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Religiosity and obsessive–compulsive behavior in Israeli Jews

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Abstract

Individual differences in obsessive–compulsive (OC) behavior in various cultures correlate with religiosity. The current paper explored the so far unstudied relationship between religiosity and OC behavior in Israeli Jews. Two studies were conducted. Study 1 focused on the relationship between religiosity and OC behavior in a representative sample of Israeli students. Study 2 focused on religious change and OC behavior in a non-random sample of 31 individuals who had become more religious (the MR group), and 30 individuals who were less religious (the LR group) than their parents. Instruments used were the Maudsley obsessive–compulsive inventory (MOCI), the student religiosity questionnaire, and questions about parental home observance, upbringing, and changes in religiosity. In the first study, no association was found between religiosity and OC behavior. Religiosity was related to some degree to perfectionism and to the parental attitude to upbringing. In the second study, a significant difference was observed between the MR and the LR groups on OC behavior as measured by the MOCI. Conclusion, among Israeli Jews a lot of religious observance is non-reflective, and is not associated with individual differences in personality or OC symptoms. Those who undergo religious change may do so in response to their behavioral propensities. One such path is that the more OC become MR, and the less OC less religiously observant.

Keywords: OCD; Religion; Religious change; Perfectionism; Culture

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1. Introduction

The hypothesis that there is a relationship between obsessive–compulsive (OC) neurosis and religiosity originated with Freud (1907/1953), who described religion as a universal obsessional ritual, designed to avert imaginary misfortunes and control the unconscious impulses that lead us to feel that we are causing them. This hypothesis was not popular with religious leaders of the time, and was also criticized by psychologists. Erikson (1977) pointed out that while OC behavior was accompanied by shame and was usually conducted in private, religious observance was usually conducted in social and public settings, and served to connect people rather than isolate them. While Freud's hypothesis was subject to criticism over the years it has also been studied in many different cultures both in connection to OC behavior and to obsessive–compulsive disorder (OCD).

Cognitive behavioral theory puts OC behavior on a continuum, with one or two obsessions on the one side, and full-blown OCD on the other side (Hodgson & Rachman, 1977). The fundamental difference between OC behavior of normal individuals and OCD is the way an individual relates to his ego-dystonic thoughts. An individual with OCD is unable to dismiss his obsessions (Rachman, 2002) and tends in general to overvalue the importance of thoughts (Veale, 2002). He is trapped in cognitive loops and is unable to stop thinking (Janeck, Calamari, Riemann, & Heffelfinger, 2003). The overemphasis on the importance of the obsessions encourages the compulsions and reinforces the obsessions, thus establishing strong associations that are difficult to extinguish. About 2–3% of individuals in Israel contract OCD (Zohar et al., 1992; Zohar, 1999). However, most normal individuals exhibit some degree of obsessive and compulsive behavior (Apter et al., 1996). In very young children (Zohar & Felz, 2001), in school age children (Zohar & Bruno, 1997), and in young adults (Zohar, LaBuda, & Moschel-Ravid, 1995) there are individual differences in the level of OC behavior, and in OC personality traits.

Putting together Freud's description and behavioral-cognitive theory, it is possible to hypothesize that more fearful and neurotic individuals, will be both more religious (MR) and more OC, while better adjusted individuals, will be less of both.

There is a wealth of psychiatric research studying the relationship between OCD, culture, and religious identity and practice. Tek and Ulug (2001) studied a group of outpatients with OCD in Turkey and found that while the more religious patients tended to have religious obsessions they were no different in overall severity or in their Y-BOCS profile. Tezcan and Millet (1997) found in patients in Eastern Turkey, that religious compulsions were second only to contamination and cleaning compulsions. Tek and Ulug (2001) concluded that there was no causal relationship between religiosity and OCD. Shooka, al-Haddad, and Raees (1998) studied OCD in a patient sample of Moslems and found that a high proportion had religious obsessions relating to observance and blasphemy. They attributed the religious obsessions to the cultural influence on the manifestation of the symptoms, and not as a causative factor. Chia (1996) studied a large patient sample of mainly Chinese individuals in Singapore, and found that there was no discernable relationship between religiosity and symptom severity or count in these individuals diagnosed with OCD. Raphael, Rani, Bale, and Drummond (1996) studied a large, multi-ethnic, religiously varied sample of patients in London. The majority of the religiously affiliated patients were either Roman Catholic or Christians of other denominations. They found that a higher proportion of psychiatric patients with OCD identified themselves as religious than that of the

psychiatric patients with other diagnoses. However, when the patient groups were compared, there was no over-representation of any religious group, refuting the hypothesis that certain religions were more likely to predispose to OCD than others. The authors speculated that it may not be the religious practices experienced by young children that make them vulnerable to OCD, but the rigidity and discipline that accompany their religious education. Greenberg and Witztum (1994) described OCD patients in a Jerusalem clinic serving mostly ultra-orthodox Jews. They pointed out that the Jewish religious law stresses cleanliness and exactness, and allows for repetition, all potentially OC themes. However, the religious leaders of the community as well as the patients themselves were able to discriminate between scrupulosity and OC behavior. Greenberg and Witztum (1994) conclude that scrupulosity in the observance of Jewish law was the cultural setting rather than the cause of OCD in these ultra-orthodox patients. In a further study of OCD in ultra-orthodox Jews in Jerusalem, Greenberg and Shefler (2002) found both religious and non-religious obsessions in their non-religious patients, equally ego-dystonic and disturbing.

A summary of the literature on OCD and religiosity across a variety of religions, cultures, and ethnic groups is that there is no proof that religion causes OCD. However, if the patient is religiously acculturated the OCD might assume obsessions and compulsions consonant with his religious beliefs and practices.

There are some studies of the relationship between OC behavior in normal individuals (non-OCD) and their religious beliefs and practice. Rassin and Koster (2003) found that there was a strong correlation between OC behavior, thought–action fusion, and religiosity in Catholic and Protestant undergraduates, though not in others. Abramowitz, Huppert, and Cohen (2002) developed an inventory of religious OC symptoms and tested it on a sample of American college students. They found that students who identified themselves as highly devout scored higher on the two scales of the inventory, fear of sin and fear of god's punishment. However, highly devout Christians were higher on both scale scores than highly devout Jews, suggesting that the elements of obsessive-religiosity represented in the inventory may be culture specific. Sica, Novara, and Sanavio (2002) studied the relationship of religiosity and OC behavior in a sample of Italian college students. They found that OC behavior, perfectionism, thought control, and over-importance of thoughts were all correlated with religious observance. Within religious subjects they found that only over-importance and control of thought were correlated with OC behavior. In an Irish Christian non-clinical sample, Lewis (1994) found a relationship between obsessional traits and religiosity, but not between obsessional symptoms and religiosity. A tentative summary of these studies is that in the normal population, there is a relationship between religiosity and OC ideation and behavior.

There is some evidence that harsh, rigid, exacting parenting might be associated with the development of OC symptoms and OCD in children. This association has been shown in normal adults providing retrospective reports (Cavedo & Parker, 1994), as well as in children with OCD whose parents were assessed for expressed emotion (Hibbs, Hamburger, Kruesi, & Lenane, 1993; Hibbs, Zahn, Hamburger Kruesi, & Rapoport, 1992). A relationship between strict religious upbringing and OCD has also been suggested (Okasha, Saad, Khalil, el Dawla, & Yehia, 1994), although it has not been empirically examined.

Israel is a fascinating laboratory to study the effects of Jewish religiosity and culture on obsessional beliefs and symptoms. Because it is an immigration country, there is a wealth of cultural and religious traditions and backgrounds. It is the only place on earth where Jews are a

majority, and Judaism the dominant culture, and therefore only in Israel can the influence of Jewish religiosity and culture be separated from the influence of being a minority. There is continued military, financial, and population-density stress on individuals. In a region given to fundamentalism, in Israel the dominant culture is Western and secular. Within the general secular culture there are cohesive and insular communities of ultra-orthodox, and semi-permeable orthodox communities. Personal crises may precipitate movement from ultra-orthodoxy to secularism or from a secular way of life to orthodoxy and insular ultra-orthodoxy (Greenberg & Witztum, 2001).

The focus of the current study was the relationship of religiosity, upbringing and OC behavior in non-OCD Israeli Jews. The research review in other cultures and religions suggested that a strong relationship would be found in a non-clinical sample. This hypothesis was tested on two samples: Study 1, a large random sample of college students; and Study 2, a sample of individuals selected for religious change—from observance to non-observance (less religious, LR) or the reverse (MR).

2. Method

2.1. Participants

Study 1: The sample consisted of 256 volunteers, all college undergraduates, 154 (60.1%) women, and 99 men (38.7%). Three respondents did not answer the question about sex. The age range was from 18 to 32, with a mean of 22.8. On a four-category item, 62% of the respondents described themselves as secular, 16% as traditional, 14% as orthodox, 8% as ultra-orthodox.

Study 2: The sample consisted of 61 participants, 30 who had been MR and had relaxed their religious observance, and 31 who had become MR. There were 28 (45.9%) men, and 33 (54.1%) women. The youngest was 18 and the oldest 59, with a mean age of 32.1 years. On a four-category item, 14.8% described themselves as ultra-orthodox, 34.4% as orthodox, 9.8% as traditional, and 41.1% as secular. The sample was ascertained in a snowball method, starting with some people whom the authors knew personally and extending from there.

2.2. Instruments

Study 1.

2.3. The Maudsley obsessive-compulsive inventory

The Maudsley Obsessive-Compulsive Inventory (MOCI, Hodgson & Rachman, 1977) is a 30-item yes/no inventory, which reduces to four scales: checking, cleaning, doubt, and slowness. The MOCI was translated into Hebrew, back-translated and revised, and then normed in a previous study (Zohar, LaBuda, & Moschel-Ravid, 1995), and found to be reliable and valid. The 4-factor structure of checking, cleaning, slowness and doubt was replicated in the Hebrew version, for adults (Zohar, LaBuda, & Moschel-Ravid, 1995), and for children (Zohar & Bruno, 1997).

2.4. The obsessive thought checklist

The Obsessive Thought Checklist (OTQ, Frost, Steketee, Cohn, & Griess, 1994) originated in French (Bouvard, Mollard, Cottraux, & Geurin, 1989) and was translated into Hebrew, back translated and corrected for the current study. It was chosen to supplement the MOCI because the MOCI emphasizes compulsive behaviors, while the OTQ focuses on obsessions and mental compulsions. The OTQ is a 28-item 5-category of response checklist. The Hebrew version reduces to three scales: contamination thoughts (alpha Cronbach of 0.92), just-right-perfectionism (alpha-Cronbach of 0.90), and pathological responsibility (alpha-Cronbach of 0.88).

2.5. The child and adolescent perfectionism scale

The Child and Adolescent Perfectionism Scale (CAPS, Hewitt, Newton, Flett, & Callander, 1997) is a 22-item, 5-categories of response scale, which includes the Self-Oriented Perfectionism Scale and the Socially-Prescribed Scale. It was translated and back translated and corrected for the current study. The two scales were highly reliable (0.93 and 0.85) as was the full scale (0.94).

2.6. Student religiosity questionnaire

Student Religiosity Questionnaire (SRQ, Katz, & Schmida, 1992) is a 22-item, 5-categories of response self-assessment questionnaire. It is composed of two sub-scales, a belief sub-scale and an observance sub-scale. The SRQ has alpha Cronbach lower-bound reliabilities of 0.93, 0.95 for the sub scales and 0.95 for the entire questionnaire.

2.7. Upbringing and background items

These included:

1. How would you define your parental home?
   a) Ultraorthodox b) Orthodox c) Traditional d) Secular.
2. How would you describe your parents approach to childrearing?
   a) Very permissive b) Liberal (c) Conservative (d) Harsh
3. How would you define yourself?
   a) Ultra orthodox (b) Orthodox (c) Traditional (d) Secular
4. Has there been any change in this definition in the course of time?
   a) No
   b) Yes, describe:

Study 2

2.8. The parental bonding instrument

The Parental Bonding Instrument (PBI; Parker, Tupling, & Brown, 1979). The PBI has 25 items on a 5-category Likert scale, and has been translated into Hebrew (Bachar et al., 1997). The PBI is

a self-report for adults, in which they are asked to describe each of their parent's attitudes to them as they were growing up, until they were 18 years of age. The PBI reduces to Maternal Warmth and Maternal Control, Paternal Warmth and Paternal Control, with alpha Cronbach lower-bound reliabilities of 0.85–0.95.

In addition to the PBI study 2 used the MOCI, the SRQ and the Upbringing and background items.

2.9. Data analysis

Initial data analyses for both studies were performed in SPSS for Windows 11. For all analyses, the criterion for reporting significant results was set for $p<0.05$. When the probability was higher results are reported as non-significant, NS.

3. Results

Study 1 as previously described.

3.1. Relationship between religiosity and obsessive–compulsive behavior

There was no correlation between religiosity as measured on the SRQ and OC behavior as measured by the MOCI ($r=0.1$, $p>0.05$) and the OTQ ($r=0.06$, $p>0.05$).

3.2. Relationship between obsessive–compulsive behavior and perfectionism

Socially prescribed perfectionism (SPP) correlated positively with obsessive thoughts as measured by the OTQ ($r=0.41$, $p<0.05$) and with OC behavior as measured by the MOCI ($r=0.34$, $p<0.05$). Self-oriented perfectionism also correlated positively with the OTQ ($r=0.26$, $p<0.05$) and with the MOCI ($r=0.18$, $p<0.05$).

3.3. Relationship between perfectionism and religiosity

Only a weak association was found between perfectionism and religiosity. The SPP and the SRQ did not correlate significantly. The SOP gave a low positive correlation with the SRQ ($r=0.12$, $p<0.05$). There was nearly no correlation between religious belief and religious practice $r=0.09$, $p>0.05$.

3.4. Relationship of parental approach to upbringing and obsessive–compulsive behavior

One-way analysis of variance on the OTQ scores was conducted dividing the sample into four groups according to their answers on parental upbringing. Most of the participants described their parents as either liberal ($N=182$, 72.5%) or conservative ($N=52$, 20,7%) leaving less than 10% of the sample for the two other categories. The overall result was $F(3, 251)=8.25$, $p<0.05$. Post hoc contrasts with Scheffe correction showed that those who described their parents approach as

liberal were significantly lower on the OTQ (mean = 23.52, SD = 3.5) than those who described their parents as conservative (mean = 26.56, SD = 3.8). A similar analysis of variance on the MOCI scale did not give significant results.

3.5. Post hoc analysis: obsessive–compulsive levels and religious change

Most of the sample, 86%, defined their own and their parent's religiosity as the same, on the four-category item. The remaining 14% were 36 respondents, of whom 24 (9%) had changed toward less religiosity, and 12 (5%) toward more religiosity. Those who had become MR were higher on OC measures than those who had become LR as summarized in Table 1.

Study 2 as previously described.

3.6. Religiosity and upbringing

The second sample was selected for religious change. The correlation between religious belief and religious observance in this sample was $r = 0.89$, $p < 0.000$. This correlation is significantly different from the one found in sample 1 ($z = 9.24$, $p = 0.000$). There was a difference in the level of religious belief and observance between the MR and the LR groups, as summarized in Table 2. The LR group came from MR parental homes, and the MR group from primarily traditional and secular parental homes. Contrary to expectations, the LR group reported a higher level of conservative or harsh upbringing than did the MR group. The measure of parent–child relationship (PBI) did not yield any group differences, for any of the four resulting scales: maternal warmth, maternal control, paternal warmth, or paternal control.

3.7. Obsessive–compulsive behavior and religious change

The hypothesis that the MR group would be higher on measures of OC than the LR group was largely supported. Table 3 summarizes the group differences for the total MOCI score as well as

Table 1
Post hoc analysis of Study 1—comparison of the religious change groups on measures of obsessivity and perfectionism

	More religious $N = 12$ Mean (SD)	Less religious $N = 24$ Mean (SD)	T-value (p)	Cohen's d
Religious belief	41.58 (11.9)	27.04 (10.7)	3.7 (0.000)	1.28
Religious observance	39.33 (11.2)	28.62 (11.3)	2.69 (0.01)	0.95
Socially prescribed perfectionism	26.66 (7.4)	24.00 (7.8)	NS	0.35
Self oriented perfectionism	36.92 (10.0)	36.00 (8.6)	NS	0.10
MOCI total	8.62 (3.9)	6.54 (4.2)	NS	0.51
MOCI cleaning	3.42 (1.7)	2.00 (1.9)	2.12 (0.04)	0.79
OTQ total	31.08 (16.2)	19.46 (14.3)	2.20 (0.03)	0.76
OTQ cleanliness	6.33 (5.1)	4.29 (5.1)	NS	0.40
OTQ "just right"	16.17 (6.4)	10.29 (6.7)	2.09 (0.04)	0.90
OTQ pathological responsibility	9.58 (7.5)	4.87 (4.5)	2.38 (0.03)	0.76

Table 2
Study 2—comparison of the more (MR) and less (LR) religious groups on religiosity and perceived parenting

	MR group ($N=31$) Mean (SD)	LR group ($N=30$) Mean (SD)	Cohen's d
Religious belief[a]	51.6 (6.5)	25.7 (12.2)	2.65
Religious observance[b]	54.2 (8.1)	24.5 (11.3)	3.02
Maternal warmth	30.6 (6.0)	29.8 (5.3)	0.14
Paternal warmth	29.0 (5.4)	28.6 (5.7)	0.07
Maternal control	39.2 (5.8)	38.0 (3.8)	0.24
Paternal control	39.4 (5.4)	39.8 (5.8)	−0.07
Harshness of upbringing[c]	25.8% conservative or harsh	50% conservative or harsh	
Religiosity of parental home[d]	54.4% traditional 32.2% secular	83.3% religious	

[a] $t=10.4$, df = 59, $p<0.000$.
[b] $t=11.8$, df = 59, $p<0.000$.
[c] $\chi^2=3.8$, $p<0.05$, df = 1.
[d] $\chi^2=40.0$, $p<0.000$, df = 3.

Table 3
Comparison of the more- and less-religious groups on OC behavior

	MR group ($N=31$)	LR group ($N=30$)	Cohen's d
Total MOCI score[a]	10.5 (4.4)	7.5 (3.8)	0.73
Cleaning (MOCI)	3.1 (2.2)	2.9 (1.8)	0.10
Slowness (MOCI)[b]	1.6 (1.2)	0.5 (1.2)	0.92
Checking (MOCI)[c]	2.9 (2.2)	1.7 (1.9)	0.58
Doubt (MOCI)	2.8 (1.3)	2.5 (1.2)	0.24

[a] $t=2.8$, $p<0.01$, df = 59.
[b] $t=4.3$, $p<0.000$, df = 59.
[c] $t=2.4$, $p<0.02$, df = 59.

the four sub-scales: checking, cleaning, doubt, and slowness. There are significant differences for the total and for two of the four sub-scales, and the other two sub-scales while not attaining significance were in keeping with the others in that the mean of the MR group was numerically higher than that of the LR group.

4. Discussion

4.1. Religious observance and religious belief in Israeli Jews

Unlike the various denominations of Christianity, being a Jew is not primarily an issue of belief. To be a practicing Jew, a certain level of observance is required, including ritual rest on Saturday, communal prayer, observance of laws about eating and not eating certain foods in certain

combinations. Much less emphasis is placed on the individual's belief, intentions, or motivations than in Christian practice. It would be reasonable to hypothesize that thought–action fusion, thought control, and pathological responsibility would naturally play a much smaller part in the religious cognitive world of a Jew than in that of a Christian. Partial corroboration for this hypothesis can be found in the work of Abramowitz et al. (2002), who found that highly devout Christians scored high on two belief scales related to religion and OC, while devout Jews did not. The differentiation between behavior and thought in Judaism is further supported by the fact that even Jews who define themselves as secular maintain a significant level of Jewish ritual practice (Levy, Levinson, & Katz, 1993).

In this context, it is reasonable that the correlation between religious belief and practice in Study 1 of unselected college students was low. Most of them defined themselves exactly as religiously observant as their parents. A study of motivations for religious practice in Israeli Jews (Lazar, Kravetz, & Fredrich-Kedem, 2002) found that those who defined themselves as secular practiced certain Jewish rituals, and explained that the rituals served to preserve their family structure and cohesion, and was what they were accustomed to from their parent's home, reminding them of their childhood. They did not cite belief as a motivation for practice. Thus for most Israeli Jews, religiosity is culturally transmitted, and provides family structure and identity.

4.2. Israeli Jewish religiosity and religious change

While the level of religiosity of most young adults in Israel can be attributed to the accident of birth, this is not true for those who made a choice and changed their level of religiosity, from that practiced in their parent's home. When individuals undergo a visible behavioral change they are often viewed as deviant by their environment. If the change is radical, and/or if the environment is very restrictive, the deviance might be judged pathological. On those occasions when religious change and actual psychopathology are associated, it is not always clear if the change in religious behavior precedes some kind of psychopathology, or if the reverse is true. Greenberg and Witztum (2001) have studied this question in the context of psychosis and religious change to ultra-orthodoxy. They found that in nearly all cases, psychotic symptoms preceded the religious change. In the samples of the two studies in the current report, all participants were normal high functioning individuals, certainly not suffering from serious psychopathology. However, those that underwent a change and became MR were distinctively more OC than those who underwent a change in the opposite direction. Although in both studies subjects were only tested once, making temporal sequence and causality impossible to infer, it seems likely that the OC tendencies were a characteristic of the individual and therefore preceded the religious change, and were possibly part of the process that brought the change about.

The very high correlation between belief and practice in the second sample suggests that these individuals are reflective and consciously chose their way of life to match their behavioral propensities and their cognitive world.

4.3. Upbringing and obsessive–compulsive behavior

Individuals who develop psychopathology experience their parents as low in caring and high in control. This general principle is consonant with the popular view in Western culture that children

need love and some level of autonomy in order to develop a healthy and independent functioning self. There are countless studies showing this association, and a few will do for demonstration. Anorectic girls describe their mothers as less caring and more controlling than do comparison girls (Laporte, Marcoux, & Guttman, 2001). Depressed children and children at risk for depression describe their mothers as more controlling and less warm than controls (Stein et al., 2000). A large mixed patient sample of non-psychotic individuals, described their mother as less warm and more controlling than a community contrast group (Gilbert & Gerlsma, 1999). Cavedo and Parker (1994) found that individuals higher in OC behavior described their parents as more controlling and less warm than individuals with lower OC levels. A problem with all the empirical studies cited in support of the general principle is that they rely on the child's report via the PBI and thus do not separate the mother's rejection of the child from the child's subjective feeling of being less loved. Two studies attempted to disentangle this causal loop. The first was a large family study of depressed children and children at risk for depression (Duggan, Sham, Minne, Lee, & Murray, 1998). In these families, it was shown that perceived parenting of depressed children followed the expected pattern of being higher in control and lower in caring than non-depressed children in these families, but the differences could be attributed to their neuroticism and thus to a bias in attribution. A large study of twins who were parents (Perusse, Neale, Heath, & Eaves, 1994) found heritability in parental bonding behavior of the parents according to a special form of the PBI; the most heritable of the PBI scales was maternal warmth. Thus, it appears that asking children about their perception of their parents behavior toward them does not adequately separate the child's pathology from the putative cause, parenting.

In the current Study 1, we found partial support for a relationship between perceived parenting and OC, in that those individuals who described their upbringing as harsh or conservative had higher levels of OC than those who described their upbringing as liberal or very permissive. The results of Study 2 supported this association only partially. The LR group described their parental upbringing on a single four-category item as harsh or conservative, while the MR group were more likely to describe it as permissive or liberal. This significant difference between the groups may indicate that harsh or conservative upbringing by religious parents is an incentive for leaving the fold. On the other hand, it may be the perception of the parental behavior that arose after an adolescence of struggle between the child who was not religiously inclined and the parents, anxious to have their child follow the home values. On the continuous scales of the PBI, the MR group was no higher on parental control or lower on parental warmth than the LR group. It should be noted that other studies did not always find this relationship between perceived parenting and pathology. Vogel, Stiles, and Nordahl (1997) compared outpatients with OCD to outpatients with depression and normal controls, and found the expected association in the depressed patients, but not in those with OCD.

5. Conclusion

In Israeli Jews, the relationship between OC ideation and behavior and religiosity is not evident on the whole. However, individuals whose religious practice has strengthened are higher in OC behavior than those who have become less religious. A longitudinal study might shed light on the temporal and causal relationship between the religious change and the OC tendencies. The

culture-specific relationship between religiosity and OC is interpreted as reflecting the "doing" nature of Judaism versus the "believing" or thinking nature of Christianity.

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