Religious Beliefs and Obsessive-Compulsive Disorder: Exploring Mutual Influences and Potential Roles in Symptom Development

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Abstract. This paper examines how religious beliefs influence the expression of obsessive–compulsive disorder (OCD), focusing on scrupulosity—a subtype involving fears of blasphemy, moral violation, and ritual inaccuracy, and is also known as ROCD. Empirical studies, including cross-cultural research, lead to three patterns of association: negative, positive, and neutral associations. Negative associations include increased obsessional thinking, moral thought-action fusion, and ritual repetition in religions with high purity and strict rules. The positive ones result when spirituality promotes flexibility, social support, and low moral guilt, as in the case of specific Hindu and Sikh cultures. Neutral findings refer to the fact that religiosity cannot be viewed as causing OCD; it may, however, influence the form of symptom expression. In addition, this paper discusses how reframing compulsive rituals as symptoms of OCD may serve to reduce feelings of guilt, improve adherence to treatment, and accommodate authentic religious behaviors. Clinical applications include culturally adapted psychotherapy, collaboration with faith leaders, and recognition of secular scrupulosity-all attesting to the complex and context-dependent nature of the relationship between religiosity and OCD. This emphasizes the relevance of understanding cultural and religious variables both in research and clinical practice.

Keywords: religion, OCD, scrupulosity, correlations, rituals

1. Introduction

Religiosity is a potential factor causing obsessive–compulsive disorder (OCD) [1].

Ritual is a term often mentioned in both religions and OCD. The fact that ROCD (religious OCD), also known as scrupulosity (a subtype of OCD involving fear of blasphemous thoughts, repeating prayer, moral obsessions, etc.), exists seems to support their connection. However, while religious themes are common, there is no conclusive evidence that any specific religion causes OCD. Religious traditions that emphasise purity, sin, and ritual (e.g., Catholicism, Islam) may influence how OCD manifests, not whether it develops ([2]). No single religion causes OCD. However, even if religion itself cannot cause OCD, why does religion still affect OCD to some extent? Does labelling some religious compulsions as OCD act as a protective factor, and how can this benefit patients while also causing them to stay with OCD?

Therefore, this paper aims to find out why and how religious beliefs influence OCD or have no effect on it. Especially on why religion can cause OCD in some people, but can help with OCD symptoms in other cases.

The context of OCD can be affected by religion, and there are different types of relationships. There are three relationships made by different papers, stating that religion can have negative associations, positive associations, or no effect, with some studies even finding mixed results in the same experiment. This paper explores how religiosity and spirituality are related to each other.

This paper uses a paper from Psychology of Religion and Spirituality by [3] as a primary source to discuss the three types of associations, adding information from other papers for further detail. This paper used two groups of participants in its experiment: a nonclinical group with 746 participants with diverse religious affiliations, and a clinical group with 24 individuals formally diagnosed with OCD. Participants completed six standardised self-reflective questionnaires, and all three types of conclusions were drawn from this study.

2. Negative associations

2.1. Experiment review

A common finding across studies is that scrupulosity is strongly correlated with obsessional thinking. Religious crises, defined as feeling alienated from God or the community, were also consistently linked to scrupulosity. These crises showed moderate to strong correlations with thought–action fusion, the belief that merely having a thought increases the likelihood of a negative event or is morally equivalent to the act itself, as well as with OCD symptom severity [4].

Evidence also shows that higher religiosity is often associated with more obsessional thoughts and related symptoms. For example, Muslims were found to score higher on OCD symptoms, thought control concerns, and the use of worry as a coping strategy compared to Christians. Characteristics of Islam, such as its emphasis on rituals, cleanliness, and strict behavioral rules, may contribute to these patterns, while Christians showed a stronger influence of religiosity on morality-related thought–action fusion [5].

Cultural context figures significantly in the manner of religiosity interacting with OCD. In collectivist societies, social conformity, interdependence, and moral alignment with the community are emphasized, and religiosity usually forms an integral part of cultural norms. Such a backdrop might give way to a greater internalization of moral obligations and greater distress when intrusive thoughts conflict with such values. On the other hand, more individualistic societies promote personal autonomy, self-expression, and flexible belief systems that allow holding religious beliefs without rigid cognitive or moral associations with intrusive thoughts. Despite these differences, religiosity seemed to increase sensitivity to the controlling thoughts and moral fusion of thoughts and actions in both cultural settings.

Further research on Muslim populations demonstrated that rituals and religious doubt are core aspects of OCD severity. Self-doubt during prayer, such as repeatedly asking oneself, "Did I pray correctly?", and repetition of ablution were especially noted in more severe cases. At the same time, high levels of spirituality were reported but were not associated with OCD severity. Such findings indicate that while spirituality itself may not intensify OCD, specific religious rituals linked to purity and correctness are strongly associated with heightened symptom severity, and that religious doubt and compulsions are hallmark features of ROCD [6].

2.2. An explanation

The reason why patients might want to stay with OCD may be due to the immediate relief brought by negative reinforcement. When patients try to push away unwanted thoughts or feelings, suppression occurs. Suppression is a type of experiential avoidance, and such avoidance is thought to maintain symptoms through negative reinforcement: when avoidance reduces distress in the short term, the behaviour is reinforced, making future avoidance more likely.

The religious framework provides a detailed set of rules and consequences that OCD can latch onto. Fear of spiritual consequences increases distress and motivates compulsions, and cultural and community expectations can intensify symptom severity. Some papers found that by recognising these actions as OCD, guilt, fear, and community pressure can be reduced. When individuals realise that certain behaviours are driven by OCD rather than religious commandments, it reframes the meaning of their symptoms. Instead of interpreting intrusive thoughts or repeated acts as moral or spiritual failings, they can view them as a treatable mental health issue. This reduces self-blame and anxiety, which in turn lowers the emotional intensity driving compulsions [7].

2.3. Treatment effects

Most people experience intrusive thoughts, but in OCD these are misinterpreted as dangerous or morally unacceptable. This appraisal triggers distress, leading to compulsions—behaviours or mental acts aimed at neutralising the thought or preventing harm. Compulsions reduce distress immediately, which reinforces the behaviour (negative reinforcement). This short-term relief prevents the person from learning that the feared outcome is unrealistic. Over time, compulsions can even increase intrusive thoughts; for example, frequent handwashing reminds the person of contamination risk.

Once compulsions are identified as symptoms, patients are more open to evidence-based interventions. Without this reframing, religious individuals may resist therapy, fearing it will make them less observant or spiritually unsafe [8]. Labelling behaviours as OCD allows therapists to position treatment not as reducing faith but as removing a psychological barrier to genuine worship. This shift in perception has been shown to improve treatment adherence and reduce dropout rates in religious populations.

Religious compulsions are no longer valued as spiritual practices by the patient or community when they are viewed as symptoms of OCD. Since excessive ritual actions can become entrenched in OCD due to social and self-validation, this recognition breaks a significant maintenance loop [8]. Patients might instead concentrate on practising their religion authentically, fulfilling their faith's obligations without going beyond what is necessary. This can enhance mental health and, ironically, result in a more robust and lasting religious life.

3. Positive associations

While some factors and religion can worsen OCD symptoms, there are also researches that found some aspects of religion are helping to reduce guilt.

3.1. Experiment review

Research suggests that spirituality and certain religious frameworks can serve as protective factors in relation to OCD. Spirituality, defined as the personal experience and expression of the sacred and the search for meaning, connection, and transcendence, has been shown to reduce symptom severity,

especially through the “universality facet”—the belief in a shared human bond and an orderly universe. In clinical samples, higher spirituality was consistently associated with lower OCD severity [3].

Similarly, cultural and religious contexts appear to shape how religiosity interacts with OCD. For example, patients in India with higher religiosity reported lower moral guilt scores, suggesting that religious culture, especially among Hindus and Sikhs, may allow more flexible interpretations of ritual, which might protect against the development of rigid scrupulosity [9].

Other findings highlight the broader psychosocial benefits of religion: Religion may produce emotional conformity, community support, and a coping structure; it can offer structured rituals that provide routine and emotional predictability. Religion can connect individuals with faith leaders or clergy, who can become clinical allies in therapy, and reinforce a nonjudgmental spiritual outlook, which may reduce the self-critical aspect of scrupulosity [10].

3.2. An explanation

An explanation of why and how religion can help in OCD is that there is cultural flexibility in religious practice. In Hinduism and Sikhism (as seen in Indian contexts), religious rituals are often symbolic and open to interpretation. This flexibility may allow individuals to adjust or skip rituals without as much guilt or fear, making it harder for OCD to latch onto religious content.

3.3. Treatment effects

In one study, [11] conducted research to find the effect of religious CBT on ROCD. Traditional Cognitive Behavioral Therapy (CBT) with Exposure and Response Prevention (ERP) is an effective treatment for OCD; religiously oriented patients commonly resist this approach, however, since they conceive their compulsions as religious duties. Religious CBT overcomes this barrier by integrating faith into evidence-based modalities, thus rendering the former more acceptable. Patients receiving Religious CBT exhibited significant decreases in symptoms of OCD relative to standard care, with gains maintained at both 3- and 6-month follow-ups. Participants reported lower levels of guilt and increased acceptance of therapy because the approach resonated with their spiritual beliefs. These results indicate not only that Religious CBT diminishes symptom severity but also that such therapy enhances adherence to that therapy by showing respect for the patient's cultural and religious context and provides a promising model for addressing scrupulosity and other religious symptoms of OCD.

4. Neutral

[3] also found that compulsions were not meaningfully related to religiosity or spirituality. Religious involvement and fundamentalism (strict adherence to a specific set of core beliefs, often within a religious context) were not significantly correlated with OCD symptom severity.

[1] Turkish sample found no significant relationship between religious practice (measured by the Religious Practices Index, RPI) and religious obsessions. OCD severity scores (Y-BOCS) did not differ significantly between those with and without religious obsessions. They concluded that religiosity does not cause OCD but may shape its expression.

[3]& [4]’s study found the buffering role of spirituality and its moderating effects. Universality moderated the relationship between religiosity and moral thought–action fusion and fundamentalism (only in clinical samples). This suggests that feeling connected to all humanity may reduce the harmful effects of rigid religious beliefs on OCD-related thoughts.

5. Conclusion

The link between religion and OCD is shaped by many factors. It is complex, multifaceted, and cannot be reduced to a simple cause-and-effect model. Religiosity itself does not directly cause or affect OCD symptoms, it can either make OCD symptoms worse, better, or sometimes no effect. Religion, to some extent, can shape how symptoms appear and are interpreted. Strict religious frameworks may intensify obsessions and compulsions, while spirituality and more flexible traditions can reduce guilt, provide support, and even protect against symptom severity. In some cases, religion has little effect at all, showing that cultural context and personal interpretation are key. Overall, religion acts as a lens through which OCD is experienced—sometimes worsening it, sometimes helping recovery, and sometimes playing no role. Recognising this complexity can help us develop culturally sensitive treatment and research.

6. Evaluating methods

6.1. Strengths

Religious studies often include cross-cultural comparisons [3], [4] and [5] included participants from multiple cultures and religions (e.g., Turkish Muslims vs. Canadian Christians; Jews, Christians, Hindus, Muslims). This allowed examination of how religious context and culture shape OCD symptoms, not just religiosity levels.

Secondly, most of the studies used standardised, validated tools to measure OCD symptoms, religiosity, and related beliefs. For OCD severity, common tools included the Y-BOCS (Yale-Brown Obsessive Compulsive Scale) and the DOCS (Dimensional Obsessive-Compulsive Scale). For scrupulosity, the PIOS (Penn Inventory of Scrupulosity) was frequently used. For religiosity or spirituality, measures like the Religious Practices Index (RPI), the Belief into Action Scale (BIAS), and the Spiritual Involvement and Beliefs Scale (SIBS) captured different aspects of faith and spirituality. For maladaptive beliefs, tools like the OBQ (Obsessive Beliefs Questionnaire) and the TAFS (Thought–Action Fusion Scale) were applied.

Using validated instruments increases reliability, reduces measurement bias, and allows findings to be compared across different studies and cultures.

Additionally, the inclusion of clinical samples provides real-world relevance and greater symptom variability.

6.2. Limitations

However, the small sample size may indicate that the generalisability of the results is limited. The only study that looked at demographic differences was [6], but they also focused only on Muslims.

Additionally, many studies used simple or single-scale religiosity measures such as frequency of prayer or self-rated religiousness. These unidimensional measures of religiosity do not capture the complexity of faith, such as spirituality, religious doubt, fundamentalism, and internal conflict. This may partly explain the mixed findings on religiosity–OCD links.

Finally, and most importantly, all studies used self-report questionnaires, which are subject to social desirability bias, especially in religious questions. Participants often wish to present themselves as devout. This can also lead to limited introspective accuracy, and there was no verification of clinical diagnoses in nonclinical samples.

7. Discussion

7.1. Strengths and limitations

The paper synthesizes findings from multiple studies, covering both negative, positive, and neutral associations between religiosity and OCD.

It highlights nuanced patterns rather than oversimplifying religion as purely protective or harmful, and focuses on why religion can exacerbate or protect against OCD symptoms. However, the cited studies are cross-sectional, therefore there is lack of longitudinal evidence.

7.2. Application

Culturally and Religiously Sensitive Therapy – OCD symptoms often take shape within the patient's cultural and religious framework. For example, in collectivist Muslim societies (Turkey, Lebanon, parts of India), religious rituals and moral codes are deeply tied to identity, so intrusive thoughts about purity or blasphemy cause greater distress. In more individualistic contexts (Canada, U.S.), the same beliefs may not be as rigidly connected to morality. By understanding the client's specific faith background, we can avoid assuming all religious practices are OCD and distinguish between healthy devotion and compulsive repetition.

Involving Clergy or Faith Leaders – Patients may struggle to separate religious duty from compulsive behaviour. A trusted clergy member can help clarify doctrine and support therapeutic goals. Studies such as Buchholz et al. emphasised the role of the religious community in offering emotional support.

Recognising Secular Scrupulosity – Studies found that non-religious individuals can have obsessive moral or ethical rigidity, showing that OCD targets moral domains regardless of faith. Therefore, we should screen for moral perfectionism in all patients, not just religious ones.

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