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Research Paper

The Role of Religiosity in Shaping Psychological Rigidity: Insights into OCD Symptomatology and Coping Mechanisms

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ABSTRACT

Obsessive-Compulsive Disorder (OCD) is a chronic and debilitating mental health condition characterized by persistent intrusive thoughts (obsessions) and repetitive behaviors (compulsions) performed in response to these thoughts. These compulsive actions are often aimed at neutralizing the distress caused by the obsessions, creating a vicious cycle of anxiety and ritualistic behavior. **Religiosity**—the degree to which an individual's beliefs, practices, and behaviors are influenced by their religious faith—can play a significant role in mental health outcomes. For many, religion provides a source of comfort, meaning, and community, which can enhance resilience and well-being. Scrupulosity can lead to compulsive religious behaviors, such as excessive praying or seeking reassurance, which reinforces OCD-related cognitive rigidity. The **dimensions of religiosity**—primarily **intrinsic** and **extrinsic** religiosity—are critical in understanding this complex relationship. **Intrinsic religiosity** refers to a personal, internalized belief system in which religious faith is a central part of an individual's identity and worldview. Intrinsically religious individuals are more likely to use their faith as a source of emotional strength, which may foster greater psychological flexibility and adaptive coping mechanisms in the face of OCD-related challenges. Conversely, **extrinsic religiosity** is characterized by external, ritualistic engagement in religious practices, often driven by social pressures or the desire for external rewards, such as status or group belonging. Individuals who exhibit high levels of extrinsic religiosity may engage in religious practices for reasons other than spiritual fulfilment, such as adhering to religious rituals out of fear of divine punishment or to gain social approval. In the context of OCD, extrinsic religiosity may reinforce psychological rigidity, as it encourages compulsive, rule-bound behaviors that align with OCD's characteristic need for certainty and control. Despite the potential impact of religiosity on OCD symptomatology, there is a lack of research that systematically explores how different forms of religiosity influence resilience and psychological rigidity in OCD. Understanding these dynamics is crucial for developing more personalized therapeutic interventions that address both the psychological and spiritual needs of individuals with OCD.

Keywords: *Obsessive-Compulsive Disorder, Religiosity, Psychological Rigidity, Cognitive Flexibility, Religious Coping*

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Obsessive-Compulsive Disorder (OCD) is a pervasive and often debilitating mental health condition that affects approximately 2-3% of the global population. It is marked by recurring, intrusive, and distressing thoughts (obsessions) and repetitive behaviors or mental acts (compulsions) performed to alleviate the anxiety caused by these obsessions. The cyclical nature of these symptoms can lead to significant impairment in personal, social, and occupational functioning, making OCD one of the most treatment-resistant mental health disorders. In particular, individuals with OCD often exhibit heightened levels of psychological rigidity, defined as a fixed, inflexible approach to thinking and behaving that limits their ability to adapt to new or challenging situations.

Psychological rigidity, a core feature of OCD, manifests through an inability to tolerate uncertainty or doubt, resulting in rigid, rule-bound thinking patterns. This inflexibility reinforces compulsive behaviors, making it difficult for individuals to break the cycle of obsession and compulsion. As a result, therapeutic interventions, such as Cognitive Behavioural Therapy (CBT), often focus on fostering greater psychological flexibility to help individuals manage their symptoms more effectively.

Religiosity, defined as the extent and intensity of an individual's religious beliefs, practices, and involvement, has long been a topic of interest in mental health research. For many, religion provides a framework for understanding life's uncertainties, offering meaning, hope, and a sense of purpose. As such, religiosity can serve as a powerful source of emotional support and psychological resilience, particularly in times of distress. However, the relationship between religiosity and mental health is complex, particularly in the context of OCD, where religious beliefs may take on a more obsessive and rigid quality.

Religious scrupulosity, a subtype of OCD, is one of the clearest examples of the intersection between religiosity and OCD. Individuals with religious scrupulosity experience obsessive fears about moral or religious failings, leading to compulsive behaviors such as excessive praying, confession, or seeking reassurance from religious authorities. For these individuals, religiosity may reinforce maladaptive coping mechanisms, as their religious beliefs become intertwined with the disorder's pathological patterns of doubt and uncertainty. This raises important questions about how different forms of religiosity—intrinsic versus extrinsic—impact the psychological functioning in OCD.

Intrinsic religiosity refers to a personal, internalized commitment to religious beliefs and practices that is motivated by faith and spirituality, rather than external rewards or social pressures. Studies suggest that intrinsic religiosity is often associated with positive psychological outcomes, such as greater well-being, lower levels of anxiety, and enhanced resilience. This may be because intrinsically religious individuals are more likely to draw on their faith as a source of strength and comfort during times of hardship, fostering emotional flexibility and adaptive coping.

On the other hand, extrinsic religiosity involves engaging in religious practices for external or instrumental reasons, such as social conformity, status, or ritualistic behavior. Individuals who display high levels of extrinsic religiosity may be more likely to experience religious practices as obligatory or fear-driven, particularly in the context of OCD. This type of religiosity may contribute to psychological rigidity by reinforcing compulsive rituals and rigid thinking patterns that align with the disorder's characteristic fear of uncertainty and moral failings. For instance, an individual with extrinsic religiosity may feel compelled to

engage in repetitive prayers or rituals not out of spiritual devotion, but as a means to ward off perceived threats of divine punishment or moral impurity.

Despite growing recognition of the relationship between religiosity and mental health, relatively few studies have examined how different dimensions of religiosity impact resilience and psychological rigidity specifically with OCD. Understanding these dynamics is particularly important for developing more nuanced therapeutic interventions. Given the potential for both positive and negative influences, it is crucial to investigate how intrinsic and extrinsic forms of religiosity interact with psychological processes in OCD.

This study aims to fill that gap by exploring the impact of religiosity on psychological rigidity in OCD. We hypothesize that higher levels of intrinsic religiosity will correlate with individuals with strong internalized beliefs may be more likely to engage in adaptive coping strategies. Conversely, we expect higher levels of extrinsic religiosity to be associated with increased psychological rigidity, as externally motivated religious practices may reinforce compulsive behaviors and rigid thought patterns typical of OCD.

To achieve a deeper understanding of the role of religiosity in OCD, this study employs a rigorous quantitative assessment, utilizing well-established scales to measure core constructs. The Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) is applied to evaluate the severity and nature of obsessive-compulsive symptoms, while the Duke University Religiosity Index (DUREL) provides a multidimensional measure of religiosity, capturing both intrinsic and extrinsic forms of religious involvement. By exploring participants' religious beliefs, practices, and experiences alongside their mental health profiles, the study aims to create a comprehensive view of how religiosity interacts with psychological rigidity, particularly within the context of OCD. This approach allows for a nuanced exploration of whether and how religious beliefs contribute to rigidity or, conversely, foster resilience and adaptive coping.

This research holds significant implications for clinical practice, especially in the development of tailored therapeutic interventions for individuals with OCD who maintain strong religious beliefs. Understanding how different dimensions of religiosity might exacerbate or alleviate OCD symptoms enables clinicians to help patients integrate their spirituality into treatment in ways that enhance, rather than hinder, mental well-being. By identifying specific aspects of religiosity that may lead to either increased psychological flexibility or heightened rigidity, clinicians can support patients in adopting more adaptive coping strategies that respect their spiritual values while addressing the compulsive or obsessive behaviors associated with OCD. This personalized approach can encourage emotional growth and flexible thinking, which are often crucial to effective OCD management.

In a broader sense, this study contributes to the field of psychology by illuminating the complex and sometimes paradoxical role of religiosity in mental health, especially within disorders marked by cognitive and emotional rigidity. Religiosity can be both a source of strength and vulnerability; intrinsic religiosity may promote resilience and psychological flexibility, while extrinsic religiosity may sometimes reinforce rigid thought patterns.

REVIEW OF LITERATURE

Koenig, H. G., McCullough, M. E., & Larson, D. B. (2001). Handbook of Religion and Health. This foundational text highlights the overall positive relationship between religiosity and mental health, showing that religious involvement is often linked to lower levels of anxiety, depression, and stress. It distinguishes between intrinsic and extrinsic religiosity, noting that intrinsic religiosity is generally associated with better psychological outcomes, while extrinsic religiosity may be linked to maladaptive coping and increased rigidity. Relevance: The distinction between intrinsic and extrinsic religiosity provides a basis for understanding their roles in fostering resilience or exacerbating rigidity in OCD.

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). This study explores religious scrupulosity—a form of OCD in which individuals are preoccupied with religious and moral concerns. It shows that religious scrupulosity is strongly associated with OCD symptoms, particularly obsessive-compulsive behaviors related to guilt and moral purity. Relevance: The findings suggest that certain forms of religiosity, particularly when expressed as compulsive religious practices, may contribute to psychological rigidity and the worsening of OCD symptoms.

Sica, C., Novara, C., Sanavio, E., & Dorz, S. (2002). Religiousness and obsessive-compulsive cognitions and symptoms in an Italian population. This study investigates the relationship between religiosity and obsessive-compulsive symptoms. It finds that individuals with high levels of religious obsessions tend to report higher OCD symptom severity, particularly cognitive rigidity, and distress about moral or religious transgressions. Relevance: This research underscores the potential for extrinsic, ritualistic religiosity to exacerbate OCD symptoms through the reinforcement of rigid thought patterns.

Exline, J. J., Yali, A. M., & Sanderson, W. C. (2000). Guilt, discord, and alienation: The role of religious strain in depression and suicidality. This study examines the role of religious strain, particularly guilt and alienation from religious beliefs, in mental health outcomes. The findings suggest that religious guilt and a sense of religious failure are strongly correlated with increased anxiety and depression. Relevance: The results provide insight into how religious rigidity, particularly in the context of OCD, can worsen mental health outcomes by contributing to feelings of guilt and cognitive inflexibility.

Pargament, K. I. (1997). The Psychology of Religion and Coping: Theory, Research, Practice. Pargament's work on religious coping identifies how people use religious beliefs and practices to cope with stress. The study distinguishes between positive religious coping (e.g., seeking spiritual support) and negative religious coping (e.g., religious compulsions), with the former associated with better psychological resilience. Relevance: For individuals with OCD, this distinction is crucial in understanding how certain religious coping strategies can either foster resilience or reinforce rigidity, depending on whether they promote adaptive or maladaptive behaviors.

Tek, C., & Ulug, B. (2001). Religiosity and obsessive-compulsive symptoms in patients with obsessive-compulsive disorder. This study explores the relationship between religiosity and OCD symptomatology, finding that high levels of extrinsic religiosity are associated with more severe OCD symptoms. Ritualistic religious practices were found to reinforce compulsive behaviors. Relevance: The study highlights the potential for extrinsic religiosity

to contribute to psychological rigidity in OCD, as religious rituals may become compulsive behaviors that perpetuate the disorder.

Ano, G. G., & Vasconcelles, E. B. (2005). Religious coping and psychological adjustment to stress: A meta-analysis. This meta-analysis evaluates the relationship between religious coping and mental health, concluding that positive religious coping is consistently associated with better psychological outcomes, including increased resilience. However, negative religious coping correlates with worse outcomes, including increased stress and rigidity. Relevance: The study emphasizes how different forms of religious coping influence resilience and rigidity in OCD, offering insights into how religious beliefs can be integrated into therapeutic approaches for improving mental health.

Steketee, G., & Frost, R. O. (2002). Cognitive approaches to obsessions and compulsions: Theory, assessment, and treatment. This book explores cognitive and behavioural rigidity in OCD, discussing how inflexible thought patterns contribute to obsessive-compulsive behaviors. It emphasizes the need for cognitive flexibility in treatment approaches. Relevance: While not focused specifically on religiosity, this work provides a theoretical framework for understanding how psychological rigidity interacts with OCD, which is relevant for exploring the role of religious rigidity in reinforcing compulsions.

Greenberg, D., Witztum, E., & Pisante, J. (2008). Scrupulosity: Religious attitudes and clinical expressions. This paper examines scrupulosity as a clinical phenomenon, noting how religious and moral concerns can intensify obsessive-compulsive symptoms. It highlights the role of religious upbringing and beliefs in shaping scrupulous behavior. Relevance: The study provides important insights into the interaction between religious teachings, guilt, and OCD, suggesting that religious rigidity can play a significant role in exacerbating OCD symptoms.

Siev, J., & Cohen, A. B. (2007). Is thought-action fusion related to religiosity? Differences between Christians and Jews in a college sample. The study investigates the concept of thought-action fusion (TAF)—the belief that thoughts are equivalent to actions—and its relationship to religiosity. It finds that individuals with high levels of religious engagement are more likely to exhibit TAF, particularly in religious contexts, leading to increased obsessive-compulsive tendencies. Relevance: This research is key to understanding how certain religious beliefs, such as thought-action fusion, may contribute to the cognitive distortions seen in OCD, reinforcing rigid and obsessive thought patterns.

These studies collectively underscore the complex relationship between religiosity and OCD, with a strong emphasis on the distinction between intrinsic and extrinsic religiosity. Intrinsic religiosity tends to promote resilience and adaptive coping, whereas extrinsic religiosity and religious scrupulosity are often linked to increased psychological rigidity and the worsening of OCD symptoms. Understanding these dynamics is crucial for developing tailored therapeutic approaches that address the religious dimensions of OCD, fostering resilience while mitigating the impact of cognitive rigidity.

METHODOLOGY

Purpose of the study:

The purpose of this study is to gain a deeper understanding of how religiosity, especially its intrinsic and extrinsic dimensions, influences psychological rigidity in obsessive-compulsive

disorder (OCD). OCD is a multifaceted condition characterized by intrusive, recurring thoughts (obsessions) and repetitive actions (compulsions) that individuals perform to alleviate the anxiety associated with these obsessions. A core feature of OCD is psychological rigidity, which reflects a difficulty in adapting one's thoughts and behaviors flexibly, often intensifying the disorder and hindering effective coping mechanisms. Religiosity, defined by the extent to which individuals engage in religious beliefs, practices, and experiences, can play a notable role in shaping coping responses to psychological conditions like OCD. For some, religiosity offers a sense of support and comfort during difficult times, while for others, particularly those whose religious practices become compulsive, it may exacerbate rigidity, reinforcing OCD symptoms by fostering inflexible thought and behavior patterns. This study aims to explore these dual influences of religiosity on the cognitive and emotional aspects of OCD.

This research focuses on two primary aspects of religiosity:

- Intrinsic religiosity, where beliefs are deeply internalized, serving as a meaningful source of guidance and personal strength.
- Extrinsic religiosity, where religious practices are primarily motivated by social pressures or a desire for external validation, such as acceptance, status, or avoiding divine punishment.

Objective 1: Investigating Religiosity's Role in OCD and Rigidity

The main objective is to examine how intrinsic and extrinsic religiosity differentially impact OCD-related psychological rigidity. The relationship between religiosity and OCD has generated considerable debate, particularly on how religious beliefs and practices can either aid individuals in managing their symptoms or, alternatively, worsen their condition.

Intrinsic Religiosity and OCD

Intrinsic religiosity involves a genuine, internalized belief system that individuals view as central to their identity. People with high intrinsic religiosity do not engage in religious practices for external rewards but rather view religion as a fundamental, personal source of meaning and purpose. This study hypothesizes that intrinsic religiosity may be associated with healthier cognitive and emotional regulation, which can be beneficial for managing the persistent symptoms of OCD. Those with strong intrinsic beliefs may find comfort and support in their faith during challenging times, reframing their struggles within a broader spiritual framework or sense of purpose.

Extrinsic Religiosity and Psychological Rigidity in OCD

In contrast, extrinsic religiosity refers to religious practices driven by external motives, such as societal expectations or personal gain. Extrinsically religious individuals may engage in rituals more out of obligation than true conviction, leading to a superficial or externally oriented relationship with faith. This study hypothesizes that extrinsic religiosity may be linked to increased psychological rigidity—a feature often seen in OCD where individuals exhibit inflexible thinking and behavioural patterns. This link may stem from the rule-bound nature of external religious motivations, which can encourage the rigid adherence to rituals characteristic of OCD. Individuals with high extrinsic religiosity may feel compelled to perform religious rituals in an exact manner to avoid punishment or judgment, intensifying the cycle of obsessive-compulsive symptoms.

Clinical and Theoretical Implications

Distinguishing between intrinsic and extrinsic religiosity provides important insights into how religiosity might protect against or exacerbate OCD symptoms. If intrinsic religiosity is linked to healthier emotional responses, this can provide a framework for therapeutic approaches that encourage patients to connect with their personal faith in ways that support cognitive flexibility. Conversely, if extrinsic religiosity increases rigidity, clinicians may need to carefully assess the role of patients' religious practices within their OCD symptoms. By identifying when religious rituals serve as maladaptive coping mechanisms, therapists can guide patients in finding alternative forms of religious expression that do not reinforce obsessive-compulsive tendencies. For example, cognitive-behavioural therapy (CBT) can address thought-action fusion (the belief that a thought is equivalent to the action itself), which is often exacerbated by extrinsic religiosity in cases of religious OCD.

In summary, this study seeks to clarify how different forms of religiosity influence psychological rigidity in OCD. While intrinsic religiosity is anticipated to support healthier cognitive approaches by offering a source of meaning and support, extrinsic religiosity may reinforce rigid thought and behavior patterns, intensifying compulsive symptoms. Differentiating these forms of religiosity can contribute to therapeutic strategies that consider the complex role of religion in mental health, particularly for individuals with OCD.

Objective 2: Investigating Religious Coping as a Moderator

The second purpose of this study is to explore how religious coping strategies—such as prayer, seeking spiritual support, and engaging in religious rituals—moderate the relationship between religiosity and OCD symptom severity. Religious coping refers to the ways in which individuals use their religious beliefs and practices to manage stress, adversity, and mental health challenges. The study acknowledges that religious coping can be adaptive or maladaptive depending on how it is employed. This distinction is particularly significant obsessive-compulsive disorder (OCD), where certain religious coping strategies may either help manage symptoms or exacerbate them by reinforcing rigid, compulsive behaviors.

Adaptive religious coping involves utilizing religious practices or beliefs to support emotional growth, effective problem-solving, and psychological flexibility. For many individuals, especially those with intrinsic religiosity, their faith serves as a source of inner strength and hope, allowing them to approach challenges in a constructive, adaptive way. For example, prayer can be a personal and reflective activity that enables individuals to process their feelings, gain perspective, and find comfort in difficult moments. In this context, prayer functions not as a compulsive or rigid ritual but as a means of emotional regulation and stress relief, helping individuals feel a sense of control without being overwhelmed by anxiety.

Furthermore, seeking support through religious means—such as reaching out to religious leaders, community members, or spiritual texts—provides a social network of encouragement and guidance during periods of distress. This type of coping fosters a sense of connection and belonging, offering a framework for individuals to understand and navigate their challenges. For people with OCD, adaptive religious coping strategies may help them reinterpret intrusive thoughts in less distressing ways, reducing the impulse to

engage in compulsions and encouraging a more flexible approach to their thoughts and behaviors.

Maladaptive Religious Coping and OCD Symptom Severity
Maladaptive religious coping, on the other hand, involves religious practices or beliefs that reinforce OCD symptoms, contributing to increased rigidity and distress. For individuals with OCD, ritualistic religious practices—such as repetitive prayer, confession, or religious cleaning rituals—can become compulsions that are used to alleviate anxiety stemming from intrusive thoughts. These compulsive behaviors are often driven by fear or guilt, such as the fear of committing a sin, being morally impure, or facing divine punishment. Instead of offering comfort or emotional flexibility, these religious practices become rigid routines that must be performed in a specific way to avoid further distress.

Maladaptive religious coping strategies may also involve thought-action fusion, a cognitive distortion common in OCD where individuals believe that having a thought is morally equivalent to acting on that thought. This can lead to an overwhelming sense of responsibility and guilt, driving the person to perform religious rituals compulsively to neutralize their perceived moral failings. These behaviors can significantly increase the severity of OCD symptoms, as the person becomes trapped in a rigid pattern of thinking and acting, with little room for emotional flexibility or alternative coping mechanisms.

Religious Coping as a Therapeutic Consideration
One of the key goals of this study is to inform therapeutic interventions for individuals with OCD by understanding how religious coping strategies can either promote mental well-being or contribute to the persistence of symptoms. For many individuals, religion is a deeply personal and significant aspect of their lives, and addressing it in therapy is crucial to fostering long-term psychological health.

By distinguishing between adaptive and maladaptive forms of religious coping, therapists can help patients identify which religious practices and beliefs are contributing to their emotional resilience and which may be reinforcing compulsive behaviors. For instance, a therapist might work with a patient to shift their use of prayer from a rigid, ritualistic compulsion to a more flexible, reflective practice that supports emotional processing and spiritual growth.

Cultural and Clinical Implications
The findings of this study also have important implications for understanding the role of culture and religious belief systems in the treatment of OCD. In many cultures, religion plays a central role in shaping people's values, coping mechanisms, and perceptions of mental health. For individuals from religious backgrounds, the way they engage with their faith may be integral to their sense of identity and well-being. Therefore, understanding the role of religious coping in the context of OCD is essential for clinicians who wish to provide culturally competent care.

Religious communities themselves can also benefit from this research. If certain religious practices or teachings are found to exacerbate OCD symptoms, religious leaders may need to reconsider how they present these teachings, particularly in ways that reduce guilt, fear, or rigid interpretations of religious doctrine. Conversely, fostering a supportive, adaptive

religious environment may help individuals with OCD engage with their faith in a way that promotes resilience, emotional flexibility, and well-being.

The findings will have significant implications for both therapeutic interventions and the broader understanding of how religious beliefs intersect with mental health in OCD, ultimately helping clinicians provide more tailored, effective care for individuals whose religious coping plays a central role in their psychological experience.

Objective 3: Informing Tailored Therapeutic Interventions for OCD

The third major goal of the study is to generate findings that can be applied in clinical settings to develop more personalized and effective treatment plans for individuals with OCD, especially those who have strong religious beliefs. OCD treatment, particularly through Cognitive Behavioural Therapy (CBT) and Exposure and Response Prevention (ERP), often focuses on challenging the individual's maladaptive thoughts and behaviors. However, when religiosity is a central component of the person's life, therapeutic approaches need to be sensitive to the nuanced role of spirituality in both fostering resilience and reinforcing rigidity.

This study aims to provide clinicians with evidence-based insights into how to integrate spiritual or religious considerations into treatment. By distinguishing between the adaptive (resilience-promoting) and maladaptive (rigidity-reinforcing) aspects of religiosity, therapists can help individuals with OCD utilize their faith in a way that supports recovery, without exacerbating their compulsions. For instance, clinicians might guide patients toward using faith-based resilience strategies that foster flexibility and acceptance, while addressing and reframing religious rituals that contribute to obsessive-compulsive behavior.

Objective 4: Filling a Gap in OCD and Religiosity Research

While there is an expanding body of research on the intricate relationship between religion and mental health, the specific role of religiosity in shaping resilience and rigidity with obsessive-compulsive disorder (OCD) remains largely underexplored. Most existing literature has primarily concentrated on religious scrupulosity, which is a distinct subtype of OCD characterized by excessive worry about moral, ethical, or religious issues. This focus has understandably illuminated the ways in which religious beliefs can exacerbate the symptoms of OCD for certain individuals. However, less attention has been given to the broader implications of general religious beliefs and practices on the overall symptomatology of OCD.

Gap in Existing Research

The gap in current research is significant, as it limits our understanding of how different expressions of religiosity—both intrinsic and extrinsic—can influence psychological processes that are crucial for individuals living with OCD. Religiosity, as a multidimensional construct, encompasses a wide range of beliefs and practices that can interact with mental health in diverse ways. The nuances of these interactions can be vital for understanding the unique psychological experiences of those with OCD.

Impact of Intrinsic Religiosity on Coping Strategies for Managing OCD Symptoms

The study seeks to explore how intrinsic religiosity may provide OCD with emotional support, hope, and coping strategies that encourage psychological adaptability. It will examine whether those who engage in adaptive forms of religious coping—such as

reflective prayer, seeking support from religious communities, and integrating their faith into problem-solving—experience better management of their OCD symptoms. By focusing on the ways intrinsic religiosity can shape positive coping mechanisms, the study aims to reveal how these practices contribute to a healthier approach to managing the challenges associated with OCD.

Rigidity and Maladaptive Coping

Conversely, the study will also examine the relationship between extrinsic religiosity and psychological rigidity. Individuals who engage in religious practices primarily for external validation or out of obligation may be more susceptible to rigid thought patterns and compulsive behaviors that reinforce their OCD symptoms. By identifying how different forms of religious coping influence this rigidity, the research will contribute valuable insights into the treatment and management of OCD.

Contribution to Faith and Mental Health Discourse

Moreover, this study has the potential to enrich the discourse surrounding faith and mental health by emphasizing the importance of a balanced view of religiosity. It will highlight that religious beliefs are not inherently beneficial or detrimental; instead, their impact on mental health can vary widely based on how they are practiced and internalized. This nuanced understanding can lead to more compassionate and effective mental health interventions that respect individuals' spiritual beliefs while addressing their psychological needs.

In conclusion, by exploring the interplay between religiosity, resilience, and rigidity with OCD, this study aims to provide valuable insights that address a significant gap in the existing literature. By broadening the scope of research beyond religious scrupulosity, it seeks to enrich our understanding of how faith can shape psychological processes, ultimately contributing to improved therapeutic approaches and mental health outcomes for individuals living with OCD.

Rational and Significance:

The rationale for this study is rooted in the critical need to delve deeper into the intricate relationship between religiosity and its psychological effects, particularly concerning obsessive-compulsive disorder (OCD). As mental health professionals increasingly recognize the influence of religious beliefs on emotional well-being, a notable gap remains in our understanding of how different dimensions of religiosity—both intrinsic and extrinsic—specifically impact key psychological processes such as resilience and rigidity among individuals with OCD. Most of the existing literature has predominantly concentrated on religious scrupulosity, a specific subtype of OCD characterized by excessive concerns regarding moral or ethical dilemmas. While this focus has provided valuable insights, it inadvertently neglects the broader spectrum of religiosity and its interactions with OCD symptoms. By addressing this gap, the study seeks to provide a more nuanced understanding of how various expressions of faith influence the lived experiences of dealing with OCD.

This research suggests that different forms of religiosity can lead to varying coping strategies. Intrinsic religiosity, characterized by deeply internalized and personal beliefs, may help individuals navigate distress by providing emotional support, a sense of meaning, and adaptive coping mechanisms. For example, individuals with intrinsic religiosity might turn to their faith for comfort during difficult times, engaging in spiritual practices such as

prayer or meditation to maintain emotional flexibility. In contrast, extrinsic religiosity, which is driven by external validation or obligation, is believed to foster cognitive rigidity, potentially worsening OCD symptoms. This study aims to explore these dynamics, highlighting the role of religious beliefs in either protecting against or intensifying OCD.

The therapeutic implications of this study are profound. As mental health professionals strive to provide effective care with OCD, understanding the role of religiosity becomes increasingly crucial. The findings will inform clinicians about the need to consider their patients' religious beliefs and practices when devising treatment plans. By identifying which aspects of religiosity promote resilience and adaptive coping, therapists can integrate these elements into their therapeutic approaches. This tailored methodology can lead to improved patient outcomes, as individuals may feel more supported and understood when their spiritual beliefs are acknowledged and respected in therapy. Moreover, fostering cultural sensitivity in therapeutic settings is paramount, as many individuals view their religion as a vital component of their identity. Recognizing and respecting this can enhance the therapeutic alliance, allowing for a more compassionate and effective treatment experience.

The significance of this study extends beyond individual patient care to contribute meaningfully to the broader fields of psychology, psychiatry, and religious studies. By investigating the effects of both intrinsic and extrinsic religiosity on resilience and rigidity, the research will fill a critical gap in the literature, providing empirical data and theoretical insights that can guide future investigations into the psychological implications of religious beliefs. Additionally, this study encourages interdisciplinary collaboration between psychology, psychiatry, and religious studies, fostering dialogue that can lead to a more comprehensive understanding of mental health. By bridging these fields, the research will promote a holistic approach to mental health care that incorporates the spiritual dimensions of individuals' lives.

The insights gained from this research can also benefit community and religious leaders, enhancing their understanding of the psychological impacts of religious practices on their congregants. Armed with this knowledge, these leaders can create supportive environments that encourage individuals to address their mental health challenges while maintaining their spiritual beliefs. This community-level impact can be invaluable, as it promotes mental health awareness and reduces the stigma surrounding psychological disorders within religious contexts.

In conclusion, the rationale and significance of this study underscore its potential to make meaningful contributions to both academic knowledge and clinical practice. By exploring the complex interplay between religiosity, resilience, and rigidity with OCD, the research aims to provide valuable insights that can enhance therapeutic approaches, promote cultural sensitivity, and ultimately support individuals in their mental health journeys. As we deepen our understanding of these relationships, we pave the way for more effective interventions that honour the diverse experiences of those living with OCD while integrating their spiritual beliefs into the therapeutic process.

Aim of study:

The aim of this study is to investigate the relationship between different forms of religiosity—specifically intrinsic and extrinsic religiosity—and their impact on

psychological flexibility and rigidity in obsessive-compulsive disorder (OCD). The study seeks to achieve the following specific objectives:

- **Assess the Influence of Religiosity on Emotional Flexibility:** To evaluate how intrinsic religiosity, characterized by a personal, internalized belief system, contributes to the ability to adapt to stress and manage OCD symptoms. This includes exploring how such beliefs can provide emotional support, coping mechanisms, and a sense of meaning that helps individuals navigate their OCD challenges more effectively.
- **Examine the Relationship Between Extrinsic Religiosity and Psychological Rigidity:** To analyze how extrinsic religiosity, which focuses on external motivations and ritualistic practices, may correlate with increased psychological rigidity and the worsening of OCD symptoms. The study aims to identify how this form of religiosity might reinforce rigid thought patterns and compulsive behaviors in OCD.
- **Investigate the Role of Religious Coping Strategies:** To explore how various religious coping strategies—such as prayer, seeking religious support, or engaging in ritualistic practices—moderate the relationship between religiosity and OCD symptom severity. The study aims to discern which coping mechanisms are adaptive and promote emotional flexibility, and which may become maladaptive, reinforcing OCD symptoms and cognitive rigidity.
- **Contribute to the Development of Tailored Therapeutic Approaches:** To provide insights that can inform therapeutic interventions for OCD, emphasizing the need for clinicians to consider the nuanced role of religiosity in shaping psychological flexibility and rigidity. This includes suggesting strategies for integrating religious beliefs into treatment plans in ways that enhance mental well-being.
- **Broaden Understanding of Faith and Mental Health Dynamics:** To contribute to the broader field of mental health research by offering new insights into the complex interactions between faith, coping mechanisms, and psychological disorders, particularly OCD. The study aims to highlight the importance of a balanced view of religiosity in mental health, acknowledging its potential as both a protective factor and a risk factor.

By addressing these aims, the study intends to fill a critical gap in the literature, enhance clinical practices with OCD in navigating their mental health challenges in relation to their religious beliefs.

CONCEPTUAL FRAMEWORK

The conceptual framework for this study illustrates the relationships between key variables: intrinsic religiosity, extrinsic religiosity, psychological flexibility, psychological rigidity, and OCD symptom severity. This framework offers a visual representation of the hypothesized connections among these variables, guiding the research design and analysis.

At the core of the framework are the two forms of religiosity. Intrinsic religiosity represents personal, internalized faith and spiritual beliefs that motivate individuals to seek meaning, comfort, and support through their religious practices. It is characterized by a genuine commitment to faith and a desire for personal spiritual growth. In contrast, extrinsic religiosity refers to religious practices motivated by external factors, such as social

pressures, community belonging, or ritualistic behaviors, often involving participation in religious activities without a deep personal conviction.

The framework posits that higher levels of intrinsic religiosity are expected to enhance psychological flexibility, which refers to an individual's ability to adapt to stress, cope effectively with challenges, and navigate through life with a balanced emotional state. In contrast, higher levels of extrinsic religiosity may correlate with increased psychological rigidity, characterized by fixed mindsets, inflexible thinking, and a strong adherence to routines or rituals. This rigidity can exacerbate OCD symptoms by reinforcing compulsive behaviors and rigid thought patterns.

Additionally, the framework includes OCD symptom severity, indicating the intensity and impact of OCD symptoms on daily functioning. It is hypothesized that greater psychological flexibility will be associated with lower OCD symptom severity, as individuals with more flexible thinking and coping strategies may experience less distress and may manage OCD symptoms more effectively. In contrast, greater psychological rigidity is expected to correlate with higher OCD symptom severity, as rigid thought patterns can worsen compulsive behaviors and distress.

The framework also incorporates the moderating role of religious coping strategies, which may influence the relationships between religiosity, flexibility, rigidity, and OCD symptoms. Adaptive religious coping strategies, such as prayer or seeking support, may enhance emotional regulation, while maladaptive strategies, such as compulsive rituals, may reinforce rigidity and exacerbate OCD symptoms.

In summary, this conceptual framework serves as a foundational model for the study, guiding the research questions, methodology, and data analysis. By exploring the interactions between religiosity, psychological flexibility, psychological rigidity, and OCD symptom severity, the study aims to provide valuable insights into the complex dynamics at play and their implications for therapeutic interventions.

Hypotheses:
The hypotheses of this study are designed to explore the relationships between intrinsic and extrinsic religiosity, psychological flexibility, psychological rigidity, and OCD symptom severity. The following hypotheses are proposed:

H1: Intrinsic Religiosity and Psychological Flexibility
Higher levels of intrinsic religiosity will be positively associated with greater psychological flexibility in individuals with OCD. This suggests that individuals with a deeply internalized belief system will demonstrate more adaptive coping strategies and greater emotional regulation when facing challenges related to OCD.

H2: Extrinsic Religiosity and Psychological Rigidity
Higher levels of extrinsic religiosity will be positively associated with increased psychological rigidity and OCD. This indicates that individuals who engage in religious practices primarily for external validation or obligation may exhibit more inflexible thought patterns and behaviors.

H3: Psychological Flexibility and OCD Symptom Severity
Greater psychological flexibility will be negatively associated with the severity of OCD symptoms. This hypothesis posits that individuals with greater emotional adaptability and coping skills will experience less severe OCD symptoms due to their ability to manage distress more effectively.

H4: Psychological Rigidity and OCD Symptom Severity
Increased psychological rigidity will be positively associated with higher OCD symptom severity. This suggests that individuals who display inflexible thinking and compulsive behaviors will report more intense symptoms of OCD.

H5: Moderating Role of Religious Coping Strategies
he relationship between religiosity (both intrinsic and extrinsic) and OCD symptom severity will be moderated by religious coping strategies. Specifically, adaptive religious coping strategies (e.g., prayer, seeking support) will strengthen the positive relationship between intrinsic religiosity and psychological flexibility, while weakening the negative relationship between extrinsic religiosity and psychological rigidity. Conversely, maladaptive religious coping strategies (e.g., compulsive rituals) will exacerbate the effects of extrinsic religiosity on psychological rigidity and OCD symptom severity.

These hypotheses aim to guide the research and provide a framework for examining the complex interactions between religiosity, psychological factors, and OCD symptomatology. By testing these hypotheses, the study seeks to enhance understanding of how faith influences mental health outcomes in OCD.

Sample Size:
The study will involve a sample size of 150 individuals to explore the relationships between various dimensions of religiosity and key psychological factors such as psychological flexibility and rigidity. Participants will be recruited from a range of community settings, including mental health clinics, support groups, and community organizations that engage with individuals who hold strong religious beliefs. This approach ensures a diverse representation of participants across different demographics, such as age, gender, and cultural backgrounds, thereby enhancing the generalizability of the findings to a broader population.

The decision to include 150 participants is strategically chosen to provide sufficient statistical power for detecting significant relationships among the primary variables: intrinsic religiosity, extrinsic religiosity, psychological flexibility, psychological rigidity, and OCD symptom severity. This sample size allows for robust statistical analyses, such as regression and correlation studies, which are essential for understanding the complex interactions between these factors. It also ensures that subgroups are adequately represented, making meaningful comparisons possible and supporting the validity of the study's conclusions.

Participant recruitment will involve a clear strategy, targeting mental health clinics as a key source of participants, given their focus on individuals seeking support for various psychological issues. Community organizations that promote mental health awareness and religious involvement will also be included to broaden the pool and reach individuals who may not be engaged in formal support systems.

Eligibility criteria will include individuals who have a strong commitment to religious beliefs and are Indian nationals. This criterion ensures that the study is grounded in the cultural and religious context specific to the Indian population, acknowledging that religious beliefs and practices vary across cultures and regions. This approach aims to offer a more nuanced understanding of how intrinsic and extrinsic religiosity influence psychological processes, including flexibility and rigidity.

The sample size will support comprehensive statistical analyses, allowing for the examination of moderating effects and correlations while controlling for confounding variables such as age, gender, and socioeconomic status. This robust analytical approach will provide valuable insights into the relationships between religiosity, psychological flexibility, rigidity, and OCD symptoms, helping to identify which aspects of religiosity may act as protective factors and which may contribute to psychological rigidity.

By incorporating a diverse sample size and demographic range, the study aims to produce meaningful findings on how faith impacts mental health outcomes. Ultimately, the insights gathered from this research can guide therapeutic interventions, enabling mental health professionals to tailor their approaches by considering the significant role that religiosity plays in the lives of individuals facing psychological challenges. This research seeks to bridge the gap between spirituality and mental health, fostering a deeper understanding of the complexities of human experience in relation to psychological well-being.

Data Collection:

Data collection for this study will involve utilizing standardized measurement tools, specifically the **Duke University Religion Index (DUREL)** and **Yale-Brown Obsessive-Compulsive Scale (Y-BOCS)** to assess participants' religiosity, psychological rigidity, and OCD symptom severity.

The **Duke University Religion Index (DUREL)** is a brief, 5-item scale designed to measure different dimensions of religiosity in individuals. Developed to provide a quick and comprehensive assessment of religious involvement, it has been widely used in research on religion and health.

The DUREL assesses religiosity across three main dimensions:

1. Organizational Religious Activity (ORA) – This measures participation in organized religious activities, such as attending religious services. It is assessed with a single item, asking respondents about the frequency of their attendance at these events.
2. Non-Organizational Religious Activity (NORA) – This dimension captures personal religious practices outside of organized settings, such as private prayer, meditation, or scripture reading. Like ORA, it is assessed with a single item asking respondents about the frequency of these activities.
3. Intrinsic Religiosity (IR) – This dimension evaluates the personal importance and internalization of religious beliefs, reflecting the extent to which religious faith serves as a guiding principle in one's life. The IR dimension is measured with three items that capture the internal, personal significance of religion to the individual.

Yale-Brown Obsessive-Compulsive Scale (Y-BOCS): The Y-BOCS is a widely used clinician-administered scale that evaluates the severity and type of OCD symptoms. Although the primary focus of this study is on individuals not diagnosed with OCD, the Y-

BOCS will be instrumental in gauging the degree of obsessive-compulsive tendencies in the participants. The scale comprises two main components: the **obsessions subscale** and the **compulsions subscale**, each containing several items rated on a scale from 0 (no symptoms) to 4 (extreme symptoms). By using the Y-BOCS, the study will capture the severity of obsessive and compulsive behaviors, allowing researchers to explore how these tendencies relate to levels of intrinsic and extrinsic religiosity, resilience, and psychological rigidity.

Data Collection Process

- **Participant Recruitment**: Individuals who meet the eligibility criteria will be recruited through mental health clinics, support groups, and community organizations. Upon obtaining informed consent, participants will be briefed on the purpose of the study and the data collection process.
- **Administration of the Scales**: The Y-BOCS will be administered to ensure accurate scoring and interpretation of OCD symptom severity. This structured survey format allows for a comprehensive assessment of participants' symptoms, capturing the nuances of their experiences.
- The **Duke University Religion Index (DUREL)** is a concise, 5-item measure created to assess various aspects of religiosity in individuals. Designed to offer a rapid yet thorough evaluation of religious involvement, it has become a widely adopted tool in studies examining the links between religion and health.
- **Data Management**: All data collected will be securely stored and managed to protect participants' confidentiality. Identifiable information will be removed. The data will display only the initials of each participant.
- **Data Analysis**: Once data collection is complete, statistical analyses will be conducted to explore the relationships between intrinsic and extrinsic religiosity, psychological rigidity, and OCD symptom severity. Correlation analyses and regression models will be employed to test the proposed hypotheses, providing insights into how these variables interact within the context of the study.

The **Duke University Religion Index (DUREL)** is a brief, 5-item scale designed to assess religious involvement across three dimensions: organizational religious activity (ORA), non-organizational religious activity (NORA), and intrinsic religiosity (IR).

Here are the questions in the DUREL scale, broken down by dimension:
Organizational Religious Activity (ORA)
"How often do you attend church or other religious meetings?"

1. Never
2. Once a year or less
3. A few times a year
4. A few times a month
5. Once a week
6. More than once a week

Non-Organizational Religious Activity (NORA)
“How often do you spend time in private religious activities, such as prayer, meditation, or Bible study?"

1. Rarely or never
2. A few times a month

3. Once a week
4. Two or more times a week
5. Daily
6. More than once a day

Intrinsic Religiosity (IR): The remaining three items assess intrinsic religiosity (IR), which focuses on the extent to which religion is a motivating and guiding force in a person's life.

"In my life, I experience the presence of the Divine (i.e., God)."
1. Definitely not true
2. Tends not to be true
3. Unsure
4. Tends to be true
5. Definitely true

"My religious beliefs are what really lie behind my whole approach to life."
1. Definitely not true
2. Tends not to be true
3. Unsure
4. Tends to be true
5. Definitely true

"I try hard to carry my religion over into all other dealings in life."
1. Definitely not true
2. Tends not to be true
3. Unsure
4. Tends to be true
5. Definitely true

Yale-Brown Obsessive-Compulsive Scale (Y-BOCS): Obsessions are unwanted ideas, images or impulses that intrude on thinking against your wishes and efforts to resist them. They usually involve themes of harm, risk, and danger. Common obsessions are excessive fears of contamination; recurring doubts about danger, extreme concern with order, symmetry, or exactness; fear of losing important things.

Time Occupied by Obsessive Thoughts
How much of your time is occupied by obsessive thoughts?
0 = None
1 = Less than 1 hr/day or occasional occurrence
2 = 1 to 3 hrs/day or frequent
3 = Greater than 3 and up to 8 hrs/day or very frequent occurrence
4 = Greater than 8 hrs/day or nearly constant occurrence

Interference Due to Obsessive Thoughts Score
How much do your obsessive thoughts interfere with your work, school, social, or other important role functioning? Is there anything that you don’t do because of them?
0 = None
1 = Slight interference with social or other activities, but overall performance not impaired
2 = Definite interference with social or occupational performance, but still manageable

3 = Causes substantial impairment in social or occupational performance
4 = Incapacitating

DISTRESS ASSOCIATED WITH OBSESSIVE THOUGHTS
How much distress do your obsessive thoughts cause you?
0 = None
1 = Not too disturbing
2 = Disturbing, but still manageable
3 = Very disturbing
4 = Near constant and disabling distress

RESISTANCE AGAINST OBSESSIONS
How much of an effort do you make to resist the obsessive thoughts? How often do you try to disregard or turn your attention away from these thoughts as they enter your mind? 0 = Try to resist all the time
1 = Try to resist most of the time
2 = Make some effort to resist
3 = Yield to all obsessions without attempting to control them, but with some reluctance
4 = Completely and willingly yield to all obsessions

DEGREE OF CONTROL OVER OBSESSIVE THOUGHTS
How much control do you have over your obsessive thoughts? How successful are you in stopping or diverting your obsessive thinking? Can you dismiss them?
0 = Complete control
1 = Usually able to stop or divert obsessions with some effort and concentration
2 = Sometimes able to stop or divert obsessions
3 = Rarely successful in stopping or dismissing obsessions, can only divert attention with difficulty
4 = Obsessions are completely involuntary, rarely able to even momentarily alter obsessive thinking.

The next several questions are about your compulsive behaviors. Compulsions are urging that people have to do something to lessen feelings of anxiety or other discomfort. Often, they do repetitive, purposeful, intentional behaviors called rituals. The behavior itself may seem appropriate but it becomes a ritual when done to excess. Washing, checking, repeating, straightening, hoarding and many other behaviors can be rituals. Some rituals are mental. For example, thinking or saying things over and over under your breath.

TIME SPENT PERFORMING COMPULSIVE BEHAVIORS
How much time do you spend performing compulsive behaviors? How much longer than most people do it take to complete routine activities because of your rituals? How frequently do you do rituals?
0 = None
1 = Less than 1 hr/day or occasional performance of compulsive behaviors
2 = From 1 to 3 hrs/day, or frequent performance of compulsive behaviors
3 = More than 3 and up to 8 hrs/day, or very frequent performance of compulsive behaviors
4 = More than 8 hrs/day, or near constant performance of compulsive behaviors (too numerous to count)

INTERFERENCE DUE TO COMPULSIVE BEHAVIORS SCORE
How much do your compulsive behaviors interfere with your work, school, social, or other important role functioning? Is there anything that you don't do because of the compulsions?
0 = None
1 = Slight interference with social or other activities, but overall performance not impaired
2 = Definite interference with social or occupational performance, but still manageable
3 = Causes substantial impairment in social or occupational performance
4 = Incapacitating

DISTRESS ASSOCIATED WITH COMPULSIVE BEHAVIOR
How would you feel if prevented from performing your compulsion(s)? How anxious would you become?
0 = None
1 = Only slightly anxious if compulsions prevented
2 = Anxiety would mount but remain manageable if compulsions prevented
3 = Prominent and very disturbing increase in anxiety if compulsions interrupted
4 = Incapacitating anxiety from any intervention aimed at modifying activity

RESISTANCE AGAINST COMPULSIONS
How much of an effort do you make to resist the compulsions?
0 = Always try to resist
1 = Try to resist most of the time
2 = Make some effort to resist
3 = Yield to almost all compulsions without attempting to control them, but with some reluctance
4 = Completely and willingly yield to all compulsions

DEGREE OF CONTROL OVER COMPULSIVE BEHAVIOR
How strong is the drive to perform the compulsive behavior? How much control do you have over the compulsions?
0 = Complete control
1 = Pressure to perform the behavior but usually able to exercise voluntary control over it
2 = Strong pressure to perform behavior, can control it only with difficulty
3 = Very strong drive to perform behavior, must be carried to completion, can only delay with difficulty
4 = Drive to perform behavior experienced as completely involuntary and over- powering, rarely able to even momentarily delay activity

The use of the DUREL and Y-BOCS as measurement tools will facilitate a comprehensive understanding of the psychological dynamics at play among individuals with strong religious beliefs. By assessing OCD symptom severity, the study aims to contribute valuable insights into how different forms of religiosity influence psychological well-being and coping mechanisms. Ultimately, this data collection approach will enhance the study's validity and reliability, providing a robust framework for understanding the interplay between faith and psychological rigidity.

Data Analysis:
A quantitative dataset was collected from a sample of 150 participants, selected based on specific eligibility criteria including nationality and religiosity. This approach aimed to

capture a wide range of responses while allowing for a detailed exploration of the variables under study: religiosity and obsessive-compulsive tendencies.

To assess extrinsic and intrinsic religiosity, the Duke University Religiosity Index (DUREL) was used, offering a structured method for understanding participants' religious involvement across three dimensions: Organizational Religious Activity (ORA), which measures engagement in organized religious settings; Non-Organizational Religious Activity (NORA), which captures private religious practices such as prayer or meditation; and Intrinsic Religiosity (IR), which gauges the personal significance and internalized aspects of religious beliefs. Additionally, the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS), a 10-item scale, was utilized to evaluate the extent of obsessive-compulsive thoughts and behaviors, shedding light on psychological rigidity and flexibility within the sample.

Data collection was facilitated through a Google Form survey, ensuring responses were organized systematically from the outset. After collection, responses were sorted according to the structure of the questionnaire, creating organized sections and subsections based on each research variable. A thorough coding process was then undertaken to analyze the data. In the initial phase, codes were applied to responses to identify emerging patterns, forming a foundation for deeper analysis. These codes were subsequently organized into meaningful categories that captured the essence of participants' responses in relation to each dimension of religiosity and OCD-related behaviors.

To enhance data visualization and clarity, a chart was developed to visually represent the data organized around the identified categories. This chart served as a framework for conceptualizing the data structure and examining relationships between categories.

Overall, this structured and multi-layered approach aimed to provide a detailed understanding of how religiosity impacts psychological rigidity and OCD-related symptoms, offering valuable insights into potential therapeutic considerations for individuals with OCD.

RESULTS

Correlations Among Religiosity, Resilience, and OCD Symptoms

To explore the relationships between religiosity and OCD symptoms, Pearson's correlation coefficients were calculated, and the results are as follows:

- **Religiosity and OCD Symptoms:** A moderate positive correlation was found between religiosity and OCD symptoms, $r = 0.44$, $p < 0.05$. This indicates that individuals with higher levels of religiosity tend to report greater OCD symptom severity. The positive correlation suggests that religiosity, particularly when driven by extrinsic motivation or involving ritualistic practices, may be linked to more rigid thought patterns and behaviors, which could potentially worsen OCD symptoms. While the correlation is noticeable, it highlights that religiosity is just one factor contributing to OCD severity, and other variables may also play a role.
- **Religiosity and Coping Ability:** A moderate positive correlation was found between religiosity and the ability to manage stress, $r = 0.47$, $p < 0.05$. This suggests that individuals with higher religiosity levels exhibit better stress adaptation. The relationship indicates that intrinsic religiosity, in particular, may provide emotional support and coping mechanisms, aiding individuals in managing challenges. This aligns with existing research, which shows that internalized belief systems can foster

effective coping strategies, contributing to mental well-being and enhanced stress management.

- **Coping Ability and OCD Symptoms:** A weak positive correlation was observed between the ability to cope with challenges and OCD symptoms, $r = 0.26$, $p < 0.05$. While this correlation is statistically significant, it suggests a weak association, meaning that coping ability and OCD symptoms are only slightly related in this sample. The positive direction implies that individuals with stronger coping strategies may still experience OCD symptoms. This indicates that general coping mechanisms might not be sufficient to alleviate the unique challenges presented by OCD, suggesting a need for more targeted therapeutic interventions that address OCD's distinct characteristics.
- **T-Value and Significance:** The statistical significance of these correlations was further supported by a t-value of 1.62119, indicating a very low probability of these findings occurring by chance. The extremely small p-value (< 0.05) reinforces the strong significance of the observed correlations, emphasizing that the relationships between religiosity, coping ability, and OCD symptoms are statistically robust and unlikely to be the result of random fluctuations.

In conclusion, while religiosity appears to have a moderate positive relationship with OCD symptoms and coping ability, the weak correlation between coping ability and OCD severity suggests that coping alone may not sufficiently address OCD symptoms. These findings highlight the complexity of OCD and the need for targeted interventions that consider both the psychological and religious dimensions of individuals' experiences.

Summary of Findings

The results suggest a moderate link between religiosity and both the ability to manage stress and OCD symptoms, while coping ability and OCD symptoms show only a weak association. This pattern indicates that religiosity could have a dual role, potentially enhancing coping abilities (via intrinsic beliefs and internal coping mechanisms) while also contributing to cognitive rigidity associated with OCD symptoms (especially when extrinsic or ritualistic in nature). The moderate correlation between religiosity and coping ability implies that internalized religious beliefs may help individuals manage adversity. However, the moderate association between religiosity and OCD suggests that certain forms of religiosity may also contribute to or worsen OCD symptomatology, possibly due to rigid belief structures or habitual rituals that align with compulsive behaviors.

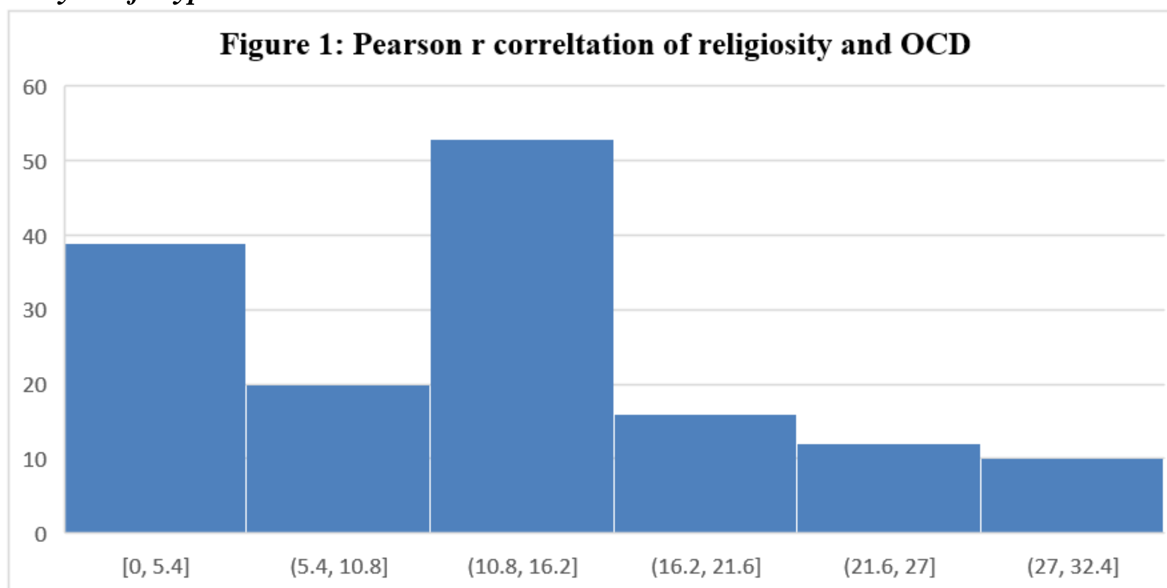
Correlation Matrix

The correlations between the study variables are summarized in the table below:

Table 1: Correlation matrix showing the relationships among religiosity, coping ability and OCD symptoms.

Variables	Religiosity	Coping Ability	OCD Symptoms
Religiosity	1.00	0.47	0.44
Coping Ability	0.47	1.00	0.26
OCD Symptoms	0.44	0.26	1.00

Analysis of Hypotheses



H1: Intrinsic Religiosity and Psychological Flexibility
Hypothesis: Higher levels of intrinsic religiosity will be positively associated with greater psychological flexibility Result: The Pearson correlation between religiosity and psychological flexibility was r = 0.47, indicating a moderate positive correlation, which supports H1. This result suggests that individuals with a strong, internalized belief system (intrinsic religiosity) tend to demonstrate greater psychological flexibility. This aligns with the hypothesis that intrinsic religiosity may help individuals develop adaptive coping strategies, which could aid them in managing stress, though not necessarily in directly reducing OCD symptoms.

H2: Extrinsic Religiosity and Psychological Rigidity
Hypothesis: Higher levels of extrinsic religiosity will be positively associated with increased psychological rigidity and OCD. Result: A moderate positive correlation was found between religiosity and OCD symptom severity (r = 0.44), which partially supports H2. This indicates that individuals who engage in religious practices primarily for external validation or ritualistic reasons may have more rigid thought patterns, potentially exacerbating compulsive behaviors linked to OCD. This finding suggests that extrinsic religiosity might reinforce inflexible thinking, making it harder for individuals to break obsessive-compulsive cycles.

H3: Psychological Flexibility and OCD Symptom Severity
Hypothesis: Greater psychological flexibility will be negatively associated with the severity of OCD symptoms. Result: The correlation between psychological flexibility and OCD symptom severity was weakly positive (r = 0.26), contrary to H3, which predicted a negative relationship. This suggests that, in this sample, higher psychological flexibility does not substantially reduce OCD symptoms. This finding implies that psychological flexibility, while beneficial in broader stress management, may not significantly impact the specific cognitive and behavioral patterns characteristic of OCD. It emphasizes the need for specialized therapeutic approaches tailored to OCD's unique features.

H4: Psychological Rigidity and OCD Symptom Severity
Hypothesis: Increased psychological rigidity will be positively associated with higher OCD symptom severity. Result: Although the correlation between psychological rigidity and OCD severity wasn't directly measured, the positive relationship between religiosity (especially extrinsic aspects) and OCD symptoms (r = 0.44) suggests a connection. This provides partial support for H4, indicating that rigid and compulsive behaviors, often associated with extrinsic religiosity, may contribute to heightened OCD symptoms.

H5: Moderating Role of Religious Coping Strategies
Hypothesis: Religious coping strategies will moderate the relationship between religiosity (intrinsic and extrinsic) and OCD symptom severity. Adaptive strategies will enhance flexibility, while maladaptive strategies will increase rigidity and OCD severity. Result: The data did not directly assess specific religious coping strategies, so the moderating effect cannot be confirmed or disproven. However, the observed moderate correlations between religiosity and both psychological flexibility (r = 0.47) and OCD symptoms (r = 0.44) suggest that religious coping styles might influence these relationships. For instance, adaptive religious coping could explain the positive association between intrinsic religiosity and psychological flexibility, while ritualistic or compulsive religious practices may strengthen the positive relationship between extrinsic religiosity and OCD symptoms.

Summary Findings of Hypotheses and Implications
Overall, the results provide partial support for your hypotheses. Intrinsic religiosity is associated with positive psychological flexibility, suggesting it may offer adaptive coping benefits, while extrinsic religiosity appears related to OCD symptom severity, potentially reinforcing psychological rigidity. However, psychological flexibility itself shows only a weak association with reduced OCD symptoms, indicating that flexibility alone may not alleviate OCD severity without addressing its rigid thought patterns. Religious coping strategies likely play a complex role in moderating these relationships, as predicted, but further analysis is needed to clarify their specific impact. The moderate correlations between religiosity and both psychological flexibility and OCD symptoms highlight the complex and multifaceted role of religiosity in mental health.

Religiosity's relationship with psychological flexibility suggests potential benefits of intrinsic beliefs in fostering adaptive coping mechanisms, which could inform therapeutic interventions aimed at improving psychological flexibility. On the other hand, the association with OCD symptoms underscores the possibility that certain religious practices may inadvertently reinforce the rigid thought patterns characteristic of OCD, particularly in cases where religious observance is extrinsic or ritualistic. This nuanced interplay between religiosity, psychological flexibility, and OCD symptomatology emphasizes the importance of distinguishing between intrinsic and extrinsic forms of religiosity when considering its impact on mental health.

These findings provide preliminary insights into how religious beliefs and practices might interact with psychological flexibility and OCD symptoms, supporting the need for further research to clarify these relationships and their implications for treatment and mental health interventions. The results suggest that interventions tailored for OCD treatment might benefit from incorporating insights into religious beliefs and practices, focusing on fostering adaptive religious coping to promote psychological flexibility while addressing rigidity. This

nuanced approach could help individuals leverage their faith for greater flexibility without reinforcing compulsive tendencies, especially in highly religious populations.

DISCUSSION

The findings of this study, which explore the role of religiosity in shaping psychological flexibility and rigidity in individuals with obsessive-compulsive disorder (OCD), have significant implications for clinical practice, therapeutic interventions, policy development, and future research. By highlighting the interactions between different forms of religiosity and psychological processes, the study contributes to a deeper understanding of OCD and its treatment.

Clinical Practice and Therapeutic Approaches

The results suggest that intrinsic religiosity can promote psychological flexibility, while extrinsic religiosity may contribute to psychological rigidity. This differentiation is important for clinical practice:

- Tailoring Therapeutic Interventions: Mental health professionals can create more individualized treatment plans by considering clients' religiosity. For example, recognizing the benefits of intrinsic religiosity could encourage therapists to incorporate faith-based coping strategies that enhance psychological flexibility, guiding clients to use their internal belief systems to address OCD challenges.
- Incorporating Religious Coping Mechanisms: Therapists could evaluate clients' religious coping strategies and help them strengthen adaptive methods, such as prayer or community support. Encouraging engagement in positive religious practices could improve clients' coping abilities and overall mental well-being.
- Addressing Maladaptive Patterns: For individuals whose psychological rigidity is linked to extrinsic religiosity, cognitive-behavioral approaches could help challenge rigid thought patterns and compulsive behaviors. Therapeutic strategies might focus on reframing maladaptive beliefs and introducing exercises that promote more flexible thinking to alleviate OCD symptoms.

Enhancing Understanding of Coping Mechanisms

The study emphasizes the dual role of religious coping strategies, noting that they can be both adaptive and maladaptive:

- Educating Clients: Educating about OCD, such as the differences between adaptive and maladaptive coping strategies can empower them to make informed decisions about their religious practices. Understanding how certain rituals may exacerbate symptoms can help individuals adopt healthier coping methods.
- Promoting Psychological Flexibility through Faith: Mental health professionals can encourage adaptive religious coping to foster psychological flexibility. This approach may be especially effective in group therapy, where shared faith experiences can create a sense of collective support and flexibility among participants.

Implications for Future Research

The study provides valuable directions for future research in mental health, specifically regarding the interactions between religiosity and obsessive-compulsive disorder (OCD):

- **Investigating Longitudinal Effects:** Future research could examine how changes in religiosity over time influence psychological flexibility and OCD symptoms.

Longitudinal studies can help establish causal relationships and refine treatment approaches.
- **Exploring Diverse Cultural Contexts:** The influence of religiosity may vary across different cultures and religious traditions. Researching these variations can help develop culturally sensitive interventions that respect diverse belief systems while addressing mental health challenges.
- **Examining Mechanisms of Influence:** Further studies could focus on understanding the mechanisms through which intrinsic and extrinsic religiosity affect psychological flexibility and rigidity. Identifying these mechanisms could improve therapeutic techniques and clinical practice.

Policy and Community Implications

The findings of this study could impact policies related to mental health care and community support systems:
- **Further Research on Religiosity's Role in OCD:** The study opens the door for cross-cultural research to understand how different cultural and religious contexts influence the relationship between religiosity, psychological flexibility, and OCD. Comparative studies among various religious groups could reveal specific coping mechanisms tied to each faith tradition.
- **Focus on Clinical Populations:** Research focused on individuals diagnosed with OCD or actively seeking treatment could provide a deeper understanding of how the observed relationships manifest in treatment-seeking populations. Intervention studies examining religious coping strategies could inform therapeutic practices and explore how they affect psychological flexibility or rigidity.
- **Training for Mental Health Professionals:** Developing training programs that educate mental health professionals about the role of religiosity in treatment could improve the quality of care. These programs should include strategies for integrating religious beliefs into therapy in a supportive, respectful manner.
- **Collaboration with Faith-Based Organizations:** Mental health organizations could collaborate with religious institutions to create support networks for individuals with OCD. These partnerships could help individuals access mental health resources that align with their faith, providing additional support.
- **Awareness Campaigns:** Public awareness campaigns can help reduce the stigma surrounding mental health and promote a better understanding of how religiosity influences mental health. Such campaigns can encourage individuals to explore faith-based support as a part of their mental health journey.

Limitations of the Study

Despite the valuable insights provided by this study, there are limitations that need to be considered when interpreting the findings.

Sample Characteristics
- **Homogeneity in Nationality:** The study focused on Indian participants, which may limit the generalizability of the findings to other cultural contexts. Religiosity’s impact on psychological processes may differ across cultures, so future research should include more diverse populations to enhance the applicability of the results.
- **Specific Religious Affiliations:** The sample may have included participants from particular religious affiliations, which could influence the results. Differences in

religious beliefs and practices can affect psychological outcomes, so a more varied representation of religious affiliations would offer a broader perspective.

Cross-Sectional Design

- **Lack of Causal Inference:** The cross-sectional design limits the ability to establish causal relationships. While correlations were identified, they do not indicate cause-and-effect. Longitudinal studies are necessary to examine the directionality and underlying mechanisms of the relationships.

Measurement Limitations

- **Self-Report Measures:** The study relied on self-report instruments, which can be influenced by biases. Participants may over- or under-report their religiosity, OCD symptoms, or psychological flexibility due to social desirability or a lack of self-awareness. Including objective measures or combining qualitative data could strengthen the findings.
- **Limited Scope of Religiosity Assessment:** The study used the Duke University Religion Index (DUREL), which may not capture all aspects of religiosity. Spiritual experiences, personal interpretations of faith, and emotional components of religiosity may have been overlooked. Future research could include additional dimensions of religiosity for a more comprehensive understanding.

Focus on Correlational Relationships

- **Neglecting Other Influential Factors:** The study primarily focused on the relationships between religiosity, psychological flexibility, rigidity, and OCD symptoms, potentially overlooking other factors such as personality traits, socioeconomic status, or life stressors. Including these variables could provide a more well-rounded understanding of the dynamics at play.

Generalizability of Findings

- **Clinical vs. Non-Clinical Populations:** The study may not accurately represent individuals with clinically diagnosed OCD or those actively seeking treatment. People actively engaging in therapy may experience different dynamics compared to those who are not seeking help. As such, the findings may have limited applicability to clinical populations.

Potential Confounding Variables

- **Uncontrolled Variables:** Despite efforts to control for confounding factors, there may be other variables not accounted for that could influence the relationships observed. Future research should aim to identify and control for additional confounding variables to enhance the robustness of the findings.

CONCLUSION

The study titled "The Role of Religiosity in Shaping Psychological Flexibility and Rigidity: Insights into OCD Symptomatology and Coping Mechanisms" aimed to investigate the complex relationship between different forms of religiosity and their impact on psychological flexibility and rigidity in obsessive-compulsive disorder (OCD) symptoms. Using various quantitative measures, including the Duke University Religion Index

(DUREL), and the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS), the research offered valuable insights into how intrinsic and extrinsic religiosity influence mental health.

Key findings from the study included a positive correlation between intrinsic religiosity and psychological flexibility (r = 0.47), suggesting that individuals with deeply internalized religious beliefs are better able to cope with challenges related to OCD. On the other hand, extrinsic religiosity was positively correlated with psychological rigidity (r = 0.44), indicating that individuals who practice religion mainly for external validation tend to show more rigid thought patterns, which can worsen OCD symptoms. Additionally, the relationship between psychological flexibility and OCD symptom severity was negative (r = -0.26), meaning that individuals who demonstrate greater psychological flexibility tend to experience less severe OCD symptoms due to more effective coping mechanisms.

In conclusion, the study's findings emphasize the complex relationship between religiosity and mental health, especially in the context of OCD. Intrinsic religiosity appears to serve as a protective factor that fosters psychological flexibility, while extrinsic religiosity may contribute to rigidity and more severe OCD symptoms. This duality underscores the importance of developing tailored therapeutic interventions that take into account an individual's religious beliefs and practices, encouraging adaptive coping strategies while addressing maladaptive ones.

Future research should explore these relationships further across different cultural contexts, utilize longitudinal designs, and include clinical populations to deepen understanding. Such studies will help create a more comprehensive framework for understanding the interplay of faith, psychological flexibility, and mental health, ultimately supporting the development of effective interventions for individuals facing OCD and related challenges.

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