Religious symptoms have been recognized as a presentation of obsessive-compulsive disorder (OCD) for centuries. The two main treatment strategies for OCD, cognitive behavior therapy (exposure and response prevention [ERP]), and SSRIs have been shown to be effective in religious OCD. The presentation of religious OCD within formal prayer, reported in Judaism and Islam, poses special challenges of inaccessibility of personal prayer, sanctity of the symptom, and the status of the therapist. A method of guided-prayer repetition, a variant of ERP, is described, and its successful application is reported in three cases of ultra-orthodox Jewish men with prayer as the main symptom of their religious OCD. © 2009 Wiley Periodicals, Inc. J Clin Psychol 65: 396–405, 2009.

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Introduction

The existence of intrusive thoughts at times of prayer has been recognized for many centuries (Greenberg, Witztum, & Pisante, 1987). In Of Religious Melancholy, the Bishop of Norwich wrote of good and moral worshippers assailed by “naughty and sometimes blasphemous thoughts” that “start in their minds, while they are exercised in the worship of God” despite “all their efforts to stifle and suppress them” (Moore, 1692/1963, p. 252). In Judaism, such symptoms are presented as the repetition of the contents of the formal daily prayers. The possibility of repeating formal prayers for fear of not having said them with adequate devotion is mentioned in the Babylonian Talmud, completed by the end of the fifth century (Greenberg & Shefler, 2008), while the nineteenth century, Yiddish writer Shalom Aleichem...
provides a graphic account of compulsive praying in one of his novels about Jewish village life in Russia:

The praying of Shaya-Dovid, the religious penitent, was indeed wonderful, unlike the praying of any other creature. Shaya-Dovid does not pray in a whisper, but raises his voice, shouts and moves worlds with his praying. It would seem he is of weak faith. He suspects that the Holy One Blessed be He hears not a poor man’s prayer be it said softly. But more than that, he is unsure of himself and hesitates as he may have erred in his prayer and left out one word, so that he is in the habit of repeating every word and every line twice over. He gives up of his own time and adds to the Almighty (and says his prayers as follows):

“Blessed…Blessed, is he who spoke…is he who spoke, and there was…and there was; Blessed is He who spoke and there was… Blessed is He who spoke and there was…the world…the world.” (Aleichem, 1968, p. 90)

Obsessive-compulsive disorder (OCD) with religious symptoms has been described in epidemiological studies in many countries and many religions (Foa et al., 1995; Karadağ, Oguzhanoglu, Ozdel, Atesci, & Amuk, 2006; Okasha, Saad, Khalil, el Dawla, & Yehia, 1994; Assarian, Biqam, & Asqarnejad, 2006; Khanna & Channabasavanna, 1988; Greenberg & Witztum, 1994). It is notable that a recently developed measure of religious OCD, the Penn Inventory of Scrupulosity (PIOS), does not specifically mention prayer nor indeed is there any reference to rituals. The reason for this may be that PIOS was developed as a general measure of scrupulosity for all religions, the 19 items having two factors, one relating to fear of God and the other fear of sin (Abramowitz, Huppert, Cohen, Tolin, & Cahill, 2002). Despite the general nature of the PIOS, repetitive confession does feature in it. Confession is a Christian ritual that has a long history as a compulsive behavior (Bainton, 1951), although personal confession is not a feature of most other religions. In Judaism and Islam, prayer and ritual feature prominently in the descriptions of religious OCD (Greenberg & Witztum, 1994; Okasha et al., 1994). Remarkable in their similarity to the symptoms we have described in samples of ultra-orthodox Jewish patients with OCD, Okasha et al. wrote:

Moslems are required to pray five times a day. Each prayer is preceded by a ritualistic cleansing process, which implies the washing of several parts of the body in specific order, each three times … . The prayers themselves are different in length and consist of certain phrases and “souras” from the Holy Kuran that have to be read in certain sequence. The emphasis on cleanliness or ritual purity is the cornerstone of most of the compulsive rituals. The numbers of prayers and the verbal content can be the subject of scrupulousness, checking and repetition. (1994, p. 194)

There are two main treatment strategies that have been shown to be effective for OCD, cognitive behavior therapy (CBT), exposure and response prevention (ERP), and SSRIs (Foa et al., 2005), and both strategies have been shown to be effective in religious OCD (Huppert, Siev, & Kushner, 2007; Fallon et al., 1990). Nevertheless, as described by Huppert et al. (2007), treating religious OCD in ultra-orthodox Jews with ERP poses special difficulties that require sensitive management: Sufferers
cannot be asked to break religious laws as part of their exposure program—some may prefer to remain with their OCD than run the risk of performing transgressions—and treatment will invariably involve consultation with the patient’s rabbi, although both patient and rabbi will then be asked to abjure from further consultation to avoid reassurance seeking and giving.

The form of religious symptoms in OCD resembles non-religious symptoms (Greenberg & Shefler, 2002). In our work with ultra-orthodox Jewish patients with OCD, the commonest content involves prayer and pre-prayer ablutions in men, and menstrual purity and dietary laws in women. The forms of the symptoms we tend to find are repetitions and avoidance in prayer, washing and checking in pre-prayer ablutions, and menstrual purity and dietary laws. Although the last three presentations are sufficiently difficult to treat given the concerns described by Huppert et al. (2007), they reported a rate of success similar to that noted usually with ERP.

Sufferers from religious OCD whose symptoms involve praying usually have the following features: When they reach the most important parts of the formal prayers, they may hesitate before beginning, fearing they are not concentrating adequately. If they proceed to the important sections, they may repeat the section again and again (see Shalom Aleichem quoted above). The types of cognitions that preoccupy sufferers are varied: They may fear that they were not concentrating, had not said the words correctly, had lewd thoughts, or did not believe in God at that moment. This last reason is a form of blasphemous thought. The most important sentence in Jewish prayer, a main focus for compulsive repetition, is Shema Yisrael, which is a line declaring the unity of God, that the Code of Jewish Law states must be said with devotion to its meaning (Greenberg & Witztum, 1994). Although these concerns are given certain legitimacy in the Code of Jewish Law (Greenberg & Witztum, 1994), typical of OCD in other areas, sufferers are aware that most do not pray in the way that they do. Further, they may find that their prayers take so long that they do not complete their prayers during the period of the day demanded in the Code of Jewish Law and, in extreme cases, find that their extended prayers encroach on time that should be spent in study, with family, etc. (Greenberg, 1984).

Using the usual methods of ERP, we have requested that the patient refrain from ritualizing and have noted certain difficulties in application. Prayer is a private behavior, practiced in a meditation-like isolation, even if the pray-er is surrounded by other pray-ers in the synagogue. Unlike washing or checking, repeated words or phrases in prayer occur in an instant and are difficult to stop, and it is difficult to refrain from pausing. A pause is a non-behavior and as such it is difficult to “prevent.” Further, prayer is not a behavior that can be carried on outside its natural habitat, but it must be said to fulfill the daily obligation to pray and not as an “exercise,” otherwise there will be no compulsive urge to repeat. As a result, if a therapist asks a patient to recite the prayers aloud in his presence in the clinic, as a demonstration or for therapeutic purposes, the patient is likely to report little difficulty and is likely to compare the process with “just reading” or reading psalms, and not praying, and therefore not subject to the laws of prayer. This combination of difficulties that are intrinsic to Jewish religious prayer have led us to find that if, according to the guidelines of exposure and response prevention, the patient is asked to continue praying, not pause, or repeat even if he thinks he may have erred, the patient will often experience great difficulty.
Method

To overcome these limitations, we have developed the following method of guided-prayer repetition. The patient is asked to prepare an audio-record of his prayer difficulties as a baseline, and the number of repetitions and pauses are noted. The patient ideally does this during his regular prayers, either in a synagogue or alone. Provided the problem is well demonstrated over a short period, only a 10-minute sample is necessary, so that if it occurs at particular sections in the prayers, they should be recorded. The two compulsive behaviors in prayer are either repetition or delay, and ideally one begins treatment with repetition as the targeted behavior, as we have found that it is easier to change and the results are more rapid and vivid. The patient is aware of progress as he repeats less in contrast to a shortening of pauses. The awareness of success increases his motivation for any other work that has to be done.

It is recommended to choose a sample prayer of about 50 words in length during the course of prayer where the repetitions invariably occur. This becomes the focus of the in vivo interventions of the patient and therapist. The sessions often take place in a synagogue but always at the time of prayer, although usually when the room is empty, so that the session does not attract attention and cause embarrassment. The prayer recited by the patient at the session is his formal prayer. The therapist instructs the patient as follows:

When you come to the part of the prayer where you tend to repeat (for example, Shema Yisrael, or the first blessings of Amidah—a prayer with many blessings recited quietly while standing at least three times daily), two details are critical. The first is that you must say it loud enough for me to hear what you are saying. The second is that you should try not to repeat words. If, however, you find this too difficult and you do repeat, then that is understandable, because it is not easy to stop so quickly. But, if you do repeat a word or phrase, then you are to return to the beginning of that line in Shema Yisrael or back to the beginning of the Amidah and you must start again. I am standing next to you and I will indicate to you to go back. This repetition helps you learn to say the prayer without repeating words. Any questions? Then let us begin.

If shortening pauses is the focus of intervention, then the patient is instructed as follows:

We want you to pray without long pauses. So if you pause more than, for example, 5 seconds before a word, then I will indicate to you to begin the prayer again from the beginning.

The maximum permitted pause time that is chosen is based on the baseline average. We select a time somewhat less than the baseline. The permitted pause time is shortened gradually during the sessions until it approximates normal speech.

We ask the patient to begin the prayer again in any one session as many times as it takes until he is able to recite the selected section without any repetitions or long pauses. For this reason, it is important to choose a section of prayer that is not too long, as we want the patient to reach the criterion of success in the session itself. It may happen that the patient is told to go back to the beginning as many as 30 times,
but this will happen only rarely if we are consistent in applying the rule. All sessions are audio recorded for purposes of objective measurement.

Between sessions, the patient is asked to do the best he can, not to repeat. Initially he is told not to use the guided-prayer repetition technique when he is alone. We have found that patients are initially unable to consistently apply the prayer repetition in the absence of a therapist or co-therapist. Instead, as homework, he is asked to take a sample of the prayers he says on his own and mark the number of repetitions. This is to give us some idea of the amount of generalization taking place outside the sessions, although the issue of generalization only becomes of central concern once significant improvement begins to take place in the sessions. Once he has achieved mastery of his prayers during the sessions, with no repetitions or long pauses, he is asked to practice the technique, as homework, on his own during other prayers, which occur outside the sessions. After the end of therapy, we use follow-up sessions when he records himself with a hidden microphone during actual prayers in the synagogue. The clinical work and intervention take place in the sessions with the therapist, which are initially about twice a week in the first weeks.

Results

We present here the results of three patients with compulsive praying who were treated with guided-prayer repetition. None were receiving SSRIs at the time of treatment. To date, the approach has been offered to four ultra-orthodox young men. Only one asked not to continue, after an initial session in which the therapist and patient had stood together in prayer and he had been unable to overcome an 8-minute pause before starting the Amidah.

Case A was first seen when aged 18, with a 7-year history of repetitions and pauses in his daily prayers. Over the years, he had also suffered from excessive doubts, a need to recall past events, compulsive asking of questions to seek reassurance, and religious hand-washing compulsions, although these were not currently troublesome. He had received a brief trial of cognitive behavioral therapy (CBT) in which he was told to refrain from prayer if he experienced difficulty and was then referred for a trial of SSRIs, which he took for 5 months without benefit. His repetitions did not occur at any specific section, but could occur in all parts of the prayers. His morning prayers could take more than an hour, when the congregation would finish in 40 minutes. However, he left out more than half of the prayers to finish in that time. He also prayed loudly; he believed this would help him not repeat words. It did not help, but it did attract attention, which caused him great embarrassment. As a result of his symptoms, his daily prayers were distorted in form, truncated in content, and they took up hours of his day.

During four initial sessions in the clinic, he recorded his baseline of repetitions and would repeat during a session on average 70 times. Treatment comprised having him return to the beginning of his prayer if he repeated a word compulsively. He found this particularly disturbing as this could entail repeating the name of God, which is forbidden (“Thou shall not take the name of your God in vain.” Exodus 20:7); but, he was finally convinced on the basis of the religious ruling that teachers and pupils are allowed to repeat God’s name if this is necessary for learning, as he was learning again how to pray correctly and therefore he was permitted, if necessary, to repeat. Because of time constraints, the therapist initially began with an abbreviated format of the morning prayers. As his prayers speeded up some prayers that had been omitted were added, initially the Amidah, and after another 6 weeks, the morning
blessings. In spite of the additional prayers—and additional opportunity to repeat words—Case A was able, with practice, to keep the total number of repetitions to a minimum (0–10 repetitions during sessions). He was seen 23 times over 4 months, about twice a week. He then asked if he could work on his own without sessions, as he felt that he had learned the technique and could apply it on his own. The therapist agreed. Six weeks after the end of treatment, Case A met with the therapist in a synagogue for a follow-up prayer. The therapist sat next to him during the prayer while he prayed the full text with no repetitions and at a normal pace. Further follow-up 3 years later under the same conditions had the same positive results, and he reported that his prayers were unabridged and completed without repetitions in normal time.

Case B was 24 years of age when first seen, married with one child, and with a 2-year history of repetitions in his prayers. There were no other symptoms of OCD. His repetitions occurred particularly at Shema Yisrael and the beginning of Amidah. He reported that other aspects of his life were not problematic. His wife was not aware of his problem because it only manifested itself in public prayer when men are separated from women. He had not sought treatment previously.

In the initial sessions, his repetitions gradually decreased from 190 to 50, even before the guided-prayer repetition was introduced. During these sessions, the therapist stood at his side and recorded all repetitions. It was our impression that the presence of the therapist may have resulted in an increased awareness that may have facilitated the patient’s efforts not to repeat. Once told to implement the guided-prayer repetition, he had to return to the beginning of the line Shema Yisrael, while in Amidah, the attention was initially on the first two blessings, and he had to go back to the start if he repeated. Once he improved, the remaining blessings were included one-by-one in the sessions, so that if he repeated, he had to go right back to the start. With this, his repeating reduced and within six sessions there were no repetitions. The patient reported improvement in his prayers outside the sessions. He was seen for follow-up at 7 months and observed by the therapist during a real-time prayer session in the clinic and prayed smoothly with no repetitions. On two later occasions, the therapist observed him at prayer in a synagogue, where his prayer was normal.

Case C was 20 years of age when first seen, with a 4-year history of a range of symptoms: He spent a lot of time in pre-prayer ablutions, was awake till 2:00 to 3:00 a.m. owing to his excessive cleaning in the bathroom before sleep, and took very long showers. In addition, he repeated words and sentences during his daily studies and when he was trying to read the weekly Torah portion. Therapy focused on his prayers where he was slow and repeated at Shema Yisrael, Amidah. Case C was brought by a supervisor from his yeshiva, who attended all sessions with him, learned the approach and applied it outside the sessions whenever they prayed together (acting as a co-therapist, Mathews, Gelder, & Johnston, 1981). During sessions, Case C could take several minutes to recite a single blessing, particularly owing to slowness, so a time limit was set, which, if passed, meant he must restart. The time limit was gradually reduced. The therapy was intensive for a period of 3 months. During that period, therapy sessions were three times a week for guided-prayer repetition. After that, Case C went home for a 3-week vacation from yeshiva. When he returned, his father and his supervisor reported that his prayers were much improved, so that sessions became less frequent. Treatment ended 3 months after his vacation, although his prayers continued to be monitored by his supervisor during actual prayers in synagogue and who reported that his prayers are recited without
tension, at a regular pace, and without repetitions. There was an improvement in the repetitions during his studies but no effect on the compulsive cleaning.

Discussion

We report significant changes in three ultra-orthodox Jewish young men who suffered from compulsive praying, using guided-prayer repetition, a variation of the ERP technique for overcoming compulsions. All three showed clear improvement which was audio recorded and observed by the therapist, and at follow-up each is praying at a regular pace and without repetitions or pauses.

In What Way Does This Approach Enhance ERP?

The understanding of ERP’s effectiveness is that it diminishes OCD by the process of habituation. The anxiety experienced during exposure persists and is not reinforced because the compulsion is not performed (response prevention), leading to a process of habituation. Habituation results in a diminution of the anxiety and the urge to ritualize because in the exposure sessions, they are not reinforced. ERP succeeds when during exposure treatment the patient restrains himself from ritualizing in spite of his compulsive urge to do so. But, if, in spite of his efforts to stop ritualizing during treatment, he cannot do so, the exposure cannot lead to habituation. In such instances, Foa and Franklin (2001, p. 255) recommend stopping therapy.

Compulsive prayer repetition is especially difficult for the patient to control during exposure sessions; the repeated word is blurted out in a second and cannot be undone. Progress cannot be made because no habituation can take place. Guided-prayer repetition can help the patient in spite of this difficulty. By having the patient repeat the prayer from the beginning—not wanting to interrupt his prayer makes this an aversive consequence—we increase his motivation to refrain from repeating. As a consequence, he repeats less during the exposure sessions, and, thus, the process of habituation, as in the usual ERP procedure, can take place.

In the usual ERP procedure, the therapist tells the patient not to ritualize. Often he can comply with this condition and then the therapy succeeds. But there are patients who are not able to comply. It is for them that the added motivation of an aversive consequence to their ritualizing can make the difference between a failed therapy and a successful one.

Guided-prayer repetition may be useful in OCD patients in religions other than Judaism with formal prayer structures, such as Islam, although the therapist should have an understanding of the laws of Islamic prayer.

ERP has a significant drop-out rate (27.5% in the trial by Foa et al., 2005), and Simpson, Zuckoff, Page, Franklin, and Foa (2008) estimated that at least 50% of OCD sufferers who attempt ERP do not respond optimally. This led Simpson et al. (2008) to use motivational interviewing as an adjunct, and guided-prayer repetition may be viewed as a creative variant to standard ERP.

The therapy described is demanding of patient and therapist, and the atmosphere is one of commitment to religious values. In this context, the therapist recommends guided-prayer repetition: If you carry out a repetition in prayer, you must start again from the beginning of the prayer. Patients have remarked that repetition in prayer is forbidden. Repeating God’s name “in vain” is a sin in Jewish law (the third of the Ten Commandments, Exodus 20:7). Before offering therapy, the therapist must be in contact with the patient’s rabbi and clarify with him if, in such cases, he would
permit the procedures we offer. Convincing the rabbi is vital to the success of therapy. By explaining the seriousness of the patient’s problem—how previous guidance and therapies have failed to help him and how this approach has proven helpful to others and that respected rabbis have permitted it—all this may help convince the rabbi to allow the procedure for therapy. If the therapist was to suggest the technique to the patient without the rabbi’s prior approval, then the therapist risks losing credibility in the patient’s eyes. The therapist and rabbi working together can usually convince the religious patient to comply.

It is important that the therapist has an in-depth understanding of the prayers and their laws, although he should not advise on religious issues, Sessions must take place at prayer time and the place suited for prayer, often a quiet synagogue. The therapist is active, listening to every word, and indicating whenever the patient must go back and start again. The therapist must be clear in his requirements and enforce them gently but firmly. When the patient sees that he will be instructed to return to the beginning without exceptions if he repeats a word, the relearning progresses more speedily. Unlike other CBT interventions, the method is not initially requested for homework. Once the patient starts praying during sessions with little tension and no repetitions or pauses, the sessions become less frequent and the patient reports generalization of gains to his prayers outside sessions. The final phase of generalization, reintroducing the improved praying behavior during prayers with a quorum in the synagogue, is crucial and requires creative thinking. How best to make the transition should be discussed with the patient. As the above cases showed, sometimes this is done with the therapist present and actively intervening, sometimes he would be a passive observer, or sometimes he would be absent, if that is the patient’s wish. Feedback from the patient as to how the transition and generalization are going would be our guide if changes are necessary in aiding the transition.

It would appear that both the active intervention of the therapist and the method of repetition are important. Case B improved to some extent with the therapist standing next to him, but major changes occurred only when the guided-prayer repetition was introduced.

**Why Does the Intervention Help?**

In considering why the intervention succeeded, we must consider several possible explanations. It would appear that, similar to ERP, guided-prayer repetition utilizes habituation. The role of guided-prayer repetition as an adjunct to ERP may be to enhance compliance not to ritualize during exposure sessions in spite of the presence of the compulsive urge. It does so by introducing an aversive consequence if the compulsion to repeat words in prayer occurs. The aversive consequence of having to begin the whole prayer from the beginning motivates the patient to refrain from repeating words during the exposure sessions. This leads to habituation and successful praying without the urge to repeat and without repeating words. Whether the approach is effective owing to its aversive nature or whether it increases motivation may be difficult to differentiate. Motivational interviewing has been incorporated into ERP in OCD with initial encouraging results (Simpson et al., 2008). Measures of motivation, such as readiness for change, were used by these authors and could be used in further studies, and guided-prayer repetition could be compared with motivational interviewing in cases of compulsive prayer.

Another possible explanation may be that guided-prayer repetition leads to greater fluency during praying, so that the compulsive word repetition is
“unlearned” and a newly learned, smooth reading is acquired. These two explanations could be tested by comparing the patient repeating just the verse, which included the compulsively repeated word, with the patient repeating the whole prayer. Repeating but one verse would be much less aversive (though still somewhat) but would allow learned fluency to take place. The opportunity for fluency learning would be equal in both groups, while the aversive consequence of repeating the whole prayer would be more severe in one group. This design would also evaluate the need for longer repetition, which some rabbis may find problematic.

Alternatively, a multiple baseline could be used with individual patients. In this design, two prayers that are problematic for the patient would be selected: one would be treated by repeating the prayer from the beginning and the other would require only repeating the verse. A comparison of improvement rates would indicate which factor—fluency or aversive consequence—was the more decisive factor.

The treatment reported was open and uncontrolled, so that more definite statements of effectiveness await controlled studies with larger samples. Such studies should compare ERP with guided-prayer repetition to find whether guided-prayer repetition is more or less effective in this group of patients than standard ERP and whether it is a useful adjunct to ERP in unresponsive cases.

References


