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RECOGNITION OF SCRUPULOSITY AND NON-RELIGIOUS OCD BY ORTHODOX AND NON-ORTHODOX JEWS

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Perceptions of psychological symptoms may be influenced by religiousness, particularly when symptom presentation is shaped by a socio-religious context. We therefore examined whether among Jews, Orthodox affiliation was related to recognition of scrupulosity as obsessive compulsive disorder (OCD). Seventy Orthodox and 23 non-Orthodox Jews were randomized to view one of two matched vignettes describing religious or non-religious OCD. Whereas Orthodox Jews were equally likely to recognize both vignettes as OCD, non-Orthodox Jews were less likely to recognize the religious than the non-religious presentation as OCD. Furthermore, Orthodox Jews were equally likely to recommend professional treatment for both scrupulosity and non-religious OCD, whereas non-Orthodox Jews were less likely to recommend professional treatment for scrupulosity compared to non-religious OCD. These findings may suggest that familiarity with Orthodox practices increases sensitivity to distinctions between scrupulosity and normative religion, thereby increasing recognition of the need for professional treatment.

Scrupulosity is a manifestation of obsessive compulsive disorder (OCD) characterized by guilt or obsessions associated with religious or moral issues and/or compulsive religious or moral observances

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that are distressing and maladaptive (Miller & Hedges, 2008). The clinical presentation of obsessions may include nonculturally sanctioned fears that one has committed or will commit sins, clinically distressing intrusive blasphemous or sacrilegious thoughts/mental images, and excessive fears that one will go to hell or be otherwise punished by God (Abramowitz, Huppert, Cohen, Tolin, & Cahill, 2002). Associated compulsions may include nonnormative prayer, repetitive or otherwise nonculturally sanctioned performance of religious practices, excessive confession or reassurance seeking from religious authorities and efforts to avoid the possibility of sin (Olatunji, Abramowitz, Williams, Connolly, & Lohr, 2007).

Although several studies have demonstrated the efficacy of behavioral treatment approaches such as exposure and response prevention, as well as cognitive therapy, in producing large reductions in general OCD symptoms (e.g., Foa et al., 2005; Whittal, Robichaud, Thordarson, & McLean, 2008), clinical research suggests that the presence of religious obsessions predicts poorer treatment outcomes even after controlling for symptom severity (Mataix-Cols, Marks, Greist, Kobak, & Baer, 2002; Nelson, Abramowitz, Whiteside, & Deacon, 2006). The reduced treatment response rate of OCD patients with religious symptoms to psychosocial treatments is a significant concern considering that an estimated 24-33% of clinical OCD cases present with religious symptoms (Antony, Downie, & Swinson, 1998; Mataix-Cols et al., 2002; Abramowitz et al., 2002). Additionally, it has been estimated that 5% of OCD outpatients in the United States report religious obsessions and compulsions as their primary presenting problem (Tolin, Abramowitz, Kozak, & Foa, 2001), and estimates of the prevalence of religious symptoms among OCD patients in the Middle East have been as high as 83% (Greenberg & Shefler, 2002).

While several factors may contribute to the treatment resistant nature of scrupulosity, community attitudes towards the disorder may have a particularly important role. For instance, religious communities may normalize symptoms of scrupulosity given their likeness to religious practices. Furthermore, scrupulosity may be viewed as an indication of piety at the community level, and its symptoms may therefore be reinforced through praise. Normalization of scrupulosity by religious communities may lead to perceptions of secular professional treatment as an affront to religious values and lifestyles; this may account for the considerable resistance that many individuals with scrupulosity demonstrate towards secular profes-

sional treatment (Miller & Hedges, 2008). A failure at the community level to recognize scrupulosity as OCD may further decrease motivation to engage in treatment or lead to poor insight, a feature that is commonly associated with scrupulosity (Abramowitz, 2001). If religious communities unknowingly normalize or sanction scrupulosity and/or convey resistance to engaging in treatment for its symptoms, it may be that community-wide psychoeducation initiatives should be used as a precursor or adjunct to psychosocial intervention. It is therefore of clinical importance to investigate whether scrupulosity is recognizable as OCD at the community level, and whether religiousness is associated with appraisals of scrupulosity.

One potentially fruitful population for studying religious community attitudes towards scrupulosity is the Jewish community, which over the past two centuries, has divided into several factions or denominations that differ substantially in both religious doctrine and cultural practice. In the current day, denominations range from the traditional Orthodox (Hassidic, Yeshiva Orthodox, and Modern Orthodox) to more secular groups (most commonly, Conservative, Reform, and unaffiliated Jews). While there is considerable inter and intra-group variance in religious attitudes and practices, several cardinal features distinguish Orthodox from non-Orthodox groups. Principally, Orthodox Judaism is founded on the premise that the *Torah* (Hebrew Bible) and its commandments, as well as the extensive interpretation of those precepts by the Talmud, are Divinely originated and are hence obligatory (Schnall, 2006). By contrast, Conservative and Reform Judaism assert that Talmudic understanding of the commandments is not legally binding and that the *Torah* is not immutable (Waxman, 1958; Meyer, 1988).

By utilizing the religion as culture approach, which specifies that the doctrine of an individuals' faith influences manifestations of values (e.g., Cohen & Hill, 2007; Cohen, Malka, Rozin, & Cherfas, 2006), these sociological divisions in fundamental doctrine offer a unique forum for evaluating religious community attitudes towards scrupulosity. Specifically, it is possible that Orthodox Jews' value of meticulous adherence to biblical commandments and associated rabbinic teachings creates a reluctance to label scrupulosity as a manifestation of OCD. Orthodox Jews may further be less likely to believe that mental health professionals can provide help for a religion-relevant problem, and therefore be less likely to recommend professional treatment for scrupulosity compared to non-religious OCD. By contrast, non-Orthodox Jews may be more impartial to-

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wards scrupulosity, and therefore be equally likely to label religious and non-religious symptoms as OCD and recommend professional treatment.

The aim of the present study was therefore to examine whether religious factors are related to community recognition of mental illness when the symptoms themselves are religious in nature. Specifically, we hypothesized that Orthodox Jews would be less likely to appraise scrupulosity than non-religious symptoms as OCD and less likely to recommend professional treatment, while non-Orthodox Jews would be equally likely to label scrupulosity and non-religious symptoms as OCD and recommend treatment.

METHOD

MATERIALS AND MEASURES

Vignettes. We created two vignettes describing moderate to severe symptoms of religious (scrupulosity) and non-religious OCD symptoms. Both vignettes portrayed a 19-year-old young man named Binyamin (a relatively common Hebrew, Jewish name). Consistent with a common presentation of scrupulosity among Orthodox Jewish males (Huppert, Siev, & Kushner, 2007; Bonchek & Greenberg, 2009), the scrupulosity vignette described difficulties related to Jewish religious rituals surrounding prayer (recitation of the Shema and donning of phylacteries). The non-religious OCD vignette described symptoms involving excessive safety concerns and checking (see Appendix for both vignettes). Three Orthodox and three non-Orthodox psychology researchers, all of whom have published peer-reviewed papers on OCD in the past five years, reviewed both vignettes. All reviewers indicated that the symptoms described in both vignettes met criteria for a diagnosis of OCD and were equally severe. Furthermore, three Orthodox rabbis reviewed the scrupulosity vignette and deemed that the behaviors described were in excess of Orthodox Jewish community standards.

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General Religiousness. We adapted a measure of general religious practices from measures used previously in Jewish samples (Rosmarin, Krumrei, & Andersson, 2009; Rosmarin, Pirutinsky, Pargament, & Krumrei, in press). The measure contained the following items: (1) How religious do you consider yourself to be? (Response anchors: Very, Moderately, Slightly, Not at All); (2) How often do you speak to God or pray? (Response anchors: Several times a day,

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Once a day, A few times a week, Once a week, A few times a month, Once a month, A few times a year, Once a year or less, Never); and (3) How often do you attend religious services? (Response anchors: Several times a day, Once a day, A few times a week, Once a week, A few times a month, Once a month, A few times a year, Once a year or less, Never). This measure demonstrated moderately high internal consistency in the sample ($\alpha = .82$).

Appraisal of Obsessive-Compulsive Disorder. A single item, "How likely do you think it is that Binyamin is experiencing obsessive-compulsive disorder?" measured appraisal using a four-point scale (very likely, somewhat likely, somewhat unlikely, and very unlikely). This item was drawn from the General Social Survey (Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999).

Attitudes Towards Professional Treatment. To measure attitudes towards professional treatment, we adapted a 9-item scale previously used by Simonds and Thorpe (2003). Participants completed items in reference to the study vignette (e.g., If I were experiencing these problems, I would try and get help from a professional therapist as soon as possible) using a 6-point Likert scale (ranging from agree totally to disagree totally). The measure demonstrated moderately high internal consistency in the sample ($\alpha = .82$).

PROCEDURE & PARTICIPANTS

Participants completed an internet-based survey. We recruited participants through several Internet outlets (e.g., synagogue announcement groups, Orthodox event listings, and religious discussion forums), as well as a number of Orthodox Jewish organizations. In addition, participants were asked to inform their friends and family members about the study to aid recruitment. As this study examined community recognition of OCD symptoms, those reporting professional or volunteer experience with the mentally ill, or a personal diagnosis of OCD were excluded. We included only participants who self-reported Orthodox or non-Orthodox Jewish religious affiliations. Furthermore, as one of the study hypotheses proposed that familiarity with normative Orthodox practice would serve to increase recognition of scrupulosity as OCD, we also excluded any non-Orthodox individuals who reported being raised Orthodox, due to their familiarly with Orthodox religious culture.

The resulting sample consisted of 93 individuals (32 males and 61 females) ranging in age from 19 to 71 years ($M = 39$; $SD = 14$). Of these participants, 70 identified as Orthodox Jews (Yeshiva Orthodox = 19, Modern Orthodox = 49, Sephardic-Religious = 1; Lubavitch = 1) and 23 identified as non-Orthodox Jews (Conservative = 16, Reform = 5, Reconstructionist = 1, Sephardic-Secular = 1).

After giving informed consent, eligible participants were directed to complete items relating to demographics, general religiousness, and religious affiliation. Participants were then randomized to view either the scrupulosity or non-religious OCD vignette. Randomization was conducted without restrictions, blocking or stratification. Participants completed the remainder of the questionnaire in respect to the vignette. This study was approved by a human subjects review board.

RESULTS

To examine religious group differences in recognition of scrupulosity and non-religious OCD, we first conducted a preliminary analysis to examine whether Orthodox and non-Orthodox participants differed in demographic and religious variables (Table 1). There were no significant differences between religious groups in terms of gender, college education, or age. As expected, Orthodox Jews reported higher levels of general religiousness than non-Orthodox Jews.

We then performed a 2-way ANOVA: vignette type (non-religious OCD vs. scrupulosity) by religious affiliation (Orthodox vs. non-Orthodox) examining appraisal of OCD. Results indicated significant main effects for both religious affiliation F (1, 89) = 4.71, p = .03, η^2 = .10, and vignette type on recognition, F (1, 89) = 12.05, p = .001, η^2 = .04, and a significant interaction between these factors, F (1, 89) = 15.39, $p < .001$, η^2 = .13. Examination of the means indicated that Orthodox participants were equally likely to appraise both the scrupulosity and non-religious vignettes as OCD, t (68) = .53, p = .60, whereas non-Orthodox participants were less likely to appraise the scrupulosity vignette as OCD, t (21) = 3.20, p = .004, η^2 = .33 (see Figure 1). For the non-religious OCD vignette all non-Orthodox participants endorsed that symptoms very likely represented OCD (100%), whereas for the scrupulosity vignette only 44% reported so, $\chi^2(3, N = 23) = 9.94$, p = .02. In contrast, among Orthodox par-

TABLE 1. Demographics of Orthodox (n = 70) and Non-Orthodox (n = 23) Participants

	Orthodox	Non-Orthodox	Test Statistic	*p*	η^2
Age—M (SD)	38.04 (13.53)	42.65 (15.42)	t (91) = 1.37	.17	.02
Gender—(% Female)	63%	74%	χ^2 (1, N = 93) = .94	.93	—
College Degree (%)	97%	100%	χ^2 (1, N = 93) = .67	.41	—
Religiousness M (SD)	22.37 (5.64)	17.13 (5.81)	t (91) = 3.84	.001	.14

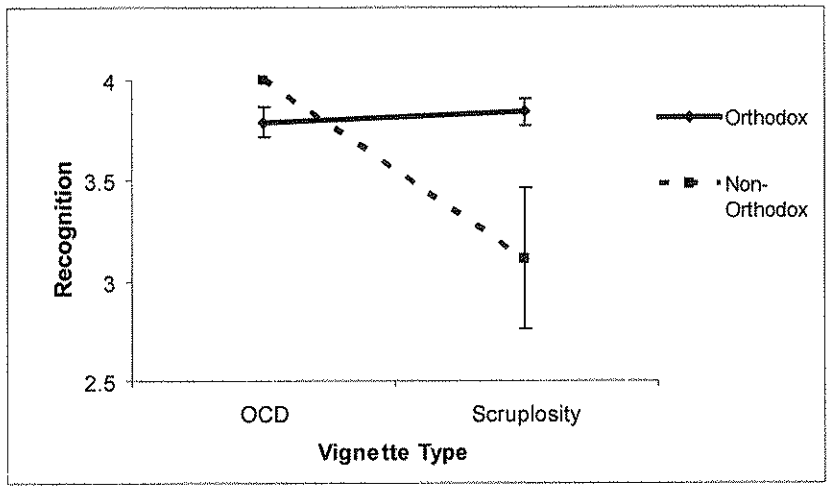

FIGURE 1. Recognition of OCD among Orthodox and Non-Orthodox Jews by Vignette Type.
Note. Points represent cell means; vertical lines depict standard error of the means.

ticipants 82% reported that the non-religious OCD symptoms very likely represented OCD, and 84%, not statistically different, $\chi^2(3, N = 70 = .86, p = .65)$ reported so for scrupulosity.

To explore religious group differences in attitudes towards professional treatment, we performed a second 2-way ANOVA: vignette type (non-religious OCD vs. scrupulosity) by religious affiliation (Orthodox vs. non-Orthodox). Results indicated no significant main effect for religious affiliation, F (1, 89) = 0.37, p = .84, but a main effect for vignette type, F (1, 89) = 7.20, p = .009, η^2 = .07, and a significant interaction between these factors, F (1, 89) = 8.59, p = .004, η^2 = .08. Examination of the means indicated that Orthodox participants were equally likely to support professional treatment for the scrupulosity and non-religious OCD vignettes t (68) = .27, p = .79, η^2 = .001. In contrast, non-Orthodox participants were less likely to support professional assistance for scrupulosity compared to non-religious OCD t (21) = 2.79, p = .011, η^2 = .27 (see Figure 2). In addition, attitudes towards professional treatment significantly correlated with appraisal of OCD (r = .47, p < .001).

Because participants were encouraged to tell family and friends about the study to aid in recruitment, it is possible that some observations in the sample were non-independent. Thus, to test the robustness of these findings within the obtained sample we uti-

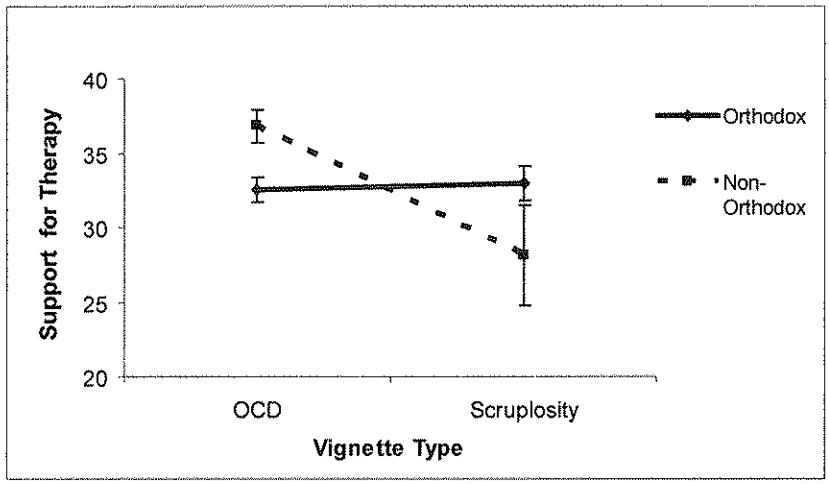

FIGURE 2. Support for Professional Therapy among Orthodox and Non-Orthodox Jews by Vignette Type.
Note. Points represent cell means; vertical lines depict standard error of the means.

lized a bootstrapping method by which we evaluated differences in recognition and attitudes towards professional treatment between scrupulosity and non-religious OCD for both religious groups in multiple (50) randomly generated sub-samples. Results were consistent with the above findings. That is, Orthodox participants were equally likely to appraise both the scrupulosity and non-religious vignettes as OCD $F(1,68) = .28$, $P = .80$, and support professional treatment $F(1,68) = .07$, $P = .79$ whereas non-Orthodox participants were less likely to appraise the scrupulosity vignette as OCD, $F(1,21) = 10.23$, $P = .004$) and less likely to support professional assistance for scrupulosity $F(1,21) = 7.80$, $P = .01$, as compared to non-religious symptoms.

DISCUSSION

In the present study, we examined whether affiliation with Orthodoxy impacted Jewish community members' recognition of scrupulosity as OCD and attitudes towards professional treatment. In particular, we hypothesized that Orthodox Jews, by virtue of their value of meticulous adherence to the precepts of Biblical and Talmudic law, might be more reluctant to label religious symptoms as

a mental illness and less likely to recommend professional treatment for them, as compared to clinically equivalent, non-religious OCD symptoms. We further predicted that non-Orthodox Jews, who do not value strict adherence to the Talmud's legal precepts (Waxman, 1958; Meyer, 1988), would be equally likely to label religious and non-religious symptoms as a mental illness and recommend professional care. Results did not support these hypotheses: Orthodox Jews were equally likely to recognize and recommend professional treatment for religious and non-religious symptoms of OCD, whereas in contrast, non-Orthodox Jews were less likely to recognize and recommend treatment for scrupulosity as compared to non-religious OCD.

These surprising findings raise a number of interesting possibilities. It may be that Orthodox Jews' strict adherence to religious law facilitates improved awareness and sensitivity to normal religious practices, thereby enhancing the identification of scrupulosity. This may indicate that general familiarity with religion serves as a necessary context for formulating appropriate judgments about scrupulosity. Knowledge of normative cultural practices is indispensable for the diagnosis of any mental illness (American Psychiatric Association, 2000), all the more so for scrupulosity, in which one of the central criteria for definition and diagnosis is that symptoms must be excessive in comparison to a patient's cultural or religious group (Ciarrocchi, 1995). By virtue of being knowledgable about Jewish religious practices, Orthodox Jews may be well equipped to recognize the need for professional treatment when faced with scrupulosity. By contrast, it is possible that non-Orthodox Jews are less familiar with normative Orthodox religious practices and are thus less capable of making distinctions between scrupulosity and religion. Non-Orthodox Jews may also be reticent to describe scrupulosity as OCD or recommend professional treatment out of fear of insulting religious individuals, or disrespecting bona fide religious standards. Non-Orthodox Jews may therefore err on the side of caution by failing to recognize religious symptoms as OCD and to recommend professional treatment. All of these possibilities warrant further research.

Our findings may also have important implications for the treatment of scrupulosity in clinical settings. This study highlights the importance of making informed and accurate comparisons between scrupulosity and normative practices of patients' communities when evaluating religious OCD symptoms. Although other

authors have asserted the importance of collaboration with clergy and family members for the purposes of building a therapeutic alliance and facilitating treatment compliance (Huppert et al., 2007), collaboration may also be necessary for diagnosis and assessment. Without gaining familiarity with the nuances of religious community standards, practitioners may unknowingly mistake scrupulosity for authentic religion. Failing to identify where normative religious practices end and OCD begins would seemingly make it unattainable to determine appropriate treatment targets and thus compromise treatment compliance and efficacy. It is also possible that some religious clients who present with scrupulosity sense that their symptoms are perceived as normative religious behavior by non-religious therapists. This may decrease motivation to engage in treatment. Furthermore, non-religious practitioners may not feel confident in their assessment of religious symptoms as OCD, and hence be unwilling to encourage exposure for fear of contravening religious norms. These factors may contribute to the treatment resistant nature of scrupulosity.

Our results further indicate that Orthodox Jews in the current sample were welcoming of professional treatment overall. This may suggest that despite stigma, the Orthodox Jewish community is open to sound, culturally appropriate psychoeducation and evidence-based treatment. It is also worth noting, however, that scrupulosity was highly identifiable among Orthodox Jewish community members in this study. This highlights the importance of assessing for social isolation, social withdrawal and stigma when treating this disorder. This may further suggest that involving family members and religious leaders as collaborators in treatment to provide social and community support may increase treatment response rates.

Several limitations of the present study should be noted. First, although the use of an internet-based recruitment strategy was necessary to facilitate the recruitment of a sufficient number of subjects in light of the generally distrustful attitude of many Orthodox Jews toward psychological inquiry, this approach may have excluded more traditional sub-sects within Orthodox community that do not generally utilize the internet (Barzilai-Nahon & Barzilai, 2005). Second, the anonymous nature of this study makes it impossible to determine whether responses were interdependent. Third, the high percentage of Orthodox Jews in the study made for a sample that is nonrepresentative of the Jewish community overall, al-

though oversampling of Orthodox Jews was necessary to conduct comparative analyses. Fourth, although we removed participants who reported professional or personal experience with mental illness, we did not directly assess knowledge of OCD. We further did not directly assess for knowledge of normative Orthodox religious practice, and instead relied on self-categorization as either Orthodox or non-Orthodox as a proxy for comprehensive knowledge of daily Orthodox practice and experiences. As well, we utilized only a single-item measure of appraisal of OCD and further did not assess whether participants may have appraised symptoms as nonnormative religious practices that are not of clinical or diagnostic significance. While we did assess whether participants viewed symptoms as warranting professional treatment, directly assessing these additional factors may allow for a more nuanced exploration of the relationship between knowledge of religion and mental illness and attitudes towards diagnosis and treatment in future studies. Finally, our study was conducted in a sample of Jewish individuals and it is possible that non-Jewish communities may be more or less likely to recognize scrupulosity as OCD. Previous research has suggested that religion and OCD-related factors are differentially related among Jews and Christians (Siev & Cohen, 2007), and it is therefore possible that appraisals may co-vary differently with religion as well as in different communities. Research within other populations using different recruitment methods, vignettes, and measures is necessary to corroborate our surprising findings.

Future research may employ more elaborate experimental designs by directly comparing appraisals of scrupulosity, non-religious OCD, and normative religious and non-religious practice, to directly assess whether religiousness interferes with recognition of scrupulosity. More broadly, future research should seek to identify how clinicians can improve their ability to distinguish between normative religiousness and scrupulosity, how psychoeducation can be promoted within religious and non-religious groups, and which specific markers promote recognition of scrupulosity (e.g., subjective distress, time spent on compulsions, interference with daily activities, interference with religious practice, cultural abnormality). Nevertheless, this study offers a much needed glimpse into the attitudes of religious communities towards scrupulosity, and the relationship between religion and recognition of its symptoms.

APPENDIX

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SCRUPULOSITY VIGNETTE

Binyamin is 19 years old and lives at home while learning at an "in-town" yeshiva (center for Jewish religious studies). Binyamin has difficulty with davening (prayer). He thinks that he does not have enough kavana (concentration), and as a result he feels compelled to repeat the first line of the Shema (a part of davening) over and over again. In one part of davening, he feels unable to continue unless he repeats the words five times. Consequently, shacharis (the morning service) can take him an extra hour to complete, and yet when finished, Binyamin still feels that he did not have enough kavana and that his prayers were not niskabel (accepted). Recently, Binyamin saw a sign in shul (synagogue) that warned of the importance of tefilin (phylacteries) and explained in detail the relevant halachos (laws). Since then, he has become preoccupied with ensuring that his tefilin are properly positioned, that they are lying directly on his head, and that the retzu'os (straps) are completely black with no stains or marks. Binyamin checks his tefilin, their position, and his retzu'os throughout davening and he finds himself worrying about them while learning. These worries increasingly consume his daily life, and those around him have become concerned.

NON-RELIGIOUS OCD VIGNETTE

Binyamin is 19 years old and lives at home while learning at an "in-town" yeshiva (center for Jewish religious studies). Binyamin has difficulty with his front door. Whenever leaving his house, he thinks that he has not locked the door and he feels compelled to return to his door over and over again to check that it is locked. He also feels unable to leave his home unless he looks over his front windows five times, to check that they are not broken. Consequently, it can take Binyamin an extra hour to leave his house and get to yeshiva, and yet, when he leaves, he is still concerned that his door is not locked. Recently, Binyamin saw a sign in the street warning about open manhole covers during construction. Since then, he has become preoccupied with ensuring that all the manhole covers in

the street are closed, that they are lying flat and level with the road, and that there are no gaps between the covers and the holes. Binyamin checks manhole covers whenever he goes to yeshiva and he finds himself worrying about them throughout his way to yeshiva. These worries increasingly consume his daily life and those around him have become concerned.

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