THE FUNCTION OF RELIGIOUS FAITH AND BELIEFS IN OBSESSIVE COMPULSIVE DISORDER

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Abstract

This paper is a review of the scientific literature regarding the topic of the function of religious faith and beliefs in Obsessive Compulsive Disorder (OCD). The mentioned papers are exploring a connection between religion and Obsessive-Compulsive Disorder (OCD) as well as religion's influence in the development of OCD, and its effect on the treatment follow-ups. Moreover, it has been shown that there are both positive and negative effects considering scientific evidence and theoretical links about religion and mental health image in the general population. Extended research regarding OCD and religion is provided. Next, we attempt to make a division between religious faith (trust - *πίστη - "**how** we believe*") and religious beliefs (the system regarding the symbol of faith - *credo - "**what** we believe")* and consequently connect them with the already existing research papers additionally with feasible new topics of research.

Keywords: *religiosity, OCD, obsessive compulsive disorder, obsessions, compulsions, scrupulosity, faith, religious studies, cognition, Cognitive Psychology, Psychology, Clinical Psychology, Psychiatry*.

Obsessive compulsive disorder (OCD) is an anxiety disorder, which is characterized by the intense presence of obsessions and / or compulsions (DSM - 5). There is a high possibility of co-morbidity with other mental disorders such as; anxiety disorders, major depression, and tic disorders (Attiulah, Eisen, & Rassmussen, 2000; Brown et al., 2001; Mayerovitch et al., 2003.)

Moreover, in ICD-10; obsessive compulsive disorder is characterized as a disorder with obsessional thoughts and/or compulsive actions. There are two major clinical symptom clusters: obsessions and compulsions. Obsessions are distressing and repetitive thoughts, ideas, or impulses that are outside of a person's volitional control (DSM IV; American Psychiatric Association [APA], 2000).

It must be stated that regular obsessions might include: fears of harming oneself or another person, serious concerns of contamination, significant somatic concerns, potent thoughts of absolute symmetry, and religious intrusions (Foa et al., 1995). The aforementioned obsessive thoughts / ideas can be recognized by the person most of the times as distressing and disquieting. Initially, the person will try to resist the urge of thinking obsessively; consequently, the thoughts, most of the times, will be associated with increased

anxiety levels. As the disorder progresses the anxiety levels become even more intolerable for the person and the thoughts can't be resisted easily anymore.

Secondly, compulsions; are defined as recurring behaviors or mental actions, that are conducted according to certain regulations and are characterized by stereotypical reactions (APA, 2000). Furthermore, compulsions might include: immoderate cleaning and washing, excessive and repeated checking, repetitious and almost "ritualistic" Behaviors, or mental compulsions (Foa et al, 1995; ICD-10). As the disorder and the obsessions evolve; the compulsions become more frequent due to the fact that the anxiety levels are also rising. In order to be relieved from the high levels of anxiety and the numerous obsessive thoughts; the person seeks comfort in compulsions and "safety" behaviors which have an intense ritualistic character. Obsessive compulsive disorder is a very serious and demanding mental illness, which excludes the patient from his or her other every day activities. The prior condition is often continual and stands firm over an individual's life (Hollingsworth et al., 1980).

Obsessive Compulsive Disorder (OCD), social functioning, and religion.

OCD can also be correlated with serious deteriorations in social functioning (Andrews, Henderson, & Hall, 2001). Moreover, as mentioned above, OCD seems to also have a symptomatology linked to religious themes. The symptoms include: intrusive thoughts (obsessions) regarding mainly religious blasphemy, hyper-morality, compulsive prayers, repeating rituals (compulsions), repetitive reassurance regarding their actions, and last but not least; washing/cleansing rituals. The percentage of the religious rituals/compulsions and obsessions correlated with OCD are called Religious Obsessive-Compulsive Disorder (ROCD) (Himle et al., 2011).

The purpose of this paper is to inspect the association between OCD and religious mental engagement regarding the manifestations of Obsessive-Compulsive Disorder as ROCD. Furthermore, we pursue an analysis between religious faith (trust - πίστη - "how we believe"), religious beliefs (the system regarding the symbol of faith - credo - "what we believe"), and evaluate if this particular division actually has a stronger correlation with the intense symptoms of ROCD. Our main intention is to delve into the deeper clinical paths of OCD - within its relation with ROCD, and perceive its clinical manifestations. The subsequent parts of the essay were inspecting also the already available research regarding OCD and religious themes, ROCD, and clinical treatments and implications.

Scrupulosity

The term "scrupulosity" defines a sub-type of OCD. Scrupulosity's characteristics include an intense presence of moral and religious fears and obsessions. It is observed; that in some particular cultures a percentage of 40-60% of the population with OCD encounter religious obsessions (Tek & Ulug, 2001). Furthermore, the content of religious obsessions and fears regarding scrupulosity consist of the idea of sin or being an immoral individual - according to the ethical laws of each religion. Nevertheless, the aforementioned themes can vary in each religion (Huppert & Siev, 2010). A very characteristic example of scrupulosity in individuals can be detected in Christian clinical population (Siev et al., 2011). The blasphemous ideations can be composed of obsessions in which the individuals are provoking God, burning in the Eternal Flames, or pays homage to the Devil. On the other hand, scrupulosity in Jewish clinical population is detected in obsessions about defying laws of behavior and ritualistic purity (Rosmarin et al., 2010). In this particular case; the prevailing compulsions are the following: excessive prayer, the individual mentally counterbalances his or her 'unacceptable' thoughts, exaggerated confessions and consultations with the clergy, and immoderate washing and checking in order to avoid spiritual contamination (Siev et al., 2011).

Scrupulosity seems to have an intense resistance to treatment methods as an OCD sub-type and therefore it hasn't been examined much. Several studies have focused on the link between religious symptoms and other (generally) variables such as: cognition, religiosity (ROCD), anxiety, depression, and stages of severity (Nelson et al., 2006; Olatunji et al., 2007; Tek & Ulug, 2001). Nonetheless, all the studies that have been done to examine scrupulosity as a clinical entity do not allow the establishment of its standard mechanisms (Tolin et al., 2001).

Moreover, after thorough examinations; clinicians have concluded that scrupulous individuals might view their symptoms as part of their religious practice and not as psychiatric symptoms. The aforesaid might occur due to the individual's inferior judgement or magical thinking (Tolin et al., 2001).

Religion and psychopathology

An observance of the recent developments in cognitive theories has led the researchers to a emphasize on the probability, that religion (or a specific aspect of religiosity) may be associated to the development or maintenance of OC symptoms. There are differences between; personal religious commitment (e.g., strength of faith), religious application (e.g., the extent to which religious faith is applied to day-to-day behaviors) and one's personal religious beliefs (e.g., whether one conceptualizes God as caring or punitive).

Furthermore, higher levels of religiosity are associated with lower levels of anxiety (Gallagher et al., 2002; Hill & Pargament, 2003; Koenig et al., 2003) and lower levels of depression (Hodges, 2002; Larson & Larson, 2003; Murphy et al., 2000). When positive mental health indicators are used, religious commitment and participation has been found to promote happiness (Campbell, Converse, & Rodgers, 1976), and most importantly; enhance one's perceived meaning in life (Emmons et al., 1998). Moreover, the crucial positive effects, which are associated with religion can be also seen in some studies and the probable negative effects which are mainly predicted by cognitive theories are consistent, only if the theory that religion is correlated with higher levels of OC symptomatology and lower levels of generalized anxiety and depression, etc.

Religious culture, OCD, & monotheistic religions.

In a research by de Bilbao F. and Giannakopoulos P., released in 2005, an interesting division it is done regarding the effect of religious culture on OCD symptomatology. The researchers are focusing on the differences of religious culture on the clinical populations with OCD. They support that dissimilar cultural aspects may affect the nature of obsessions and compulsions correlated to OCD. Specifically, a vast amount of symptoms correspondent to religious obsessions are more extensive and frequent in clinical populations from cultures in which religion in highly related and connected with the community. Moreover, by previous studies, we can observe that the clinical populations that have been examined are mainly Jewish, Muslims, Catholics, or Christians (Greenberg & Shefler, 2002; Greenberg & Witztum, 1994; Hermesh et al., 2003; Huppert, Siev & Kushner, 2007, Lewis, 1994; Lewis & Maltby, 1995; Steketee et al., 1991; Al-Solaim & Loewenthal, 2011; Rosmarin, Pirutinsky & Siev, 2010; Zohar et al., 2005; Besiroglu et al., 2012, etc.). Even though, along with the Catholic and Christian population Protestant population is examined too (Abramowitz et al., 2004; Abramowitz et al., 2002; Higgins et al., 1992, Koenig et al., 1993; Nelson et al., 2006; Steketee et al., 1991). There are only few researches regarding Obsessive Compulsive Disorder and polytheistic religions such as Hinduism or Buddhism (Okasha et al., 1994; Raphael et al.,1996). In all the aforementioned researches a correlation between religiosity or scrupulosity and OCD has been established and various divisions (e.g. between the ultra-orthodox and non-ultra-orthodox Jews) have shown that population with more intense religiosity are more likely to present ROCD symptomatology (Greenberg & Shefler, 2002; Greenberg & Witztum, 1994).

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 dis-

proportionate 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 are 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). Most researchers 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 ultra-orthodox Israelis were more likely to endorse OCD symptoms related to religion compared to those who were not ultraorthodox (Greenberg & Witztum, 1994; Greenberg & Shefler, 2002).
Ergo; clinicians and researchers should be more conscious of the fact that religious obsessions and compulsions differ and may be more rampant in certain cultures.

The distinction between religious faith (trust - πίστη - "how we believe") and religious beliefs (the system regarding the symbol of faith - credo - "what we believe").

A theoretical separation must be also done regarding religious faith, religious beliefs, and the symptomatology of OCD.

Additionally, in 1981 James W. Fowler came up with the developmental model of "Stages of Faith". The term 'Fowler's stages of faith' refers to a developmental psychology model considering faith across the life span of an individual proposed in 1981 by James W. Fowler.

"Faith" is considered as a holistic position with accord to the individual's relevancy to the universal energy. Fowler distinguishes between six stages of faith development (Fowler, 1981, 2001):

"Stage 0: Primal or Undifferentiated faith (from birth to 2 years), is characterized by an early learning about the safety of their environment (i.e., warm, safe and secure v's hurt, neglect and abuse).
Stage 1: Intuitive - Projective faith (ages of 3–7) is characterized by the psyche's unprotected exposure to the unconscious.

Stage 2: Mythic - Literal faith (mostly in school children) involves a strong belief in the justice and reciprocity of the universe.
Stage 3: Synthetic - Conventional faith (arising in adolescence) is mainly characterized by conformity.
Stage 4: Individuated - Reflective faith (from mid-20s to late 30s) implies that the individual takes personal responsibility for his or her beliefs and feelings.
Stage 5: Conjunctive faith (mid-life crisis) acknowledges paradox and transcendence relating reality behind the symbols of inherited systems.
Stage 6: Universalizing faith is sometimes called the phase of "enlightenment"." (Fowler Faith Stages. In: Seel N.M. (Eds) Encyclopedia of the Sciences of Learning, 2012).

A similar model of religious faith progression has been suggested by Oser and Gmunder (1991).

Interestingly enough; Fowler (1981) resulted that religious individuals can remain in the third stage or proceed to the stage of individualistic - reflective faith, the stage four of faith progressions, in which people can embrace new value schemes as a consequence of disclosure to different ways of life or different cultures. In 1999 James Fredericks moved beyond the prominent "pluralist" model of religions by studying theology 'comparatively' and consequently analyzes the meaning of Christianity from the prism of non-Christian religions in his book "Faith among Faiths" (James L. Fredericks. New York: Paulist, 1999).

Religious Obsessive-Compulsive Disorder (ROCD); faith, & beliefs.

The papers and researches that have been made regarding the symptomatology or treatment of OCD and ROCD focus on religious obsessions and compulsions as they consider both a matter of religious faith and beliefs.

There is a possibility if a more detailed distinction between faith and beliefs will be made - regarding the clinical population with ROCD; clinicians could be able to understand the mechanisms of ROCD and scrupulosity. A wider clinical population could be included and the religious obsessions could be understood in a more comprehensive analysis. In 2004 Abramowitz et al. examined a 8,5% population of Atheists with Obsessive Compulsive Disorder symptoms and resulted that: "The highly religious evinced more obsessional symptoms such as; compulsive washing, intolerance for uncertainty, need to control the thoughts, beliefs about the importance of thoughts, and inflated responsibility, compared to atheists/agnostics" (Abramowitz et al, 2004). In the case of atheism / agnosticism; the factor of faith (trust - πίστη - "how we believe") is probably eliminated due to the lack of standard religious rituals. In addition, religious beliefs (the system regarding the symbol of faith - credo - "what we believe") must also be examined individually. Thus, atheist and

agnostics demonstrate less obsessional and compulsive symptoms also due to the absence of faith or a religious system.

Furthermore, the very essence of particular religious beliefs and their correlation to ROCD has also been studied with Raphael, Rani, Bale, and Drummond (1996). They concluded that a larger percentage of OCD individuals were religiously associated - in a clinical status - than the control group of non-OCD individuals. Nevertheless, another study supports that OCD individuals were no more probable to be religious than individuals with other anxiety disorders or personas without generally other mental health problems (Hermesh et al., 2003).

Nevertheless, Sica and colleagues (Sica, Novara, & San-vio, 2002) resulted that highly religious individuals were more likely to manifest a correlation between OCD symptoms and high percentages of the essentiality of thoughts and the urge to regulate these particular thoughts. Additionally, there is a suggestion that religious beliefs may actually affect the essence of OCD clinical symptoms. Also, clinical patterns, propose that by believing that an individual is accountable for sinful obsessions and thoughts can force endeavors to restrain and regulate an individual's way of thinking. Thought suppression and obliteration is presumably efficient in altering reasoning for several persons. This particular 'technique' develops the repetitiveness and acuteness of obsessional reasoning regarding individuals with OCD (Tolin, Abramowitz, Prezeworski, & Foa, 2002). Moreover, in 2004 Abramowitz and colleagues (Abramowitz et al., 2004) conducted a study that supported that the percentage of profoundly pious Protestants were more likely to manifest specific OCD affiliated cognitive symptoms including the assumption that thoughts are crucial and thus; they need to be regulated. Lastly, thoughts and obsessions that are contemplated to be incongruous to an individual's authentic belief are principally probable to aggravate obsessions, among individuals with OCD symptomatology (Langlois, Freeston, & Ladouceur, 2000).

It is also essential to emphasize that a correlation between profound religiosity and specific obsessions and compulsions does not automatically demonstrate that by being highly pious concludes to the progression of specific clinical OCD symptoms. Moreover, many individuals with OCD may evolve into a more pious individual as a cognitive antiphon to their OCD symptoms, which actually might clarify, moderately, the correlation between high rates of religiosity and certain obsessive– compulsive complications.

Many exclusive cases have shown that religion can be a redemption to an individual with physical and mental health issues (Seybold & Hill, 2001) but is it really redemptive or it works as a placebo for cognition?

And last but not least; a purpose-built question comes in mind when examining ROCD and Religious Studies: Is the differentiation between faith and religious beliefs, in a more cognitive and developmental stage, will eventually

bring different results to the understanding of religious obsessions and generally ROCD?

Obsessive Compulsive Disorder (OCD) and Magical Thinking.

Patients with OCD use different strategies to control their obsessions or unwanted thoughts, including: thought replacement, distraction, obsessions' stopping, analyzing or overanalyzing the thought or obsession, and suppression of thoughts (Freeston & Ladoceur, 1997).

Clark's cognitive-behavioral model of OCD (Clark, 2004; Purdon & Clark, 2002) emphasizes on the crucial role of the non-appraisal of unsuccessful activities of thought-control attempts. Considering this particular cognitive-behavioral model, patients with OCD may have a false belief of absolute control that might be possible and consequently there is also a high inability to achieve it is failed mental control.

Nevertheless, due to the fact that neutralizing attempts have been suggested to be affiliated with magical ideation (Bocci & Gordon, 2007), procedures of thought control should be associated to magical thinking, as well as obsessive - compulsive symptomatology.

Conclusion and Limitations

Religion and religious affiliations in general have been associated with higher levels of mental but also physical health states at both the general population and individual clinical level. Nevertheless, considering the essential positive influences of religion on health, there are also specific paradigms in which religious affiliations, content, and rituals are highly correlated with mental health problems. Recent studies are connecting crucial elements of religion (e.g., religious intensity, denomination, and religious faith) and OCD are characteristic. Although, additional researches and studies are definitely needed in order to understand the specific correlations to OCD behavior and symptomatology. Moreover, regarding the clinical treatment of OCD with religious elements, we can emphasize on both essential medication and strict Cognitive Behavioral Therapy. As the years pass by a more recent and detailed research regarding the clinical treatments for ROCD and practice implications for clinicians and clergy can be organized and done.

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APPENDIX

Author(s)	*N*	Religion	Diagnostic Criteria	OCD (and general) measures	Results
Abramowitz et al. (2004)	1005	Protestant (74,8%), Catholic (16,7%), Atheist (8,5%).		OBQ, OCI-R	Obesessional 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 occurence of OCD.
Besiroglu et. al (2012)		Muslim (100%)	DSM VI		Treatment Implications regarding scrupulosity in Islamic world and OCD population.
Cefalu P. (2010)					The essay argues that; although, modern theologians manifest scrupulosity; such as religiosity was culturally acceptable, even recommended component of spiritual progress, a necessary means of receiving an unmerited bestowal of God's grace. Limitations of the current DSM criteria regarding the diagnosis of historical figures with mental pathology.
Dettore et al. (2016)	354	Jew (n=97), Christians (n=139), Muslims (n=118).	DSM VI	OBQ-87, III, PI, BAI, BDI-II	After controlling for anxiety and depression symptoms; Muslims had more severe OC symptoms and cognitions comparing to Jews and Christians. The level of religiosity did not appear to be significantly associated with OC symptoms and cognition severity.
Eremsoy & Inozu (2015)	179			DIF, MIS, TCQ, OCI-R.	Mediating role of magical thinking through punishment and worry in the relationship between religiosity and OC symptoms are novel.
Fallon et. al (1990)			DSM III		Treatment in moral or religious scrupulosity.

Gonsalvez et al. (2007)	179	No religion (n=51), Catholic (n=46), Protestant (n=58).			Religion bore a less major but significant association with OC phenomena. Religious affiliation was associated with higher level of OC symptoms. Higher levels of personal religiosity (strength of faith) were correlated with higher levels of scrupulosity.
Gonsalvez et al. (2010)	179	Catholic (n=46), Protestant (n=58), No religion (n=51), Christian (n=10), Other (n=14).			Religion bore a less major but significant association with OC phenomena. Religious affiliation was associated with higher level of OC symptoms. Higher levels of personal religiosity (strength of faith) were correlated with higher levels of scrupulosity.
Greenberg & Shefler (2002)	28	Ultra-orthodox Jew (100%).	ICD-10		Patients exhibited three times more religious OCD symptoms than non-religious symptoms.
Greenberg & Witztum (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.
Himle et al. (2012)	6082 (interviews) / 72,3% response rate.	African Americans and Black Carribeans.	DSM VI	DSM IV, WMH-CIDI.	Frequent religious service attendance was negatively associated with OCD, whereas Catholic affiliation (compared to Baptist), and religious coping (prayer) were both positively associated with OCD.
Huppert et al. (2007)		Ultra-orthodox Jew (100%).	DSM IV		
Koenig et al. (1993)	2969	Pentecostal (4,2%), Conservative Protestant (59%), Mainline Protestant (28%), Catholic (2,7%), other (1,9%), non-denominational (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	Christian (100%).		S-HOI	A positive attitude towards religion was positively correlated with obsessional personality trait in females only.
	Study 2: 167	Christian (100%).		S-HOI	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.
Mahintorabi et al. (2015)	139	Muslim Women (100%)		DRI, Y-BOCS, DRI, SCSF, RFS-R, PIOS, OBQ-44, OCCWG.	Models of OCD scrupulosity for high religious Muslim women.
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	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, & Hehia (1994)	90	Muslin, 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.
Pirutinsky et al. (2009)	169	Orthodox Jew (100%)		Two vignettes (Religious - Non-Religious OCD).	Attitudes towards mental illness may depend on how symptoms relate to community culture.
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.
Rosli et al. (2017)	Case report	G. Adolescents	DSM VI	DSM VI	
Sica et al. (2002)	165	Catholic (100%)		OBQ, III, PI	Religiosity was positively correlated with obsessionality and obsessive-compulsive cognitions.
Siev et al. (2011)	72	Catholic (28%), Protestant (17%), Jewish (6%), Muslim (3%), Hindu (1%), Other Religion (28%), No religion (18%).	DSM VI	OCI-R, PI	Scrupulous individuals endorsed that their symptoms interfered with their religious experience. More negative concept of God - More negative symptoms.

Siev et al. (2017)	77	Muslim (n=34), Jewish (n=43).	DSM VI	TAFS, OCI-R, PIOS, BDI II, STAI.	Muslim group had higher level of OC symptoms, scrupulosity, and depression.
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.
Solaim & Loewenthal (2011)		Young Muslim Women (100%)	DSM IV	MOCI	1. Help seeking behavior, 2. Perception of causality of obsessional symptoms, 3. Symptoms in the religious domain are more disturbing than in other domains, 4. Symptoms related to daily prayer.
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.
Witzig Jr. & Pollard (2012)	318	Protestant Christians (100%)		OCI-R, BDI-II, STAI-T, RCI-10, RFS, SWBS, PIOS, OBQ-44.	Scrupulosity positively correlates to obsessional beliefs and negatively correlates to religious commitment and spiritual well-being.
van der Hooft et al. (2017)	377	No religion (45%), Protestant (23%), Roman Catholic (32%).	DSM IV	DSM IV-TR, Y-BOCS, BDI, BAI	Roman Catholic patients scored significantly higher on anxiety and depression than non-religious patients and endorsed significantly more OC cognitions. The relationship between religious denomination, level of religiosity, and clinical aspects of OCD may be mediated by comorbid psychiatric symptoms (anxiety and depression).
Vassiliou A. (2014)	60	Christian (n=33), Muslim (n=12), Budhist (n=1), Hindu (n=1), Sikh (n=3), Atheist (n=6).		SCSRF	OCD symptoms were correlated with higher illusiory SC (). Religiosity levels were related to some degree to OCD symptoms.
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%).		People who became more religious were higher in OC behavior than those who became less religious.
Yossifova & Loewenthal (1999)	96	Christian and non-Christian backround (50-50%).	Analogue Scales	High religious activity - judged as obsessional and having psychological symptoms.

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; PIOS, 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.