptoms. Although prayer is the most common intervention used by clergy (Neighbors, Music & Williams, 1998), it is associated with significant risk when prescribed to persons with ROCD. Clearly, compulsive prayer is a target symptom for many people with ROCD and as such, suggestions for further prayer are likely ill-advised. In fact, marked prayer reductions, or even eliminating prayer may be the best strategy for some persons with ROCD. Clergy can be very helpful in support-

ing prayer reduction or elimination strategies which may be prescribed by a cognitive-behavioral therapist.

A critical assumption related to the above discussion is that the clergy member holds the belief that religious obsessions are not sinful and that they do not need to be confessed or countered with prayer. When clergy do judge ROCD complaints as sinful and possibly associated with a loss of salvation, sharing this belief with an ROCD sufferer can have a devastating effect. This feedback is likely to encourage the person with ROCD to attempt to suppress negative thoughts even more diligently and to perform compulsive behaviors according to even more exacting standards which will likely result in further worsening of OCD symptoms and associated functional impairments. In these circumstances, it is advisable for clergy to refer the person with ROCD to another spiritual advisor if possible. On a related note, it is important for mental health clinicians to determine whether a clergyperson holds beliefs that could be counterproductive before sending an ROCD sufferer for spiritual consultation.

Conclusion

Religion and religious involvement have been associated with higher levels of physical and mental health at both the individual and population level. However, in addition to the positive influences of religion on health, there are specific instances in which religious content and behaviors are associated with health problems. Current findings linking aspects of religion (e.g., denomination, religious intensity, and religious beliefs) and OCD are suggestive, but additional research is needed to understand their specific connections to OCD behaviors and symptoms. Clinical treatment of OCD with religious content emphasizes both medication and CBT. Specialized CBT strategies (i.e., ERP, cognitive restructuring) tailored for use in situations involving ROCD are particularly promising in achieving treatment goals. Practice implications for clinicians and clergy specifically emphasize the role of clinician and clergy beliefs in the treatment of the disorder and the development of collaborative relationships between clinicians, clergy, and patients.

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