Treating Scrupulosity in Religious Individuals Using Cognitive-Behavioral Therapy

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Scrupulosity, the obsessional fear of thinking or behaving immorally or against one’s religious beliefs, is a form of obsessive-compulsive disorder that has been relatively understudied to date. Treating religious patients with scrupulosity raises a number of unique clinical challenges for many clinicians. For example, how does one distinguish normal beliefs from pathological scrupulosity? How does one adapt exposures to a religious patient whose fears are related to sinning? How far should one go in exposures in such cases? How and when does one include clergy in treatment? We address these issues and report a case example of the successful treatment of an ultra-Orthodox Jewish woman using the treatment principles that we recommend for religious individuals with scrupulosity.

Scrupulosity is a presentation of obsessive-compulsive disorder (OCD) characterized by religious or moral fears. Less is known about the phenomenology of scrupulosity than other manifestations of OCD (e.g., Miller & Hedges, 2008), although the presence of religious symptoms in OCD predicts poorer treatment outcomes according to some studies (Alonso et al., 2001; Ferrao et al., 2006; Mataix-Cols, Marks, Greist, Kobak, & Baer, 2002; Rufer, Grothusen, Mab, Peter, & Hand, 2005) but not others (Abramowitz, Franklin, Schwartz, & Furr, 2003). Among the many possible reasons that scrupulosity may be more difficult to treat is that scrupulous individuals may view their symptoms as the domain of religion, not psychiatry, and their therapists as not having authority in the domain of religious observance (Giarracchi, 1995; Greenberg & Shefler, 2008). Moreover, they may be less willing to risk feared moral than physical consequences, and those moral consequences may not lend themselves easily to the experience of disconfirming evidence. In addition, healthy members of the religious community, including clergy, may inadvertently reinforce rituals by offering reassurance or expressing admiration for the rituals, a process somewhat analogous to the positive reinforcement received by individuals with eating disorders for losing weight. Strict or zealous adherence to religious or dietary restrictions may be commendable according to some communities, but not in those for whom it marks or masks pathology. Even if the symptoms are not admired, most religious clergy habitually discourage risking moral or religious infractions and encourage distancing oneself from potential violations (more on this below). These and other characteristics of scrupulosity render it a paradigmatic example of the complicated interplay between psychopathology and clinical technique on the one hand, and cultural sensitivity and patient values on the other (cf. APA Presidential Task Force, 2006). Hence, although the choice of exposure and response prevention (EX/RP), a first-line treatment for OCD, is indicated in the literature for treating OCD (March et al., 1997; National Institute for Health and Clinical Excellence, 2006), its implementation for religious patients with scrupulosity necessitates nuanced modifications (Abramowitz, 2001; Deacon & Nelson, 2008; Huppert, Siev, & Kushner, 2007).

EX/RP is a form of cognitive-behavior therapy specifically tailored to the treatment of OCD (for examples, see Foa & Yadin, 2009; Franklin & Foa, 2008). Individuals suffering from OCD experience obsessions—intrusive thoughts, images, or impulses—that cause anxiety or distress, and engage in compulsions (i.e., rituals)—behaviors that neutralize or reduce the distress and feared consequences related to the obsessions. Based on the premise that rituals maintain the associations (a) among triggers, obsessions, and anxiety (e.g., seeing a light switch, having a thought of the house burning down, and feeling anxious) and (b) between compulsions and anxiety relief (e.g., checking the light switch, confirming that it is turned off, and feeling relief), the technique of EX/RP requires the patient to engage in sustained exposure to feared stimuli that trigger obsessions without ritualizing. In so doing, the individual learns that anxiety decreases without performing compulsions and that the
feared consequences are unlikely to occur, information that is inconsistent with the aforementioned associations.

Some more recent conceptualizations of OCD have included a stronger cognitive component in their theoretical models and treatments (e.g., Rachman, 1997; 1998; 2003). Following Salkovskis (1985), Rachman proposes a cognitive-behavioral theory that obsessions are caused by catastrophic misinterpretations of the significance of one’s thoughts. The notion is that these thoughts are significant, and may suggest something about the nature of the person who has the thoughts. Especially in the case of scrupulosity, such conclusions are typically that the person is a sinner, immoral or evil. The interpretations of these thoughts leads to attempts at neutralization. Further elaboration of the cognitive theory of OCD includes cognitive biases in the overestimation of threat, thought-action fusion (both that the thought increases the likelihood of the occurrence or that it is morally equivalent to the occurrence), and exaggerated estimations of responsibility. In addition, the repetitive nature of the thoughts instills greater “truth value” or believability for the person, creating a stronger, vicious cycle. These notions are frequently addressed in most current treatments using EX/RP, as will be noted further below. Thus, while our discussion of treatment has a stronger behavioral emphasis than some others, we contend that the treatment is squarely within the CBT framework, and not solely a behavioral framework.

The construct of scrupulosity is not clearly defined and can be quite narrow so as to include only obsessions and compulsions unique to specific religious doctrine (e.g., eternal damnation, violation of ritual purity laws) or much broader to include more general symptoms (e.g., obsessions that one may have accidentally struck a pedestrian when driving, followed by compulsive checking motivated by the core fear that not checking would make one a “bad person”). Historically, there are many documentations of such cases within religious and clinical literatures (for examples, see Ciarrocchi, 1995; Elliot & Radomsky, 2008; Greenberg & Shefler, 2008). One may categorize a symptom as scrupulous based on whether the patient believes that religious doctrine underlies the fear rather than a more universally accepted societal code (regardless of religious beliefs); however, such a definition excludes the notion of secular moral scrupulosity characterized by beliefs about or efforts to follow all socially constructed rules in an exact or precise way (e.g., beliefs that it is immoral to drive over the speed limit or to discard a single piece of paper into the garbage instead of recycling it). Although most would agree that secular moral beliefs or efforts can fall under the rubric of scrupulosity, the boundaries of scrupulosity are difficult to define. For example, harming others, harming oneself, certain sexual activities such as incest, and stealing are considered immoral acts by most societies; however, aggressive and sexual obsessions are not typically considered scrupulosity (although Rachman [1997, 1998, 2003] does categorize all of these thoughts together as “obsessional thoughts”). One consideration in conceptualizing such symptoms is the nature of the individual’s core fear. Consider someone with aggressive obsessions about stabbing her child. Is her core fear her child’s death? Her endless guilt, shame, and isolation that would follow? If so, her symptoms do not mark scrupulosity. Is her core fear Divine retribution or being an evil person? If so, her symptoms probably represent scrupulosity. In addition, fears of culture- or religion-specific violations are more likely to indicate scrupulosity than similar fears about universal moral violations. The focus of this paper is treating religious OCD patients with core fears about culture-specific religious violations, or religious patients with scrupulosity.

The core fear across religions within scrupulosity is related to a fear of sinning. At the same time, the typical manifestation of scrupulosity differs by religion. Whereas displeasing God, going to hell, and devil worship are common obsessional themes among scrupulous devout Christians (Ciarrocchi, 1995: Purdon & Clark, 2006), especially born-again, Protestant, or Pentecostal, obsessional themes among scrupulous ultra-Orthodox Jews more closely follow the forms of general OCD themes, such as contamination/washing and doubting/checking (Greenberg & Shefler, 2002, 2008). For example, a patient may fear contamination and wash excessively, but in the case of scrupulosity, the feared contamination is religious (e.g., dietary or menstrual impurity, cleanliness before prayer). Similarly, a patient may check repeatedly that his *phylacteries* are properly aligned throughout the morning prayers. Thus, in ultra-Orthodox Jews with scrupulosity, the content is uniquely religious, but the form prototypical OCD. Scrupulous themes in devout Muslims are often similar to those in ultra-Orthodox Judaism, including issues of purity, dietary laws, prayer, and other religious behaviors. Scrupulous Catholics demonstrate a mix of these more behaviorally oriented fears (i.e., those mimicking other forms of OCD; e.g., of dropping the Eucharist during communion or needing to say Hail Mary just right) and specific belief-based fears (e.g., of going to Hell or worshipping Satan). These characteristics, of course, are generalities, and there are concerns within ultra-Orthodox Judaism and Islam that are more belief based, as well (e.g., of praying to an entity other than God or a fear of not being included in the “World to come”).

Huppert and colleagues (2007) introduced a set of adaptations to EX/RP tailored for use with scrupulous ultra-Orthodox patients. These include strategies to violate obsessional rules (the technology of EX/RP)
without violating religious law, and specific suggestions to modify the articulated rationale, enhance motivation, differentiate normative and pathological rituals, choose behavioral and cognitive interventions, as well as additional ancillary techniques. Following previous case reports demonstrating the application of EX/RP with scrupulous Catholics (Abramowitz, 2001; García, 2008) and a recent account of a specific technique for treating compulsive prayer in Jews (Bonchek & Greenberg, 2009), the aim of this report is to illustrate the implementation of EX/RP modified for use with scrupulous religious patients of various faiths. Our examples are drawn from our experience, which has been predominantly, but not exclusively, with ultra-Orthodox Jewish patients; however, we describe principles that in our experience are applicable to most religious patients with scrupulosity.

In the following sections, we present particular considerations and challenges relevant to work with scrupulous patients, including issues related to assessment, therapeutic stance, and adaptations of interventions. Specifically, we describe how to adapt psychoeducation, describe overcorrection, encourage the patient to accept the risk of sin (and why not to encourage accepting sin itself), involve clergy in a helpful manner, and conduct in vivo and imaginal exposure, as well as response prevention. Finally, we present a case example in which many of these principles are applied.

**Assessment**

A patient arises in the morning and does nothing until he takes a designated cup and pours water over his hands—once on the right hand, then once on the left, then another on the right, another on the left, until each hand has been rinsed four times. Another patient takes out a compass whenever he prays in a new place without windows in order to ensure he is praying in the proper direction. Another makes sure when taking a special windows in order to ensure he is praying in the proper direction. Another makes sure when taking a special...——

We would like to thank an anonymous reviewer for pointing out this source to us.

or Jewish patients. So how does one distinguish OCD from strict, devout observance?

The most straightforward, obvious answer is by asking the patient whether others in their religious community have the same beliefs and behaviors. As in all psychopathology, the cultural context (here, the religious context) is essential for understanding and diagnosing OCD. In addition, the clinician’s familiarity with the religious practices of the patient is extremely beneficial. The more detailed questions the therapist can ask while being respectful about the nature of the practice, the more the patient will see that the therapist is both knowledgeable and considerate (i.e., not a threat). For example, with ultra-Orthodox patients, we review common obsessions found in that community that are not found in any published checklist, including concerns about dietary regulations (kosher), family purity (niddah), violating Sabbath or Festival regulations, purity during prayer, praying with correct intent and saying each word correctly, fearing that one made an oath in vain, not understanding a rule or text perfectly, not having one’s phylacteries on correctly, and sexual immorality. Similarly, for Muslim patients, the fears can be related to purity during prayer, intent and pronunciation of prayer, direction of prayer, or dietary restrictions (pork or wine, Hallal meat). For devout Catholics, fears include not confessing sufficiently, not being in a proper state to take communion or taking communion incorrectly (e.g., dropping a crumb), or not believing sufficiently in papal doctrine. For other devout Christians, the focus is more likely to be on fear of worshipping the devil (e.g., avoiding 666, 13), or of thinking of doing other acts that will lead to burning in hell (e.g., substance abuse). Obsessions common across religions include fears of stealing or breaking things, not returning borrowed objects or money, or engaging in religiously prohibited sexual activities (e.g., incest, adultery, homosexuality). Overall, these questions elucidate Greenberg et al.’s (Greenberg, Witzum, & Pisante, 1987) recommendations for distinguishing between scrupulosity and normative practice: Does the compulsive behavior go far beyond the requirement of religious law? Does the compulsive behavior have a narrow or overly trivial focus? Are the requirements of work, prayer, and family demands ignored or not receiving enough attention due to a focus on the scrupulous issue? Once this distinction is made, understanding the specific details of the obsessions and compulsions via functional analysis and self-monitoring allows one to build a treatment plan that carefully dissects the beliefs the patient has about their obsessions via exposures and response prevention.
**Therapeutic Stance**

The therapeutic stance in treating a religious patient with scrupulosity is very important for a number of reasons. First, many extremely devout individuals are suspicious about the goals of psychologists and mental health practitioners. They may have some sense of Freud’s notion of religiosity being a form of neurotic obsessional defense that should be eliminated (Freud, 1927), or they may worry that nonreligious outsiders may view religious beliefs themselves as problematic, especially when the OCD symptoms manifest as part of the religious framework. In fact, we have heard laypeople and practitioners alike articulate this viewpoint, and patients themselves may fear its potential veracity. For example, some patients suggest that if they were not religious, they would not suffer from their problems. In addition, some of the reluctance to seek help from a mental health practitioner is due to stigma about mental illness. Individuals who are labeled as having a psychiatric disorder may have more difficulty in being accepted socially within a relatively closed, conservative social network. Such a label can lead to difficulties in arranged dates or marriages, not only for the identified patient, but also for siblings and children.

Our stance (once OCD is clearly identified as the main presenting problem) is that OCD attaches itself to each individual’s most important or core values, but is not caused by those values (cf. Rachman, 1998). Thus, the fact that they have scrupulosity and not a fear of contamination or of being responsible for something horrible happening like a house burning down is because they view serving God and adhering faithfully to religion as high priorities. Conveying this assumption provides a number of important messages, most fundamentally that we are not attempting to interfere with their religious beliefs, and we support their choice of pursuing a religious life. This stance opens the door to a number of other messages that are important both to the patient and his or her implementation of CBT (cf. psychoeducation in Rachman, 2003). They include the idea that OCD fears are not latent desires to be an apostate; to the contrary, they are OCD’s method of turning the patient’s own core values against himself or herself (the response to which—as in judo—is to harness the power of the attack against the aggressor; in the case of OCD to accept the thought. That is, to say to oneself, “I accept the risk of this sin,” thus not engaging in a mental battle with the OCD). This stance also provides a heuristic for differentiating between religious and OCD beliefs vis-à-vis treatment goals: We support behavior that facilitates the former and work to minimize behavior that maintains the latter. In addition, it allows the therapist genuinely to help the patient have a more authentic, fulfilling religious life— one guided by real attempts to serve God and not to live in obsessive fear of Him. This distinction between true awe of God accompanied by a desire to serve Him versus obsessional fear of God resonates well with many patients. According to most religious systems, the service of God is not supposed to lead to suffering, but to a sense of peace, connection, and fulfillment. The extent to which a patient’s experience is inconsistent with this can indicate that religious awe—and even fear—has been appropriat- ed by OCD. Thus, after acknowledging that OCD “knows which buttons to push,” we work to help the patient see how OCD interferes with sincere attempts at religious adherence, thereby interfering with both the valued area of religious observance itself as well as other valued areas (e.g., family).

Overall, we view this stance as one of therapeutic neutrality. We side with the patient, who has the goal of a more fulfilling religious life, regardless of our own opinion of their specific beliefs. As with any other patient, there may be times that a patient’s moral beliefs contradict those of the therapist. In such cases, the therapist should decide whether they can remain sufficiently objective to help the patient.

**Psychoeducation**

Psychoeducation about the nature of anxiety and OCD and their treatment with EX/RP is a key part to successful treatment, and the patient understanding and accepting the treatment rationale is requisite for maximal success (cf. Abramowitz, Franklin, Zoellner, & DiBernardo, 2002; Rachman, 2003). However, it is best to avoid antagonizing religious individuals with concepts that they may find counter to their belief system, such as the evolutionary function of anxiety. Instead, one can discuss what function anxiety serves, or why God created people to experience anxiety. In addition, explaining the effects of thought suppression is extremely important, with particular implications for many religious individuals. The patient may resist exposure to thoughts deemed unacceptable on religious grounds; however, by accepting them and allowing them to exist in his or her mind, the patient will actually reduce the long-term frequency and intensity of such thoughts (e.g., blasphemy). At first, the prospect of accepting sinful thoughts seems at odds with the notion found in many religions that they should be stopped or annulled, and generally we find it unhelpful to attempt to dissuade patients who believe otherwise that thoughts are morally inconsequential. Indeed, there is some evidence that religiously normative beliefs about the moral importance of thoughts are unrelated to OCD (Siev, Chambless, & Huppert, 2010). Rather, we encourage patients to consider the differences between intentional and unintentional thoughts, and between intentional thoughts for the purpose of enjoyment and those for the purpose of treatment (i.e., exposures). We
have also found many clergy willing to distinguish between (a) intentional unacceptable thoughts for enjoyment or pleasure (e.g., fantasies about elicit acts), (b) unintentional thoughts that are not pleasurable per se, but the actualization of which might be (e.g., intrusive thoughts that one could steal money), and (c) thoughts that are only related to negative emotions such as fear or disgust with no positive valence (e.g., imagining a sexual act with a family member). The first category is usually forbidden, but the latter two are typically permissible (e.g., to allow the thought to be there, “putting it on a cloud” until it dissipates and “floats away” on its own, or even to think about it purposefully). Explaining these distinctions also introduces response prevention in such a way that religious patients may be more willing to tolerate and accept obsessions without ritualizing.

**Overcorrection and Accepting the Risk of Sin**

Overcorrection is an important EX/RP technique. By tolerating more extreme exposures than are necessary in typical daily living, patients provide themselves with room for backsliding without impact on functioning, and more importantly, conservative tests of the likelihood of their feared consequences coming to fruition. The notion of overcorrection has a long history, and is similar to a behavioral recommendation of the medieval religious scholar and physician, Maimonides, in the context of correcting a character flaw (Mishna Torah, Hilchot Deot, Chapter 1). Maimonides suggested that one recalibrate by engaging in behavior of the opposite extreme with the distal goal to arrive on the “golden path,” a healthy and normal mid-range for that trait. For some patients, we describe this concept as an excellent characterization of the methodology and goal of treatment. Of course we do not imply that the rationale or mechanics of EX/RP are entirely captured by religious recommendations; however, as much as possible and reasonable, there is clinical utility in efforts to conduct treatment in the language of the patient and incorporating his or her psychological and cognitive framework. This may be particularly important for a pathological manifestation that has co-opted so much of that same language and framework.

It is worthy of emphasis that overcorrection, as with all elements of EX/RP, is derived from a specific case conceptualization that targets the patient’s core fears; treatment is not based solely on overt behavioral topography. Knowing that a patient washes or checks is insufficient to design effective exposures, for which one must understand the core fears and the function of the rituals at the most basic level possible. For example, is the patient afraid of doing something because it will lead to sin? And what will happen if they sin? Will God punish them or their family (and if so, how?)? Will they end up causing the whole community to sin (see example below)?

And if the fear is that they will end up sinning, how will that happen?

Here, we encounter a complicated issue: How does one encourage a religious patient to accept the risk of sin? First, we are emphatically against having religious patients accept sin and believe that if the community views an act or belief as a true sin, the patient should not engage in it. However, we make a clear distinction between risking the possibility of sin with normative behavior and purposefully sinning. The former is a natural part of life—one cannot live life without some level of risk—and in EX/RP we increase the level of risk without going to the point that the level of risk is forbidden by religious law. On the other hand, we do not believe it is of value for a therapist to encourage a religious patient truly to sin or even to say “I am sinning” while taking a risk. The large majority of the time, saying something like “I am taking a risk of sinning and therefore I may burn in hell,” “I am not sure whether this is a sin, but I am doing it anyway,” or “This might be a sin” is sufficient. This approach is similar to standard EX/RP for other forms of OCD, for which the patient takes risks during which they are confronted with the uncertainty of the feared consequence (cf. Grayson, 2003) without truly actualizing it. This is very clear in treatment of harm and sexual obsessions, where actual engagement in the feared act is typically immoral, unethical, and illegal, in which case in vivo exposures involve normal behavior during which the patient is confronted with fears and uncertainty (e.g., a mother who fears stabbing her children dices vegetables with them in the room). It is evident, as well, in standard treatment of washers and checkers, for whom exposures are not designed actually to contract a disease (e.g., AIDS) or to cause damage (e.g., burn down the house).

Even this approach is not readily accepted by all devout patients. Some argue that living a religious life requires avoiding not only sin, but any behavior that approaches sin. There is Talmudic precedent, for example, to set up boundaries and fence-laws to distance oneself from sin (Mishnah Avot, 1:1). If necessary, the therapist can try to establish that for individuals with OCD, distancing from sin has become a goal in its own right, ironically more

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2 We believe that for exposures in which the patient engages in behaviors that appear to be sins, such as criticizing the Church (e.g., Abramowitz, 2001), there is an implicit assumption by the therapist and patient that despite the appearance, such acts are not sins. If the therapist is not sure about whether a planned exposure is in fact a true violation of a religious dictate, then clergy should be consulted. If the response is that the exposure is prohibited, then an alternative that is approved or deemed acceptable would be used. Part of the method of determining the alternative entails striking the delicate balance between determining acceptable exposures and not engaging in excessive ritualizing about the exposure. Finding the range of “acceptable risk” behaviors in cooperation with the clergy can be the key to this balance.
than serving God, and therefore tolerating acceptable risk of sin facilitates the service of God. Indeed, OCD fears about religious observance often lead patients to neglect or even violate other religious obligations (e.g., a patient violating laws of Sabbath that forbid cleaning stains from clothes to ensure that his or her clothes are sufficiently clean for the Sabbath prayer). Furthermore, most religions have a concept of forgiveness for sins, which inherently suggests that one will inadvertently sin. Nevertheless, patients may distinguish between purposefully risking sin and inadvertently sinning, and it can be more effective to evaluate the relative value in (a) striving to achieve good acts and a positive relationship with God and to religion by accepting a risk of sin, versus (b) excessive and distressing pursuit of absolute avoidance of one sin at the expense of other sins or opportunities for positive religious experiences (e.g., excessive ritualistic prayer interfering with religious study or at the expense of helping others).

Imaginal exposure is particularly indicated when OCD fears are difficult to confront or disconfirm in vivo, and can be helpful in treating scrupulosity in general, and in leading patients to tolerate acceptable risks. In such cases, the goal of the imaginal exposure is to create scenarios that depict engaging in relatively low-risk behaviors that end up causing extreme consequences. For example, one might create a script in which the patient refrains from cancelling a negative thought with compulsive prayer, opting for the long-term goal of satisfaction with life and religion instead of compulsive behavior to neutralize the risk that the thought was truly sinful. The scenario would continue based on the patient’s idiographic fears—that eventually the community rejects them for being evil, that they die and are judged to damnation for not having repented for that one thought, or that the decision to risk sin initiated a downward spiral into a life of sin. Conducted as such, imaginal exposure is an exposure to the feared consequence, but also a means for experiential cognitive challenging. In the context of imagining the consequences of sin, the patient may recognize their efforts to avoid even the possibility of inadvertent sin as excessive or inconsistent with their religious beliefs. It is important to note that making the scenario unrealistically extreme from the outset (e.g., that they begin by purposefully praying away from Mecca or intentionally dropping the host during communion) may interfere with the ability of the patient to engage in the scenario, prevent activation of the pathological fear, and thereby dampen the effect of the exposure. Instead, the scenario should depict realistic behavior that results in an unlikely but feared consequence. Imaginal exposure works well when the patient discovers that the likelihood of the feared consequence is actually much lower than initially believed and he or she is more willing to tolerate risk (i.e., exposure).

Another common issue that arises in the treatment of a religious patient is how much to include overcorrection related to prayer. For example, if the patient prays excessively for the health of family every time they see a bad number or color, should one go to the opposite extreme and pray for their family to get sick and die? We believe that praying for negative outcomes is often incompatible with the religious patient’s belief in the efficacy of prayer, and that there are reasonable alternatives to such an extreme. For example, instead of praying compulsively for the family’s health, the patient can pray that God execute His will: “May whatever You will dictates happen to them, whether it be sickness or health.”

Ultimately the therapist is not a religious authority and may not successfully convince the patient that it is acceptable to risk sin or even to engage in behaviors that appear somehow counter to his or her beliefs. At such times, the recruitment of clergy may be useful.

**Involving Clergy**

Recent discussions of the inclusion of religious authorities in CBT treatments for OCD suggest that appropriate clergy can be helpful at times (Elliott & Radomsky, 2008; Greenberg & Shefler, 2008; Huppert et al., 2007). In contrast, outside the context of treatment, clergy can inadvertently or unknowingly make recommendations that perpetuate a religious OCD patient’s anxiety. Unhelpful responses from clergy include telling a patient that they will burn in hell for evil thoughts that must be purged, suggesting that more meaningful or intensive prayer or study of their religious cannon will reduce intrusive thoughts, stating that psychologists have no business dealing with issues related to spirituality, suggesting rituals to cancel intrusive thoughts (such as specific prayers or absolutions), suggesting that the patient is correct in not taking risks of sinning, and encouraging overt avoidance. In other cases, the clergy provides direct reassurance in a way that facilitates the vicious cycle of obsessions and compulsive reassurance seeking.

How does one avoid such responses? Psychoeducation about the nature of OCD and EX/RP to the clergyman or woman is often necessary (cf. Elliott & Radomsky, 2008), but may not be sufficient. Clergy are bound to their religious code, and as such, it is important to describe how the patient’s OCD interferes with his or her religious life and to emphasize the common goal of helping the patient better achieve their religious aims. We have found (working predominantly with ultra-Orthodox rabbis) that such a stance is typically well received. When consulting on religious questions, the therapist should

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3 It can be necessary to recruit the patient’s own clergy to help the patient accept such a notion.
be honest and transparent, demonstrating a basic
knowledge of the religious issues in question or present-
ing as naïve and well-intentioned (whichever is more
accurate). Furthermore, an attitude of respect and
collaboration, whatever the therapist’s personal opinion
of the religious belief system, is far more likely to facilitate
treatment than an outlook that the psychologist knows
better than the clergy. Sometimes it is important to
explain the necessity, for the purposes of conducting EX/
RP, of seeking leniency in the religious law, which may be
unfamiliar or unnatural for many religious authorities:
“How close to the limits of religious law can we go without
violating it?” instead of “How does one avoid or reduce
the risk of sin?” At times this acknowledgment can be
explicit, and at times carefully worded questioning is
sufficient. For example, instead of or in addition to
asking, “Is it permissible to have thoughts about sinning?”
or even “Is it permissible to touch a milk bottle and then
eat meat?” one might ask, “What are the most extreme
thoughts that would be still permissible to think purpose-
fully? Which are allowed to come to mind without
distracting or cancelling them? What if the cancellation
of the thoughts actually leads to more thoughts of this
type?” Phrased as such, the question itself conveys the
messages that treatment requires pushing the boundaries
of religious law, but that the therapist and patient intend
to stay within the limits of that law. Our experience is that
these questions are typically respectfully answered by
clergy, especially if they understand the distress the
patient is experiencing and that the goals of treatment
are not to undermine their faith, but to support it.

In our experience, being direct with clergy about the
role that reassurance seeking plays in the maintenance of
obsessions (via temporary neutralization) is typically
accepted quickly. In fact, the clergy have usually
experienced the futility in trying to provide reassurance
and are often quite open to trying something different. In
addition, if the patient directly asks the clergy not to
answer or provide reassurance, this strengthens both
individuals’ resolve. Frequently we do this by having the
patient carefully word the question so that the request of
not providing reassurance does not result in provision of
reassurance. For example, the wording of the question
could be “Is it ok for me not to ask any more questions
regarding XXX (i.e., the topic related to my OCD) and
that I will take responsibility for any sins which are then
caused by my not asking any further questions regarding
this topic?” The latter part of the question maintains the
acceptance of risk of sin and ambiguity, thereby working
around the potential reassurance from the first part of the
question. If the clergy can be guided to answer that the
patient should in fact refrain from further questions and
should also accept the risk of sinning without other
rituals, the intervention can be extremely helpful.

In situations where the religious authority forbids the
implementation of an exposure, the therapist can enlist
the authority to help design an acceptable alternative. In
fact, our experience with some highly respected religious
authorities in Judaism is that they are quite sympathetic to
the patient’s suffering and eager to assist. We have been
able not only to design effective exposures jointly with
clergy at times, but have also received clear assistance in
terms of working on ritual prevention. We have had rabbis
inform patients that they will no longer answer questions
related to OCD (which provided the patients with
reassurance), suggest that the patient is obligated to
take risks, and even that they are religiously mandated not
to engage in compulsions. Clearly, such statements need
to be used with care and consideration of the individual’s
specific problems, and the therapist must remain alert to
the possibility that advice from clergy can serve as a ritual
or eliminate the patient’s perceived risk of sin.4

Although we have heard and read (e.g., Elliot &
Radomsky, 2008) that one may want to shop for a
sympathetic religious authority, this is not always feasible
or wise. There are many religious individuals who have a
personal connection with a religious authority (this is
mandated within ultra-Orthodox Judaism, and common
in all religions), and to “cherry pick” a more liberal figure
may have little or even negative impact, as the patient may
feel that you are trying to proselytize a more liberal view
than they believe. Our stance is that it is preferable to
approach the patient’s personal religious authority
whenever possible.

Even when one has identified a cooperative religious
authority, who should approach him or her, when, and
how? If possible, we prefer to discuss the issues with the
patient, therapist, and clergy all present (e.g., the patient
calling from the therapist’s office on speaker phone). If
the patient is uncomfortable with direct contact between
the therapist and clergy or if it is not feasible, then the
therapist and patient should formulate questions for the
clergy together so as to eliminate potential rituals or
reassurance-seeking, and ideally responses from clergy
should be recorded to minimize post-hoc rationalizations
or obsessive uncertainty. (Because such recordings can
end up being used compulsively through rereading or
memorizing, it may be best for the therapist to keep the
record rather than the patient.) Nevertheless, it is always
possible that residual doubt will remain in the patient’s
mind following such consultations; such is the nature of
OCD. If a patient truly believes there is important

4 This is a complicated area. In early stages of treatment, simple
knowledge (e.g., Psychoeducation from the clergy on what is actually
the religious belief about the feared issue) may in fact eliminate the
fear. However, in most cases of OCD doubts about the issues continue
to build (e.g., “did I hear right?,” “did I ask right?” “what if this
situation is different?,” etc.)
information missing, the therapist might ask the patient to (a) predict the clergy’s response and their confidence in the prediction, and (b) agree that if the prediction is accurate, the patient will refrain from asking for further clarifications or ask the clergy whether it is acceptable to do so. To whatever extent possible, we encourage the patient to stop asking any questions related to their OCD and instead to accept the doubt (see also Huppert et al., 2007, for more examples of this with ultra-Orthodox Jewish patients).

### Case Example

We provide a case example demonstrating many of the aforementioned points. In order to protect the confidentiality of patients who live in close-knit communities, details of the case presented herein have been altered. Sara is a something of a hybrid of actual patients treated; however, care was taken to portray a representative, if conglomerate, case.

Sara is a married, 36-year-old ultra-Orthodox Jewish mother of eight children who sought treatment due to her anxiety and distress about coming into contact with or creating unkosher food. Although she had always been concerned with keeping kosher, Sara noted that the responsibility of keeping a kosher kitchen when she got married at age 20 precipitated clinical impairment. She reported engaging in significant rituals including excessive handwashing, cleaning, praying, mental reviewing, and reassurance seeking. In addition, she engaged in significant avoidance, usually compelling her husband to cook. Her fears negatively impacted her relationship with her husband and children and also prevented her from accomplishing many tasks in and out of the house. She is an assistant teacher at one of the local community schools, and noted that she was able to function better there than at home, with the exception of snack and meal times. To alleviate her anxiety, Sara arranged with the primary teacher to take breaks during snack and meal times. Sara’s Y-BOCS score was 30, indicating severe OCD. In addition, she met criteria for major depressive disorder, recurrent, current episode mild via a structured interview which reviewed most DSM-IV-TR (American Psychiatric Association, 2000) Axis I disorders. She accepted a recommendation to engage in twice-weekly 2-hour sessions of EX/RP (cf. Foa & Vadin, 2009).

Sara described few other OCD-related concerns, with some mild fears of contamination from germs and general checking of the stove and electric appliances, but these were subclinical and did not cause significant distress or interference, which the concerns about creating or coming into contact with unkosher food did. In addition, the therapist inquired about a number of different areas of religious concern, and the fear of unkosher food was the only one endorsed. At the end of the intake, the therapist conveyed to Sara that she had OCD and provided psychoeducation about the CBT model of OCD and its treatment. Sara reported that she understood that she needed help, although at many times she wished she just were not Jewish, in which case she would not have such problems. She noted that those very thoughts exacerbated her fears, as she felt guilty for having them and redoubled her efforts to ensure that she did not make any mistakes in the kitchen that would lead to making something unkosher. The therapist responded supportively, stating, “It makes sense that you imagine that if you weren’t Jewish you wouldn’t have these concerns. On one level you are right—I have never seen a non-Jewish patient seeking treatment for fear of making things treif/not kosher. On the other hand, the likelihood is that if it weren’t kashrut [keeping kosher], it would be something else—perhaps AIDS or other germs, or perhaps fears of breaking other rules or of harming people. You have the unfortunate vulnerability to OCD. OCD manifests in different ways for different people—it gloms onto whatever is most important to that person. For you, making sure that you don’t do an aveirah [sin] by eating or serving things that are unkosher is important and so it pushes those buttons.” The patient replied, “I do always ask, Why me? And, Why about kashrut? I would much prefer to have normal fears of germs or something else. That seems like it would be easier to handle. Why is this my punishment? What have I done?” Therapist: “And how do you answer yourself?” Sara: “I know we all have our tests in life, and I guess this is mine. Hopefully, it means I will suffer less in the world to come.” Therapist: “It is true that we all have our tests and challenges, and I hope that you can see your being in treatment as part of your test.”

This led to a discussion of both Sara’s goals and core fears. Sara articulated that she hoped to be able to function normally, like other women do in her community, and that she can be a good mother, wife, and teacher, all of which she perceived as valued aspects of her role in serving God. Upon further inquiry by the therapist regarding her fears, Sara stated that her specific fears were that she would either create or come into contact with unkosher food, which would then make the food she was serving and eating unkosher. This would mean that she would be sinning and leading her family to sin as well. In addition, her pots and pans would become unkosher, and whenever she cooked, the food would be unkosher. Furthermore, not only would she be responsible for the permanence of unkosher in her house, but she would thereby lead to many others to sin. In her community, people frequently cook for each other to celebrate or support life cycle events. Thus, Sara would bring food to others, cause the whole community to eat unkosher food, and thereby spread sin. This, in turn, would lead to her “burning in hell.” (It should be noted that the concept of
hell is not nearly as developed or emphasized in Judaism as in Christianity [Telushkin, 1991], and Sara’s conception did not reflect hell à la Dante’s inferno. Nonetheless, the concept is important for the treatment.

In addition to understanding Sara’s core fear, the therapist spent this session and the next understanding the parameters of her fears while working to ensure that the patient accepted the rationale of the treatment. The latter part is essential, and in our experience, takes more time with scrupulous individuals than with many other OCD patients. It became clear that her fears were quite extensive—she was afraid that milk would get on the bottom of her shoes or on some other part of her clothes and that it would track throughout the house (a concern that only patients with OCD would have). Then, meat would do the same. This would cause an unkosher mixture that could then get into the kitchen. Interestingly, she was concerned about this mixture occurring throughout her house, similar to more standard contamination fears.

In the same sessions, the therapist introduced the notion that Sara would need to take more risks about making things unkosher. Not surprisingly, this notion made her quite anxious, and her immediate reaction was that such risks are forbidden. The therapist asked the patient whether (a) others agree that such risks are forbidden, and (b) whether there were other things she was not doing that were preferable to continual cleaning and washing rituals. Sara said, “Well, it is a bit exaggerated, but we are not supposed to risk sinning.”

Given the therapist’s knowledge of Judaism, he was able to state confidently that there are in fact many acceptable risks and that the concept of not allowing cold milk and meat to mix outside of her kitchen had no basis. However, the therapist emphasized that he is not a rabbi and that he would work directly with Sara’s rabbi to determine the boundaries of treatment.5 Sara agreed to this and they then started constructing a fear hierarchy (see Table 1 for sample items). The hierarchy was faxed to Sara’s rabbi for approval, and the therapist asked the rabbi for other guidelines about how far the rabbi would permit in terms of risking mixtures in order to allow some flexibility in the execution of the treatment. The rabbi agreed from the outset that Sara knew how to keep kosher well, that none of her previous OCD-driven questions for which she consulted with him were problematic, and that she could be told to refrain from all questions about keeping kosher unless she was absolutely sure that the question was not an OCD question (see Huppert et al., 2007, for some more examples of how this can be done). These instructions shifted the burden of proof from demonstrating that something was permissible (e.g., via consultation with the rabbi) to demonstrating that something was questionable before asking. The rabbi agreed that he was allowing her to take risks that would still be her responsibility if she made a clear violation (like purposefully mixing milk and meat). This latter point is fundamentally discrepant from

<table>
<thead>
<tr>
<th>Situation</th>
<th>SUDS (0-100)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cooking macaroni and cheese on one part of the stove while cooking chicken soup on another</td>
<td>100</td>
</tr>
<tr>
<td>Touching an open package of cheese then an open package of meat</td>
<td>100</td>
</tr>
<tr>
<td>Touching clean milk silverware after touching an open package of meat- with 2 sec rinse</td>
<td>99</td>
</tr>
<tr>
<td>Mixing up the refrigerator so that milk and meat are on the same shelves</td>
<td>98</td>
</tr>
<tr>
<td>Touching cheese then a closed package of meat</td>
<td>95</td>
</tr>
<tr>
<td>Touching an open package of meat after touching clean milk silverware</td>
<td>90</td>
</tr>
<tr>
<td>Using a meat spoon to put flour into bowl to bake a dairy cake</td>
<td>85</td>
</tr>
<tr>
<td>Touching clean milk silverware and then touching clean meat silverware</td>
<td>80</td>
</tr>
<tr>
<td>Touching a closed package of meat and then an open package of cheese</td>
<td>80</td>
</tr>
<tr>
<td>Touching an open package of cheese after touching clean meat silverware</td>
<td>80</td>
</tr>
<tr>
<td>Touching an open package of cheese before touching clean meat silverware</td>
<td>50</td>
</tr>
<tr>
<td>Touching a closed package of meat after touching clean milk silverware</td>
<td>30</td>
</tr>
<tr>
<td>Touching clean milk silverware after touching a closed package of meat</td>
<td>30</td>
</tr>
<tr>
<td>Touching a closed package of cheese after touching clean meat silverware</td>
<td>30</td>
</tr>
<tr>
<td>Touching a closed package of cheese before touching clean meat silverware</td>
<td>30</td>
</tr>
<tr>
<td>Touching meat and dairy silverware together</td>
<td>20</td>
</tr>
</tbody>
</table>

5 Explicit acknowledgment that the therapist is not a religious authority serves two functions. First, it conveys the message that treatment is not designed to erode religious values or adherence. Second, in the long run it facilitates exposure treatment because the therapist’s encouragement to engage in exposures that risk the possibility of sin is less likely to reassure the patient of the permissibility of doing so.
the perceived general standard within Sara’s religious community, according to which individuals are encouraged to turn to rabbinic authorities who take responsibility for their rulings. Of course, practically, all individuals make their own every-day decisions, and the goal of the treatment is for the patient to allow herself to function as do others in her community. Sara recalled the rabbi's instruction throughout treatment. For example, at a later time she touched a pot used for cooking dairy and experienced the intrusive thought that her hand now had milk on it, and the milk may have spread to the meat that she was now preparing to cook. Nevertheless, she continued cooking a meat dish without washing because she was not sure she really touched milk. It was communicated that she needs to learn to “trust her soul” (i.e., to trust her implicit intuition) and not seek explicit reassurance by asking questions, checking, washing, or mental reviewing. The therapist also helped Sara see her current stance towards religion as anxiety-driven, based on fear of a punishing God and not on awe and respect that could lead to a more healthy relationship with God.

During exposures these concepts were reiterated as motivation and permission to engage in the treatment, while at the same time EX/RP itself required Sara to take risks that were overtly articulated and recognized during exposures. For example, she would touch the outside of a piece of raw meat, and that I will make the food treif and that I will serve it to my family, friends, and that I will end up treifing up the whole community and burning in hell. However, I want to live my life with peace and happiness, raising my family, relating to my family, teaching and serving God without OCD. Therefore, I will take the risk.” The therapist emphasized that this should not become a compulsive mantra, and that Sara should work on stating the purpose of her exposure in different ways to avoid it becoming a ritual.

Treatment proceeded with significant work on generalizing exposures at home. Three treatment sessions were conducted in her home to help Sara work on the hardest items on her hierarchy. She learned to engage in exposures and accept risk, uncertainty, and anxiety, and was gradually able to cook and function fully in her home and at school. After 17 sessions of treatment, Sara had a score of 14 on the Y-BOCS and reported feeling like a weight had been lifted from her, even though the obsessional thoughts were not completely gone. The therapist received notes from Sara over the next year asking how to address various issues related to exposure. Otherwise, she reported maintaining her gains well. She even reported that one of her children accidentally knocked over a bottle of cold milk onto a piece of raw meat, and that she was able to rinse it off and cook it—as per religious law—albeit with some anxiety.

Summary

Throughout this article, we have emphasized the need to approach the treatment of the scrupulous religious patient with respect. The goal of treatment should be to help the patient realize their own goals, often including better and healthier religious functioning (e.g., having a closer relationship with God, feeling like one is serving God in the best way possible, feeling an integral part of the religious community). Trying to familiarize oneself with the rules and culture of the religious community is extremely helpful. The ability to adapt the concepts from EX/RP using the patient’s own values and language enhances the therapeutic alliance, and facilitates better communication and understanding of the treatment rationale, enhanced motivation, and reduced skepticism or concerns about conflicts of values between the patient and therapist. This is the ideal of evidence-based practice.

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