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Religious observance and obsessive compulsive washing among Iranian women

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ABSTRACT

This study examined relationships between religiosity, scrupulosity, cognitive beliefs and Obsessive–Compulsive Disorder (OCD) among High Religious (HR) and Low Religious (LR) Muslim women with OCD washing subtype (OCD-W) who presented for treatment in Tehran. Four groups of women were recruited for the study: HR Muslim women with OCD washing subtype ($n=33$); HR Muslim women without OCD ($n=45$); LR Muslim women with OCD-W ($n=31$); LR Muslim women without OCD ($n=30$). The OCD-W group had higher scores than the non-OCD group on measures of scrupulosity and beliefs. The HR group had higher scores on religiosity, scrupulosity and beliefs than the LR group. Compared to LR Muslim women with OCD, HR Muslim women were first diagnosed with OCD symptoms at a later age, their OCD symptoms were of maximum intensity at a later age, first sought help for OCD at a later age, were older at the time of their last visit to a health professional, were less likely to have been previously treated for OCD and scored higher on self-report measures of OCD symptomatology at the time of assessment. These findings have implications for models of OCD scrupulosity and for early diagnosis and treatment of OCD for highly religious Iranian Muslim women.

1. Introduction

Obsessive Compulsive Disorder (OCD) is characterised by the presence of persistent and intrusive obsessions, which may result in the performance of repetitive behaviours known as compulsions (American Psychiatric Association, 2013). OCD is associated with significant impairment for individuals across many areas of life, such as work, school, social activities and family settings (Bobes et al., 2001; Fontenelle et al., 2010; Subramaniam, Abdin, Vaingankar, & Chong, 2012).

Although OCD prevalence is approximately equal across different countries (Karno, Golding, Sorenson, & Burnam, 1988; Kolada, Bland, & Newman, 1994; Mohammadi et al., 2004; Weissman et al., 1994), variation has been found in the frequency and theme of the obsessions experienced by people in different cultures (Ghassemzadeh, Khamseh, & Ebrahimkhani, 2005). While contamination obsessions and washing compulsions are among the most common OCD symptoms (de Silva, 2003), religious symptoms (e.g., fear of impurity, repeating prayers) have been found to be more common among Iranian (67%; Ghassemzadeh et al., 2005; 62%; Ghassemzadeh et al., 2002), Israeli (50%; Greenberg, 1984) and Saudi Arabian samples (50%; Mahgoub & Abdel-Hafeiz, 1991), compared to a Spanish sample with OCD (7.5%; Labad et al., 2008) and a sample with OCD from the USA (21%; Mataix-Cols, Rauch, Manzo, Jenike, & Baer, 1999).

Related to this, Rachman (1997) proposed that the beliefs and practices of a particular religion may influence the expression of an individual's OCD symptoms. While studies conducted in Australia suggest that people with OCD wash because they feel contaminated by dirt and germs and seek to reduce the risk of disease or illness (e.g., Jones & Menzies, 1997, 1998), samples from Iran, Egypt, Saudi Arabia and Israel have reported that their OCD washing rituals are driven by beliefs about purity (Greenberg & Shefler, 2002; Okasha, Saad, Khalil, El Dawla, & Yehia, 1994). Notably, purity is associated with the cultural practices of religions such as Islam and Judaism (e.g., Al-Solaim & Loewenthal, 2011; Ghassemzadeh et al., 2005; Greenberg & Shefler, 2002; Shooka, al-Haddad, & Raees, 1998). Specifically, fear of impurity and the performance of washing and cleansing religious rituals related to impurity have been observed in both Muslim samples with OCD (Ghassemzadeh et al., 2002, 2005), and Jewish samples with OCD

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(De Bilbao & Giannakopoulos, 2005; Greenberg & Witztum, 1994). Both Islam and Judaism include cleansing rituals among their religious practices (Greenberg & Shefler, 2002; Okasha et al., 1994). Additionally, OCD washing-related symptomatology associated with religiosity has also been found in Christian samples (Abramowitz et al., 2004).

Scrupulosity is an obsessional theme that has a close relationship with religiosity and morality (Yaryura-Tobias & Neziroglu, 1997; Yorulmaz, Karanci, & Tekok-Kilic, 2002) and is common among those with OCD (Abramowitz et al., 2002). Higher levels of religiosity have been found to be associated with scrupulosity, regardless of religious affiliation (Gonsalvez, Hains & Stoyles, 2010). People with scrupulosity may perform compulsions such as repeatedly seeking reassurance from religious leaders, repeatedly engaging in cleansing and purifying rituals, excessive praying, or repeating passages from sacred texts (Greenberg & Huppert, 2010; Sharma, Kumar, & Sharma, 2006). Research investigating scrupulosity and religiosity in OCD is important given that people with scrupulosity respond poorly to treatment compared to people with OCD without scrupulosity (Alonso et al., 2001; Ferrao et al., 2006). Additionally, Abramowitz and Jacoby's (2014) cognitive–behavioural model of scrupulosity proposes that strong adherence to religious beliefs and principals maintains scrupulosity by increasing the likelihood that an individual will misinterpret unwanted intrusive thoughts as personally significant and sinful.

It has also been suggested that those with scrupulosity may understand their OCD symptoms to be a part of their usual religious practice, and therefore not seek professional help to change their thoughts and behaviours (Huppert & Siev, 2010). Previous research has revealed that the most common first source of assistance about OC symptoms in scrupulous people are religious authorities like clergy, Rabbis, Imams and faith based healers (Huppert & Siev, 2010; Wills & DePaulo, 1991). Greenberg and Shefler (2002) reported that participants with OCD preferred to receive psychotherapy for their non-religious symptoms but preferred to talk to their Rabbi about their religious symptoms. Therefore, understanding the relationship between OCD symptomatology and religious beliefs and practices may have important implications for treatment (Akuchekian, Jamshidian, Maracy, Almasi, & Davarpanah Jazi, 2011).

Al-Solaim and Loewenthal (2011) recruited a sample of Muslim females with OCD ($n=15$) from central Saudi Arabia in order to explore the role of religion in the manifestation of OCD symptoms. Using semi-structured interviews the researchers found that 14 (93%) of the women reported that religious OCD symptoms caused them the most suffering or distress. The majority also reported praying was the main behaviour they used to decrease OCD-related anxiety. While it is not possible to say that religion had a causal role in the development of OCD, it did appear to influence how the OCD symptoms were manifested in this small sample (Al-Solaim & Loewenthal, 2011).

Ghassemzadeh et al. (2005) recruited a sample of 135 Iranian Shia Muslims diagnosed with OCD and found that religious symptoms, such as fear of impurity, were significantly more common in females (77%) compared to males (47%). However, like other studies, Ghassemzadeh et al. did not employ a control group of Iranians with OCD who were not highly religious to examine the extent to which these findings are specific to religion rather than ethnicity. Thus, there is evidence that religiosity (Greenberg & Shefler, 2002) and/or religious affiliation (Abramowitz et al., 2004; Ghassemzadeh et al., 2005) is associated with OCD symptom presentation. However, some researchers have not found a relationship between religiosity and OCD. For example, Tek and Ulug (2001) found no relationship between religiosity and features of OCD among 45 Turkish outpatients with OCD. Similarly, Raphael et al. (1996) did not find a significant association between religion and OCD symptoms among 49 British patients with OCD.

It should be noted that some of the research discussed above employed small samples, and this may account for inconsistent findings. Additionally, the lack of a low religious control group in many studies (Al-Solaim & Loewenthal, 2011; Ghassemzadeh et al., 2005), means that the specificity of findings to religious affiliation rather than broader cultural factors also limits the conclusions that can be drawn from previous work. This study aimed to address these limitations by recruiting a large sample of female Muslims with and without OCD-Washing (OCD-W) who varied in religiosity. Obtaining a better understanding of the nature of OCD-W within a religious society may improve early access to effective treatment, as well as help to direct treatment plans for HR Muslim patients with OCD.

Consistent with previous findings it was predicted that there would be a significant effect of both religiosity and OCD-W status on a measure of scrupulosity. The study also explored the relationship between OCD-W status and religiosity and beliefs regarding, Perfectionism/Certainty, Importance/Control of thoughts and Responsibility/Threat estimation subscales of the Obsessive Beliefs Questionnaire (OBQ-44; Obsessive Compulsive Cognitions Working Group, 2005). The current study is the first investigation of cognitive variables in women with and without OCD-W with high and low religiosity in Iran.

2. Method

2.1. Participants

A total of 139 Iranian Muslim females aged 18–64 years (mean age=37.7 years; SD=11.1) were recruited for either the OCD-W group ($n=64$) or the non-OCD control group (Non-OCD; $n=75$). Participants in the OCD-W group were recruited from Tehran University counselling centre and four private psychiatric clinics in Tehran. All participants in the OCD-W group were females diagnosed by psychiatrists and psychologists as meeting criteria for OCD with predominant washing concerns. Participants without OCD were invited to take part in the study through advertisements at medical and psychological centres in Tehran.

All participants were further divided into High Religious (HR) ($n=78$) and Low Religious (LR) ($n=61$) groups based on their response to a question from the Duke Religion Index (Koenig, Parkerson, & Meador, 1997). Those who answered “definitely true of me” or “tends to be true” to the item “my religious beliefs are what really lie behind my whole approach to life” were allocated to the HR group, and those who chose “definitely not true” or “tends not to be true” to the same item on the DRI were allocated to the LR group. This is similar to the procedure used by Inozu, Clark, and Karanci (2012) to define their high religious and low religious groups.

2.1.1. Materials

Background Demographic Questionnaire included questions about age, marital status, educational background, age of OCD onset, content of OCD symptoms, OCD symptom severity, as well as questions pertinent to level of religiosity, such as the number of prayers per day, the locations chosen for daily prayer, the type of religious rituals engaged in and the number of days fasting in a year.

Yale–Brown Obsessive–Compulsive Scale (Y–BOCS; Goodman et al., 1989a; Goodman, Price, Rasmussen, & Mazure, 1989b). The Y–BOCS is a clinician administrated scale comprising 10 items (Goodman et al., 1989a, 1989b). This scale measures symptom severity and provides five rating dimensions for obsessions and compulsions: (1) time spent or occupied with obsession or