OBSESSIVE-COMPULSIVE DISORDER: THE RELATIONSHIP BETWEEN DYSFUNCTIONAL BELIEFS, SPIRITUAL GUILT, AND MENTAL REPETITIONS

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ABSTRACT
Obsessive-Compulsive Disorder (OCD) is a multifaceted psychiatric condition characterized by intrusive, unwanted thoughts (obsessions) and repetitive behaviors or mental acts (compulsions) aimed at reducing distress. This article investigates the complex relationship between dysfunctional cognitive beliefs, spiritual guilt, and mental repetitions in the development and perpetuation of OCD symptoms, especially in cases where religious themes predominate, a subtype often termed scrupulosity. The paper explores how unconscious feelings of guilt, fear of divine punishment, and rigid or distorted religious beliefs intensify obsessive-compulsive cycles by reinforcing the need for mental or behavioral rituals as a form of atonement or reassurance. It further discusses the limitations of conventional cognitive-behavioral therapy when spiritual dimensions are overlooked and proposes an integrative therapeutic approach that combines evidence-based cognitive restructuring with spiritually sensitive interventions such as emotional release, forgiveness, and reframing of religious narratives. By addressing both psychological and spiritual aspects of the disorder, this holistic approach fosters emotional liberation, reduces symptom severity, and promotes sustained recovery.

Keywords: Obsessive-Compulsive Disorder. Dysfunctional Beliefs. Spiritual Guilt. Religious Scrupulosity. Cognitive-Behavioral Therapy. Forgiveness. Mental Repetitions. Spiritual Interventions.

1 INTRODUCTION

Obsessive-Compulsive Disorder (OCD) is a chronic psychiatric condition characterized by intrusive thoughts (obsessions) and repetitive behaviors or mental acts (compulsions) performed to reduce distress or prevent feared events. Although the disorder has traditionally been approached from a strictly cognitive-behavioral and neurobiological standpoint, recent studies suggest that deeper belief systems, including dysfunctional religious or spiritual constructs, play a significant role in the onset and maintenance of OCD symptoms. Particularly, feelings of spiritual guilt, unconscious fear of punishment, and distorted religious beliefs have been found to intensify compulsive patterns, especially in individuals raised in highly moralistic or punitive spiritual environments.

This conceptual image portrays the emotional and spiritual conflict experienced by individuals with religious Obsessive-Compulsive Disorder (OCD), particularly scrupulosity. Set within a dimly lit church, the figure in prayer is surrounded by overlapping words—"Impurity," "Guilt," "Forgiveness," and "Punishment"—symbolizing the intrusive thoughts, moral anxiety, and inner turmoil driven by dysfunctional beliefs and spiritual guilt. The looming shadow of a cross reinforces the weight of perceived divine judgment, while rays of light from a stained-glass window suggest the possibility of grace, healing, and cognitive-spiritual reconciliation. The composition visually encapsulates the core psychological and theological themes explored in the article.

Figure 1

Symbolic depiction of religious OCD: a person in spiritual distress surrounded by intrusive concepts of guilt, impurity, and forgiveness
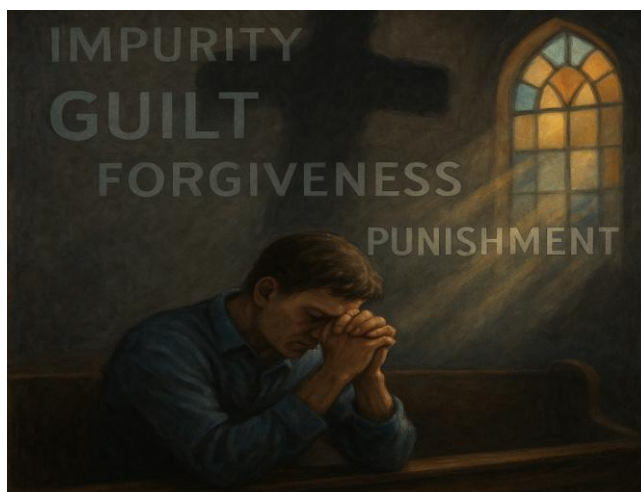
Source: Created by the author.

Cognitive models of OCD emphasize the role of maladaptive beliefs in the interpretation of intrusive thoughts. Salkovskis et al. (1998) proposed that individuals with OCD misinterpret these thoughts as highly significant and threatening, which leads to anxiety and compulsive efforts to neutralize the perceived danger. These beliefs often revolve around inflated responsibility, perfectionism, and the need to control thoughts. When religious or spiritual dimensions are added to this framework, a subtype of OCD often referred to as "scrupulosity" emerges, marked by excessive concerns with morality, sin, and divine punishment. According to Abramowitz, Huppert, Cohen, Tolin, and Cahill (2002), individuals with religious scrupulosity often engage in compulsive prayer, confession, or ritualistic behavior as a means to absolve perceived moral transgressions. Such rituals can become rigid, prolonged, and unproductive, thus reinforcing the OCD cycle.

The influence of spiritual guilt in OCD may be linked to early developmental experiences involving religious indoctrination or moral rigidity. Studies have shown that people who internalize punitive images of God or rigid spiritual doctrines are more likely to interpret intrusive thoughts as signs of moral failing, leading to chronic guilt and the need for mental or behavioral atonement (Nelson, Abramowitz, Whiteside, & Deacon, 2006). This spiritual guilt becomes a powerful emotional driver of compulsions, as the individual attempts to find reassurance or redemption through repetition, confession, or avoidance. In this sense, mental repetitions—such as counting, reviewing, or mentally reciting prayers—may serve both a symbolic and emotional function, aiming not only to relieve anxiety but also to restore a sense of spiritual purity or divine favor.

Interventions for OCD that address these underlying beliefs must go beyond traditional exposure and response prevention (ERP) to integrate cognitive restructuring and, when appropriate, spiritual or existential reflection. Freeman et al. (2014) emphasize the need to challenge irrational beliefs and reinterpret intrusive thoughts through a more compassionate, realistic, and non-punitive lens. For individuals whose OCD symptoms are heavily influenced by spiritual themes, therapy may benefit from exploring their religious narratives in a therapeutic context—assessing whether their spiritual frameworks support healing or perpetuate distress. Recent clinical insights have highlighted the value of forgiveness, self-compassion, and spiritual reframing in reducing obsessive guilt and promoting emotional liberation (Exline, Pargament, Grubbs, & Yali, 2014).

One promising approach involves combining cognitive-behavioral therapy with spiritually integrative practices focused on emotional release and self-forgiveness. These include guided imagery, meditative prayer, or therapeutic conversations about divine grace and compassion, especially when conducted in collaboration with spiritual advisors or faith-sensitive clinicians. While caution must be exercised to avoid reinforcing obsessive religious behavior, therapeutic work centered on releasing spiritual guilt can help dismantle the obsessive-compulsive structure at its existential root. As noted by Huppert and Siev (2010), addressing the emotional and moral dimensions of OCD may be crucial in reducing symptom chronicity and enhancing long-term resilience.

The flowchart illustrates the decision-making process of a cost minimization analysis, a method used to compare two or more interventions that produce equivalent outcomes. It begins with identifying potential interventions, followed by confirming that their results are clinically the same. Once equivalency is established, the option with the lowest overall cost is selected. This approach is particularly valuable in healthcare and therapy settings, where multiple treatment strategies may yield similar benefits, and choosing the most cost-effective solution ensures optimal resource allocation without compromising quality or outcomes.

Figure 2

Decision-making flowchart for cost minimization analysis in spiritually integrative OCD therapy
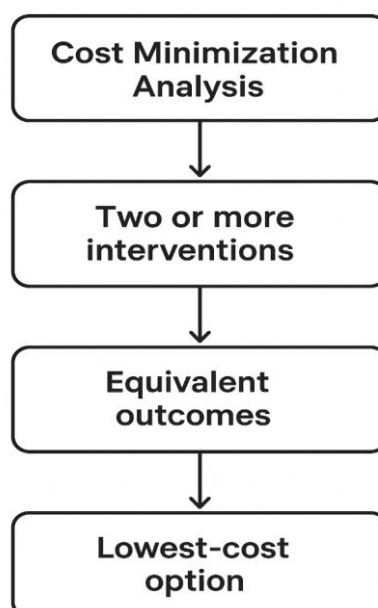
Source: Elabored by author.

Ultimately, understanding OCD through the lens of dysfunctional beliefs, spiritual guilt, and mental repetition offers a more comprehensive view of the disorder. It reveals how unconscious fears of condemnation and misinterpretations of spiritual duty can fuel compulsive behavior, and how a combination of cognitive and spiritual healing techniques may lead to lasting relief. Such an integrative approach underscores the importance of treating not just the behavior, but the whole person—mind, body, and spirit.

A growing body of neuropsychological research supports the notion that individuals with OCD display hyperactivity in brain regions related to error detection, such as the anterior cingulate cortex (ACC). This heightened error monitoring may partly explain the persistent sense of "incompleteness" or "not-just-right" experiences often reported by OCD patients (Simon, Kaufmann, Müsch, Kischkel, & Kathmann, 2010). When filtered through a lens of rigid or punitive belief systems, this neurobiological predisposition may amplify a person's fear that even minor or imagined infractions carry dire moral or spiritual consequences, thus reinforcing compulsive checking, confessing, or praying. The physiological and cognitive dimensions of OCD, therefore, interact dynamically with learned belief systems, particularly those surrounding punishment, morality, and divine judgment.

In clinical settings, patients with religious OCD often report a chronic struggle between their spiritual ideals and their intrusive, unwanted thoughts—leading to deep inner conflict and identity confusion. According to Buchholz (2019), the distress in scrupulosity arises not merely from fear of punishment but from a perceived failure to meet divine expectations, which becomes internalized as a form of spiritual inadequacy. This emotional burden frequently manifests as repetitive mental acts aimed at achieving moral certainty or divine approval. Unlike compulsions driven by contamination fears or symmetry needs, these mental rituals are more difficult to detect and resist, as they are often mistaken by the individual for authentic religious practices.

The therapeutic challenge lies in helping patients differentiate between genuine spiritual practices and compulsive rituals. Research by Siev and Cohen (2007) shows that individuals with scrupulosity may struggle to discern when their behaviors are motivated by devotion versus fear, leading to an overreliance on rigid routines and avoidance of perceived spiritual risk. For example, a person may feel compelled to repeat a prayer multiple times until it feels "perfect" or abstain from receiving sacraments out of fear of being impure. Such behaviors, while appearing religious, are rooted in the

compulsive logic of OCD and serve to alleviate immediate anxiety rather than nurture authentic spiritual growth.

Interventions that include spiritual psychoeducation have been found beneficial in addressing these patterns. Teaching patients about the psychological nature of intrusive thoughts, alongside respectful exploration of their spiritual frameworks, allows for healthier reinterpretation of their experiences. Sibrava, Wilhelm, and Barlow (2006) emphasized the importance of validating clients' faith without reinforcing the compulsive aspects tied to it. When appropriate, therapists may work in tandem with clergy or spiritual counselors who understand mental health dynamics and can offer religious guidance that promotes acceptance and grace over perfectionism and guilt.

Moreover, forgiveness-based interventions have shown promising results in reducing OCD-related guilt and shame. Research by Toussaint, Owen, and Cheadle (2012) demonstrated that individuals who engaged in forgiveness exercises reported lower levels of psychological distress and rumination. In the context of OCD, fostering forgiveness—both divine and self-directed—can interrupt the compulsive need for absolution. It offers a pathway to reconcile intrusive thoughts and imperfections without resorting to endless rituals. By integrating emotional forgiveness with cognitive reappraisal, patients may experience a reduction in the internal pressure that sustains obsessions and compulsions.

Finally, long-term treatment outcomes appear to improve when interventions address the existential dimensions of OCD. According to Purdon, Rowa, and Antony (2007), individuals with OCD often report a diminished sense of meaning or agency due to their constant internal struggle. When therapy embraces both cognitive restructuring and existential exploration—such as reflections on grace, human fallibility, and spiritual worth—patients may begin to reframe their suffering not as a moral failure but as a psychological condition that can be compassionately understood and managed. This holistic approach invites a shift from control to acceptance, from fear to faith, and ultimately, from repetition to restoration.

REFERENCES

1. Abramowitz, J. S., Huppert, J. D., Cohen, A. B., Tolin, D. F., & Cahill, S. P. (2002). Religious obsessions and compulsions in a non-clinical sample: The Penn Inventory of Scrupulosity (PIOS). Behaviour Research and Therapy, 40(7), 825–838. https://doi.org/10.1016/S0005-7967(01)00070-5

2. Buchholz, J. L. (2019). Scrupulosity: A faith-based model of treatment for religious OCD. Journal of Psychology and Christianity, 38(1), 22–33.

3. Exline, J. J., Pargament, K. I., Grubbs, J. B., & Yali, A. M. (2014). The Religious and Spiritual Struggles Scale: Development and initial validation. Psychology of Religion and Spirituality, 6(3), 208–222. https://doi.org/10.1037/a0036465

4. Freeman, J. B., De Nadai, A. S., Geller, D. A., & Franklin, M. E. (2014). Evidence base update for psychosocial treatments for pediatric obsessive-compulsive disorder. Journal of Clinical Child & Adolescent Psychology, 43(1), 7–26. https://doi.org/10.1080/15374416.2013.804398

5. Freitas, G. B., Rabelo, E. M., & Pessoa, E. G. (2023). Projeto modular com reaproveitamento de container marítimo. Brazilian Journal of Development, 9(10), 28303–28339. https://doi.org/10.34117/bjdv9n10-057

6. Gotardi Pessoa, E. (2025). Analysis of the performance of helical piles under various load and geometry conditions. ITEGAM-JETIA, 11(53), 135–140. https://doi.org/10.5935/jetia.v11i53.1887

7. Gotardi Pessoa, E. (2025). Sustainable solutions for urban infrastructure: The environmental and economic benefits of using recycled construction and demolition waste in permeable pavements. ITEGAM-JETIA, 11(53), 131–134. https://doi.org/10.5935/jetia.v11i53.1886

8. Huppert, J. D., & Siev, J. (2010). Treating scrupulosity in religious individuals using cognitive-behavioral therapy. Cognitive and Behavioral Practice, 17(4), 382–392. https://doi.org/10.1016/j.cbpra.2009.07.003

9. Nelson, E. A., Abramowitz, J. S., Whiteside, S. P., & Deacon, B. J. (2006). Scrupulosity in patients with obsessive-compulsive disorder: Relationship to clinical and cognitive phenomena. Journal of Anxiety Disorders, 20(8), 1071–1086. https://doi.org/10.1016/j.janxdis.2006.02.001

10. Purdon, C., Rowa, K., & Antony, M. M. (2007). Thought–action fusion and the relationship between intrusions and compulsions. Behaviour Research and Therapy, 45(1), 37–47. https://doi.org/10.1016/j.brat.2006.01.009

11. Salkovskis, P. M., Shafran, R., Rachman, S., & Freeston, M. H. (1998). Multiple pathways to inflated responsibility beliefs in obsessional problems: Possible origins and implications for therapy and research. Behaviour Research and Therapy, 36(11), 1053–1072. https://doi.org/10.1016/S0005-7967(98)00076-X

12. Sibrava, N. J., Wilhelm, S., & Barlow, D. H. (2006). Cognitive-behavioral therapy for obsessive-compulsive disorder with religious obsessions. In J. S. Abramowitz & A. C. Houts (Eds.), Conceptualization and Treatment of Obsessive-Compulsive Disorder (pp. 261–286). Springer.

13. Siev, J., & Cohen, A. B. (2007). Is thought–action fusion related to religiosity? Differences between Christians and Jews. Behaviour Research and Therapy, 45(4), 829–837. https://doi.org/10.1016/j.brat.2006.05.001

14. Simon, D., Kaufmann, C., Müsch, K., Kischkel, E., & Kathmann, N. (2010). Frontal hyperactivation in obsessive–compulsive disorder during tasks of inhibitory control: An event-related fMRI study. Psychiatry Research: Neuroimaging, 183(2), 113–118. https://doi.org/10.1016/j.pscychresns.2010.04.011

15. Toussaint, L., Owen, A. D., & Cheadle, A. (2012). Forgive to live: Forgiveness, health, and longevity. Journal of Behavioral Medicine, 35(4), 375–386. https://doi.org/10.1007/s10865-011-9362-4