Blasphemous thoughts in obsessive–compulsive disorder: A case series

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ABSTRACT

Obsessive–compulsive disorders (OCDs) are one of the top 10 contributors of debilitating medical illnesses and are the fourth most common psychiatric disorder. Blasphemous thoughts, also known as scrupulosity, as an obsessional theme has piqued curiosities long before it was considered a neurosis. Such obsessions may or may not have an accompanying compulsion and comprise 5% of the patients of OCD. The case series is of three patients suffering from repetitive, intrusive, ego-dystonic, and distressing blasphemous thoughts, which are extremely distressing to them, rendering them unable to perform any other activity. The symptoms also indicate the presence of comorbid depressive and anxiety disorders, developing secondary to the blasphemous thoughts. Inadequate knowledge in this subtype of OCD mandates the need for more studying and research, especially with new texts suggesting the implementation of faith-assisted psychotherapy in addition to the conventional psychotherapy and pharmacotherapy.

Keywords: Blasphemous thoughts, blasphemy, obsessive–compulsive disorder, scrupulosity

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considered a neurotic illness. Such thoughts were not given recognition as a psychiatric illness even until the 20th century, until early psychiatric theoreticians such as Freud and Janet stepped into the picture. Even to date, this subtype of OCD remains largely unexplored, owing to various factors such as lack of studies done for religious obsessions; reticence of such patients to readily disclose their symptoms, stemming from valid fears of societal and familial rejections, and limited purview of psychiatric illnesses, particularly among Indian population. Here, we report three cases diagnosed with OCD, with blasphemous thoughts being the major obsession causing distress.

**CASE REPORTS**

**Case 1**

A 27-year-old Hindu unmarried male, B.Com graduate, working as a bank accountant, presented to the psychiatry OPD with the chief complaints of having intrusive thoughts of gods and goddesses performing sexual acts among themselves and with him and of urinating near temples and over idols, which he was unable to control. His thoughts were also sometimes associated with penile erections, which was inciting him to masturbate two to three times daily, if not more. The patient was apparently well 6 months ago, when he first had sexual thoughts of the Goddess whose photograph was strung right across his cabin at his workplace. It would only occur when he would look at that photo frame, initially, so he changed the seating at his workplace, in vain, however, as he was now having thoughts of himself sharing sexual relations with not just one Goddess but also various goddesses. Besides that, he also began having thoughts of gods and goddesses sharing sexual relations among themselves. After 2–3 months, the patient developed a new symptom – the urge to urinate near temples, and over the idols, he would come across while traveling in the city. Sometimes, the patient would yield to the compulsions of urinating near temples, but understanding the negative implications of being caught by devotees and priests, he would try hard to fight the urges. He, as a result, would be excessively particular in picking routes which would not have idols or temples, whenever he would travel. These thoughts and urges kept increasing progressively until he was unable to think of anything else all day. The patient derived deep distress from such thoughts as he began to believe that he was a sinner worthy of celestial punishment for doing so. He acknowledged these thoughts as originating in his own mind but was unable to stop them on his own accord. The quality of his work and his social relations began deteriorating. His sleep reduced, and he began witnessing decreased interest in routine activities. Upon feeling completely incapacitated to even arise from bed and get ready for work, the patient decided to get psychiatric help. Mental status examination revealed a kempt, cooperative young male, in touch with reality, describing the mood as “guilty,” and having a dysphoric affect. He had obsessive thoughts of performing sexual acts with gods, goddesses, and his colleagues; which was followed by an urge of masturbation. Memory, orientation, and insight were unimpaired. Y-BOCS score 22, corresponding to moderate symptoms. He was put on fluoxetine 30 mg and cognitive behavior therapy with gradual improvement in his symptoms.

**Case 2**

A 65-year-old Hindu male, a farmer living with wife, two sons, and their families, belonging to lower socioeconomic strata, came to psychiatry OPD with complaints of having thoughts of killing the gods and goddesses he would worship, by manual strangulation or by beating them, particularly Lord Shiva, for the past 2 years. These thoughts, being antagonistic to his principles, were causing him great distress. Initially, such thoughts would occur two-to-three times a day, for 5–10 min, mostly when he was alone; but over the course of time, the frequency and duration of such thoughts, both, began to increase. After 9–10 months, he also began having thoughts of killing his grandchildren. He recognized these thoughts as his own and accepted that they were immoral. The associated distress kept increasing progressively and made him anxious and sad. He would complain of palpitations and sweating accompanying the anxiety and developed a gloomy disposition from the persistent and pervasive sadness. He would avoid festivals, stopped praying, and eventually stopped staying in the company of his grandchildren too. His sleep and appetite were greatly diminished. Four-to-five months before presentation, the thoughts became unrestrainable and would persist all day long, even when he was involved in any activity.

The patient used to consume country liquor two to three times a week since he was a 25-year-old. He stopped consuming alcohol 4 months ago, thinking it would bring a stop to the distressing and repetitive thoughts. Premorbidly, the patient was a very devout man and held a strong faith in religion and deities, particularly Lord Shiva. The patient had a history of transient ischemic attack 15 years ago, after which he was also diagnosed with hypertension, and has been on oral antihypertensives since then. Mental status examination revealed kempt cooperative patient, having widened palpebral fissures and forehead creases, conveying mood as despairing, affect being dysphoric. Preoccupying thoughts of obsessive nature were present, not associated with any compulsion. The patient had intellectual insight. Y-BOCS score was 28 corresponding to moderate-severe symptoms. He is currently C. fluoxetine 60 mg OD.
and tablet clomipramine 10 mg HS, maintaining regular follow-ups and has 80% improvement.

**Case 3**
A 23-year-old Hindu female, married for 5 years, living with her husband, a 4-year-old son, and a 20-weeks-old daughter, and in-laws in a joint family, belonging to the middle socioeconomic strata, came to psychiatry OPD with complaints of having thoughts which were extremely distressing to her. The thoughts were of her performing sexual acts with Lord Hanuman and also of her children sharing incestuous relations. The thoughts first began 2–3 days after delivery of her daughter, 5 months ago. They would initially occur only when she would happen to view her newborn daughter’s genitals, whereas bathing her or cleaning her, when she would happen to see Lord Hanuman’s image on her daughter’s genitals. This persisted for around a month. After that, she began having thoughts of her son having sexual relations with her daughter. This would earlier occur only when her two children were sitting or playing together but eventually began occupying her thoughts throughout the day. Alongside, the thoughts of her performing sexual acts with gods also began increasing. The thoughts were also associated with vivid visualization of the act as if occurring in front of her eyes and continuing to be seen by her even when she would shut her eyes in an attempt to stop the images. She would try her best to suppress such thoughts by diverting her mind to other thoughts or by keeping herself occupied with work, which, albeit effective in the beginning, was not helping her. These thoughts grossly violated her moral and religious ethics and were causing her immense distress. She took cognizance that the thoughts were her own, and that they were unreal and impossible. She would feel apprehensive with palpitations, tightness in chest, and restlessness. She also began reporting no interest in the world around her and her daily activities. She completely stopped breastfeeding her daughter, and vehemently refused to have any sexual relations with her husband. She would have multiple episodes of inconsolable crying in the day. She no longer felt she deserved to live. She was barely eating and not able to sleep for more than 10–15 min a day. Desperate for a remedy, she came to her sister-in-law in Pune, as her in-laws were not very understanding of her illness, and came to psychiatry OPD with her sister-in-law.

The patient had similar symptoms 1-month after the delivery of her first child, 4 years ago. After her son became a month old, her parents took her to a temple for a religious ritual. Over there, as she was praying in front of the idol of a Goddess, she first experienced an intrusive, distressing, unwanted thought, defying her principles: of the goddess sharing a sexual relationship with the priest in the temple. She got anxious at that thought and left the temple immediately. However, the thoughts kept recurring whenever she saw an idol of a god or a goddess, imagining herself having sexual relations with the gods, and her husband having sexual relations with the goddesses. The thoughts kept worsening, and she was unable to stop them despite trying to. They persisted for a year, but resolved spontaneously upon the death of her husband’s paternal grandmother, due to being extremely caught up in the rituals and rites for 17 days following her death. After that, they never recurred or distressed her, until the current episode. Premorbidly, she held a firm belief in religion and was a very dedicated devotee of Lord Hanuman. She would pray for 30 min every morning. She would regularly observe fasts and would spearhead all the religious functions at home with great vigor. She would often narrate stories from the Ramayana and Mahabharata to her children, and would regularly read religious scriptures at home. Mental status examination revealed a young lady hiding her face with her saree. Conveying mood as self-contemptuous, having a reactive, and dysphoric affect. Preoccupying thoughts of obsessive nature were present, not associated with any compulsion. The patient had an intellectual insight. Y-BOCS score was 31, corresponding to moderate-severe symptoms. The patient was started on capsule fluoxetine 40 mg OD and tablet clonazepam 0.5 mg and was advised to review back after 5 days, to which she did not comply and was eventually lost to follow-up.

**DISCUSSION**

The above three cases are patients suffering from OCD having repetitive and intrusive thoughts of blasphemous nature. Two of the three cases are men, and two of the three cases are hailing from urban areas. One of the three was not religiously inclined, the other two being devout Hindus. All three were facing debilitating distress and were incapacitated. All three were striving hard to rid themselves of the thoughts but were completely unsuccessful in their attempts. Two of the three cases had obsessions of both religious and sexual themes, combined; and only one had no sexual component in their religious obsessions. The compulsions are seen in two cases: urge to urinate and masturbate and intentional avoidance of temples and idols is seen in the first, urge to stay away from gods and religious functions and grandchildren is seen in the second. All three patients were cognizant of the need for medical attention for their symptoms and came for consultation on their own accord. Y-BOCS scale interpreted all of them to have moderate, or moderate-to-severe illnesses. The two who attended follow-up showed satisfactory improvement in symptoms with treatment.
Sigmund Freud, in the 19th century, first observed religious obsessions in a sample of Catholics, to test the relationship between intrinsic religiosity and the development of obsessive-compulsive symptoms pertaining to religion, and found inconclusive results. Lewis and Greenberg tried to test Freud’s ideas and all culminated in not only being unable to find a relationship between the two but also found how religious obsessions were associated with great distress and internal conflict in the patient. All religions imply the presence of various rites and rituals, involving meticulous care, and attention. Islam being a religion having fastidiously ritualistic practices, still was not the one to have a higher predisposition to develop the illness, as compared to others. Studies have discovered equal preponderance among all religions. However, various studies also suggest the existence of positive associations between the degree of religious staunchness and the culmination into religious obsessions. Some religions and clergymen propagate and glorify impossible moral standards and practices, and also lay great emphasis on the severe forms of celestial punishment ensuing violation of any religious ethic, irrespective of its significance. Even harboring certain thoughts violate the principles of some religions, and can prove to be distressful to an individual, even in the absence of obsessions. Such values and cultures may prove to be breeding ground for the development of blasphemous and religious-based obsessions, as the patient cannot help having fixations over the correct conductance of rites and rituals, and the morbid fear resulting from the violation of any religious doctrine. Existing literature evidences that blasphemous thoughts have heuristic obsessions, and may coexist with the obsessions of contamination and doubt and symmetry; however, the most common overlapping obsessions are unacceptable thoughts of sexual or violent nature. Patients with scrupulosity have a more varied presentation of obsessions, rather than compulsions when compared to patients without obsessions of a religious nature. Conversely, the presence of varying types of obsessions and not compulsions became a good predicting factor for religious obsessions. These suggest that the religious obsessions are mostly a “pure obsessive” category and are more likely to not have an accompanying compulsion, as compared to other obsessive categories.

There are reports to suggest the higher prevalence of coexistent depressive and anxiety disorders in patients with blasphemous obsessions, which was seen in our patients. Such patients have also been seen to have anankastic traits and personalities, more than patients with other obsessions. Obsessions of such nature were also associated with poorer insight than others: owing to their perceptions of sinning, the desecration of their long-standing morals, and practices, and the inability to perform religious rites and rituals, which are otherwise sacrosanct to them. However, our patients had good insight and sought treatment on their own.

Coming to the modalities of treatment, besides obvious use of pharmacotherapy, cognitive, and behavioral psychotherapy form the mainstay of treatment: in which techniques to desensitize from the associated anxiety and guilt are taught to the patient in an effort to make them cope better with their debilitating obsessions. However, contemporary therapies requiring patients to shun their beliefs may result in discontinuation and disregard for psychotherapy. Therefore, it seems ideal to have some modifications in the handling of patients with blasphemous thoughts and religious obsessions, in means of having therapies integrated with their religious beliefs and principles of faith: to successfully overcome religious obsessions and compulsions, without grossly defying the basic ideologies of the patient. This case series highlights the basic symptomatology and the presentation of patients suffering from OCD having blasphemous thoughts.

Declaration of patient consent
The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Conflicts of interest
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REFERENCES
1. Reddy YC, Rao NP, Khanna S. An overview of Indian research in obsessive compulsive disorder. Indian J Psychiatry 2010;52 Suppl 1:S200-9.
2. Gururaj GP, Math SB, Reddy JY, Chandrashekar CR. Family burden, quality of life and disability in obsessive compulsive disorder: An Indian perspective. J Postgrad Med 2008;54:91-7.
3. Sadock BJ, Sadock VA, Ruiz P. Kaplan and Sadock’s Comprehensive Textbook of Psychiatry. 10th ed. Philadelphia: Wolters Kluwer; 2017.
4. Avgoustidis AG. Obsessions from the past: A study of the chapter on “blasphemous thoughts” in “The Ladder of Divine Ascent” (7th century AD). Asian J Psychiatr 2013;6:595-8.
5. Tek C, Ulug B. Religiosity and religious obsessions in obsessive-compulsive disorder. Psychiatry Res 2001;104:99-108.
6. Abramowitz JS, Jacoby RJ. Scrupulosity: A cognitive-behavioral analysis and implications for treatment. J Obsessive Compuls Relat Disord 2014;3:140-9.
7. MdRosli AN, Sharip S, Wan Ismail WS. Religious-integrated therapy for religious obsessive-compulsive disorder in an adolescent: A case report and literature review. Ment Health Relig Cult 2018;21:204-9.