OBSESSIVE-COMPULSIVE DISORDER AND JEWISH RELIGIOSITY

| Author(s): | Hermesh, Haggai M.D.; Masser-Kavitsky, Ruth Ph.D.; Gross-Isseroff, Ruth D.Sc. |
| Issue: | Volume 191(3), March 2003, pp 201-203 |
| Publication Type: | [Brief Reports] |
| Publisher: | © 2003 Lippincott Williams & Wilkins, Inc. Anxiety Disorders and Behavior Therapy Unit, Petah Tikva, Israel and Sackler Faculty of Medicine, Tel Aviv University, Tel Aviv, Israel. Send reprint requests to Dr. Hermesh, Geha Psychiatric Hospital, PO Box 102, Petah Tikva 49100, Israel. The authors thank Professors David Greenberg and Abraham Weizman for helpful comments and suggestions. |

Jewish religious teachings and practices are markedly ritualistic in nature. Hundreds of laws govern each minute detail of everyday life, as stipulated in the Jewish Code of Law, or Shulchan Aruch (Karo, 1565). Cleanliness and personal hygiene are strongly emphasized, and there are numerous washing and checking procedures. Children are encouraged to perform these activities from an early age.

Several clinicians working with patients with obsessive-compulsive disorder (OCD) in Israel have noted that an unusually high percentage are orthodox Jews (Greenberg et al., 1987; Greenberg and Witztum, 1994). These reports, together with the preponderance of checking and washing rituals in OCD (Goodman et al., 1989), prompted our hypothesis of a possible link between Jewish religiosity and OCD.

In 1907 Freud (1941) was the first to note a similarity between religious and obsessive-compulsive behaviors, which he emphasized as the individual’s "private religion." Other investigators (Akhtar et al., 1975) have suggested that obsessions and compulsions are culture-specific, with a crossover to religious behavior. Greenberg and Witztum (Greenberg and Witztum, 1994; Greenberg, 1984) discussed the difficulty in differentiating normal religious behaviors from OCD in religious patients. Hoffnung et al. (1989) stressed the importance of therapists’ full knowledge about the religion and religiosity of their Jewish patients with OCD. All these reports, however, were based on case series and qualitative patient assessments. In a more recent study, Rasmussen (1993) claimed that Catholics and Jews with a strict religious upbringing were more likely than patients with a more secular upbringing to develop religious, aggressive, and sexual obsessions. Mahgoub and Abdel-Hafez (1991) reported a higher rate of religious content in the symptoms of Muslims with OCD. Others (Fallon et al., 1990) found that religious scrupulosity responds well to anti-OCD treatment with serotonin reuptake inhibitors (e.g., fluoxetine and cimipramine).

Steketee et al. (1991) conducted a comprehensive study of the relationship between the type and level of obsessive-compulsive symptoms, types of Christian religious practice, degree of religiosity, and guilt. A significant positive correlation was found between severity of OCD and degree of religiosity. However, comparison of patients with OCD and patients with panic disorder (PD) failed to yield a difference in the number of practicing religious persons. Raphael et al. (1996) reported that patients with OCD were more frequently affiliated with a religion than were psychiatric patients without OCD, but this difference disappeared when the type of religion was controlled, making a definite conclusion impossible.

To the best of our knowledge, this is the first systematic study of the specific relationship between Jewish religiosity and OCD.

We attempted to answer three questions: Are more patients with OCD religious than patients with other anxiety disorders and mentally healthy individuals? Is there a connection between intensity of OCD pathology and degree of religiosity? Do religious patients with OCD have more religious obsessions than nonreligious patients with OCD?

Methods

Subjects.

Three groups of 22 patients each (11 men and 11 women) were compared. Group 1 consisted of patients recruited from consecutive referrals to the Anxiety Disorders Unit of Geha Psychiatric Hospital (mean age, 36.3 ± 9.9 years), who met the DSM-III-R (Am Psychiatric Association, 1987) criteria for OCD (First et al., 1995). Group 2 consisted of outpatients (mean age, 38.5 ± 9.5 years) attending the same unit who met the DSM-III-R criteria for PD with or without agoraphobia. The patients with PD were matched for sex, age, and referring therapist. Group 3, the control group, consisted of age- and sex-matched outpatients (mean age, 39.5 ± 10.3 years) undergoing minor surgery at two close general municipal hospitals who were free of DSM-III-R axis I disorders. These hospitals serve the same catchment area of mixed religious and secular neighborhoods as Geha Psychiatric Hospital. All subjects voluntarily participated in the study after having signed an informed consent form.

Measures.

Obsessive-compulsive symptomatology was assessed with the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS; Goodman et al., 1989; Di-Nardo, 1985). Panic symptomatology was assessed with the Anxiety Disorder Interview Schedule-Revised (ADIS-R; Beck et al., 1961), and depression was measured with the Beck Depression Inventory (BDI; Beck et al., 1961). The religious content of the symptomatology was assessed by adding an item on the religiosity of the central obsession during the previous last month to the Y-BOCS checklist.

Jewish religiosity was measured with Relscale (Ben Meir and Kedem, 1979), three scales of the Jewish religiosity questionnaire (self-rated) developed by Ben Meir and Kedem for the Israeli population, and a global rating scale of religiosity rated by an external rater. The Relscale includes 23 forced-choice items covering six...
domains of religiosity: reference group, type of schooling, ritualistic behavior, faith, religious education at home, and dynamics of the connection to religion. The Ben Meir and Kedem scales consist of two parts: 20 yes-no questions covering the behavioral aspect of religiosity and six questions covering the faith aspect.

The intercorrelation among the five religiosity scales was high (Spearman-Brown \( r = .72 - .94, p < .05 \)). These results support the validity of the scales and strongly suggest that the use of a single global religiosity score is sufficient when the assessment is made by a professional of the Jewish religion who is familiar with its external common characteristics, which is one of the measures used in the current study.

Procedure.
To avoid possible sampling biases, each contributing therapist (total of six) referred four or five consecutive patients with OCD and PD who were then assessed by the remaining therapists for eligibility for the study. On the assumption that religious patients would be preferentially referred by their rabbis to religious therapists, we included three religious and three nonreligious referring therapists. The recruitment of subjects was conducted from October 1990 to May 1991, a period of 7 months.

To test interrater reliabilities, five subjects were rated for religiosity and Y-BOCS scores independently by the two assessors masked to each other’s findings. The interrater reliabilities were found to be high (Spearman-Brown \( r = .94 - 1.0, p = .05 \)).

Statistical Analyses.
Scores on the global Jewish religiosity scale ranged from 1 to 4, so the nonparametric Kruskal-Wallis test, Scheffe test and Mann-Whitney tests were used, with Spearman-Brown coefficients of correlation.

Results
There was no intergroup difference in the distribution of country of origin of the patients or their parents.

The mean Relscale scores for the three groups were as follows: 25.7 ± 22.1 for the OCD group, 14.0 ± 8.8 for the PD group, and 27.1 ± 18.0 for the control group. The corresponding scores on the Ben Meir-Kedem scale were 9.0 ± 6.2, 6.1 ± 3.3, and 10.6 ± 4.8, respectively, on a one-way rank analysis of variance. A significant difference was noted among the Relscale scores of three groups (Kruskal-Wallis H-test): 758.5 for the OCD group, 569.5 for the PD group, and 883.0 for the control group (\( H_c = 6.157, df = 2, p = .045 \)). The Conover procedure, which tested the differences between each pair of groups, yielded a significantly lower degree of religiosity in the patients with PD than in the control group (\( R = 14.25, R_{crit} = 9.34 \)). The OCD group also scored lower than the control group, but this difference failed to reach statistical significance (\( R = 5.66 \)). There was no significant difference in religiosity between the OCD and PD groups. All comparisons were tested for the other four assessments of religiosity, and all were confirmed (Scheffe test).

To investigate the relationship between obsessive-compulsive psychopathology and religiosity in the patients with OCD, each of the five religiosity scores was correlated with a Y-BOCS score, which was divided into four categories: obsessions (items 1-5), compulsions (items 6-10), total (items 1-10), and global for OCD (items 1-15). None of the 20 correlations (Spearman-Brown \( r = .02 - .27 \)) was significant.

To test the relationship between the content of obsessions and the degree of religiosity of the patients with OCD, we categorized the main obsession of each patient as religious or nonreligious. We then used the Mann-Whitney U-test to compare the degree of religiosity between patients with religious and nonreligious obsessions. No significant difference was noted (\( U1 = 68.5, U2 = 48.5, u = .635, p = .53 \)).

Discussion
The main finding of the current study was the lack of a preponderance of religious individuals among the patients with OCD compared with the patients with another anxiety disorder and with mentally healthy controls. This is in line with a previous negative report on Christian patients with OCD (Steketee et al., 1991) but contradicts recent findings on the connection between OCD and religiosity in a Christian sample (Sica et al., 2002). At the same time, the limited sample size and risk of type II error should be taken into consideration, together with the possibility of sampling bias owing to the lower likelihood of orthodox Jews being referred to a psychiatric setting compared with nonreligious Jews, because of the strong taboo on mental illness in this community. However, because this bias would be true for the OCD and the PD groups and we took steps to minimize this bias, the likelihood is not high.

The lack of correlation between the intensity of the obsessive-compulsive symptoms and the degree of patient religiosity may mean that intense religiosity does not lead to relief from OCD. It may also mean that religious patients with OCD differentiate between rituals dictated by religious laws and psychopathological compulsive rituals, even when they resemble each other. The puzzling lack of correlation between degree of religiosity and content of the central obsession points to a difficulty among orthodox Jews to distinguish between obsessive-compulsive and religious rituals.

Because we found only negative results contradicting all our hypotheses, their interpretation is entirely speculative. The findings of the current study could corroborate the notion that a higher degree of religiosity is associated with better mental health (Braam et al., 2001; Rasmussen, 1993). It may also suggest that the use of a single global religiosity score is sufficient when the assessment is made by a professional of the Jewish religion who is familiar with its external common characteristics, which is one of the measures used in the current study.

References


15. Karo J (1565) Shulchan Aruch. Venice. [Context Link]


