Scrupulosity: A cognitive–behavioral analysis and implications for treatment

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ABSTRACT

Scrupulosity involves obsessive religious doubts and fears, unwanted blasphemous thoughts and images, as well as compulsive religious rituals, reassurance seeking, and avoidance. This article provides a comprehensive review of the nature of scrupulosity, including (a) a detailed clinical description, (b) information about how to differentiate scrupulosity from normal religious practice, (c) cross cultural aspects of scrupulosity, and (d) the relationships between scrupulosity and religiosity. Next, evidence is presented in support of scrupulosity as a presentation of obsessive compulsive disorder (OCD), and a cognitive–behavioral model of scrupulosity extending current models of OCD is outlined. In this model, the influence of religion on the misinterpretation of unacceptable intrusive thoughts, the ways in which symptom content depends on one's religious identification, and the role of intolerance of uncertainty are emphasized. Finally treatment implications are discussed for applying exposure and response prevention and cognitive techniques to the specific concerns relevant to scrupulosity.

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1. Introduction

More and more, the collection of signs and symptoms that we call obsessive–compulsive disorder (OCD) is becoming recognized as highly heterogeneous. Accordingly, various "mini models" of particular presentations of this problem have emerged, such as those for contamination (Rachman, 2004), checking (Rachman, 2002), hoarding (which is no longer considered a primary symptom of OCD; Frost & Hartl, 1996), symmetry and ordering concerns (Summerfeldt, 2004), repugnant obsessions (Rachman, 2003), relationship obsessions (Doron, Szepsenwol, Karp, & Gal, 2013), and postpartum presentations of OCD (Fairbrother & Abramowitz, 2007). These models are grounded in empirical evidence and are continually evaluated and reformulated. In many cases, they have also led to the development of treatment programs for relatively homogeneous manifestations of OCD. One such presentation that is well-known to clinicians and researchers, but has been relatively understudied and lacks such a well-articulated conceptual mini model, is scrupulosity—obsessions and compulsions having to do with religion and morality. In this article, we review the current state of knowledge of scrupulosity and apply the cognitive–behavioral framework for understanding OCD to conceptualizing the development and maintenance of this particular presentation

of the problem. The application of this conceptual model to the treatment of scrupulosity is also described.

2. The nature of scrupulosity

2.1. Clinical description

Scrupulosity literally means *fearing sin where there is none*. Common religious obsessions include recurrent doubts that one has committed sins or moral transgressions by mistake or without realizing it (e.g., "Was I cheating on the test when I gazed quickly around the room?"), intrusive sacrilegious or blasphemous thoughts and images (e.g., "The devil is helping me get through the day"), doubts that one is not faithful, moral, or pious enough ("What if I don't really love God as much as I should?"), fears that one didn't perform a religious prayer or ceremony properly ("What if my mind wandered while I was worshiping?"), and persistent fears of eternal damnation and punishment from God ("What if I'm not saved?"). Common religious compulsive rituals include excessive praying, repeating religious rituals and bible verses until they are done or said "perfectly", seeking unnecessary reassurance from clergy or loved ones about salvation or other religious matters, and excessive or inappropriate confession. Individuals with scrupulosity often avoid situations and stimuli that trigger their obsessions and compulsions, such as places of worship, bibles and other religious icons, listening to sermons, reading

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religious literature, and anti-religious or sinful materials (e.g., pornography, alcohol, books about atheism or the devil).

2.2. Presentations of scrupulosity

As with other presentations of OCD, scrupulosity is highly idiosyncratic and heterogeneous. Whereas one patient might turn to religious icons as a way of *relieving* obsessional fear, another might avoid such icons because they *trigger* unwanted blasphemous thoughts. Clinical observations suggest at least four (sometimes overlapping and not mutually exclusive) presentations of this problem:

(a) Generally ego dystonic intrusive thoughts (e.g. sex, violence, immoral acts, etc.) that are interpreted at least in part within a religious framework. The content of such thoughts might not be specifically religious, but the appraisals of the thoughts and associated ritualistic and neutralizing behaviors usually involve religious themes. For example, a man evaluated in our clinic experienced unwanted obsessional thoughts about engaging in sexual behavior with his sister. He appraised these thoughts as "abominations" and "sent by the Devil", and he engaged in repeated prayer when they occurred.

(b) Ego dystonic thoughts specific to religion (e.g. images of Jesus having an erection on the cross) that would be generally considered blasphemous, and rituals and neutralizing strategies that may or may not involve religious themes. For example, an Orthodox Jewish woman we evaluated experienced distressing obsessional images of desecrating the Torah scrolls in her synagogue. To relieve her obsessional guilt, she avoided the synagogue, but engaged in compulsive hand washing rituals, as well as checking (calling the synagogue) and seeking reassurance (from the rabbi) that she, in fact, had not acted on her obsessions by mistake.

(c) Ego syntonic thoughts of a religious nature, perhaps concerning questions of faith or interpretations of texts, which develop into obsessions; and checking and reassurance-seeking rituals. For example, a Roman Catholic man found himself considering that abortion could be justified in some instances (which is contrary to the Church's stance). This led him to question his own faith and compulsively seek reassurance from his Priest that he was still a good Catholic.

(d) Obsessional doubts about whether religious rules and commandments have been followed correctly, or whether one is "faithful enough". The person desires to act in accordance with his or her religion, but fears he or she is not. For instance, a devoutly Mormon woman had obsessional doubts that she had sinned by masturbating each time she wiped her genitalia after using the bathroom. She engaged in confession and reassurance-seeking rituals, and avoided her place of worship.

2.3. Measurement of scrupulosity

Abramowitz, Huppert, Cohen, Tolin, and Cahill (2002) developed the only psychometrically validated self-report measure of scrupulosity available to date—the Penn Inventory of Scrupulosity (PIOS). Using factor analysis, these authors identified two overarching cognitive dimensions of scrupulosity: (a) the fear of having committed a religious or moral sin, and (b) the fear of punishment from God. In many cases, the "sins" feared by individuals with scrupulosity represent relatively minor religious or moral transgressions that are either pardonable or not of central importance to overall religious observance. Examples include the accidental or unavoidable violation of the Sabbath, mispronunciation of a word during prayer, experiencing unbidden "lustful" images or sensations of sexual arousal outside

of marriage, and swallowing one's saliva on a day of fast. The individual is also usually perceived as inculpable (or easily pardoned) by others of the same religion, including religious authorities (although in some instances, the person's religious community reinforces the person's concern over sin, as is discussed further below). Nevertheless, the scrupulous patient experiences intense guilt and anxiety and may take extreme measures to reduce this distress through compulsive ritualizing and reassurance seeking.

2.4. Scrupulosity and other aspects of OCD

Data from various clinics indicate that although scrupulosity can overlap with any other presentation of OCD (e.g., contamination; Nelson, Abramowitz, Whiteside, and Deacon, (2006)), it is most prominent among patients whose primary symptoms involve unacceptable obsessional thoughts (e.g., pertaining to sex and violence; Abramowitz, Franklin, Schwartz, and Furr, (2003), Rachman, 2003). Although it does not appear to indicate a more globally severe form of OCD (Siev, Baer, & Minichiello, 2011a; Tek & Ulug, 2001), scrupulosity is associated with increased depressive and anxious symptoms (Nelson et al., 2006) as well as obsessive–compulsive personality traits (Siev, Steketee, Fama, & Wilhelm, 2011b). Tolin, Abramowitz, Kozak, and Foa (2001) also found that independent of the severity of OCD symptoms, patients with religious obsessions had poorer insight, more perceptual distortions, and more magical ideation than did those with other types of obsessions. Considering that scrupulosity involves the perception of sin, fear of violating (or having violated) religious standards, and fear of punishment from God, it is not surprising that affected individuals experience a great deal of guilt, anxiety, and interference with their ability to practice their religion (Siev et al., 2011a), in addition to impaired social and occupational functioning.

2.5. Scrupulosity versus normal religious practice

In some instances it is challenging to distinguish scrupulosity from healthy religious practices, especially since the content of scrupulous obsessions and compulsions often has some basis in conventional religious belief and practice. Moreover some members of the individual's religious community might unsuspectingly support or encourage the patient's scrupulous behavior, perceiving it simply as overzealous (yet innocuous) religious adherence. The person with scrupulosity, however, typically has excessive and rigid (obsessional) concerns regarding a few particular facets of religious practice, which ironically may interfere with other (often more important) aspects of observance. For example, one patient in our clinic described such an extreme fear of being punished for having unwanted "impure" thoughts when she entered a place of worship that it resulted in her missing worship services altogether. Healthy religious observance, on the other hand, is generally typified by more moderate and flexible approaches to most areas of religious belief and practice, viewing perfect adherence as more of an ideal than as an imperative that is necessary to avoid subjective guilt or the threat of severe punishment. Another potential marker of scrupulosity is the degree of distress associated with religious practice even if the individual does not exceed standards, per se. That is, healthy religious practice is usually associated with positive emotions, whereas religious compulsive rituals are usually associated with fear and anxiety (Greenberg & Shefler, 2008).

2.6. Prevalence

The available evidence suggests that religious obsessions and compulsions are a fairly prevalent manifestation of OCD. In the DSM-IV field trial, for example, which was conducted in the United

States, 5.9% of 425 OCD patients reported religious obsessions, making this the fifth most common obsessional theme (Foa et al., 1995). In 5% of the field trial patients, religion was the *primary* obsessional theme (Tolin et al., 2001). Higher estimates were later reported by Eisen et al. (1999) and Mataix-Cols, Marks, Greist, Kobak, and Baer (2002), who found that 10% and 33% (respectively) of their large patient samples experienced religious obsessions. Findings from less secular societies indicate even higher rates of scrupulosity, with as many as 50% and 60% of OCD patients in Saudi Arabia and Egypt (respectively) reporting religious obsessions (Mahgoub, & Abdel-Hafeiz, 1991; Okasha, Saad, Khalil, El-Dawla, & Yehia, 1994).

2.7. Scrupulosity and religiosity

The findings reviewed immediately above are consistent with other studies suggesting that higher levels of scrupulosity (i.e., obsessive and compulsive symptoms that focus on religion) are associated with greater religiousness in clinical and nonclinical individuals (e.g., Abramowitz et al. (2002), Abramowitz, Deacon, Woods, and Tolin (2004), Greenberg and Witztum (1994), Greenberg and Shefler (2002), Lewis and Maltby (1995), Nelson et al. (2006), Okasha et al. (1994), Sica, Novara, and Sanavio (2002), Siev and Cohen (2007), Steketee, Quay, and White (1991)). Yet, this should not be taken to infer that the relationship between religiosity and scrupulosity is causal—indeed, the studies conducted to date are merely correlational. Moreover, the vast majority of religious people do not suffer from OCD, a fact that must be accounted for in explanatory models. In fact, scrupulosity was not associated with higher levels religiosity among Jews (Abramowitz et al., 2002; Hermesh, Masser-Kavitzky, & Gross-Isseroff, 2003), American Protestants (Nelson et al., 2006), Turkish Moslems (Tek & Ulug, 2001), and Iranian schoolchildren (Assarian, Biqam, & Asqarnejad, 2006). Although these divergent findings may be attributable in part to measurement and other methodological differences, this research indicates that the relationship between religiosity and scrupulosity is a complex one that requires further study, especially from a cross-cultural perspective.

2.8. Is scrupulosity an OCD subtype, dimension, or a separate syndrome?

Once classified as an anxiety disorder, OCD was moved in DSM-5 to its own category of obsessive–compulsive related disorders (which also includes skin picking disorder, hair-pulling disorder [a.k.a. Trichotillomania], body dysmorphic disorder, and hoarding disorder; American Psychiatric Association, 2013). Some authors (Miller & Hedges, 2008) have proposed that scrupulosity also be classified as distinct from OCD on the basis of the following: (a) the presence of more magical thinking and poorer insight than other presentations of OCD, (b) less robust treatment response than other forms of OCD, (c) the experience of obsessional thoughts as less intrusive and unacceptable relative to other OCD themes, (d) weak correlations between measures of scrupulosity (e.g., the Penn Inventory of Scrupulosity) and global measures of OCD, (e) the ability to distinguish scrupulous obsessions and compulsions from other forms of OCD, and (f) the substantial overlap between scrupulosity and obsessive–compulsive personality disorder (OCPD).

On the other hand, there appears to be abundant clinical and research evidence to support the conceptualization of scrupulosity as merely a (fairly common) thematic presentation of OCD. First, although at a topographical level differences between scrupulosity and other manifestations of OCD seem evident (although there are also many overlaps), when one examines these phenomena at a functional level, there is very little to suggest a separate scrupulosity

syndrome. Specifically, as with other sorts of obsessions (e.g., thoughts of germs, violent images), the types of religious obsessions described previously provoke anxiety and urges to use the same types of compulsive, ritualistic, and neutralization strategies that function to alleviate anxiety, distress, doubt, and the obsessional thoughts themselves (e.g., checking, washing, thought suppression). Moreover, all of these strategies sometimes have the desired anxiety-reducing effects, yet usually only temporarily, thus completing a vicious cycle that is negatively reinforced by the occasional reduction in distress.

A second observation that suggests scrupulosity is merely a presentation of OCD is that most treatment studies that have examined response among different OCD manifestations suggest that patients with religious OCD symptoms respond as well to recommended interventions (i.e., exposure and response prevention) as do those with other presentations of OCD (e.g., Abramowitz et al. (2003), Huppert, Siev, and Kushner (2007)). A third reason for conceptualizing scrupulosity as a symptom of OCD is that religious obsessions frequently co-occur with other types of obsessions, especially those pertaining to sex and violence (e.g., Abramowitz et al. (2003), (2010), Mataix-Cols, Rosario-Campos, and Leckman (2005), McKay et al. (2004)). Thus, we agree with Greenberg and Huppert (2010), who consider scrupulosity a *presentation* of OCD.

3. A cognitive–behavioral model of scrupulosity

We have applied the cognitive–behavioral model of obsessional problems (e.g., Rachman, (1997), Salkovskis (1999)) to explain the development and persistence of scrupulosity. This approach emphasizes the role of dysfunctional beliefs about, and misinterpretations of, otherwise normal and universal unwanted intrusive thoughts and doubts as playing a central role in obsessions. As depicted in Fig. 1, this model also incorporates the influence of religious doctrine and the fact that many important aspects of religion (e.g., one's relationship with God) are not subject to guarantee or objective verification, and must be taken on faith. The ways in which the scrupulous person tries to gain assurances and manage intrusive thoughts and doubts backfires and sets in motion a self-perpetuating vicious cycle.

3.1. Misinterpretation of normal intrusions

As with the cognitive–behavioral approach to obsessional problems in general (Rachman, 1997; Salkovskis, Shafran, Rachman, & Freeston, 1999), the model of scrupulosity begins with the finding that unwanted and intrusive thoughts (i.e., thoughts, images, and doubts that encroach into consciousness; e.g., "God is dead", "What if I committed a sin by mistake") that are contrary to one's moral or religious belief system are normal occurrences for most everyone from time to time (e.g., Rachman and de Silva (1978)). Whereas most people (even most strictly religious people) regard such intrusions as insignificant "mental noise", the cognitive–behavioral model proposes that such intrusions may develop into clinical obsessions if the person believes strongly that such thoughts are highly personally significant or threatening.

For example, most faithful Christians who experience an unwanted intrusive thought such as, "God is a hateful bastard" would treat it as just a meaningless thought that is incongruent with what they believe according to their religion. The thought would not be given too much importance or consideration, and thus sooner or later would unceremoniously disappear from consciousness. However, if the person holds more rigid beliefs about the meaning of thoughts, such as "I must never think of bad things", "I wouldn't be thinking this thought if it was
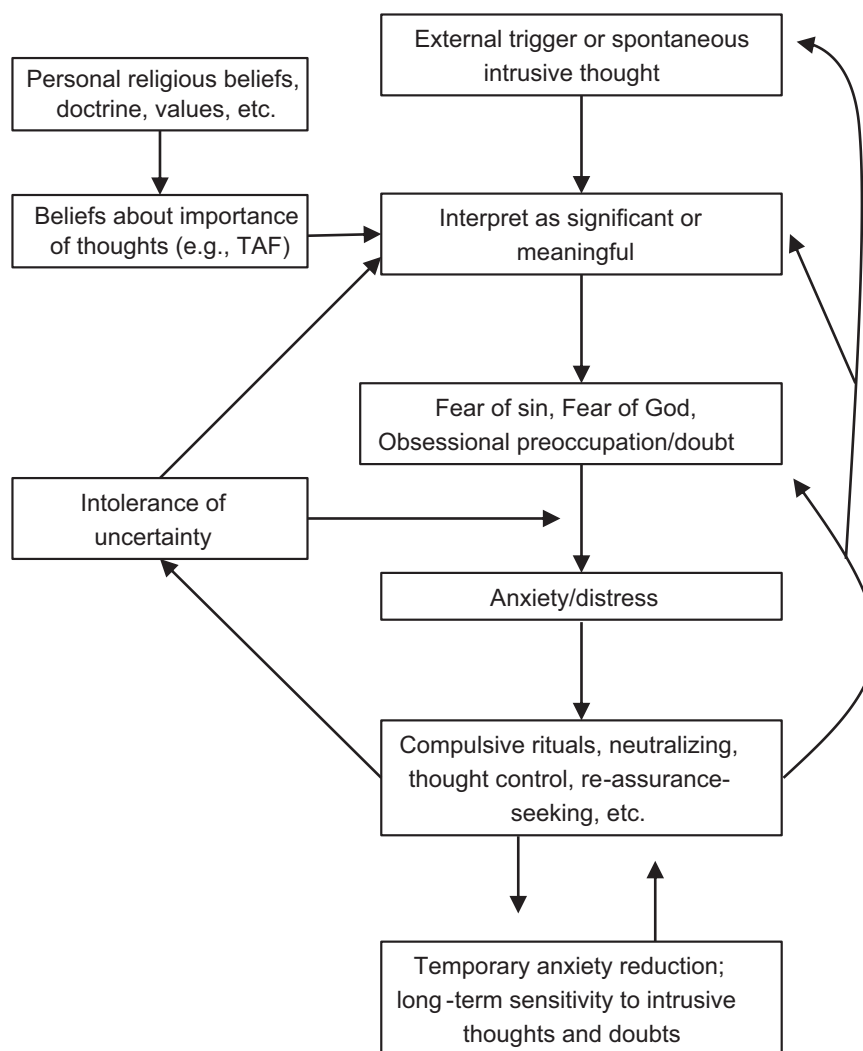
Fig. 1. A cognitive–behavioral model of scrupulosity.

unimportant", "I can and should control my thoughts", and "My thoughts are telling about the kind of person I am", he or she will appraise this *unwanted* thought as highly significant – perhaps as a sin – even if it goes against his or her typical thoughts, behavioral disposition, and sense of self (e.g., "It's a sign that I am falling away from God"). This leads to doubt, distress, additional fear of sin and fear of God, and urges to control or dismiss the thought and "put things right", as we discuss further below.

3.2. The influence of religion on the misinterpretation of intrusions

Although beliefs about the importance and need to control intrusive thoughts probably result from multiple factors, some authors (e.g., Rachman (1997), Salkovskis et al. (1999)) have suggested that religious doctrine can foster such beliefs because it (a) imposes explicit moral standards for thinking and behaving, (b) is inculcated by influential authority figures (e.g., clergy), and (c) includes the possibility of severe punishment (e.g., eternal damnation). The 10th commandment from the Bible, for example, forbids *coveting* (i.e., wishing to have) another person's "property" (which includes his wife). Similarly, in his Sermon on the Mount, Jesus warns his followers, "You're familiar with the command to the ancients, 'Do not murder'. I tell you that anyone who is so much as angry with a brother or sister is guilty of murder" (Matthew 5:21–22) and "I say to you that everyone who looks on a woman to lust for her has committed adultery already in his

heart" (Matthew 5:27–28). These passages exemplify the position that thoughts and actions are morally equivalent and that control over thoughts is important to avoid sin and punishment.

Research indicates positive associations between religiosity and beliefs about the importance of thoughts, particularly *thought–action fusion* beliefs (TAF; Shafran, Thordarson, & Rachman, 1996). TAF refers to two types of cognitive distortions, (a) the belief that thinking of something immoral is the same as committing an immoral act (Moral TAF), and (b) the belief that thinking of something negative increases the likelihood of the corresponding event (likelihood TAF). Moral TAF in particular, has been associated with strength of religiosity in several studies (Abramowitz et al. (2004), Berman, Abramowitz, Pardue, and Wheaton (2010), Cohen and Rozin (2001), Inozu, Karanci, and Clark (2012), Rassin and Koster (2003), Sica et al. (2002), Siev and Cohen (2007), Yorulmaz, Gençöz, and Woody (2009)). That is, highly religious people, relative to non-religious or less devout individuals, perceive the presence and meaning of negative unwanted thoughts as more personally significant, influential, and immoral. This relationship appears to be pronounced among Christians relative to other religious groups (e.g., Cohen and Rozin (2001), Inozu et al. (2012), Rassin and Koster (2003), Siev and Cohen (2007), Williams, Lau, and Grisham (2013)). Studies also show that religiosity can be associated with the extreme fear of God and with the fear of committing sin. Although not part of most mainstream religions, the view that God is angry and vengeful,

waiting for people to commit sins so that he can punish them, is often observed in individuals with scrupulosity (Abramowitz et al., 2002; Nelson et al., 2006).

Accordingly, as is shown in the top left of Fig. 1, we propose that strong adherence to religious beliefs, ideals, and doctrines makes one vulnerable to developing the sorts of beliefs that lead to the misinterpretation of normal intrusions in ways that maintain scrupulosity. We hypothesize that once such thoughts are misinterpreted as significant and possibly sinful, they become highly salient obsessional preoccupations—that is, the person becomes increasingly sensitive to the thoughts' occurrence. The thoughts (and the possibility of punishment from God) become the focus of more and more attention, and become increasingly ubiquitous. Thus, the very thoughts that scrupulous individuals believe are sinful and should be banished end up becoming *more* frequent. This creates intense obsessional distress and doubt.

3.3. Symptom content depends on which religion

It is apparent that the theme of one's obsessions and compulsions is at least in part determined by the matters that are most important in his or her value system and sense of self. As Rachman (2003) has pointed out, it is not surprising that people with violent obsessions are typically those who consider themselves to be very gentle, those with contamination fears tend to highly value cleanliness, and individuals with scrupulosity are typically highly devout. Indeed, the types of unwanted intrusive thoughts that are most subject to misinterpretation are those that already have a particular significance to the person. An implication of this principle for scrupulosity is that given the substantial theological differences across religions, it is expected that the precise themes of religious obsessions and compulsions will vary depending on the religious traditions, values, customs, and doctrines that the person adheres to and holds as important, and on the religion-specific sins the person wishes to avoid committing.

For example, while an Orthodox Jew might have obsessional doubts that he violated dietary laws which are important in Judaism (e.g., keeping milk and meat separate), a Roman Catholic might confess the same "sin" several times to a Priest; confession being an important ritual within Catholicism. Further still, a Protestant Christian might have persistent doubts over whether she truly accepts Jesus as her savior, a Muslim might obsess that his prayers were not uttered "perfectly enough", and those following Hinduism might engage in compulsive washing rituals —the Hindu religion and Indian culture emphasizing issues of purity and cleanliness. On the other hand, a Christian would be unlikely to have obsessions about the Jewish dietary laws since these do not pertain to Christian tradition; a Jew or Hindu individual would not have obsessions about Jesus or Mohammed; and a Muslim would not be afflicted with obsessions about salvation, which is a uniquely Christian concept.

Some religions emphasize judgments about morality and the importance of thoughts more than others. Christianity, for example, places great importance on individual conscience and maintaining certain beliefs—one's relationship with God and salvation hinges more on *belief* rather than on *deeds* (Cohen, 2003; Favier, O'Brien & Ingersoll, 2000). On the other hand, Judaism, Hinduism, and Islam emphasize behavioral traditions and customs more than belief. Thus, the associations between religiosity, Moral-TAF, and scrupulosity may not be ubiquitous across all religions. Judaism and Islam are more ritualistic religions, with behavioral commandments for adherents to follow (Siev & Cohen, 2007; Okasha, 2004). It is not surprising that Christians endorse higher TAF beliefs compared to Jews (Siev & Cohen, 2007; Williams et al., 2013) and compared to Muslims (Inozu et al., 2012). Jews and Muslims with scrupulosity might be more prone to misinterpret intrusive doubts about having properly fulfilled religious customs and commandments. Hindus, on the other hand, might be most prone to obsessional doubts about dirt and impurity.

Of course, even within religious denomination there exists heterogeneity. Among Christians, for instance, scrupulous concerns might focus not just on beliefs per se, but on their sense of their relationship with God. Moreover, the idea of belief-based and behaviorally-based religious practice is best conceptualized as orthogonal and dimensional, as opposed to falling on a bipolar scale. A given individual might show belief-based religious practice, behaviorally-based practice, or both. Some groups of orthodox Jews, for example, emphasize the importance of both behavioral *and* belief-based practices. Indeed, one sign of difficulty for an individual might be the disparity between his or her personal ideas about religious practice and those of their religious community.

3.4. The role of intolerance for uncertainty

If religiosity is positively associated with beliefs that unwanted thoughts are important, and such beliefs are associated with scrupulosity, why do most religious people not suffer with scrupulosity (or OCD in general)? Perhaps the relationship between rigid beliefs about thoughts (e.g., TAF) and religion is not always pathological. Indeed, religious commentary distinguishes between thoughts that are *unwanted* and actively resisted versus those that are *deliberate* and generated within the context of genuine lust, anger, hatred, jealousy, and the like (Ciarrocchi, 1995). This is reflected in the adage "You cannot stop a bird from flying over your head, but you can stop it from making a nest in your hair" (Author unknown[1]). Implicit in this proverb is the idea that while it is natural (and morally acceptable) to experience *unbidden* tempting or distressing thoughts, willfully provoking or dwelling on such thoughts can be sinful and may have destructive effects (Cougle, Purdon, Fitch, & Hawkins, 2013).

Our clinical observations indicate that people with scrupulosity often have difficulty with the distinction between sinful and non-sinful thoughts. More specifically, whereas they are usually able to *speculate* (when pressed) that their unwanted intrusions are probably not technically sinful, at the same time they seem more mindful and distressed than most people that this is merely speculation. That is, scrupulous individuals appear to require a *guarantee* or *proof* that their speculation is unequivocally correct—that they have not committed a sin and that they will not receive punishment from God. The problem, however, is that scrupulosity tends to focus on matters that are not subject to such proof or assurance (i.e., they cannot be guaranteed and must be taken on faith). Patients misinterpret intrusive thoughts in ways that raise doubts about the following (among other things):

- Have I committed sins by mistake?
- Do I have sufficient faith in God?
- Does God approve of me? Is God is angry with me?
- Am I sure that I don't love the Devil?
- Am I saved? Am I going to heaven when I die?
- Have I done enough worshipping, praying, or confessing?
- Am I pure enough?
- Am I too proud?
- Have I correctly obeyed religious laws, customs, and commandments in God's eyes?

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[1] This quote has been attributed to Martin Luther, but there is no record of it in his writings.

Accordingly, we propose that most people who engage in healthy religious devotion are inoculated against scrupulosity by their *faith*—defined as belief that is based on trust or confidence, as opposed to actual *proof*. That is, faithful members of religious communities generally accept (if they consider it at all) that the sorts of doubts listed above cannot be proven with certainty one way or the other; and they are satisfied that their healthy participation in standard religious behavior (e.g., attending services, etc.) is sufficient to satisfy their spiritual, moral, or religious obligation (or placate God), despite the fact that they cannot have a guarantee of this (and occasionally have normal doubts about it). On the other hand, scrupulosity is characterized by an *intolerance of uncertainty* (IU), which refers to "beliefs about the necessity of being certain … and about adequate functioning in situations which are inherently ambiguous" (Obsessive Compulsive Cognitions Working Group, 1997, p. 678). That is, people with scrupulosity have trouble accepting the inherent uncertainty of particular religious beliefs and doctrines (e.g., "God loves me"). They believe that they can (and must) obtain absolute proof, and consequently experience a great deal of anxiety and distress when they realize that no such proof exists. Other members of their religion accept these beliefs and doctrines on faith; but it is as if those with scrupulosity have *lost their faith in faith*.

Although there have been no studies focused on the relationship between IU and scrupulosity in particular, numerous investigations demonstrate an association between IU and OCD symptoms in general (Boelen & Carleton, 2012; Calleo, Hart, Björgvinsson, & Stanley, 2010; Dugas, Gosselin, & Ladouceur, 2001; Holaway, Heimberg, & Coles, 2006; Jacoby, Fabricant, Leonard, Riemann, and Abramowitz 2013; Mahoney & McEvoy, 2012; McEvoy & Mahoney, 2011, 2012; Tolin, Abramowitz, Brigidi, & Foa, 2003), even above and beyond depression, anxiety sensitivity, and worry (Steketee, Frost, & Cohen, 1998). Some studies have found that individuals with OCD have higher levels of IU than do those with other anxiety disorders (Steketee et al., 1998; Tolin, Worhunsky, & Maltby, 2006), suggesting that IU is a cognitive distortion with specific relevance to OCD. Additionally, IU has been particularly strongly linked with obsessing and mental neutralizing (Abramowitz & Deacon, 2006; Holaway et al., 2006; Tolin, Brady, & Hannan, 2008), and with the unacceptable thoughts dimension of OCD (Jacoby et al., 2013), which as previously mentioned, overlap most closely with scrupulosity. Accordingly, the relationship between IU and symptoms of scrupulosity deserves further consideration. In particular, we hypothesize that IU mediates the relationship between religious fears/doubts and scrupulosity, and between Moral TAF and scrupulosity.

3.5. Maladaptive behavioral responses

Conceptual models of obsessional problems (e.g., Rachman (1997), Salkovskis et al. (1999)) propose that the distress associated with obsessional preoccupation and doubt leads to attempts to reduce this distress by trying to control the intrusions, analyze their meaning and restore a sense of certainty, or dismiss them; or to take action to prevent feared harmful consequences (e.g., divine punishment). Accordingly, the scrupulous person might repeat religious rites and rituals to excess (or until "perfect"), ask others for reassurance about the doubts, try to suppress unwanted thoughts and doubts from consciousness, perform unnecessary religious behavior such as excessive praying or confessing, and avoid situations and stimuli (e.g., religious icons) that serve as reminders of the thoughts and thus trigger their occurrence.

Avoidance behavior, thought suppression, compulsive rituals, and other neutralizing strategies, however, are counterproductive in several ways. First, because they sometimes temporarily provide a reduction in obsessional distress, such strategies are negatively

reinforced and evolve into strong patterns that can consume substantial time and effort and interfere with functioning. Second, because they sometimes reduce anxiety and uncertainty (albeit temporarily), these behaviors prevent the person from learning that they can cope with the temporary discomfort associated with the intrusive thought or doubt until it naturally subsides with time. Third, avoidance and rituals (e.g., attempts at distraction and suppressing unwanted intrusions) paradoxically lead to an increase in the frequency of obsessions (resulting in obsessional preoccupation), possibly because the distracters become reminders (retrieval cues) of the intrusions (Najmi, Riemann, & Wegner, 2009). This further amplifies doubt and uncertainty. Finally, given that absolute certainty about some of these matters can never truly be attained (e.g., "Am I going to Hell?"), the very act of repeated checking and re-assurance seeking only further fuels the obsessional thinking and need for certainty, as well as misinterpretations of obsessional thoughts as significant (e.g., Rachman (2002), Radomsky, Gilchrist, and Dussault (2006)). These maintenance processes are represented by the arrows in Fig. 1 leading upwards from compulsive behavior.

3.6. Summary of the model

In summary, we propose that scrupulosity emerges from otherwise commonly occurring intrusive thoughts that are misinterpreted as significant based on exaggerated and maladaptive beliefs about the importance of thoughts (e.g., TAF). The development of these beliefs might have its roots in the person's religious doctrine, although it is exaggerated for the person with scrupulosity. Misinterpretation of normal intrusive thoughts as highly meaningful leads to the fear of sin and of God, and obsessional preoccupation and doubt specific to the individual's particular religious beliefs. In the context of an intolerance of uncertainty, the mere *possibility* that one has sinned (and could be punished) provokes high levels of anxiety and distress. The person then engages in various compulsive, avoidance, and neutralizing strategies to reduce the distress, achieve certainty, banish the unwanted thought or doubt, and elude feared negative consequences; yet these strategies only intensify the sense of uncertainty, lead to more unwanted intrusions, and to greater obsessional preoccupation. Moreover, they are negatively reinforced by the brief reduction in distress that they occasionally engender; thus they are repeated "compulsively".

4. Treatment implications

The cognitive–behavioral formulation of scrupulosity just described suggests the use of similar psychological treatment procedures as those used with other presentations of OCD: namely, cognitive–behavior therapy (CBT), which includes psychoeducation and treatment planning, exposure and response prevention (ERP), and cognitive therapy techniques. The details of implementing these procedures in general are described elsewhere (e.g., Abramowitz, Deacon, and Whiteside (2011)), thus in this section we present some strategies, informed by the conceptual model, for adapting and implementing this approach for scrupulous patients. As suggested in the conceptual formulation, the overall aims of the treatment for scrupulosity are to (a) weaken maladaptive beliefs that are inconsistent with the person's religion (e.g., overly rigid beliefs about the importance of intrusive thoughts), (b) increase tolerance for doubt and uncertainty, and (c) weaken the need for compulsive rituals, avoidance, and other neutralizing responses which prevent belief change and tolerance of uncertainty. We conceptualize treatment as helping scrupulous patients be able to follow their religion in a more healthy and faithful way—an idea we convey to patients we work with.

4.1. Psychoeducation and treatment planning

From the initial treatment sessions, the therapist can begin helping the patient to critically think through his or her own rigidly held beliefs about God, sin, and uncertainty. For example, it is worth discussing with patients (e.g., using Socratic dialogue) the differences between their views of God as petulant, easily angered, and vengeful, versus the view of most mainstream religions (and most likely his or her own religion) which teach that God loves all people unconditionally. Similarly, scrupulous patients' extreme fears and doubts about sin by *unwanted* thoughts or mistakes are often at odds with the view of most mainstream religions that sin requires (a) intentionally deciding to do things one knows is sinful or evil (e.g., murder someone) and (b) remaining remorse-less[2]. The therapist can also help the patient recognize the inconsistencies between (a) the belief that God created the human mind, and (b) the fear that God does not understand that everyone sometimes has thoughts that are contrary to their true faith and personal beliefs. A similar contradiction is that between the definition of *faith*, which is a central part of religious adherence, and the patient's intolerance of uncertainty and doubt. Thus, an important take home message is that the patient has in a sense created his or her own religion where faith is not enough—rather he or she requires a *guarantee* about things that cannot be guaranteed, and about which most practitioners of the same religion accept based on faith. The therapist can discuss how treatment will help the patient become a more faithful follower of his or her religion since it will help them to *trust* God, rather than being fearful.

4.2. Exposure

4.2.1. Implementation with scrupulosity.
The conceptual model we describe is consistent with the use of exposure therapy to promote *tolerance* of intrusive thoughts, uncertainty, and anxiety; as opposed to promoting habituation of anxiety during exposure (e.g., Abramowitz and Arch (2014)). That is, the aim of treatment is for scrupulous patient to believe, "I'll be okay because I can tolerate anxiety and uncertainty," rather than, "I'll be okay because I know my fear will go away by the end of the exposure". The later approach, although commonly considered a desired outcome of exposure (e.g., Foa and Kozak (1986)), can also interfere with long-term retention of learning during this type of treatment (e.g., Craske et al. (2008)). One way to promote tolerance of anxiety and uncertainty is to elaborate on the uncertainty of feared consequences using imaginal exposure (e.g., "you can't be sure if God is upset with you"). For example, in vivo exposures to external stimuli that trigger doubts could be combined with imaginal exposures to help patients learn that they can manage such normal doubts, as opposed to trying to analyze, suppress, or gain reassurance about them (which maintains the problem).

Another method, *expectancy tracking*, can also be used to this end. In this technique, rather than keeping track of subjective units of discomfort ("SUDS"), as is typical during exposure, the therapist can track the patient's expectancies of tolerating uncertainty, with the goal of continuing the exposure until the maximum expectancy is violated (Abramowitz & Arch, 2014). For example, the therapist could assess how long the patient believes she could tolerate feeling uncertain over whether she has committed "an unpardonable sin"

and what activities she believes she could and could not accomplish while feeling this way. Exposures that provoke uncertainty over sin would then be used to induce doubt, and the patient would practice remaining uncertain and engaging in activities until the maximum predictions were exceeded. The goal would be for the patient to repeatedly learn that she can tolerate uncertainty and accomplish daily tasks without a guarantee (i.e., she can manage on faith alone).

4.2.2. Selecting exposure stimuli.
Deciding on the specific situations and thoughts for in vivo and imaginal exposure is a delicate issue with scrupulous patients and should be consistent with the goal of helping the person learn and practice tolerating uncertainty (i.e., developing greater faith). Exposure situations that flagrantly violate religious laws are neither appropriate nor consistent with this goal. Patients with scrupulosity fear they *might* have sinned; thus exposure should entail situations that evoke doubts and uncertainty about sin, *but that do not involve committing blatantly sinful behavior itself*. As an analogous situation, consider an OCD patient with the obsession that that her food might be contaminated with urine. Her pathological anxiety involves uncertainty over whether or not her food is contaminated, not what to do when there is urine on her food. Therefore, rather than actually putting urine on her food, exposure would involve learning to manage acceptable risks, such as eating food while in the bathroom. Still, the nature of exposures that will evoke doubt and uncertainty over outcomes that require faith necessitates that the patient be familiar with, and accept, the rationale for exposure. If the reason for engaging in such exposures is not clear to the patient, he or she may view CBT as an assault on his or her religion.

4.3. Response prevention

The purpose of response prevention is also to help patients learn that they can tolerate uncertainty and become more "faithful"; that is, to discover that they do not need to rely on excessive religious behavior (e.g., prayer, confession, repeating rituals), clarifications, or assurances to resolve their scrupulous concerns or to escape from anxiety and uncertainty. Yet it is not only overtly compulsive rituals that must be targeted. Any behavior performed in attempt to acquire reassurance or "deal with" intrusive thoughts, anxiety, or doubt should be identified and targeted in response prevention. It can be easy to overlook mental rituals, for example, such as analyzing or trying to "figure out" if one has sinned or if God would be angry in a given situation. The presence of a therapist, loved one, or religious authority can also be important response prevention targets since such people might implicitly or explicitly serve as safety cues or provide reassurance, thus preventing tolerance of uncertainty. This highlights the importance of having patients practice exposures on their own, in the absence of the therapist (or anyone else), in addition to practicing in session. This also underscores the importance of getting any family members or clergy on board with refraining from providing reassurance to patients during treatment. For patients who persistently ask questions about the possibility of sin, salvation, and the like, refraining from providing reassuring answers and instead explaining the importance of remaining uncertain and using faith, is an important skill to teach those close to the patient.

For similar reasons we generally prefer that patients not schedule visits with clergy members to discuss the lawfulness of the treatment plan (i.e., ERP exercises). Indeed, most patients will have already discussed similar matters with their clergy (often repeatedly), thus they likely already have a sense of what the clergy member's response would be. In such cases, such a visit could equate to reassurance-seeking. In line with the aims of treatment, we suggest first engaging patients in a discussion of

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[2] Of course, many patients will say that they cannot be sure whether their thoughts are wanted or unwanted, and whether they are truly remorseful. For example some patients interpret the *anxious* arousal they feel with unwanted sexual thoughts as genuine *sexual* arousal, which might mean that they are not remorseful and have committed a sin. This illustrates the need for treatment techniques addressing the intolerance of uncertainty.

what (based on previous visits) the clergy member is *likely* to tell them (even though they don't know for sure), and help the patient to have faith that this answer would probably not change. That said, there may be situations in which avoiding consultation with clergy prevents the patient from learning how to consult with clergy effectively and non-ritualistically; which might be important skills for use after treatment. Among Orthodox Jews, for example, learning guidelines to evaluate what constitutes a bona fide religious question (versus OCD-related reassurance) and how to consult with a rabbi without seeking reassurance may be beneficial. Furthermore, as Huppert and Siev (2010) point out, (careful) consultation with clergy can motivate the individual to engage in ERP because the clergy member can articulate the minimum religious requirement or the permissible behavior that closest approaches sin. The patient would then engage in exposure exercises they know intellectually are acceptable, but still violate obsessional fears and cause anxiety.

Finally, in planning which behaviors to target in response prevention, patients often require assistance with differentiating between healthy religious behaviors on the one hand, and compulsive rituals (i.e., religious behaviors performed in response to obsessional fear and doubt) on the other. Allowing the patient to take the lead in sorting this out can be helpful. Religious behavior motivated by obsessional thoughts is not technically "religious"—such behavior is "fear-based" rather than "faith-based." Here, the assistance of family members and religious authorities who can reinforce the distinction between healthy and unhealthy religious practice can be helpful. Of course, such individuals must also be educated about the rationale for ERP and the functional aspects of behavior. In general, religious rituals that are performed as meaningful expressions of faith and religious identity (even those that bring about solace in a general sense) do not need to be stopped during ERP. On the other hand, rituals performed as a means of assuaging obsessional anxiety, guilt, or shame, should be ceased. To illustrate, whereas seeking general support from a religious authority or one's community is healthy religious behavior, seeking reassurance regarding particular obsessional fears should be considered off limits during ERP. Similarly, praying for the courage to engage in ERP would be considered appropriate, whereas praying for forgiveness regarding obsessional fears would be considered a violation of response prevention. It is important to assess the intent, proportion, and occasion of particular behaviors (as opposed to their topography) when determining whether a seemingly religious behavior should be targeted in response prevention.

4.4. Cognitive techniques

Therapists working with scrupulous patients occasionally fall into the trap of trying to convince the patient that his or her obsessions are illogical, unlikely to come true, or otherwise senseless. Some therapists use cognitive restructuring to try to demonstrate to the patient that an obsessional fear is unlikely to occur (e.g., "Where's the evidence that your soul is possessed by the devil?"). Yet although the obsession intuitively seems like an apt target for rational debate (because of its irrationality), this approach overemphasizes short-term anxiety reduction (and reassurance), and will have only a transient beneficial effect at best. Furthermore, as previously mentioned, there is no way to achieve full certainty about the sorts of spiritual or enigmatic concerns that scrupulous patients experience (e.g., whether one's soul is possessed by the devil). Rationality-based debates will, therefore, prove futile. It is likely that many have already tried (and failed) using such approaches to talk the scrupulous person out of their fears.

Instead, we suggest that cognitive restructuring for scrupulosity address the likelihood of tolerating anxiety, uncertainty, and distressing intrusive thoughts. Verbal cognitive techniques, for example, can be used to help patients discuss and challenge their need for absolute certainty over matters that other followers of their religion accept on faith. Therapists can help patients make lists of the pros and cons of continuing to try to gain certainty versus learning to live with normal everyday uncertainty and accept such enigmatic things on faith. Through such techniques, patients might come to realize that they already accept uncertainty in most other areas of her life (e.g., driving in a car to the treatment session!), and so have ample evidence that they can function sufficiently even in a state of uncertainty. The use of cognitive techniques in this way could set the table for the sorts of ERP assignments described previously to diminish the significance of obsessional thoughts and uncertainty.

5. Conclusions

Scrupulosity can be conceptualized as a presentation of OCD focused on religious and moral themes that are exaggerated and distinct from normal religious practice. The relationship between scrupulosity symptoms, one's degree of religiosity, and his or her religious affiliation is complex, yet a growing body of research has added to our knowledge of the problem. Research and clinical observations lead to a cognitive–behavioral model of scrupulosity that assumes that to some degree, one's religious beliefs and values influence the misinterpretation of normally occurring unwanted thoughts as potentially sinful or foreboding of divine punishment. Because many religious matters are not subject to disconfirmation, but only to faith, patients' intolerance of uncertainty leads to intense anxiety and urges to reduce this anxiety using strategies that end up having the opposite effects. This model has a number of implications for how cognitive–behavioral treatment techniques, such as exposure, response prevention, and cognitive interventions, can be applied in the treatment of scrupulosity. Helping patients recognize that their need for certainty has resulted in a failure of their religious faith can be a potent rationale for engaging in treatment. Treatment can be viewed as helping patients to practice their own religion more faithfully, as opposed to out of fear. Because the stakes are subjectively very high for the scrupulous individual – he or she might believe that their immortal soul or relationship with God is in danger – it is important for clinicians to hold an empathic position, develop the trust needed for patients to take (subjective) risks, and obtain the clarity needed to negotiate the intricacies of this presentation of OCD.

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