Relationship Of OCD To Rituals & Symbolism

John Fraim

6/11/11

Hypothesis: The chemical make-up of brains in ancient man had less levels of serotonin available to bind the postsynaptic receptor between nerve endings in brain cells. This lack of serotonin filled daily life of the ancients with obsessive thoughts and compulsory behavior exhibited by belief in the magic power of symbols and ritualism. Evolution of mankind has increased levels of serotonin available in the brains of modern man resulting in a decreased belief in the magic power of symbols and ritualism. However, increase in serotonin has varied amongst individuals and has not been as great in some as others. For those given the modern diagnosis of Obsessive Compulsory Disorder (OCD) - as well as related anxiety disorders — the lower serotonin levels cause reversion to obsessions and compulsions similar to ancient mankind.

Implications: OCD was the common trait of ancient mankind. Today, individuals with low levels of serotonin might be viewed as ancients inhabiting the modern world. Might this low-high serotonin level have a relationship in defining such diverse areas as 1) world cultures 2) nationalities 3) political affiliations and 4) socio-economic groups?

------ Comments -------

Hello John - good to hear from you again!

Your question is difficult to answer because we are learning so much about OCD that almost anything you say about it is outdated by the time you say it. With that caveat in mind, however, my current view is this.

1) We all have tendencies toward OCD-type behaviors simply as part of our human condition. For most people, our little "superstitions" are unobtrusive enough that we remain within the "normal" range.

2) In certain circumstances, those human tendencies toward OCD-type behaviors periodically spill out of the "normal" range and become noticeable to self and others as "symptoms" of a more clinical condition.
3) Circumstances of high stress, high anxiety, and a few other circumstances, appear to be what trigger people into the "spill" of OCD out of the "normal" range and into the "problematic" or clinical condition (exhibiting symptoms problematic for self and others - not just the little superstitions, but compulsions severe enough that they block the forward movement of living.)

4) Some people are more prone to these "spills" - we might say that they have a lower circumstance threshold than others - and this low threshold seems to run in families (i.e., is inherited) and very likely genetically rooted.

5) Therefore, our little superstitions on one end of the continuum and clinical OCD on the other is not itself a direct caused by mortality anxiety. It is simply part of the characteristics of the kind of species we are. This would correspond to Becker's "ontological axis."

6) However, the specific ways in which these behaviors manifest in any specific case will likely be impacted and contoured by the death denial strategies (habitual behavioral style) of the person, which indeed are impacted and contoured by mortality anxiety and death denial.

Does this make sense to you? How do you view it? Maybe you would like to pose this question to the Becker Discussion List - there are quite a number of people on that list with considerable training and experience in the common psychosocial conditions and might have a much better view of things that do I.

Keep in touch!

Dan Liechty

Associate Professor of Social Work and a member of the Graduate Faculty at Illinois State University.

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Hi John,

Interesting topic and similar to what I have written on recently--neuroscience and states of consciousness, dreams, psychedelics, the risk-taker's gene. It is all about serotonin!! I can send the papers along if you are interested. I have never heard Sonu mention anything about OCD, and the appearance of his study in his house gives no indication. If anything he was hypomanic--which is a serotonin issue. He didn't need much sleep. What episode are you referring to in the RB? I can run this by Sonu.

Best,

Nancy

Nancy Furlotti
Past President
LA Jung Institute

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Helmut Wautischer is Senior Lecturer of Philosophy at Sonoma State University and holds a Ph.D. from the University of Graz, Austria (1989). Originally trained in epistemology and analytic philosophy, he expanded his interests to conduct research in comparative philosophy, including philosophical anthropology, with a strong emphasis on consciousness studies. His publications include Tribal Epistemologies: Essays in the Philosophy of Anthropology (Aldershot: Ashgate Publishing, 1998) and Ontology of Consciousness: Percipient Action (Cambridge: The MIT Press, June 2008). He is co-editor of Existenz: An International Journal in Philosophy, Religion, Politics, and the Arts, and is webmaster for the Paideia Project at Boston University. Here at SSU, he is an elected member to two sub-committees of the Academic Senate (FSAC: Faculty Standards and Affairs committee, and AFS: Academic Freedom Subcommittee).

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Relationship Between Religion-related Factors and Obsessive Compulsive Disorder

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Abstract
This exploratory study sought to determine whether selected religion-related factors differentiated between 86 patients with obsessive compulsive disorder (OCD), 73 patients with panic disorder, and 292 patients with other psychiatric (non-anxiety) disorders. A standard history questionnaire was used to obtain information from patients concerning religion of origin, involvement in religious activities, religious conflict, and perceived religiousness of parents. It was found that the percentage of patients who reported experiencing religious conflict was significantly higher for the OCD group than for the other two groups. Other findings suggested associations between Catholicism and OCD and between Protestantism and panic disorder, but further research is needed to clarify these relationships.
This article is based on a paper presented at the 98th annual convention of the American Psychological Association, Boston, August 1990.

OCD definition from Wikipedia - http://en.wikipedia.org/wiki/Obsessive–compulsive_disorder

SSRIs are believed to increase the extracellular level of the neurotransmitter serotonin by inhibiting its reuptake into the presynaptic cell, increasing the level of serotonin in the synaptic cleft available to bind to the postsynaptic receptor.

Mayo Clinic visit – ritualistic behavior to avoid a bad report on physical

John Mizenko – Rich (Cleveland Clinic)/Jungian

Michael Meade – Myth and storytelling

RELATIONSHIP BETWEEN RELIGION-RELATED FACTORS AND OBSESSIVE COMPULSIVE DISORDER

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http://www.angelfire.com/rebellion2/hothot/doc/religion/ocd.html

This exploratory study sought to determine whether selected religion-related factors differentiated between 86 patients with obsessive compulsive disorder (OCD), 73 patients with panic disorder, and 292 patients with other psychiatric (non-anxiety) disorders. A standard history questionnaire was used to obtain information from patients concerning religion of origin, involvement in religious activities, religious conflict, and perceived religiousness of parents. It was found that the percentage of patients who reported experiencing religious conflict was significantly higher for the OCD group than for the other two groups. Other findings suggested associations between Catholicism and OCD and between Protestantism and panic disorder, but further research is needed to clarify these relationships.

For centuries religious leaders, physicians, and others have been interested in the relationship between religion and mental health (Coleman, Butcher, & Carson, 1980). In recent years, clinicians and researchers have debated and attempted to determine whether religion is more likely to have positive or negative effects on mental health (Bergin, 1980a, 1980b; Crawford, Handal, & Wiener, 1989; Ellis, 1980; Frenz & Carey, 1989; Sharkey & Malony, 1986; Williams, Larson, Buckler, Heckman, & Pyle, 1989). However, research has not yielded consistent findings (Bergin, 1983; Crawford et al., 1989; Frenz & Carey, 1989). Most studies have examined people with different religious affiliations or varying degrees of religiousness and compared their responses on measures of psychological adjustment or pathology (Bergin, 1983; Bergin, Masters, & Richards, 1987; Crawford et al., 1989; Williams et al., 1989). Surprisingly, very few studies have employed samples including individuals who have been formally diagnosed as having a mental disorder. It is particularly notable that there has been little systematic research on religion and obsessive compulsive disorder (OCD), a condition in which

religious themes are often present.

OCD is an anxiety disorder characterized by obsessions and compulsions. An obsession is an intrusive and recurrent thought, image, or impulse, and it is usually experienced as being senseless or irrational (American Psychiatric Association, 1987). Some common obsessions that have religious content are sinful or blasphemous thoughts, doubt concerning spiritual matters, indecision about whether an action is right or wrong, excessive guilt, fear of committing a sin, fear of not saying prayers or confession properly, fear of not adequately explaining an action to God or a priest, fear of dying and going to hell, and fear of contamination by something unholy or impure. A compulsion is a repetitive, ritualistic behavior performed to reduce or prevent the discomfort associated with an obsession (American Psychiatric Association, 1987). People with OCD often engage in compulsions involving religious activities. Examples include excessive church attendance and confession, lengthy prayers, repetition of portions of prayers, excessive cleansing for religious activities, repetitious reassurance-seeking from clergy or others, rituals to prevent punishment or harm, and checking to prevent infractions of religious dietary laws (Foe & Tillmanns, 1980; Greenberg, 1984, 1987; Greenberg, Witzum, & Pisante, 1987; Steketee, Quay, & White, 1989; Weisner & Riffel, 1960).

Because religious themes are often salient in OCD, it is possible that the development of this disorder in some people is influenced by religious factors. The results of a recent study by Steketee, Quay, and White (1989) suggest that there is indeed a relationship between religion and OCD symptoms but that it is quite complex. To further examine the relationship between religion and OCD, the present study sought to determine whether religious factors differentiated between a sample of patients with OCD and patients with other types of disorders.

METHOD

Subjects

Subjects were 451 inpatients who received care at the

Behavioral Treatment Unit of St. Louis University Medical Center from January 1983 through October 1989. The sample was divided into three groups based upon DSM-III diagnoses assigned by the unit's psychologists and psychiatrist. Diagnoses were determined after initial evaluation and adjusted or reconfirmed upon discharge from the hospital. The subjects consisted of 86 patients (36 males, 47 females, 3 unspecified) diagnosed as having obsessive compulsive disorder (OCD), 73 patients (29 males, 43 females, 1 unspecified) assigned a diagnosis of panic disorder (with or without agoraphobia), and 292 patients (84 males, 198 females, 10 unspecified) given a psychiatric diagnosis other than an anxiety disorder. Diagnoses assigned to the third group included adjustment reaction, depression, eating disorder, headache, and personality disorder. No patients with a psychotic disorder, organic brain syndrome, or a primary diagnosis of substance abuse were involved in this study. For the total sample, the age range was 10-80 years, and the mean age was 38.87 years (SD = 15.78). Years of education ranged from 4-20 with a mean of 14.11 (SD = 2.93).

Procedure

A 114-item history questionnaire was completed by all subjects upon their admission to the Behavioral Treatment Unit. Responses to two sections of the questionnaire that included items concerning demographic and religious information were tallied. The section on religion assessed patients' religion of origin, whether they perceived their parents as religious, whether they were currently involved in organized religious activities, and whether they were currently experiencing religious conflict or doubt.

RESULTS

Description of the Sample

The majority of patients in all three diagnostic groups were women. Compared to the other two groups, the non-anxiety psychiatric group had a significantly lower proportion of men, X[sup2] (2,N = 437) = 6.78, p = .03.

Mean ages of patients in the OCD, panic disorder, and nonanxiety psychiatric groups were 34.93 years (SD = 15.81; range = 10-79), 39.65 years (SD = 14.70; range = 1674), and 39.81 years (SD = 15.92; range = 12-80), respectively. The three groups differed significantly in average age, F (2,434) = 3.18, p = .04. A Scheffe paired comparisons test indicated that the mean age of the non-anxiety psychiatric group was significantly higher than that of the OCD group. The education levels of the three groups also were not equivalent. Mean number of years of education was 14.04 (SD = 2.86; range = 4-20) for the OCD group, 13.10 (SD = 2.44; range = 8-18) for the panic disorder group, and 14.38 (SD = 3.02; range = 5-20) for the non-anxiety psychiatric group, F (2,385) = 4.97, p = .007. A Scheffe test indicated that the panic disorder group had significantly fewer years of education than did the non-anxiety psychiatric group.

Religion-Related Factors

Distribution of patients in the three diagnostic groups across categories of religious affiliation are summarized in Table 1. The X[sup2] value was not significant, X[sup2] (6,N = 422) = 10.73, p = .097, but it was in the equivocal range. Examination of the distribution of subjects suggests that a higher percentage of panic disorder patients indicated an affiliation with Protestantism, whereas Catholicism was the most common religious affiliation for the OCD group and, to a lesser extent, the nonanxiety psychiatric group. Separate analyses of the male and female subsamples did not yield any significant differences.

Data regarding other religion-related factors appear in Table 2. The experience of religious conflict was not randomly distributed across the three groups, X[sup2] (2,N = 403) = 10.45, p = .005. The OCD group had a higher percentage of patients reporting religious conflict than did the panic disorder group, and the percentage for that group was higher than that for the non-anxiety psychiatric group. There were no significant differences between the three groups in the proportion of patients who reported being currently involved in an organized religious activity, X[sup2] (2,N = 422) = 2.78, p = .248, perceiving their father as "religious," X[sup2] (2,N = 408) = 1.42, p = .490, or perceiving their mother as "religious," X[sup2] (2,N = 420) = 2.46, p = .292. No significant differences

were found for any of these religion-related variables when male and female subsamples were analyzed separately.

DISCUSSION

Results indicate that religious conflict may be more closely associated with OCD than with other psychiatric conditions. This finding is compatible with our observation of the frequent occurrence of religious doubt or uncertainty in the obsessions of these patients and of the similarities between religious rituals and some compulsions. However, religious conflict is by no means restricted to OCD patients. In each of the other diagnostic groups there were subjects who reported experiencing religious conflict. It is notable that the percentage of the panic disorder group reporting religious conflict was higher than that found for the non-anxiety psychiatric group. Religious issues may be associated with other anxiety disorders as well as with OCD, though perhaps to a lesser extent.

The equivocal findings indicating possible associations between OCD and Catholicism and between panic disorder and Protestantism warrant further discussion. Similar findings were reported by Steketee et al. (1989), but their samples may have been too small to obtain statistical significance. Interestingly, a study by Levendusky and Belfer (1988) found Catholics disproportionately represented in an agoraphobic sample, but no OCD sample was included for comparison. Any definitive conclusions concerning religious background and OCD or other psychiatric conditions would be premature at this time. Even if certain psychiatric disorders are eventually found to be disproportionately prevalent among specific religious denominations, models that ascribe pathogenic properties to broad categories of religion are unlikely to have much heuristic value. Our clinical experience indicates that in most major religious groups there are some individuals who develop OCD. It is therefore more likely that stronger relationships will be found between OCD and specific features of religious background that transcend denominational groupings. We suggest that these features might be found in the content of religious teachings (e.g., admonishments against impure thoughts), characteristics of the ways in which religious ideas are presented (e.g., "dichotomous" or "all or nothing" theologies), and the extent to which formal ritual

is integrated into religious ceremony.

Given that no single dimension of religious experience is likely to be perfectly associated with OCD, it will be useful for future researchers to consider possible interactions between religion and individual characteristics that might predispose someone to experience obsessions and compulsions. For example, people who are excessively guilt-ridden or who have strong perfectionistic tendencies may be particularly vulnerable to developing obsessive compulsive patterns under the influence of certain religious experiences. If this is the case, multifactor models will be necessary to understand fully the relationship between OCD and religion.

One value of the present study is the inclusion of three relatively large samples of clinically defined psychiatric populations. It is, however, an exploratory study with some limitations. For example, the data examined in this investigation were limited to those gathered during our routine evaluation process. Future research should test specific hypotheses concerning more clearly defined aspects of religious experience. Such research will be most instructive if it is designed to allow for examination of possible interactions between individual traits and features of the religious environment in which an individual is raised. Another limitation of the present study is that even though our patient samples were clearly defined, it cannot be assumed that they represent homogeneous populations. Future research may need to examine possible sub-populations of obsessive compulsive individuals for whom religious factors may have a greater pathogenic impact. For example, patients whose obsessions or compulsions clearly reflect religious themes could be compared to other OCD patients.

Prior studies have revealed that religion is a complex, multidimensional phenomenon. Some aspects of it appear to be related to mental wellness, others are associated with mental illness, and others have no clear relationship to mental health (Bergin, 1983; Bergin et al., 1987; Larson, Pattison, Blazer, Omran, & Kaplan, 1986; Spilka, Hood, & Gorsuch, 1985). The relationship between religion and OCD is not likely to be any less complicated. At a time when biological theories of psychiatric disorders are receiving unprecedented attention, it is important not to let

complications such as the difficulty of defining and measuring variables (Bergin, 1983; Crawford et al., 1989; Larson et al, 1986; Spilka et al., 1985) preclude attempts to study religious and other psychological dimensions of OCD. A better understanding of the complex relationship between obsessions, compulsions, and a variety of factors related to religious background, practice, and beliefs will not be gained without a great deal more research.

NOTES

This article is based on a paper presented at the 98th annual convention of the American Psychological Association, Boston, August 1990.

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TABLE 1
Distribution of Subjects Within Diagnostic Groups
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by Religion of Origin

	Diagnostic group					
	OCD (N - 86)		Panic disorder (N - 73)		Non-anxiety psychiatric (N - 292)	
Religion of origin[a]	n	%	n	%	n	%
Protestant	29	36	36	51	98	36
Catholic	46	57	25	36	129	48
Jewish	3	4	5	7	22	8
Other	3	4	4	6	22	8

[a]X[squared] (6,N = 422) = 10.73, p = .10
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TABLE 2
Distribution of Subjects Within Diagnostic Groups for Four Religion Factors

	Diagnostic group					
	OCD (N - 86)		Panic disorder (N - 73)		Non-anxiety psychiatric (N - 292)	
Religion factor	n	%	n	%	n	%
Experiences religious conflict/doubt	41	53	29	43	86	33
Participates in organized religious activity	48	61	34	47	148	55
Perceives father as "religious"	34	45	26	37	98	37
Perceives mother as "religious"	45	57	31	44	142	52

[a] For a few subjects, data were missing for one or more factors. For each factor, the percentages presentd are based on the total number of subjects who provided data for that factor.

[b] X[squared] (2,N = 403) = 10.45, p = .005

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Relationship Between Religion-Related Factors and Obsessive Compulsive Disorder

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This exploratory study sought to determine whether selected religion-related factors differentiated between 86 patients with obsessive compulsive disorder (OCD), 73 patients with panic disorder, and 292 patients with other psychiatric (non-anxiety) disorders. A standard history questionnaire was used to obtain information from patients concerning religion of origin, involvement in religious activities, religious conflict, and perceived religiousness of parents. It was found that the percentage of patients who reported experiencing religious conflict was significantly higher for the OCD group than for the other two groups. Other findings suggested associations between Catholicism and OCD and between Protestantism and panic disorder, but further research is needed to clarify these relationships.

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