Etiology of Religious Scrupulosity: A Discussion

Nicholas Antonio Inclan

School of Behavioral Sciences, Liberty University

Author Note

Nicholas Antonio Inclan

I have no known conflict of interest to disclose.

Correspondence concerning this article should be addressed to Nicholas Antonio Inclan

Email: ninclan@liberty.edu

Abstract

Known as one of the earliest documented mental ailments, religious scrupulosity remains an understudied thematic presentation of obsessive-compulsive disorder (OCD). Early religious scholars documented what was previously known as religious struggles, have been retrospectively reviewed by several psychiatric clinicians. With the advancement of psychopathological research, updated retrospective psychiatric analysis has been conducted regarding early religious writings of what was previously characterized as religious struggles. Research over the past decade has been reviewed herein that discusses etiological factors in the development of religious scrupulosity. These theories include the cognitive behavioral (CB) model of obsessions and the triple vulnerability theory of emotional disorders. Within the triple vulnerability theory of emotional disorders, the specific psychological vulnerability component is discussed as a salient component to the etiology of religious scrupulosity and is a supporting theoretical component to the CB model of obsessions. Future research considerations are provided along with actionable proposition of fostering a collaborative relationship between mental health professionals and Christian church leadership.

Keywords: religious scrupulosity, obsessive-compulsive disorder, psychopathology, developmental psychology, Christianity

Etiology of Religious Scrupulosity: A Discussion

Obsessive-compulsive disorder (OCD) is classified as a psychological ailment that includes the experience of obsessions and / or compulsions (American Psychiatric Association, 2022). Obsessions as identified by the American Psychiatric Association [APA] (2022) are unwanted, intrusive, or disturbing images, thoughts, or urges, whereas compulsions are identified as recurring behaviors or mental activity individuals feel obligated to perform in response to obsessive activity or according to specific rules that require rigorous application. Though OCD is identified as a mental disorder, obsessive thoughts and compulsive behaviors are not inherently psychopathological. Indeed, non-clinical levels of obsessive compulsive (OC) symptoms are ubiquitous within several cultures and subpopulations (Abramowitz et al., 2014b; Berman et al., 2010; Hunter, 2022; Rachman & de Silva, 1978). The phenomenology of non-clinical levels of OC symptoms have been thoroughly studied for decades (Abramowitz et al., 2014b; Berman et al., 2010; Rachman & de Silva, 1978).

Certainly, outlined by Abramowitz et al. (2014b) several studies investigating the phenomenology of OC symptoms, non-clinical participants are considered analogous to individuals diagnosed with clinical levels of OC symptoms. Though non-clinical levels of OC symptoms are ubiquitous (Abramowitz et al., 2014b; Berman et al., 2010; Hunter, 2022; Rachman & de Silva, 1978) levels of OC symptoms that meet diagnostic threshold for a diagnosis of OCD are reported between 1 – 2% (Fawcett et al., 2020; Friedman-Ezra et al., 2024) and 2 – 3% (Abramowitz et al., 2014b) of the population. Clinical levels of OC symptoms are experienced by the presence of excessive obsessions qualified as unwanted, intrusive, and disturbing which cause marked distress, discomfort, or anxiety (Abramowitz & Buchholz, 2020; APA, 2022; Lack, 2023). Further, compulsive behaviors are performed in response to obsessive

activity functioning methodology to alleviate distress or anxiety and mitigate negative events or situations from occurring (APA, 2022; Lack, 2023).

OCD Categories and Early Reports of Scrupulosity

The presentation of OCD symptoms spans across life domains but does share homogenous characteristics (Abramowitz et al., 2014b). Studies utilizing cluster analysis have illuminated homogenous characteristics that have led to the development of thematic structures of OCD symptoms (Abramowitz et al., 2014b). Thematic structures include but are not limited to contamination, sexual orientation, suicide, existentialism, harm, scrupulosity, and pedophilia (Lack, 2023). Though thematic structures of OCD have been thoroughly researched, limited research has been conducted exploring the etiology of religious scrupulosity obsessive-compulsive disorder (RS-OCD; Abramowitz et al., 2002; Abramowitz & Jacoby, 2014a).

RS-OCD although understudied (Abramowitz et al., 2002; Abramowitz & Jacoby, 2014a) may be known as one of the first recorded occurrences of what has come to be known as OCD. Early reports of what would be described as clinical levels of OC symptoms come from the historical records of religious scribes (Lack, 2023; Osborn, 2023). A prominent example of historical reports of clinical levels of OC symptoms is described by Osborn (2023) in his retrospective psychiatric analysis of Martin Luther.

Martin Luther popularly known for his role in resisting the Roman Catholic Church's position of obtaining salvation, led a theological break from the Roman Catholic Church, to start a revolutionary religious path known as the Protestant Reformation (Greenberg et al., 1987; Osborn, 2008; Osborn, 2023). What is not commonly known is the psychological condition Martin Luther suffered from, which arguably led to the theological break from the Roman Catholic Church. However, to deter others from following Martin Luther's reformed theology,

for centuries Catholic polemicists and other religious scholars purported theories of Martin Luther varying from Luther as being controlled by Satan to Luther's suffering from such mental impairment that his ability to form rational thoughts was non-existent (Osbon, 2008; Osborn, 2023). These alleged theories have been refuted with advancements in psychological and scientific research. In the 1900s, two esteemed clinicians provided a retrospective psychiatric analysis of Luther's psychological state (Osborn, 2023). One clinician concluded Luther suffered from a degenerative brain disorder while the other clinician, Erik Erikson, concluded Luther suffered from a "borderline psychotic state" (Osborn, 2023, p. 3). These early retrospective psychiatric analyses were refuted by Lutheran experts and greater advancements in psychological and scientific research (Osborn, 2023). With the advancement of the past 50 years in psychopathology, Luther's mental troubles have undergone a revised psychiatric analysis and can be best classified as what is now known today as OCD, specifically a sub theme known as religious scrupulosity (Osborn, 2023).

Religious Scrupulosity Obsessive-Compulsive Disorder

Scrupulosity is not a new term; it is well known in theological and psychological contexts. The term scruple, originally derived from Latin as scrupulus, held the meaning of a minor jagged pebble stuck in a shoe causing significant distress, discomfort, and negative interference while walking (Weisner & Riffel, 1960). In English, scruple evolved into a term that represented an association with morality and a sensitive conscience (Weisner & Riffel, 1960). Today, after systematically researching OCD dating back as far as the 1800s (Lack, 2023) researchers have identified and operationalized a constellation of clinical psychiatric symptoms known as RS-OCD (Huppert & Siev, 2010; Cefalu, 2010; Leins & Williams, 2018; Moroń et al.,

2022) or simply religious scrupulosity (Miller & Hedges et al., 2008; Yorulmaz et al., 2009; Smith-Schrandt, 2023).

RS-OCD is commonly identified in the scientific literature as fearing evil where there is none (Abramowitz & Buchholz, 2020), accepting religious responsibility that is over exaggerated or non-existent (Weisner & Riffel, 1960), the experience of pathological guilt and pathological insistence that a religious or moral standard has been violated (Miller et al., 2024). RS-OCD is a distinctive presentation of OCD and can be difficult to identify as there are significant heterogeneous presentations (Abramowitz & Jacoby, 2014a). Though RS-OCD contains significant heterogeneity, RS-OCD shares a constellation of symptoms, including persistent doubts regarding sin, salvation, obsessive concerns regarding God's divine punishment and persuasive urges to engage in excessive religious behaviors (Abramowitz et al., 2002). Though sufferers of RS-OCD have the appearance of being highly religious, the obsessions and behaviors are performed out of significant fear of punishment from God, and experienced as anguish, discomfort, and anxiety, resulting in clinical impairment (Miller et al., 2024).

Religious Scrupulosity Development

Theories over the past half century have been purported to explain the etiology and treatment of OCD (Weisner & Riffel, 1960; Rachman et al., 1970; Rachman & de Silva, 1978; Salkovskis et al., 1997; Lack 2023), with some gaining minimal traction and others substantial traction. A leading theory that has gained substantial empirical scientific support is the cognitive-behavioral (CB) model of obsessions (Rachman & de Silva, 1978; Salkovskis et al., 1997; Salkovskis et al., 1998; Rachman, 1997; Rachman, 1998; Abramowitz et al., 2002; Abramowitz & Jacoby, 2014a; Abramowitz & Buchholz, 2020; Lack, 2023). The CB model of obsessions highlights the cognitive and behavioral factors of OCD (Lack, 2023). Indeed, the CB model

emphasizes the role of dysfunctional beliefs and misinterpretations of what would otherwise be identified as useless intrusive activity (Abramowitz & Jacob, 2014a). The CB model was in part developed on the work conducted by Beck (1976) and later developed by research conducted by Rachman and de Silva (1976), Rachman (1997), Salkovskis (1985), Salkovskis et al., (1997) and Salkovskis (1999).

Within the CB model, significant emphasis is placed on cognitions, both unwanted ego-dystonic cognitions and ego-syntonic cognitions (Moroń et al., 2022). Regarding religious scrupulosity, instead of deciphering cognitions antagonistic to one's moral convictions or religious faith as normal unwanted intrusive activity (e.g., Rachman & de Silva, (1978)), cognitions antagonistic to one's moral convictions or religious faith (e.g., "God is a liar", "What if I am not saved", "Did I just lust after her/him"), are interpreted as significantly threatening and worthy of substantial purging or neutralizing efforts (Abramowitz & Jacoby, 2014a).

In line with the CB model (Salkovskis et al., 1997; Salkovskis et al., 1998; Rachman, 1997; Rachman, 1998; Abramowitz et al., 2002; Abramowitz & Jacoby, 2014a; Abramowitz & Buchholz, 2020; Lack, 2023), the misinterpretation of what otherwise would be considered normal unwanted intrusive activity (e.g., Rachman & de Silva, (1978)) causes the individual to engage in religious behaviors (e.g., pray, confess the intrusive thoughts to a pastor or church leader, read scripture, or recite scripture). Though the behaviors have the appearance of pious origins, the behaviors function as neutralizing mechanisms and a negative reinforcement (Mitchell et al., 2020). Further in line with Beck's (1976) cognitive theory and within the CB model (Lack, 2023), the experience of negative affectivity (e.g., anxiety, panic, disgust) associated with religious laden cognitions or behaviors are subject to misinterpretation and the development of dysfunctional beliefs. Indeed, suffers of religious scrupulosity may experience

negative affect in association with a stimulus (e.g., cognition, movie, song, person, place, etc.) and misinterpret the experience of negative affectivity as an indicator from God to perform some religious oriented behavior (e.g., avoid, pray, recite scripture, confess, or seek biblical counsel).

Religious Scrupulosity Development: Can be exacerbated by the Church

Further, as RS-OCD symptomatology involves religious content, obsessions and compulsions are commonly misinterpreted by clinicians and church leadership as high religious devotion (Pirutinsky et al., 2015; Huppert & Siev, 2010). With the outward appearance of religious practices, religious community members, including pastors and church leaders, may ignorantly reinforce obsessive and compulsive rituals by lauding the religious behaviors (Huppert & Siev, 2010; Abramowitz & Bucholz, 2020). Rachman (1997) emphasized, individuals who are taught or learn that cognitions hold significant value will have a greater propensity to obsess, particularly concerning religious teachings and beliefs. Studies highlighted by Abramowitz et al. (2004) indicate strength of religious commitment and religious affiliation are associated with cognitive biases functioning as underlying psychological mechanisms in the etiology and maintenance of OCD. A study conducted by Abramowitz et al. (2002) evidenced results indicating highly religious Protestants demonstrated an increase in fear of God and placed a greater significance on cognitions that were considered sinful when compared to Jewish, Catholic, and less religious Protestants. Further, in a study conducted by Siev and Cohen (2007) a sample described as Christians scored higher on the cognitive bias moral though-action fusion subscale, compared to obsessive samples in normative data. Taken together, though research has not identified that general religious affiliation is a casual link to the development of RS-OCD (Abramowitz et al., 2004), it has illuminated the reconsideration of doctrinal elements, such as, teachings regarding intrusive activity, as religious teachings may be a significant risk factor in

the development of OCD (Abramowitz & Bucholz, 2020; Buchholz et al., 2019; Cougle et al., 2013; Cefalu, 2010; Huppert & Siev, 2010; Mauzay & Cuttler, 2018).

Religious Scrupulosity Development: Triple Vulnerability Theory

The idiographic experiences of individual suffering from RS-OCD further align with the specific psychological vulnerability component in the triple vulnerability theory of emotional disorders (Barlow, 2002; Barlow et al., 2014; Sauer-Zavala & Barlow, 2021). Barlow (2002), Barlow et al., (2014) and Sauer-Zavala and Barlow (2021) purport the specific psychological vulnerability as instrumental in the acquisition of specific pathological expressions of anxiety and fear occurring through principles of classical conditioning via observational, direct experiences, or instructional learning (Sauer-Zavala & Barlow, 2021). The specific psychological vulnerability supports the CB model of obsessions (Salkovskis et al., 1997; Salkovskis et al., 1998; Rachman, 1997; Rachman, 1998; Abramowitz et al., 2002; Abramowitz & Jacoby, 2014a; Abramowitz & Buchholz, 2020; Lack, 2023) as the obsessions function as direct experiences and instructional learning which is a critical factor in the acquisition of specific pathological expressions of anxiety and fear. In regard to religious scrupulosity, unwanted intrusive activity (e.g., “Is Jesus real”, “Did I commit a sin”, “Did I pray long enough”) or negative affectivity associated with religious laden content / context, would be considered the specific psychological vulnerability and a critical component in Barlow’s triple vulnerability theory of emotional disorders (Barlow, 2002; Barlow et al., 2014; Sauer-Zavala & Barlow, 2021) that contributes to the development and maintenance of RS-OCD.

Conclusion

Religious scrupulosity though arguably the first recorded instance of what we now know as OCD (Lack, 2023), remains an understudied thematic structure of OCD (Abramowitz et al.,

2002; Abramowitz & Jacoby, 2014a). Theories formulated over the past half century (Weisner & Riffel, 1960; Rachman et al., 1970; Rachman & de Silva, 1978; Salkovskis, 1985; Salkovskis et al., 1997; Lack 2023) have illuminated etiological bases for the acquisition of obsessions and compulsive behaviors. The CB model of obsessions (Rachman & de Silva, 1978; Salkovskis, 1985; Salkovskis et al., 1997; Salkovskis et al., 1998; Rachman, 1997; Rachman, 1998; Abramowitz et al., 2002; Abramowitz & Jacoby, 2014a; Abramowitz & Buchholz, 2020; Lack, 2023) provides a cohesive developmental explanation of the etiology and maintenance of religious scrupulosity. Further, the CB model of obsessions (Rachman & de Silva, 1978; Salkovskis, 1985; Salkovskis et al., 1997; Salkovskis et al., 1998; Rachman, 1997; Rachman, 1998; Abramowitz et al., 2002; Abramowitz & Jacoby, 2014a; Abramowitz & Buchholz, 2020; Lack, 2023) aligns with the triple vulnerability theory of emotional disorders purported by Barlow (Barlow 2002; Barlow et al., 2014; Sauer-Zavala & Barlow, 2021).

Though a half century of research has been conducted regarding OCD, there remains significant gaps that are worth additional psychopathological investigation. One area of psychopathological investigation involves the intersectionality between religious teaching, specifically, Pentecostal and Charismatic denominations, and religious scrupulosity. Though research does not suggest religious affiliation as a causal factor in the development of religious scrupulosity (Abramowitz et al., 2004), research does suggest religious doctrine may increase the probability of the development of religious scrupulosity in individuals prone to develop emotional disorders (Abramowitz & Bucholz, 2020; Buchholz et al., 2019; Cougle et al., 2013; Cefalu, 2010; Huppert & Siev, 2010; Mauzay & Cuttler, 2018). Taken together, with further psychopathological investigation into the etiology of religious scrupulosity, perhaps a greater

partnership between mental health professionals and religious church leadership can develop with a goal of disseminating psychoeducation regarding the etiology of religious scrupulosity.

References

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

Abramowitz, J. S., Deacon, B. J., Woods, C. M., & Tolin, D. F. (2004). Association between Protestant religiosity and obsessive-compulsive symptoms and cognitions. *Depression Anxiety*, *20*(2), 70-76. https://doi.org/10.1002/da.20021

Abramowitz, J. S., & Jacoby, R. J. (2014a). Scrupulosity: A cognitive–behavioral analysis and implications for treatment. *Journal of Obsessive-Compulsive and Related Disorders, 3*(2), 140-149. https://doi.org/10.1016/j.jocrd.2013.12.007

Abramowitz, J. S., Fabricant, L. E., Taylor, S., Deacon, B. J., McKay, D., & Storch, E. A. (2014b). The relevance of analogue studies for understanding obsessions and compulsions. *Clinical Psychology Review*, *34*(3), 206-217. https://doi.org/https://doi.org/10.1016/j.cpr.2014.01.004

Abramowitz, J. S., & Buchholz, J. L. (2020). Chapter 4 - Spirituality/religion and obsessive–compulsive-related disorders. In D. H. Rosmarin & H. G. Koenig (Eds.), *Handbook of Spirituality, Religion, and Mental Health (Second Edition)* (pp. 61-78). Academic Press. https://doi.org/https://doi.org/10.1016/B978-0-12-816766-3.00004-5

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

Barlow, D. H. (2002). *Anxiety and its disorders: The nature and treatment of anxiety and panic, 2nd ed*. The Guilford Press.

Barlow, D. H., Ellard, K. K., Sauer-Zavala, S., Bullis, J. R., & Carl, J. R. (2014). The Origins of Neuroticism. *Perspectives on Psychological Science*, *9*(5), 481-496. https://doi.org/10.1177/1745691614544528

Beck, A. T. (1976). *Cognitive Therapy and The Emotional Disorders*. New York: International Universities Press.

Berman, C. N., Abramowitz, S. J., Pardue, M. C., & Wheaton, G. M. (2010). The relationship between religion and thought–action fusion: Use of an in vivo paradigm. *Behaviour Research and Therapy*, *48*(7), 670-674. https://doi.org/10.1016/j.brat.2010.03.021

Buchholz, J. L., Abramowitz, J. S., Riemann, B. C., Reuman, L., Blakey, S. M., Leonard, R. C., & Thompson, K. A. (2019). Scrupulosity, religious affiliation and symptom presentation in obsessive compulsive disorder. *Behavioural and Cognitive Psychotherapy*, *47*(4), 478-492. https://doi.org/https://doi.org/10.1017/S1352465818000711

Cougle, J. R., Purdon, C., Fitch, K. E., & Hawkins, K. A. (2013). Clarifying relations between thought-action fusion, religiosity, and obsessive–compulsive symptoms through consideration of intent. *Cognitive Therapy and Research*, *37*(2), 221-231. https://doi.org/10.1007/s10608-012-9461-8

Cefalu, P. (2010). The doubting disease: Religious scrupulosity and obsessive-compulsive disorder in historical context. *Journal of Medical Humanities 31*(2), 111-125. https://doi.org/10.1007/s10912-010-9107-3

Fawcett, E. J., Power, H., & Fawcett, J. M. (2020). Women are at greater risk of ocd than men: A meta-analytic review of OCD prevalence worldwide. *The Journal of Clinical Psychiatry*, *81*(4). https://doi.org/10.4088/JCP.19r13085

Fernandez, S., Sevil, C., & Moulding, R. (2021). Feared self and dimensions of obsessive compulsive symptoms: Sexual orientation-obsessions, relationship obsessions, and general OCD symptoms. *Journal of obsessive-compulsive and related disorders*, *28*, 100608. https://doi.org/10.1016/j.jocrd.2020.100608

Fitch, K. E., & Hawkins, K. A. (2013). Clarifying relations between thought-action fusion, religiosity, and obsessive–compulsive symptoms through consideration of intent. *Cognitive therapy and research, 37*(2), 221-231. https://doi.org/10.1007/s10608-012-9461-8

Friedman-Ezra, A., Keydar-Cohen, K., van Oppen, P., Eikelenboom, M., Schruers, K., & Anholt, G. E. (2024). Loneliness in OCD and its determinants. *Psychiatry Research*, *337*, 115963. https://doi.org/https://doi.org/10.1016/j.psychres.2024.115963

Greenberg, D., Witztum, E., & Pisante, J. (1987). Scrupulosity: Religious attitudes and clinical presentations. *The British journal of medical psychology 60*, 29-37. https://doi.org/10.1111/j.2044-8341.1987.tb02714.x

Hunter, J. (2022). Seeking God's presence: The dopaminergic-defense hypothesis. *Journal for the Cognitive Science of Religion*, *8*(1), 32–68. https://doi.org/10.1558/jcsr.22411

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

Inozu, M., Ulukut, F. O., Ergun, G., & Alcolado, G. M. (2014). The mediating role of disgust sensitivity and thought-action fusion between religiosity and obsessive-compulsive symptoms. *International Journal of Psychology*, *49*(5), 334-341. https://doi.org/https://doi.org/10.1002/ijop.12041

Inozu, M., Kahya, Y., & Yorulmaz, O. (2020). Neuroticism and religiosity: The role of obsessive beliefs, thought-control strategies and guilt in scrupulosity and obsessive–compulsive symptoms among Muslim undergraduates. *Journal of Religion and Health*, *59*(3), 1144-1160. https://doi.org/https://doi.org/10.1007/s10943-018-0603-5

Lack, W. C. (2023). *Obsessive-Compulsive Disorder: Etiology, Phenomenology, and Treatment (2nd Ed.)*. Onus Books.

Leins, C., & Williams, T., M. (2018). Using the bible to facilitate treatment of religious obsessions in obsessive compulsive disorder. *Journal of Psychology and Christianity*, *37*(2), 112-124.

Mauzay, D., & Cuttler, C. (2018). Dysfunctional cognitions mediate the relationships between religiosity, paranormal beliefs, and symptoms of obsessive-compulsive disorder. *Mental Health, Religion & Culture*, *21*(8), 838-850. https://doi.org/10.1080/13674676.2019.1583176

Miller, C. H., & Hedges, D. W. (2008). Scrupulosity disorder: An overview and introductory analysis. *Journal of Anxiety Disorders*, *22*(6), 1042-1058. https://doi.org/https://doi.org/10.1016/j.janxdis.2007.11.004

Mitchell, R., Hanna, D., & Dyer, K. F. W. (2020). Modelling OCD: A test of the inflated responsibility model. *Behavioural and Cognitive Psychotherapy, 48(3), 327-340. https://doi.org/https://doi.org/10.1017/S1352465819000675*

Moroń, M., Biolik-Moroń, M., & Matuszewski, K. (2022). Scrupulosity in the network of obsessive-compulsive symptoms, religious struggles, and self-compassion: A study in a non-clinical sample. *Religions*, *13*(10). 10.3390/rel13100879

Olatunji, B. O., Berg, H., Cox, R. C., & Billingsley, A. (2017). The effects of cognitive reappraisal on conditioned disgust in contamination-based OCD: An analogue study. *Journal of anxiety disorders*, *51*, 86-93. https://doi.org/10.1016/j.janxdis.2017.06.005

Osborn, I. (2008). *Can Christianity Cure Obsessive-compulsive Disorder?: A Psychiatrist Explores the Role of Faith in Treatment*. Brazos Press.

Osborn, I. (2023). *Martin Luther's Obsessive-Compulsive Disorder: How the Great Reformer Cured OCD and What He Learned*. OCD Resources Publishing.

Pirutinsky, S., Siev, J., & Rosmarin, D. H. (2015). Scrupulosity and implicit and explicit beliefs about God. *Journal of Obsessive-Compulsive and Related Disorders*, *6*, 33-38. https://doi.org/https://doi.org/10.1016/j.jocrd.2015.05.002

Rachman, S., Hodgson, R., & Marzillier, J. (1970). Treatment of an obsessional-compulsive disorder by modelling. *Behaviour Research and Therapy*, *8*(4), 385-392. https://doi.org/10.1016/0005-7967(70)90058-6

Rachman, S., & de Silva, D. P. (1978). Abnormal and normal obsessions. *Behaviour Research and Therapy*, *16*(4), 233-248. https://doi.org/10.1016/0005-7967(78)90022-0

Rachman, S. (1997). A cognitive theory of obsessions. *Behaviour Research and Therapy*, *35*(9), 793-802. https://doi.org/10.1016/s0005-7967(97)00040-5

Rachman, S. (1998). A cognitive theory of obsessions: Elaborations. *Behaviour Research and Therapy*, *36*(4), 385-401. https://doi.org/https://doi.org/10.1016/S0005-7967(97)10041-9

Salkovskis, P. M. (1985). Obsessional-compulsive problems: A cognitive-behavioural analysis. *Behaviour Research and Therapy*, *23*(5), 571-583. https://doi.org/https://doi.org/10.1016/0005-7967(85)90105-6

Salkovskis, P. M., Westbrook, D., Davis, J., Jeavons, A., & Gledhill, A. (1997). Effects of neutralizing on intrusive thoughts: An experiment investigating the etiology of obsessive-compulsive disorder. *Behaviour Research and Therapy*, *35*(3), 211-219. https://doi.org/10.1016/s0005-7967(96)00112-x

Salkovskis, P. M., Forrester, E., & Richards, C. (1998). Cognitive–behavioural approach to understanding obsessional thinking. *The British Journal of Psychiatry*, *173*(S35), 53-63. https://doi.org/https://doi.org/10.1192/S0007125000297900

Sauer-Zavala, S., & Barlow, D. H. (2021). *Neuroticism: A new framework for emotional disorders and their treatment*. The Guilford Press.

Smith-Schrandt, H. L. (2023). Scrupulosity Obsessive-Compulsive Disorder in Children. *Journal of Psychosocial Nursing & Mental Health Services*, *61*(11), 10-16. https://doi.org/https://doi.org/10.3928/02793695-20231011-03

Weisner, W. M., & Riffel, P. A. (1960). Scrupulosity: Religion and obsessive compulsive behavior in children. *American Journal of Psychiatry*, *117*(4), 314-318. https://doi.org/10.1176/ajp.117.4.314

World Health Organization (2021). *International statistical classification of diseases and related health problems* (11th ed.). https://icd.who.int/

Yorulmaz, O., Gençöz, T., & Woody, S. (2009). OCD cognitions and symptoms in different religious contexts. *Journal of Anxiety Disorders*, *23*(3), 401-406. https://doi.org/https://doi.org/10.1016/j.janxdis.2008.11.001