
When Religion and Obsessive-Compulsive Disorder Collide: Treating Scrupulosity in Ultra-Orthodox Jews



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Evidence-based practice suggests that clinicians should integrate the best available research with clinical judgment and patient values. Treatment of religious patients with scrupulosity provides a paradigmatic example of such integration. The purpose of this study is to describe potential adaptations to make exposure and response prevention, the first-line treatment for obsessive-compulsive disorder, acceptable and consistent with the values of members of the Ultra-Orthodox Jewish community. We believe that understanding these challenges will enhance the clinician's ability to increase patient motivation and participation in therapy and thereby provide more effective treatment for these and other religious patients. © 2007 Wiley Periodicals, Inc. *J Clin Psychol* 63: 925-941, 2007.

Keywords: cognitive-behavioral therapy; evidence-based practice; obsessive-compulsive disorder; religion; scrupulosity; values

The past decade has seen a cross-disciplinary movement toward evidence-based practice (EBP) in multiple areas of health care. In the field of clinical psychology, this has been highlighted by the recent appointment of a presidential task force on EBP by the president of the American Psychological Association (APA). The resultant APA policy statement describes EBP in psychology as “the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (APA Presidential Task Force, 2006, p. 273), a definition consistent with EBP as characterized in other medical fields (e.g., Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000). The primary function of psychotherapy outcome research is to improve clinical practice by facilitating the development, identification, and implementation of efficacious treatments. Attempting to address and operationalize cultural, religious, and moral values

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within such clinical research is considerably more difficult, even given a general recognition of the importance of multicultural competence in psychotherapy practice.

There exists a paucity of research investigating whether multicultural issues, including spiritual values, moderate treatment outcome efficacy. The limited research body in this area provides some empirical evidence directly demonstrating that integrating spiritual issues improves treatment outcome efficacy for depressed, religious patients (Propst, Ostrom, Watkins, Dean, & Mashburn, 1992). One of the most salient examples of a disorder that is inherently and inextricably linked to a patient's value system is that of scrupulosity in obsessive-compulsive disorder (OCD), which often is manifest within a particular system of religious observance and beliefs. In such cases, it seems essential to integrate issues of religion and treatment (Ciarrocchi, 1995). Our purpose here is to describe adaptations for the treatment of scrupulosity in Orthodox Jews when using exposure and response prevention (EX/RP), a form of cognitive-behavioral therapy (CBT) that has a substantial evidence base in the treatment of OCD. We will touch upon broadly applicable issues of religiosity, scrupulosity, and pathology, but will focus primarily on issues that arise when tailoring treatment to this population. Our experience is that the best outcomes for these patients can be obtained when integrating research evidence and clinical expertise while working within the clients' value system.

Obsessive-Compulsive Disorder and Religion in Ultra-Orthodox Jews

Obsessive-Compulsive Disorder

Obsessive-compulsive disorder is a disorder in which individuals experience intrusive or unwanted thoughts, images, or impulses that cause anxiety (obsessions), and engage in repetitive behaviors or thoughts that provide temporary relief from the anxiety (rituals or compulsions; American Psychiatric Association, 2000). Obsessions are not merely exaggerated worries grounded in reality; they are rather phobic reactions to thoughts, images, or impulses (e.g., Steketee & Barlow, 2002). In most cases, individuals with OCD experience the obsessions as ego-dystonic and often recognize that the compulsions are irrational.

Obsessive-compulsive disorder symptoms have been classified into a number of common subtypes, including contamination obsessions with cleaning compulsions; accidental harm obsessions with checking compulsions; aggressive, sexual, and religious obsessions associated with compulsions to prevent negative outcomes; symmetry obsessions with ordering and arranging compulsions; and doubting or perfectionism obsessions with counting and repeating compulsions (cf. Mataix-Cols, Rosario-Campos, & Leckman, 2005). Hoarding is currently considered another subtype of OCD, but there is accumulating evidence to suggest that it may better be conceptualized as distinct from OCD (e.g., Grisham, Brown, Liverant, & Campbell-Sills, 2005; Wu & Watson, 2005). Most people with OCD actually have symptoms that cross subtypes, although one or two categories are typically primary (Huppert et al., 2007).

Scrupulosity is a type of OCD in which individuals' obsessions focus on religious or moral fears, such as sin, divine retribution, and the implications of being an evil or bad person (Ciarrocchi, 1995; Purdon & Clark, 2005). Scrupulosity can be phenomenologically similar to other OCD subtypes (e.g., an individual who repeats a religious requirement to be certain she or he performed it properly), but the ultimate feared consequence is religious or moral in nature. Although usually related to religious observance or beliefs, scrupulosity can also manifest in extreme forms of moral behavior in a nonreligious context, and nonreligious individuals can also be affected by these concerns.

Religiosity and Obsessive–Compulsive Disorder

Epidemiological data examining multiple, diverse cultures, suggest that lifetime and annual prevalence rates of OCD do not differ by culture except where prevalence rates for all psychiatric disorders differ (e.g., Horwath & Weissman, 2000; Weissman et al., 1994). Moreover, there is evidence of considerable cross-cultural similarity in terms of subtype classification and even frequencies (Insel, 1984). In contrast, the specific presentation of OCD symptoms may depend on cultural knowledge and beliefs. For example, contamination obsessions evolve over time with respect to particular diseases of concern during those time periods (e.g., AIDS during the 1980s, SARS in the early 2000s). Similarly, researchers have noted that religious patients have religious themes in their OCD reflective of their religion's beliefs, practices, and rituals (e.g., Greenberg, 1984; Khanna & Channabasavanna, 1988; Okasha, Saad, Khalil, El-Dawla, & Yehia, 1994; Rasmussen & Tsuang, 1986; Greenberg & Witzum, 1994).

Although few in number, studies that directly investigate the relationship between religiosity and OCD fail to demonstrate an association between religiosity and the development of clinically significant OCD symptoms. Steketee, Quay, and White (1991) found no difference between people with OCD and other anxiety disorders in terms of religiosity, although among those with OCD, religiosity was correlated with symptom severity. In one Jewish Israeli sample, religiosity did not distinguish between patients with OCD, those with panic disorder, and healthy controls (Hermesh, Masser-Kavitzky, & Gross-Isseroff, 2003). Similarly, Zohar, Goldman, Calamary, and Mashiah (2005) found that there was no relationship between OCD behavior and religiosity in a nonclinical population of Israeli Jews. Furthermore, in the experience of Orthodox Israeli Jews with OCD, there does not appear to be anything qualitatively different between religious and non-religious symptoms (e.g., distress, degree of insight, etc.; Greenberg & Shefler, 2002). Another recent study found no relationship between severity of OCD and religiosity, and small associations between religiosity and scrupulosity within a sample of patients with OCD (Canterino, Huppert, Cahill, & Foa, 2006).

Two studies have reported some association between religiosity and nonclinical OCD symptoms; however, a cursory reading of those studies can be misleading. Abramowitz, Deacon, Woods, and Tolin (2004) administered the Obsessive–Compulsive Inventory—Revised (OCI-R; Foa et al., 2002) to highly religious Protestants, moderately religious Protestants, and agnostics/atheists. The OCI-R yields six subscales and the highly religious group differed from the other two groups on only two of the subscales (one after Bonferroni correction). It should be noted, however, that the mean scores for the highly religious group in this study were lower on all six scales than the mean scores for the nonanxious control group in the normative data (Foa et al., 2002). Similarly, Sica, Novara, and Sanavio (2002) recruited undergraduate students and individuals from religious Catholic institutions. The participants were divided into three groups based on level of religiosity, and completed the Padua Inventory, which yields four subscales and a total score (Sanavio, 1988). The highly religious group reported more symptoms than the least religious group on one subscale. Again, however, the actual mean scores for the highly religious group were lower on the total score and all subscales than were the means for nonclinical groups in normative data reported by other studies (cf. Williams, Turkeimer, Schmidt, & Oltmanns, 2005). Thus, there were few group differences reported by Abramowitz et al. (2004) and Sica et al. (2002), and those group differences do not appear to approach a threshold for clinically significant symptoms.

Appropriate behavior is environmentally determined, and just as healthy surgeons wash their hands relatively often, it may be the case that people in certain cultures or

religious groups are slightly more bothered by intrusive thoughts. In fact, although religiosity and OCD-related metacognitions such as thought–action fusion have been correlated in a number of studies, one recent study found large differences in that relationship between equally religious Jews and Christians groups, such that thought–action fusion was not significantly related to religiosity in the Jewish sample, but was in the Christian sample (Siev & Cohen, 2007). Religious or cultural variations in thoughts and behavioral processes without corresponding differences in prevalence rates of pathology suggest that such thoughts and processes are not always pathological.

All of these findings converge to suggest that clinicians should be careful not to convey an attitude that blames religion for OCD symptoms. Clinician assumptions regarding a religious individual's vulnerability for OCD are likely to influence how religion is addressed in treatment. If, despite the lack of empirical basis (cf. Purdon & Clark, 2005), religion is conceptualized as causing OCD, the therapist may think that the patient's religious faith must be controlled or reduced to support treatment. If the therapist conveys that the patient's religious beliefs or community support the pathology, then the therapist may adopt a disadvantageous stance toward the patient that can undermine trust and empathy, and lead to conflict. It is likely that attempting to confront a patient's religious beliefs will interfere with treatment, whereas working respectfully within the confines of the individual's religious laws and traditions will establish rapport and facilitate treatment compliance. Understanding that OCD is not caused by religious adherence, but rather that such adherence can influence how OCD manifests in religious patients (i.e., in religious obsessions and compulsions) enables the clinician to use the patient's religious beliefs as a framework to treat the disorder more effectively. Recruiting rather than combating patient religiosity in service of treatment supports the patient in reclaiming religion as an aspect of their life that brings meaning and comfort, rather than distress.

Ultra-Orthodox Judaism¹

Prior to elaborating on treatment and adaptations, we give a brief background for the Orthodox Jewish community to provide a context for those variations. The word *orthodox* is defined from the Greek as “correct thought” and is more commonly understood as “conforming to established doctrine especially in religion” (Merriam-Webster, 2003). Within Judaism, Orthodoxy signifies individuals who generally believe in the divinity of the Written Law (Torah) and Oral Law (Talmud) and who, at minimum, practice the core observances of the 613 mitzvos (commandments) that define Orthodox observance. These are Shabbos (observance of the Sabbath, the holy day of rest), kashrus (dietary laws), and niddah (laws of family purity). Due to the nature of Orthodox laws such as prohibitions against driving on Shabbos and the need to obtain kosher food, Orthodox Jews tend to reside in socially and geographically close-knit communities.

Judaism is a practice-oriented religion, characterized by numerous rituals and laws that permeate nearly every area of existence. Jewish law, or halacha, is a detailed legal code that is based on rabbinic interpretation of the Torah and Talmud and establishes its application in daily life. Customs relating to precise practice differ even within the Orthodox community, and it is expected that community members have specific rabbis on whom they rely for legal and spiritual guidance. Especially in Ultra-Orthodox Judaism,

¹For more details regarding the customs, sociology, and psychology of the Ultra-Orthodox Jewish community see http://en.wikipedia.org/wiki/Haredi_Judaism and links therein. For discussions of the community and issues of mental health and their treatment see Greenberg and Witztum (2001), Paradis, Friedman, Hatch, and Ackerman (1996), Paradis, Cukor, & Friedman (2006), or <http://www.reliefhelp.org>.

(a more theologically strict and traditional version of Orthodox Judaism, where adaptations to treatment are likely to be essential), rabbinic authority supercedes individual autonomy. Ultra-Orthodox Jews place great importance on the position of rabbis not only as spiritual leaders of the community, but as sources of personal guidance as well. It is common even for someone quite learned to ask a rabbi questions that an outside observer might imagine could be answered for oneself. As a result, clergy are often not attuned to the ways in which their interactions and authoritative reassurance can function as compulsions to maintain the OCD, and it may be necessary to educate them about the role of compulsive reassurance seeking. Patients with OCD often utilize rabbis for reassurance seeking; when beset by obsessive doubt, patients can feel like even the simplest minutiae require rabbinical guidance, which goes beyond community standards.

In addition to observing the above restrictions and guidelines, the Ultra-Orthodox community is characterized by its attempt to limit contact with the secular world to protect traditions from outside influence. Ultra-Orthodox Jews often have a culture of distrust of the outside world, and of psychology in particular. Indeed, as a field, some aspects of psychology have historically devalued religion (e.g., Freud's *Future of an Illusion*; Freud, 1927). Many Ultra-Orthodox Jews believe that psychological knowledge has already been determined by rabbinical teachings and wisdom which have been passed down from generation to generation for more than 2000 years, and that such knowledge is far superior to that of fledgling modern psychology. However, within the community, recent attention has been called to the compatibility of CBT and classical rabbinic approaches (Twersky, 1993).

There are various streams and sects of Ultra-Orthodox Jews that are distinguished by differences in customs and dress, with community members strongly adhering to these unique traditions. Most men within the Ultra-Orthodox community study Jewish texts fulltime in yeshiva until marriage, and many study in a kollel (advanced institute for Torah study for married men) for many years following marriage. Stipends for kollel study are typically small, and many wives work to support the family financially. It should be noted that this is an arrangement desired and valued by the wives as well as the husbands. When OCD symptoms interfere with a patient's ability successfully to study fulltime, alternative career pursuits can be viewed by some as unfortunate or second best. In addition, women marry by their early twenties and birth control is used sparingly, so it is typical for a 30-year-old woman to have five or more children. Women experience social pressure to continue to have children, and those who cannot (e.g., because of medications that may have contraindications for becoming pregnant) may have significant concerns about stigma. Furthermore, most marriages are arranged through matchmakers, and the knowledge that a sibling or parent has been diagnosed with a mental illness such as OCD can raise significant concerns about marriage prospects for the whole family.

Each community (sometimes defined by geographic location and sometimes defined as individual sects within various geographical locations) has its own norms and customs. It is necessary to understand the values of each community to understand an individual patient's particular challenges and concerns. Some of these differences include the emphasis placed on studying Jewish texts fulltime versus the value of other commandments, variances in observance of dietary laws (e.g., the exact details of ritual slaughter that are permissible), and standards of modesty and/or normative dress. Many of these details are revealed by determining who the individual's rabbinical authority is.

Within both Orthodox and Ultra-Orthodox communities, there exists a range of individual practice variation. For example, even within a community, individuals may have different practices regarding the allowance of being alone with a nonfamily member of

the opposite sex (yichud). Whereas some may refuse to be alone in an office with someone of the opposite sex, others may be alone if the door is cracked open, or closed but not locked. Nuances of these laws will not be discussed here. However, this illustrates the many issues that might not otherwise occur to the therapist, but that can affect the patient's comfort greatly (for a discussion of shaking hands, see Paradis et al., 1996). The therapist should be aware of and comfortable with the variations of practice to which the patient adheres. At the same time, the therapist should determine whether the individual's practice is more stringent than the community practice, and whether it is being influenced by OCD.

How can a practitioner best understand the values of the community and reflect respect for such values? If one sees a patient with issues about Jewish law, it can be very helpful to seek advice from the patient, their family members (with consent), Orthodox clinicians, or rabbis with experience with mental health issues regarding treatment guidelines. This will aide the clinician in understanding many of the guidelines for treatment that would be reasonable and prevent her from asking the patient's rabbi questions that are clearly outside the boundaries of the law (as such questions may antagonize or cause distrust). In addition to adjustments to treatment that are specific to the individual and community, some general concepts are applicable to Ultra-Orthodox patients with scrupulosity that can facilitate motivation, treatment compliance, trust, and building a therapeutic alliance. These are elaborated on below (see the section Adapting EX/RP).

Scrupulosity in Ultra-Orthodox Jews

Common scrupulous thoughts of devout Christians include fear of worshipping the devil or going to hell.² In Orthodox Judaism, however, themes are focused more on cleanliness related to dietary restrictions (e.g., accidentally mixing milk and meat or bringing in unkosher food), family purity, praying correctly, or studying correctly (see Greenberg & Shefler, 2002; Paradis et al., 2006). Typical rituals include washing, checking, canceling vows, consulting rabbis, mentally reassuring oneself (reviewing conversations with a rabbi), washing hands, checking for blood, and praying. For some individuals, the consequence is being condemned in the world to come, but for others, it is rather living and spreading sin in this world (e.g., if they make unkosher food, it could spread to the rest of the community forever, making everyone sin unknowingly). These are not surprising targets for OCD, which often seems to latch onto the most important areas of one's life.

The therapist unfamiliar with Orthodox Judaism may find it difficult to differentiate true laws or customs from OCD rituals. For example, upon waking in the morning, most Orthodox Jews engage in a hand washing ritual to cleanse themselves from impurities. The steps taken for this ritual consists of the following:

Upon waking in the morning, one should wash their hands in the following manner. Before washing, one should avoid touching their mouth, nose, eyes or ears, and wash the hands as follows (for individuals who are right-handed): (1) Pick up the cup with the right hand and fill it with water. (2) Pass it to the left. (3) Pour water over the right hand and pass the cup to the left. (4) Alternate back and forth to wash three times on each hand. (5) The blessing over washing hands is then recited and the impure water should be discarded immediately. If the impure water is touched, it may require rewashing.

We include detailed instructions to show the depth of the requirements and to gain a better understanding of where the careful wording of the law may seem excessive to an

²For a discussion of scrupulosity and its treatment in Christian groups, see Ciarrocchi (1995) and Purdon and Clark (2006).

uninformed clinician who does not ascertain information about community and halachic standards for rituals. Although the description is the community standard, seeing someone do this 30 times or for 45 minutes every morning is a good clue that the religious ritual has been co-opted by OCD.

Despite the complexities that exist in disentangling OCD from religious practice, it is possible to treat such patients with EX/RP. When doing so, we believe many of the same factors that are related to positive outcome in standard EX/RP are important factors in treating Orthodox Jewish OCD patients. These include careful case conceptualization, articulation of the treatment rationale to the patient, aggressive exposure, and emphasis on complete response prevention. Most of these can be adapted by translating modern psychological concepts into religious language to meet the patient's values (cf. APA Presidential Task Force, 2006).³

Treatment

Exposure and response prevention is a form of CBT designed specifically for OCD. Dozens of studies have demonstrated its treatment efficacy in various populations, and treatment typically induces large reductions in symptoms, high percentages of clinically significant change, and lower relapse rates posttreatment than medication (e.g., Foa et al., 2005, Pediatric OCD Treatment Study Team, 2004). EX/RP, alone or in combination with medications, is currently recommended as a first line of treatment for OCD by the Expert Consensus Guidelines (March et al., 1997; National Institute for Health and Clinical Excellence, 2006).

Exposure and response prevention is based on the notion that there is a functional link between obsessions and compulsions (or avoidance): The former are anxiety provoking and the latter, anxiety reducing. By engaging in rituals or avoidance to manage their anxiety, patients reinforce their beliefs that (a) the anxiety induced by obsessions will not decrease of its own accord, and (b) negative outcomes were truly prevented by compulsions. In addition, the rituals themselves are negatively reinforcing because they provide short-term relief from intense distress. Therefore, the goal of EX/RP is to weaken the psychological links between obsessions and increased anxiety, and compulsions and decreased anxiety. Patients learn to tolerate their anxiety and that it will subside even without ritualizing, and these lessons ultimately reduce anxious reactions. Although the treatment is primarily behavioral, EX/RP facilitates a cognitive shift (e.g., in relation to probability estimations of harm, the consequences of that harm, tolerance of uncertainty, etc.), for which formal cognitive restructuring can be a helpful supplement.

Exposure and response prevention consists of exposure to feared stimuli, both external and internal, while simultaneously refraining entirely from ritual behavior and mental processes, including mental rituals or other methods of psychological avoidance (see Kozak & Foa, 1997, for more details). When possible, in vivo exposure is preferred. For example, an individual with obsessional fears of contracting a disease via contact with a public toilet seat would incrementally work up to touching public toilet seats intentionally for extended periods of time, without washing or otherwise ritualizing. The therapist would likely have the patient contaminate her environment with the toilet seat (e.g., touch the seat with a tissue and touch the tissue to objects all around the patient's house), so that

³It should be noted that for the purposes of the current article, we provide most concepts via their English translations. However, one of the aspects of helping patients be comfortable in treatment is using their own language when possible. For Ultra-Orthodox Jewish patients, this means reflecting back Hebrew and Yiddish words to convey the concepts of the treatment.

she is entirely immersed in perceived contamination, while refraining from ritualizing. Sometimes, however, in vivo exposure is not practical or sufficient, such as the case of a patient with obsessional fears of molesting a child. In such a case, the individual would still make use of in vivo exposure (e.g., bathe his child, change diapers), but also imaginal exposure, in which the patient creates and listens repeatedly to the story of his feared consequence, as if it were happening. Imaginal exposure is particularly useful as a means for exposure to stimuli that one cannot create in vivo (e.g., hell), as well as feared consequences that could arise from any situation. Hence, the individual with fears of contracting a disease might, depending on the idiosyncratic core fear, engage in imaginal exposure to actually contracting a disease, losing a job and the loyalty of a loved one, and/or living isolated and incapacitated.

Consider a patient with obsessions about physically harming other people. He has numerous compulsions involving excessive checking to ensure he did not harm others and avoidance of knives and other sharp objects. In vivo exposures for this patient would include purposefully using knives and sharp objects around other people, including people the patient feels are most vulnerable to his acts. One representative imaginal exposure might be to a scenario in which the patient decides to defeat his OCD by engaging in the in vivo exposures, but his actions result in catastrophic consequences (e.g., murdering his family). Now consider, however, an Orthodox Jewish scrupulous patient with obsessions about offending God instead of harming people, and thereby facing divine retribution. Certainly imaginal exposure to the feared consequence is appropriate, but in this case, she cannot engage in in vivo exposures that violate religious law (e.g., purposefully offending God through behaviors that are proscribed). Instead, the therapist must work with the patient—and often clergy—to understand the limits of religiously acceptable behavior, and create situations in which she can violate OCD law, but not religious law. This requires understanding, creativity, and tolerance. In the rest of this article, we relate some of the methods that we have undertaken to make such adaptations for EX/RP in treating Orthodox Jewish patients with scrupulosity.

Adapting Exposure and Response Prevention

Conceptualizing the Problem

Cognitive-behavior therapy for OCD requires a clear conceptualization of the individual patient's core concerns and fears. For example, it is not sufficient to know that someone washes excessively. A fear of contracting HIV/AIDS is very different from one of touching dirt (just because it is disgusting), which is very different from an obsession that one will become like the person whom one touches. Thus, understanding the ultimate consequence or core fear is important. Typically, treatment is designed to have patients gradually approximate acts that they perceive as elevating the risk of the core fear occurring (e.g., touching doorknobs and building up to touching a worn book about AIDS from a clinic library). As noted above, the core fear of many scrupulous Orthodox Jewish patients is either being in a state of perpetual sin in this world, or suffering the consequences of that sin in the world to come. Identifying the core fear is crucial, but requires finesse. A sin is a powerful, aversive stimulus in its own right, and patients may have difficulty relating to common questions utilized in determining core fears such as, "What will happen if you sin?" and "What would be so bad about that?" The answer given by Orthodox Jewish patients might be, "God forbid. One should do everything possible to avoid sinning." Only with careful inquiry can one determine if there are further consequences without offending the sensibility of the patient.

When treating religious patients, we believe it is not necessary or appropriate to include exposure to actual sin. Obsessional fears are usually driven more by actions that lead to increased (albeit small) risk than by actions that truly cause the feared consequence. For example, patients who are afraid of touching a book on AIDS, leaving the house with the oven on, or handling knives around their baby, typically believe that these are risky behaviors, not ones that will definitely lead to the feared consequences. During EX/RP, it is helpful for patients to accept risks by acknowledging the possibility of their feared outcomes, but most individuals do not need to state that they are definitely going to get AIDS, burn their house down, or kill their child. Exposures do not usually require individuals actually to experience the ultimate negative consequences, but rather to tolerate risk, ambiguity, and uncertainty. Similarly, scrupulous patients need not actually sin or tell themselves that they are doing so; instead, they need to allow for slightly greater risk than others normally would, without actually making the violation occur. Normative religious behavior in the community can be used as a reference point to distinguish between acceptable risk and OCD behavior (e.g., “Do your friends also wash with soap after pouring milk into a baby bottle before touching meat utensils?”). The therapist must exercise care, however, that the patient not use such information as reassurance, but rather accepts the possibility of sin with the knowledge that others take similar risks. One way of helping to ensure this is to encourage the patient to go beyond the normative without going beyond what is acceptable (e.g., although most people put meat and milk utensils in separate dish drains, if one ran out of space, some would use both drains. Although many would not, doing so would still be acceptable).

Patients with scrupulosity may decide they are willing to continue their painful OCD rituals if necessary to avoid sinning. If their ultimate goal in life is to serve God, how can they risk sin? This is why the therapist’s provision and the patient’s acceptance of the rationale for the treatment, explained during the first session and reinforced throughout the rest of the treatment, is so important.

Rationale for Treatment

Many Ultra-Orthodox Jewish patients are skeptical about the ability of nonreligious individuals to understand or effectively to treat members of this community. Often, they are afraid that they will be judged by the therapist or are concerned about allowing the therapist to know details about themselves or their families that often remain restricted to the family or community. By providing a sensitive rationale, the therapist can alleviate the skepticism and create an open, therapeutic environment. For example, a number of patients have articulated “If I just weren’t religious, I wouldn’t have this problem.” Although not necessarily intended to test the therapist, a statement such as this creates an opportunity for psychoeducation and alliance building. One response might be, “You might not have OCD about halacha, but you would likely have it about something else instead. You cannot run away from OCD.” Such statements dispel concerns that the therapist believes that religion is part of the problem.

Another part of the rationale for treatment that should be conveyed early on is that OCD is likely a barrier to the spiritual connection religious patients want to have with God, and that EX/RP can be a way to help them rebuild that relationship. Although individuals may believe that their scrupulous adherence to law is in service of God, ironically the distress from OCD often causes them to ritualize in service of OCD, sometimes even in violation of religious law. Therefore, the goal of treatment can be presented as the removal of the barrier of OCD to have a more fulfilling spiritual life. The idea is for patients to learn how to trust their knowledge and soul, instead of seeking external guidance excessively and using rituals as a means to avoid sin.

Exposure to negative thoughts, often an integral part of treatment, can raise issues of conflict. There are notions within Judaism that one should not articulate bad things for fear of them happening (*al tiftach peh*), and that some thoughts are forbidden (*hirhurim*). When treating a religious patient with OCD, engaging in a debate about whether thoughts are inconsequential can sidetrack treatment because religious patients may believe that some thoughts are in fact sinful. Instead, it is more productive to address different aspects of OCD thoughts. There are three aspects of thoughts to distinguish: (a) the nature of the thought (i.e., intrusive vs. purposeful), (b) how one deals with the thought (i.e., accepting it by not suppressing vs. purposefully elaborating on it), and (c) the intent of the thought (i.e., pleasure vs. treatment). Each of these dimensions and their interactions should be made explicit to the patient to determine what may be acceptable and what may not be. In cases of intrusive thoughts, rather than challenging whether thoughts are sinful, the therapist can note that even if they are sinful, perfection is a demand of OCD, not religion. It may be easiest to persuade a patient that they do not need to suppress unintended thoughts that they find repugnant and can instead ignore them, even if they should not engage in forbidden thoughts for pleasure. The rationale for not fighting such thoughts is that suppression frequently leads to increased intrusions whereas acceptance frequently decreases them (see also Purdon & Clark, 2005). Furthermore, the meaning of intentional thoughts when utilizing them for the purpose of exposure treatment differs substantially from equally intentional thoughts that reflect true desires (e.g., intentionally thinking "I want to worship Zeus" to provoke anxiety and ultimately reduce or eliminate such thoughts is not equivalent to actually wanting to worship Zeus). Whether such thoughts can be used purposefully for therapy may depend on one's clergy and the specific content area.

During EX/RP, response prevention often requires that the patient engage in certain behaviors even less than people without OCD. For example, someone who washes excessively may be asked to shower only every third day. Ultimately, overcorrection allows the individual to return to a normal level of behavior after they complete treatment. Although the purpose of overcorrection is to allow the patient to find a path of moderation and lead a life within the normal range of behavior, patients will often express concern that the goal of treatment is to live in the extreme (e.g., make them a dirty person), typically their main fear. In Judaism, the concept of overcorrection was elucidated by the medieval scholar, Maimonides, who described the process in reference to working on one's character traits. He advised that to refine character flaws one must adopt the extreme opposite behavior, and that by doing so, one will arrive at a middle path. Orthodox patients place great value on the study of rabbinic texts and are used to considering behavior in reference to sources in rabbinic literature. Hence, it can be useful to refer to the overcorrection process used in response prevention as part of the writings of a foremost Jewish scholar rather than a new scientific concept.

Other subtle differences in framing identical information during psychoeducation are also important. With nonreligious patients, for example, we often discuss the evolutionary function of anxiety and how it has gone awry in OCD. Some religious patients are resistant to the theory of evolution or find it heretical; for them, it can be useful to express the same concepts in religious terms: "Why did God endow us with the ability to feel anxious? What purpose does it serve?"

Enhancement of Motivation

Exposure and response prevention is challenging for patients, who are asked to tolerate extreme distress and emotionally painful anxiety. Although there is not typically a structured motivational enhancement procedure for this treatment, motivation is discussed through-

out exposure sessions. The therapist may remind the patient that it is necessary to complete treatment to enjoy their life again, to be able to have more meaningful interactions with family and friends, and to experience life more fully. However, emphasis of individual fulfillment in life over subservience to God and His laws is somewhat contrary to Orthodox Judaism. Therefore, motivation is best achieved within the framework of Orthodox beliefs. The goal of treatment is to learn to serve God more completely (i.e., without OCD) and thereby have a more fulfilling life. While there is a clear emphasis on avoiding sin, Judaism also emphasizes living life in this world. Under ordinary conditions, complete asceticism is not an ideal. It is written in Leviticus 18:5: "And you shall live by them [the commandments]," which is understood in rabbinic literature to emphasize that most commandments are violated to save a life (e.g., someone starving is obliged to eat pork if it is the only available sustenance). Patients may accept that living their lives with OCD is not truly fulfilling the underlying notion of living by the laws. This statement is similar to a passage from Proverbs (3:17–18) recited during prayer services: "[The Torah's] ways are ways of pleasantness and all of its pathways are peace. It is a tree of life to those who hold fast to it and all its supporters are happy." These statements remind the patient that the laws of the Torah are not meant to be oppressive or punitive, but rather as a means to connect with God. One should live by the commandments and not suffer through them. Treatment goals can be articulated as a means to realize the Torah-based values of living life in a pleasant way, while engaging with others around them.

Patients with scrupulosity, with excessive concern about morality and right and wrong, may be perfectionistic. A concept from Talmudic literature that can be helpful in motivating patients to reconsider perfectionism vis à vis religious practice is that "The Torah was not given to Heavenly angels" (Berachos 25b). The meaning of this statement is that angels, who are perfect and unable to err, were not chosen to receive the Torah. Rather, the Torah and its laws were given to fallible humans, who are not expected to be perfect. The legal application of this concept in deriving and establishing law is that no requirement demands absolute perfection or conveys impossible expectations.

The aforementioned interpretations of Torah passages and ideas can be helpful in convincing the patient that the goals and process of EX/RP, including small risks of sin, are acceptable and consistent with Orthodox Judaism. This approach can thereby increase motivation and compliance. A more general method of reinforcing that it is acceptable to risk sinning is to note that the patient risked their life by coming to the therapist's office (e.g., driving, crossing the street, etc.). Purposefully endangering oneself is forbidden by halacha, so this example demonstrates the permissibility of small, reasonable risks of sin. Indeed, all actions entail risk, and one must navigate life despite these risks, and not avoid life due to them.

Other legal principles in Judaism that require tolerance for objective error are the concepts of *bitul* and *rov*. The concept of *bitul* states that, under many circumstances, if one accidentally or unknowingly mixes a small proportion of forbidden food or food combination in a larger group (e.g., a drop of milk falls into a pot of chicken soup), the forbidden substance is considered nullified and the mixture is kosher. *Rov*, on the other hand, allows, under certain complex circumstances, that even the simple majority of greater than 50% is sufficient to make a mixture allowable. The mechanics of *bitul* and *rov* are complex, but of relevance is that there are times when one cannot know with certainty that something is acceptable, and it is permissible nevertheless.

Helping the Patient Distinguish Between OCD and Religious Law

Patients with scrupulosity may find it difficult to distinguish compulsive from religious rituals. One tool to help patients differentiate is the gun test. First, the patient imagines

that someone is threatening him with a gun and will shoot if the patient cannot answer a question about his obsessive fears correctly (e.g. "Do you really believe this food is not kosher?"). In this example, the patient is likely to answer correctly "because the gun test is an aid to help distinguish between what you intellectually and logically know from what you feel" (Grayson, 2003, p. 12). The second part of the gun test targets compulsions, but the scenario is similar. The patient considers whether he could refrain from rituals at gunpoint. A modification of this for a religious patient is to ask whether he needs to ritualize from the point of view of religious law, with the consequence of an incorrect answer being death. Again, the patient usually agrees that he need not carry out compulsions.

Many people with scrupulosity consider accidental violation of minor law equivalent to blatant disregard of the fundamental laws of Orthodox Judaism. From that perspective, it is understandable why they would resist accepting risks that others tolerate, and may question the halachic validity of engaging in treatment on the grounds that the therapist is asking them to sin. To this end, the McDonald's test is useful: "Is doing this the same as going to McDonald's and eating a bacon cheeseburger?" Often this can help the person gain perspective about the reality of what they are being asked to do. They are not being asked to sin, but rather to tolerate a small (and halachically permissible) possibility that they may sin.

Experiences with the population and obtained knowledge of the laws can be extremely useful in helping the patient differentiate OCD concerns from true religious violations. If knowledgeable about the boundaries of the law, the therapist's use of irreverent persuasion can help to clarify for the patient the blurred lines between OCD and reality. For example, if someone is concerned about bringing pork anywhere into one's house, the therapist can help the patient distinguish between eating or cooking pork in one's pots (forbidden) and sleeping with bacon or using a can of deviled ham as a paperweight (not forbidden).

In Vivo Exposure

In vivo exposure requires the patient repeatedly to come into contact with stimuli in response to which they normally ritualize. For some obsessions, OCD therapists adopt a relatively aggressive approach (e.g., touching a toilet seat and eating without washing). How far can one go in treating Orthodox Jews with OCD who are concerned about violating the law? We consider it fundamentally important and therapeutically sufficient to stay within the letter of the law, while pushing its limits. With fundamentalist Christians, for example, one may consider signing a false contract with the devil because when done as a treatment exercise, it is not a demonstration of true worship. Similarly, a therapist may have Orthodox Jewish patients demonstrate that they are willing to tolerate a measure of uncertainty about religious standards without violating actual law. In this regard, a priori sanctioning by a rabbinical authority is usually necessary. For example, one would not ask a person to cook meat and milk together, but may ask them to use a clean spoon designated for meat to put flour into a cake batter that has milk as another ingredient.

In addition, there are times that OCD patients ritualize by praying to prevent bad things from happening after doing an exposure. Some therapists would encourage patients to "spoil" or undo this ritual by praying for bad things to happen. However, given that religious patients believe in the efficacy of prayer, they may be reluctant to engage in such an act. An alternate approach is to ask them to undo the ritual by praying instead to "allow God's will." This suggests that if the person is to die, then allow that, and if not, then not. It inserts ambiguity and removes active attempts to prevent the negative outcome.

Unexpected situations often arise during EX/RP that require the therapist to adapt creatively. A patient with OCD about mixing milk and meat may suddenly realize that an exposure was different than planned in light of a potentially legitimate concern (e.g., she had not previously washed a dairy fork). As in any other case, it is important for the therapist to recognize that these types of thoughts may or may not be OCD obsessions, and that the patient needs to choose whether or not she can continue with the exposure despite the discomfort. If the patient is sure that this is a true violation (e.g., via the gun test or McDonald's test), then the exposure may need to be delayed until a rabbi can be consulted. If the rabbi says that the situation is in fact permissible, this information may demonstrate the need to recalibrate the patient's gauge of permissible behavior. If the patient is unsure whether it is a violation, the therapist should help the patient determine whether the doubt is legitimate (cf. the udder test described below or gun test) or represents obsessive uncertainty. It is important that the therapist avoid philosophical discussions in these types of situations, which can sidetrack and detract from treatment.

Reassurance

Seeking reassurance is a subtle form of ritualizing for many people with OCD. Often, seeking and receiving reassurance from friends, loved ones, doctors, etc., helps temporarily to decrease the patient's anxiety, but leads to repeated asking and checking. This often results in both increased anxiety and interpersonal conflict with the sources of reassurance. For scrupulous Orthodox Jews, rabbinical consultation can become a form of reassurance seeking, and some patients spend extensive time asking and re-asking halachic questions to their rabbi. Clergy unfamiliar with OCD typically provide excessive reassurance. In such cases the therapist should request the patient's permission to speak to the rabbi about not answering OCD questions, and ask the rabbi to refer the patient back to the therapist instead. When a rabbinic figure refuses to answer a question, the patient receives a powerful message that they are dealing with OCD and not true religious issues. Clergy who understand the rationale usually comply enthusiastically; for them, it is a relief from repetitive and time-consuming consultation.

There is a tension between the benefits of the patient's knowledge that EX/RP will proceed within the letter of the law (with rabbinical endorsement) and the possibility that such knowledge itself provides reassurance that can undermine the efficacy of exposures. It should be made clear that the therapist will consult with the rabbi at the beginning of treatment or may consult further at later points if necessary, but that the therapist will not continue to tell the patient and act as a proxy for the rabbi in providing reassurance. Sometimes patients can be quite convincing that a true halachic problem exists during an exposure. Without sufficient knowledge, the therapist may not be equipped to counter such arguments, and may facilitate compulsions. In such situations, rabbinic consultation by the therapist is essential, even if not relayed to the patient.

Ultimately, religious and halachic standards are best defined by the patient's rabbi. This is important because built into the halachic system are leniencies that can be applied in difficult circumstances, and rabbis, when provided with appropriate information, may feel that they can provide lenient rulings that still do not violate the letter of the law. Because rabbinic authorities often encourage people to avoid situations of halachic ambiguity or conflict rather than relying on leniencies (i.e., if something is questionable, why purposefully risk it?), the therapist should carefully help the rabbi understand the therapeutic desire to engage in particular behaviors. It is important to convey the importance of finding ways to push the patient within the law (usually via leniencies), and explain

how obsessive caution maintains the patient's OCD symptoms. Some rabbis will want time to examine the issues prior to answering. This is not deferring the therapist, but standard for difficult questions. They may even recommend consultation with a rabbi of greater authority. When there is an understanding that treatment proceeds with rabbinic approval, it is important to follow that advice and not violate his ruling even if he forbids a particular exposure. It is then incumbent on the therapist to try to work with the rabbi to determine other exposures that would be acceptable and therapeutic. These may be lesser approximations of the original *in vivo* exposure, or imaginal exposure. It is our experience that rabbis typically share the goal of helping patients improve, and are appreciative and willing to collaborate with therapists to guide them to stay within the confines of religious law. However, when they do seem to contradict what is therapeutic, it may be necessary to explain directly to the rabbi the rationale for an intervention. Two important potential barriers to consulting with rabbis can be how accessible they are and that their answers may depend on how questions are worded. The latter can be important if patients choose to ask questions themselves, as they may ask in ways that elicit more conservative responses.

When the rabbi is clear that a behavior is permissible, the therapist can work with the patient to cease reassurance seeking in the guise of religious inquiry and tolerate the anxiety. In such situations, the therapist may choose not to relay the rabbi's answer (especially if the patient has likely heard it repeatedly), and instead work with the patient on how to stop asking questions within OCD areas. Ultimately, patients need to be willing to engage in the exposure and accept the uncertainty about whether it is permissible. The notion of accepting uncertainty and acting despite the anxiety is a guideline not only for a given exposure, but also for how OCD patients must live in general.⁴

One way to help Orthodox Jews refrain from asking unnecessary questions to clergy is via the udder test. The kosher dietary laws prohibit the use of dairy pots for cooking meat food and vice versa. Cooking a cow's udder presents a unique problem because it is meat, but may contain milk. However, because organ meats are not popular, most patients have never eaten an udder and do not know in what type of pot one should be cooked. Other questions that arise for scrupulous patients can be considered in reference to the question of how to cook an udder. Questions of similarly legitimate ambiguity are permissible whereas other questions, which are less ambiguous, are not.

Discussion

Treatment of many devout individuals of different faiths or cultures requires both adaptation and understanding of the norms of the community from which they come. Although it is definitely easier if one is an "insider," there are many cases in which therapists from similar backgrounds are not available or accessible. We hope that the current article facilitates therapist understanding of how to adapt treatment to Orthodox, and especially Ultra-Orthodox, Jewish patients with scrupulosity. We have found this approach extremely effective. In a preliminary look at the first author's consecutive caseload over the last 4 years, he has treated 12 patients who are Ultra-Orthodox, 9 (75%) of whom were considered much improved or very much improved by both the therapist and the patient, and dropout rates have been low (2 out of 12 or 17%). These results are similar to reported rates for EX/RP in many studies (e.g., Foa et al., 2005). Of course, no data have been

⁴This is in contrast with the above-cited notions that one should seek guidance from a rabbi on large and small issues. The problem with patients with OCD is that they often take this further than community norms. Thus, they need to work against the prevailing culture in order to act consistently with it.

collected showing whether these adaptations are necessary or positively influence outcome or retention. However, it is the case that the use of this therapy has substantially increased the referral rate of Ultra-Orthodox patients to our clinic, suggesting that this approach is desirable within the community.

How can the guidelines and suggestions discussed in relation to treating Orthodox Jews be most effectively translated for use with other religions and cultures? First and foremost, when treating patients of any religion, it is necessary for the clinician to recognize that there is no proven causal relationship between the person's religious ritual observance and the development of their OCD. Rather, religiosity may influence the form or manifestation of OCD. This is a fundamental distinction and one that greatly impacts the way that a clinician approaches treatment. Within every religion, there are authorities that should be consulted during treatment to make sure that the practitioner has an accurate understanding of religious norms within a particular community, and can thereby tailor treatment appropriately. The treatment should be framed within the norms of the community to avoid clashes of secular and religious values. Additionally, there are likely specific styles, sayings, teachings, and doctrines within each faith that can be utilized by the clinician to increase motivation and compliance with the treatment.

The treatment outlined above, EX/RP, is the first-line treatment for OCD. The adaptations suggested above do not change or remove any of the essential elements of the treatment. These are clinical suggestions to tailor manualized treatment to members of a specific population that await further empirical investigation. Adaptation to each patient is itself a process consistent with the implementation of all treatment protocols, and the ideal of good, evidence-based practice.

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