Of 28 ultra-orthodox Jewish psychiatric referrals with obsessive compulsive disorder, 26 had religious symptoms, while 18 had non-religious symptoms. On average, each patient had three times more religious symptoms than non-religious symptoms. In only nine cases did the patients view their non-religious symptoms as the main difficulty, and all of these nine cases were ultra-orthodox from birth. There was no significant difference between the distress, resistance, sense of irrationality and hours spent daily of religious and non-religious symptoms. Further, there was no significant difference between the age of onset, age when felt to be a disturbance, and duration until help was sought. They were more likely to turn for help initially to a religious authority for a religious symptom and a mental health worker for a non-religious symptom. It may be concluded that the religious and non-religious symptoms of obsessive compulsive disorder in ultra-orthodox Jews are not experienced in markedly different ways by the sufferers. Two limitations to the study are the sample size, and the selection bias in that all had sought professional help, of itself likely to reflect their attitude to obsessive compulsive disorder.

The relationship between religious practices and obsessive compulsive disorder (OCD) has attracted provocative comparisons (Freud, 1907/1959) and refutations (Lewis, 1993). Superficially, there are similarities in that both may need to be performed repetitively and according to a certain order; precision is a virtue (anxiety reducing in OCD), whereas omission is a sin (anxiogenic in OCD) and may lead to restarting the ritual; a concern for cleanliness and repeated washing may be prominent features of both. These observations led to predictions that OCD would be more common in more religious societies (Chackroborty, 1975), and while this has not been tested specifically, the findings of a remarkably similar prevalence rate for OCD in a range of countries and cultures argue indirectly against such a claim (Weissman et al., 1994).
Lewis (1935) included religion as one of the common topics of the symptoms of OCD. Studies of the phenomenology of OCD have found that religious topics feature as symptoms with widely varied frequencies: 0% in the UK (Stern & Cobb, 1978), 6% in the US (Foa & Kozak, 1995), 11% in India (Akhtar, Wig, Varma, Pershad, & Verma, 1978) and Turkey (Egrilmez, Gulseren, Gulseren, & Küler, 1997), 27% in the US (5% as principal problem; Mataix-Cols, Rauch, Manzo, Jenike, & Baer, 1999), 40% in Bahrain (Shooka, Al-Haddad, & Ræes, 1998), 50% in Jerusalem (Greenberg, 1984) and 60% in Saudi Arabia (Mahgoub & Abdel-Hafez, 1991) and Egypt (Okasha, Saad, Khalil, Seif El Dawla, & Yehia, 1994). In none of these studies was the religious commitment of the individual patient noted, and it may be assumed that there was wide variation in the degree of religiosity in the samples.

Ultra-orthodox Jews in Israel are discernible by having distinctive clothing and separate education and living areas. Most of the men study religious texts full time, and they are involved in the surrounding secular culture as little as possible, whereas the prime value of their lives is religious study and practice (Landau, 1993; Levy, 1989). We have earlier presented the typical religious symptoms of OCD that may appear in this population and also how such symptoms may be distinguished, at times with difficulty, from normative religious practice (Greenberg & Witztum, 1994; Greenberg & Witztum, 2001).

The following study was undertaken with ultra-orthodox Jewish patients diagnosed as having OCD in order to compare their experience of their religious and non-religious symptoms of OCD. It was hypothesized that they would relate to these two types of symptoms differently: being a part of normative ritual life, religious symptoms would evoke less resistance, would be considered less senseless, and would be carried out more hours daily. Ultra-orthodox patients would be less likely to seek help for such symptoms, would delay seeking help, and would turn to a rabbi rather than to a mental health expert. Further, we hypothesized that ultra-orthodox patients with OCD with both religious and non-religious symptoms would prefer medication to behaviour therapy for their religious symptoms, as behaviour therapy might be perceived as interfering with their normative ritual life. We also considered that someone with OCD who became ultra-orthodox would relate differently to newly acquired religious practices from someone born ultra-orthodox (Witztum, Greenberg, & Dasberg, 1990).

**Method**

**Participants**

Twenty-eight ultra-orthodox Jewish patients in Jerusalem, who sought psychiatric help either at a community mental health centre or privately, took part in the study. Patients were included whose primary diagnosis met ICD-10 criteria for OCD based on a semi-structured psychiatric interview; those with concurrent depression or psychosis or signs of an organic disorder were excluded.

**Procedure**

Following the diagnostic interview in which areas of symptomatology were described, the psychiatrist conducted a structured interview of 68 questions. Patients were asked to select the one religious and the one non-religious symptom that was most prominent for detailed evaluation. The features of these symptoms (e.g. distress, resistance,
Illogicality) were rated, as were the patients’ attitudes toward treatment approaches, using a 5-point Likert scale (1–5), and they were asked to assess the number of hours spent daily and to describe any link they perceived between having OCD and religious life. In addition, a count was made of the number of religious and non-religious symptoms experienced by each patient.

Patients were usually able to discriminate between a religious and non-religious symptom. In unclear cases, the criteria used were that (1) the concern was religiously motivated (e.g. ‘I repeat lines in prayer because I did not concentrate fully, and concentration in prayer is a necessary requisite’; ‘I clean myself before prayer because it is forbidden to pray in the presence of faeces’; ‘I check my skin and nails repeatedly before ritual immersion because immersion is forbidden unless they are completely clean’); and (2) the associated ritual was part of accepted religious practice. As an example of a non-religious symptom, one patient would clean excessively after defecating and on waking up, not for religious reasons, but ‘because I would feel yucky’.

Results

The sample included 21 males and seven females with an age ranging from 17 to 43 (median = 27.5). Fourteen were single, 12 married and two divorced; 16 were Israeli-born, 11 from the US and UK and one from Belgium. None came from non-religious backgrounds, but seven were born modern orthodox and had become ultra-orthodox, whereas the remainder were ultra-orthodox from birth. Of the participants, 26 reported religious symptoms, and 18 reported non-religious symptoms of OCD. In 19 cases, the main symptom was religious; in nine cases, all ultra-orthodox from birth, the main symptom was non-religious.

The mean age of onset of OCD in our sample was 15 years, similar to other studies (Koran, 1999). The religious symptoms evaluated made their first appearance on average at age 19 and were recognized as symptoms at age 21, and treatment was sought at the age of 24. The same ages were recorded for the non-religious symptoms. Applying Wilcoxon’s signed rank test to the findings for the 16 cases that had both types of symptoms revealed no difference between religious and non-religious symptoms, for distress, resistance experienced to the thought or behaviour, the extent it was thought to be illogical, and hours spent daily. Although religious symptoms occupied more hours daily than non-religious symptoms (4.2 vs. 2.3 hours), the difference did not achieve statistical significance. Three times more religious symptoms were found than non-religious symptoms (2.36 vs. .78; Wilcoxon’s sign-rank test, $z = 3.63$, $p < .0001$).

Content of religious symptoms

Certain topics were particularly common as religious symptoms.

Prayers

Repetition of particular prayers owing to suspected inadequate concentration occurred in 11 out of the 21 males. Seven of these 11 also had cleanliness rituals before prayers. Two out of seven females were lengthy prayers, but did not view it as a problem. One female had total avoidance of prayer to prevent repetition.
Cleanliness before prayer
This involved peri-anal wiping, washing and checking in eight males. One other male patient had this concern, unrelated to prayer or religion. Two females washed their hands excessively after using the toilet.

Ritual cleanliness
Religious married women have to immerse themselves in a ritual bath one week after menstruation has ceased. Washing and checking were present in six out of seven females. The remaining female patient was single (for whom the laws of ritual cleanliness do not apply), and she washed away ‘impurity’, including after periods. Two males had concerns over their wives’ ritual cleanliness.

Kashrut (dietary laws)
Three females and two males had symptoms concerning daily dietary laws, whereas three males and one female had symptoms related to cleaning the home before Passover.

Other symptoms
Three males had intrusive sexual thoughts, and three patients were concerned they may have stolen unintentionally.

All nine with mainly non-religious symptoms were ultra-orthodox from birth. The main symptom in all seven patients who had become more observant was religious.

Content of non-religious symptoms
The commonest non-religious symptoms of OCD were cleaning to remove faeces (4) and dirt (2). The remaining symptoms each occurred in one person: damaging people, being neat, handwashing, stealing, being cleverer than others, and remembering events. Handwashing is common in OCD (Rasmussen & Eisen, 1992), yet was rare in our sample of non-religious symptoms.

Seeking help
The patients’ attitudes to help for this particular problem were evaluated in several ways. A one-tailed $z$-test for proportion comparison showed significant differences for two sources of help, in that religious authorities were approached for religious symptoms ($z = 1.80, p < .036$) and psychologists and psychiatrists were approached for non-religious symptoms ($z = 1.85, p < .03$).

Wilcoxon’s signed rank test for their attitude toward receiving medication on 16 patients who had both religious and non-religious symptoms was $z = 2.27, p < .03$, showing a tendency to prefer medication for religious symptoms.

Attitude towards ritual observance
When asked if they were meticulous in all areas of ritual observance, 14 said they were, and 14 said they were not. When asked how they feel when they perform a religious transgression, 16 used strong terms of suffering and self-condemnation, whereas 12 were more mild. Their accompanying comments express this spectrum of attitudes.
Some examples are as follows: ‘As if I was possessed by madness. Dreadful’; ‘It depends which transgression. Bad, but what can I do?; ‘It is serious, perhaps a bit depressing, but evaporates quickly’; ‘Everyone transgresses, even from pleasure, like a blue movie. As it says: “There is no righteous person who does not sin” — and I enjoy it.’

**Linking religion to OCD**

Finally, when asked if they saw a link between having OCD and their being a religious person, 12 said yes, 11 said no, and three were undecided. Their replies are presented in detail for their range and sophistication:

‘Having these thoughts is not blasphemy. They are thoughts made of plastic.’
‘If I wasn’t religious I wouldn’t do this ritual behaviour, but most religious people don’t have OCD.’
‘I realize this is my problem. As it says: “The Torah was not given to angels” — the Torah is for fallible humans.’
‘I had OCD before I became more religious. It’s the same lady in another dress. If I weren’t so religious, it would take a different form.’
‘My rabbi told me it was not religious behaviour. Until then I thought it holy.’
‘They shoved it up your—, you would burn in fire. I blame my mother, my education, but not the Torah. The Torah is wonderful.’
‘I recognize it’s a sickness, although I refuse to view my meticulousness as sickness. But I don’t want to serve God in this way.’
‘It is all to do with Jewish law and I wasn’t like this before I became more religious. If I had been born ultra-orthodox it might not have happened.’
‘If I wasn’t religious, I would not have this problem of nerves, but I could not envisage myself in any other world.’

**Discussion**

In contrast to our original hypotheses, the distress, resistance, illogicality and hours spent daily as experienced by our ultra-orthodox patients with OCD were no different in religious and non-religious symptoms. These components all feature in the ICD and DSM definitions of OCD, have been found to be prominent components of OCD (Khanna Kaliaperumal, & Channabasaanna, 1992) and are used routinely to measure severity of OCD (Goodman et al., 1989). Illogicality has not been found to be a consistent feature of OCD (Foa & Kozak, 1995), nor has change in resistance emerged as consistent with improvement (Woody, Steketee, & Chambless, 1995). Further, contrary to our initial hypothesis, our sample did not report recognizing religious symptoms later than non-religious symptoms.

The distribution of symptoms demonstrated the culture-specific nature of the content of symptoms of OCD. Prayer is a thrice daily duty for men only, and it was the main religious topic for men, while ritual immersion, which is a duty of women only, was a religious OCD symptom in all the women in our sample. Similar symptoms of concern over concentration during prayer and cleanliness before prayer and after menstruation are described in Muslim samples (Egrilmez et al., 1997; Mahgoub & Abdel-Hafeiz, 1991; Okasha et al., 1994; Shooka et al., 1998). Only Shooka et al. separated frequencies of religious content among men and women, and described post-menstruation cleaning as a symptom among women. They described the Taharah
purification ceremony before prayer as relevant to both sexes and only made a general observation that women in their sample had more washing rituals than men.

The non-religious symptoms in our sample were not the concerns or behaviours usually described in the OCD literature (Foa & Kozak, 1995) and were more similar to religious values (the need to be cleverer than other yeshiva students; a concern that one may have stolen) and practices (careful peri-anal wiping on wakening). Certain observations were striking, if not easily explained. Our patients reported three times as many religious symptoms as non-religious symptoms; in nine of the 28 participants, the principal symptom was non-religious and all were patients who were ultra-orthodox from birth, whereas religious symptoms were the primary complaint in all seven patients who had become more orthodox.

As predicted, religious symptoms were more likely to be brought for guidance to a rabbi than a mental help expert. Nevertheless, we were surprised that as many as six first sought help from a mental health expert for religious symptoms, and first sought help in most cases of non-religious symptoms from mental health experts. A possible explanation that reflects a general limitation of this study was that patients were self-selecting, in that they had sought help from a psychiatrist, thereby declaring that they perceive their problem as the domain of a mental health expert. To date, no epidemiological studies of OCD have been carried out that would establish whether these findings are generalizable to OCD in the general ultra-orthodox community.

Overall the sample preferred medication to behaviour therapy as treatment, particularly for religious symptoms. This supports the observation that cultural minorities with indigenous healers will seek out their healers’ non-medical help, and turn to secular therapists when they have not been helped, and then prefer a treatment that does not impinge on their cultural values (Kleinman, 1988).

The non-comparative data are presented in detail as an intriguing insight into these patients’ attitudes to religion, sin and OCD. Half of the sample see themselves as religiously fastidious, which may be consistent with the finding by Lewis (1993) that religiosity was not predictive of OCD but was predictive of obsessionality. Similarly, the attitudes toward sin appear to cover the whole range, from the breast-beating to the flippant. The perceived link between OCD and ultra-orthodox Judaism is particularly fascinating. Many believe that they would not have OCD if they were not religious, and even pour scorn on their upbringing, yet none overtly criticize the religion itself. The others see the religion as made for mortals, tolerating error. In their view, the OCD merely attached itself to religious practice, as it would have done to a different focus if they had not been religious.

The most striking finding is that when all of a sample of OCD patients are from one very religious group, 93% have religious symptoms. The contrast with the findings reported above from eight countries in which religious OCD symptoms were found in 0–60% of the samples is clearly to be understood as a consequence of the religiosity of the participant sample in each study. In an earlier sample that we reported from north Jerusalem, 14 out of 34 patients with OCD had religious symptoms (41%). However, of the 19 ultra-orthodox patients in the sample, 13 had religious symptoms (68%) (Greenberg & Witztum, 1994). Among the Muslim samples, Saudi Arabian and Egyptian patients with OCD had religious symptoms in 60% of the cases. Okasha et al. (1994) commented that religious symptoms predominated ‘even if the (participants) are not practising their religious duties’ (p. 194), although they did not separate the practising Muslims. In contrast, Egrilmez et al. (1997) found religious symptoms in only 11% of their Muslim sample in Turkey. They explain the difference between their results and
other Muslim samples in the realities of political and religious life in the different countries. Turkey has removed Islamic practices from public life throughout the last century, and many Turkish Muslims are very secular in their lifestyle. The same explanation applies to our own sample and may be applicable to all studies of religious symptoms in OCD. Religious symptoms occur in OCD when religious thought, and particularly religious ritual, are a central aspect of the life of the patient, consistent with Sims’ (1988, p. 162) observation: ‘For a person whose predominant thinking in health is religious, the content of their mental illness, if they become psychiatrically disordered, may well be religious also.’

References


Received 18 December 2000; revised version received 2 August 2001