Integrating family therapy into exposure-based CBT for a Spanish patient with obsessive scrupulosity

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Obsessive-compulsive symptom profiles vary widely among individuals and may be affected by cultural backgrounds. In the case of scrupulosity, moral and religious principles are the target of obsessive-compulsive symptoms. Cognitive biases and beliefs have special relevance in the origin and maintenance of obsessive scrupulosity. In addition, rigid and exaggerated beliefs about morality are held by these patients. Moral and religious principles are mainly transmitted by family. These influences may be more prominent in cultures, such as the Spanish culture, where family and religion are important values for individuals. The authors describe the treatment of a Spanish patient with obsessive scrupulosity. Family therapy strategies were integrated into exposure-based CBT in order to facilitate the modification of beliefs, behaviors, and pathological family relationships. The patient exhibited clinically significant improvements in OCD symptoms. Findings from this case show the need for individualized interventions that take into consideration cultural, social, and family factors. (Bulletin of the Menninger Clinic, 82[4], 308–325)

Keywords: obsessive-compulsive disorder, scrupulosity, case treatment, Spanish patient

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Individuals with obsessive-compulsive disorder (OCD) experience anxiety-provoking obsessions that lead them to perform compulsive and/or ritualistic behaviors to mitigate distress (American Psychiatric Association [APA], 2013). These symptoms produce considerable impairment and affect an individual's quality of life (Asnaani et al., 2017). Obsessive-compulsive symptom patterns are heterogeneous across patients, and cultural/social backgrounds may affect OCD presentation (M. T. Williams, Chapman, Simms, & Tellawi, 2017). In this sense, religious and moral values are linked to OCD in many cases, scrupulosity being a commonly occurring symptom. This obsession domain includes intrusive blasphemous thoughts and repetitive doubts about whether the individual has committed a violation of moral or religious rules. These obsessions are frequently accompanied by compulsive praying, confessing, and/or reassurance seeking (Abramowitz & Jacoby, 2014; Himle, Chatters, Taylor, & Nguyen, 2013).

Cognitive etiological models of OCD assume that intrusive thoughts or images are common phenomena in the nonclinical population. However, vulnerable individuals can make pathological interpretations of normal intrusions, promoting their transformation into clinical obsessions. Cognitive biases (e.g., inflated responsibility; Salkovskis, 1999) and beliefs about the importance of thoughts (e.g., Thought–Action Fusion [TAF; belief that thinking something inappropriate is as immoral as the action itself]; Rachman & Shafran, 1999) have been proposed as causes of misinterpretation of normal intrusions as threats. In the case of scrupulosity, it has been observed that religiosity could be positively associated with exaggerated beliefs about the importance of thoughts. Salkovskis, Shafran, Rachman, and Freeston (1999) pointed out that "strict behavioral codes inculcated by respected authoritarian or authoritative sources such as school and clergy can also lead to the development and the reinforcement of attitudes about responsibility" (p. 1062). Also, specific religious affiliations are related to identified OCD cognitive phenomena. For example, the moral dimension of TAF may be accentuated in religions such as Christianity that emphasize the importance of beliefs and moral judgments (Siev &

Cohen, 2007, A. D. Williams, Lau, & Grisham, 2013). In addition, scrupulous patients hold exaggerated beliefs concerning what is considered an assault on their moral or religious principles (Abramowitz, 2001). Behaviors that they see as immoral are generally well tolerated by the most people in society.

Regarding treatment, cognitive-behavioral therapy (CBT) focused on exposure and response prevention (ERP) is the intervention of choice for the range of OCD presentations. The effectiveness of this approach has been widely demonstrated in meta-analytic studies reporting larger effects for CBT than for wait-list, control placebo, and medication conditions (Öst, Havnen, Hansen, & Kvale, 2015; Rosa-Alcázar, Sánchez-Meca, Gómez-Conesa, & Marín-Martínez, 2008). However, some issues require special attention when treating patients with scrupulosity. First, the intrinsic nature of ERP implies a challenge to the individual's moral or religious principles. Second, exposure tasks may not always be able to prove that feared consequences will not occur (e.g., it is impossible to test whether the patient will go to Hell). Third, in many cases, these beliefs are culturally reaffirmed in contexts such as the family or religious community.

The family is one of the most important socialization agents, having a determinant role in the development of values and morality (Malti, Eisenberg, Kim, & Buchmann, 2013). This role is accentuated in societies where close relationships with family are particularly valued. Such are the cases of Latin (M. T. Williams, Mier-Chairez, & Peña, 2017) and Spanish cultures. In this latter context, family is considered one of the most important life domains in random sociological surveys (e.g., Sociological Research Center [CIS], 2014). Also, despite the existence of a decreasing trend, near 70% of the total sample in random surveys in Spain reported affiliation with the Catholic Christian religion (CIS, 2018). Therefore, the Catholic faith has been one of the values that has defined Spanish culture, and it may continue to influence moral beliefs and behaviors in particular families.

The current case report describes a young adult Spanish man who presented obsessive doubts related to his moral behavior

accompanied by compulsive checking, praying, and reassurance seeking. The patient presented consolidated beliefs that led him to consider common behaviors in early adulthood (e.g., having sexual contacts) as immoral acts. These distorted beliefs originated and were reinforced within a conservative and religious family. The patient also exhibited a submissive role within the family, requiring the approval of family members for making his own decisions and choices.

Given the peculiarities described for scrupulous cases in general, and for this patient in particular, several adaptations were included in exposure-based CBT. First, as recommended (Abramowitz & Jacoby, 2014), exposure tasks were focused more on tolerating obsessive doubts and uncertainty than on refuting feared consequences. Second, cognitive training was focused on conducting more adaptive interpretations of religious and moral beliefs. Third, family therapy strategies were included in the intervention. It was important that the patient and his family were aware of how the rigid behavioral code had contributed to the development of the patient's obsessive-compulsive symptoms. Together with the family, reinterpretation of religious and moral issues would be facilitated and improve acceptance for the patient. Finally, healthy family relationships should be reestablished to allow the patient to gain more independence and autonomy to make decisions.

Case conceptualization

Case identification

The patient described in this article was treated in a private outpatient clinic in southeastern Spain. Manuel (a pseudonym) was an 18-year-old Spanish young man from a medium-income family. At the time of intake, he was studying information technology at university and living with his parents, a 55-year-old civil servant and a 54-year-old housewife. He also had an older brother (28 years old) and sister (26 years old) who lived independently.

Presenting problem

On admission, Manuel was accompanied by his mother. He reported that over the preceding months, he had been experiencing significant distress due to the emergence of several recurrent concerns. He acknowledged that these kinds of thoughts had increased markedly following a sexual encounter with a girl. Although they used protection during sexual relationships, he could not stop thinking that the girl could be pregnant. Then he felt an intense need to check his phone, call her, or meet her to find out if she was pregnant. He thought that these obsessions were a deserved punishment by God for his immoral behavior. He felt very depressed and repeatedly asked God for forgiveness. He also reported other repetitive and irritating thoughts such as "my parents have become old, and I have disappointed them," "maybe I ran over someone with my car during my drive," or "I did or said something inappropriate." His mother reported that he frequently asked her and his sister if he had done or said something bad, if they were angry, or if he was a mean person. His mother acknowledged that she was quite worried about her son because she felt that he was suffering too much.

Manuel shared that his concerns and *tension* (a Spanish expression that means an estate of elevated anxiety) were unbearable. He could not concentrate on his academic work due to thoughts that came to mind "over and over again." He said, "*Siento que mi cabeza va a estallar"* (I feel that my head is going to explode). Moreover, he felt that he was "further and further away" from his friends, since he was avoiding going out or spending time with them due to the possibility of doing "something bad."

Manuel had high motivation for treatment due to his perception of experiencing a lot of suffering. Even though his level of insight was quite good (he considered that some of his obsessions were not very logical), he thought that some of these things could actually happen (especially the pregnancy). In addition, his beliefs about morality were highly consolidated and supported by his family. Fortunately, the family showed their willingness to collaborate with the intervention and expressed

their desire to help him even if they had to change their attitudes.

History

Although Manuel has experienced excessive concerns since he was a child, he has never received previous interventions. He said the problem began when he was 8 years old, when he did the First Communion (a Catholic traditional ceremony), and after that he started to have moral concerns about his own behavior: "I repeatedly wondered if I had done bad things to my parents, siblings, or friends." To feel better, he prayed a lot and rejected enjoying things that he liked. Family members remember that he liked to be recognized as a "good child." He was always obedient and tried to avoid conflicts.

In adolescence, he always tried to please others, thinking that otherwise he could be rejected. He was frequently concerned due to the comments of his friends, especially in conversations about sexual experiences. He refused to have sexual relationships because he thought that "the girl will think that I treat her badly" or "my mother will think that I am a bad person." Sometimes he felt the need of living experiences like his friends (having sex, drinking alcohol, or smoking), but he usually rejected these thoughts before engaging in the actions. When he started at the university, his obsessive thoughts worsened and began to interfere with his daily routines.

His parents, especially his mother, are very religious and involved in helping others. She has had anxiety problems for 20 years, taking psychopharmacological treatment without receiving psychological intervention. She described herself as a religious person, concerned about the needs of others. She described a compliant attitude in marital life. She indicated that "my husband is strict and demanding, but a good father," *hay que saberlo llevar* (a Spanish expression that means knowing how to behave toward someone to avoid conflict), "thanks to him, our children have studied and done their responsibilities." The father was demanding with himself and with his loved ones. He thought that his children had managed to study due to his efforts, because their economic resources were scarce.

The older sister was strict and determined. She thought that the mother was very permissive and thus took on the responsibility of having an important role in Manuel's education. She thought that Manuel was too idealistic and needed to learn that people should not try to get more than they are able to get. She stated that he should stop dreaming, finish his degree, and look for a comfortable life.

Assessment

Assessment was conducted by a trained clinician in two sessions. Semistructured interviews with Manuel and with both of his parents were administered to collect current complaints, as well as biographical and motivational information. In addition, the following comprehensive set of measures was administered to Manuel.

Anxiety Disorders Interview Schedule for DSM-IV Lifetime Version (ADIS-IV-L). The ADIS-IV-L (Di Nardo, Brown, & Barlow, 1994) is a widely used semistructured interview focused on anxiety and related disorders. The patient did not fulfill diagnostic criteria for any anxiety disorder.

Yale–Brown Obsessive-Compulsive Scale (Y-BOCS). The Y-BOCS (Goodman et al., 1989) is the gold standard for assessing OCD symptoms and severity. The patient's total severity score was 27, indicating moderate severity of OCD. The score on the Obsessions subscale was 15, with the patient reporting religious (e.g., fear of committing sin, fear of being punished by God), moral (e.g., excessive concerns about right and wrong, doubts about his behaviors with others), aggressive (fear of harming others, such as running over someone with a car), and miscellaneous obsessions (e.g., pregnancy of a girl with whom he had had a sexual contact, disappointing his parents). The score on the Compulsions subscale was 12, with the patient presenting compulsive checking (e.g., checking that he had not run over anybody, that he had not done something wrong), repetition (e.g., praying, asking for forgiveness), and reassurance seeking (e.g., asking his mother if she was upset).

Obsessive-Compulsive Inventory-Revised (OCI-R). The Spanish version of the OCI-R (Foa et al., 2002) was developed by Fullana et al. (2005). The OCI-R assesses severity on six dimensions of OCD: Washing, Obsessions, Hoarding, Order, Checking, and Neutralization. In this case, scores in the clinical range were observed for Obsessions (12) and Checking (7).

Obsessive Beliefs Inventory (Inventario de Creencias Obsesivas [ICO]). This self-report (Belloch, Cabedo, Morillo, Lucero, & Carrió, 2003) explores beliefs and cognitive biases related to OCD. Manuel scored high on excessive responsibility (38), overestimation of importance of thoughts (19), probability TAF (24), Moral TAF (31), importance of controlling thoughts (26), threat overestimation (54), intolerance for uncertainty (31), and perfectionism (26).

Beck Anxiety Inventory (BAI). The Spanish version of the BAI (Beck & Steer, 1990) by Sanz, García-Vera, and Fortún (2012) was used to assess severity of anxiety. The patient's total score was 24, indicating moderate anxiety. Manuel specifically reported fear of losing control, fear that something bad could happen, fear of death, and feeling terrified.

Beck Depression Inventory-II (BDI-II). The Spanish version of the BDI-II (Beck, Steer, & Brown, 1996) by Sanz and Vazquez (2011) includes 21 items in self-report format assessing depressive symptoms. Manuel obtained a score of 25, indicating moderate depressive symptoms. Sadness, pessimism, dissatisfaction with oneself, and indecisiveness were the more remarkable depressive responses.

Case formulation

According to information collected from the assessment, Manuel was diagnosed with primary OCD (APA, 2000). Despite the presence of moderate depressive symptoms, a diagnosis of major depression was not given, considering that these symptoms were secondary to his OCD.

To establish the case formulation, we utilized a cognitive-behavioral approach incorporating unique family, social, and

cultural factors related to the patient. Having matured within a family with strict behavioral rules and conservative religious and moral codes, Manuel developed distorted and rigid beliefs about "right" and "wrong." Also, since he was a child, he has been dependent and compliant, requiring the approval of family members to make decisions. At the time of treatment, these moral principles were contradictory to the behaviors exhibited by his peers, which made Manuel avoid several social situations or experience a lot of guilt if he was involved in them. Guilt and the possibility of punishment (also from God) had been inculcated by authoritarian parents, favoring the development of excessive responsibility. This led to obsessive doubts about matters such as whether he hurt someone, disappointed his parents, or said something inadequate. Assessment also showed an elevated moral dimension of TAF, which explains why Manuel felt high distress just thinking about being involved in acts that he considered immoral or sinful. This was congruent with his Roman Catholic philosophy of "sinning by thought." Finally, his elevated intolerance of uncertainty also had a role in the maintenance of his obsessive-compulsive symptoms. As a result, he had to check repeatedly if certain feared events had happened and to seek for reassurance regarding the righteousness of his behavior.

Treatment

Manuel attended thirty 1-hour sessions of individual treatment over the course of 8 months. Twenty-six sessions were attended weekly, and four sessions occurred every 2 weeks. Currently, Manuel is receiving a booster session every 2 months. A cognitive-behavioral approach was used, including psychoeducation, ERP, and cognitive training. In addition, family therapy strategies were integrated across the intervention phases.

In the first treatment session, psychoeducation had the goal of providing Manuel with an integrative explanation of the problem and the treatment rationale. Manuel was informed about how his learning experiences led him to develop distorted beliefs about certain moral issues. The excessive importance given to

these beliefs had made Manuel develop recurrent doubts around his moral behavior and other obsessive thoughts. The therapist explained how obsessions produced anxiety and distress, which Manuel tried to prevent through his compulsive behaviors. In this way, he obtained temporary relief, but his obsessions persisted because he did not learn to tolerate his doubts.

Exposure preparation started in Session 6 with the establishment of a hierarchy of fears. On the one hand, the hierarchy included several situations that Manuel avoided due to the possibility of doing immoral actions; these would be confronted in vivo. On the other hand, obsessive thoughts were also included for imaginal exposure. After Manuel rated each one using the Subjective Units of Distress Scale (SUDS) from 1 (*no distress*) to 100 (*extremely distressing*), these were organized from the lowest to the highest, as can be seen in Table 1.

At Session 8, Manuel was exposed to the first item of the hierarchy. The therapist asked him to bring to his mind the feared thought (e.g., something bad can happen to my parents) and not to pray. After two trials of 40 minutes, Manuel's SUDS score dropped from 40 to 10. Manuel was asked to repeat the trial at home. The same procedure was used with the remaining levels of the hierarchy, including therapist-guided exposures in sessions and self-guided exposures at home. Frequently, in vivo exposures evoked obsessive thoughts for imaginal exposure. For example, in the feared situation where a friend of Manuel was asked by the therapist to invite Manuel to have a drink, he experienced considerable anxiety, wondering if his parents and God could understand this behavior. He also felt strong urges to ask God for forgiveness and to pray, which were resisted during and after the exposure trial. In another step of the hierarchy, the therapist accompanied Manuel while he was driving. First, Manuel drove along streets without traffic or pedestrians, and after some trials, he drove on busy roads. Those situations raised very distressing doubts in Manuel's mind that he might have caused damage to someone. Although it was difficult and he needed support from the therapist, Manuel was able to resist the urge to check and see if something had happened. By the end of the intervention, some more challenging exposure tasks were

Table 1. **Hierarchy for in vivo and imaginal exposure**

Avoided situations for in vivo exposure	SUDS	Compulsive behaviors impeded
Going out with friends at night	50	Reviewing his behavior, asking for reassurance about whether he did anything wrong
Driving on an empty road	70	Checking phone to find out whether he ran over someone
Driving on a crowded road	80	Checking phone to find out whether he ran over someone
Meeting the girl he had sex with	80	Asking for reassurance about whether she was pregnant
Having a drink with a friend	90	Asking God for forgiveness, asking his mother if she was disappointed or angry
Telling his parents and sister that he wanted to study in a foreign country	90	Asking his family if they are angry or disappointed, asking his family if he said something inadequate
Obsessions for imaginal exposure		
Something bad can happen to my parents	40	Praying to avoid that, checking phone to find out
I am a bad person	50	Asking for reassurance, asking God for forgiveness, asking his family if they are angry or disappointed
Maybe I ran over someone with the car	90	Checking phone to find out
Maybe the girl is pregnant	100	Praying to avoid that, checking phone to find out, calling or meeting girl to ask if she was pregnant

SUDS: Subjective Units of Distress Scale.

designed (overexposure), and Manuel had to cope with more difficult situations than he would find usually in daily life. For example, the therapist created some situations in which Manuel had to defend his own opinion in front of his mother and sister. In one situation, he told them that he wanted to go to a foreign country to finish his degree. When his mother and sister started questioning this plan, Manuel had to tolerate his fear and discuss his idea as he had been trained to do in a previous session. Other overexposure tasks were not checking his mobile phone for 3 days, driving on very busy roads, and not seeing

the "pregnant" girl for a week and avoiding checking if she was truly pregnant.

Starting with Session 10, cognitive training had the main purpose of discussing moral and religious issues. During these sessions, morality-related biased beliefs were addressed. Some examples were: "Being a good person is doing what your parents want you to do," "having sexual relationships, smoking, or drinking are immoral acts," "my sister and my family know me better than I know myself; therefore, they know better than me what I have to do," and "God will punish me if I do immoral acts." Manuel was asked whether he considered his friends to be *buenas personas* (good people). He answered that they were, but sometimes they did "bad things." Through Socratic dialogue, he was encouraged to conclude that people can be good without the need to follow such rigid moral rules. Regarding religion-related beliefs, the therapist attempted to help Manuel change his perception from one based on the fear of punishment to a more positive understanding of faith as a support and guide for his life.

During the intervention, family therapy sessions were needed to modify roles, behaviors, and beliefs that were contributing to the maintenance of Manuel's scrupulous obsessions. At first, Manuel's parents acknowledged that although they had inculcated these rigid moral rules in Manuel, they were very affected by his suffering. They shared that they were sorry and wished Manuel could enjoy his life again, going out and having fun with his friends, studying, and so on. Despite his mother's fear that Manuel could "drink too much or smoke joints," she was willing to take the risk if his obsessive thinking stopped. She acknowledged that going out or having sex were behaviors typical of his age and these were not immoral. In this way, Manuel's family contributed to changing Manuel's distorted beliefs about morality. When morality rules were discussed in sessions, the family was instructed not to provide additional reassurance about the righteousness of Manuel's behavior or about what they were feeling because of his behavior. Finally, it was necessary for Manuel to take on a more independent role within the

Table 2. **Distress and avoidance ratings of feared situations from pretreatment to posttreatment**

Avoided situations for in vivo exposure	Avoidance		Distress	
	Pre	Post	Pre	Post
Going out with friends at night	50	10		
Driving on a crowded road	80	20		
Meeting the girl he had sex with	80	0		
Obsessions for imaginal exposure				
Something bad can happen to my parents			40	10
I am a bad person			50	0
Maybe I ran over someone with the car			90	20
Maybe the girl is pregnant			100	10

family. His parents learned to let Manuel make his own decisions and thus enhance his autonomy. Although the older sister did not attend sessions, she was asked not to influence Manuel's decisions and to have a fraternal relationship instead of being an authority figure for him.

Relapse prevention started in Session 27. Manuel and his therapist identified several factors that could make obsessions reappear, such as "doing things that he could consider immoral," "expressing different opinions to his parents," "thinking his parents were ill," and "feeling tired." Previously held beliefs were revised: "Having sex and fun with friends doesn't make someone a bad person," "I know what is good for me better than my sister," "I can have my own dreams and life goals," "my family loves me, but I know myself better than they know me," "God is not vengeful." Finally, Manuel was reminded of the importance of coping with his fears and avoiding rituals.

Results

Outcomes at posttreatment

At posttreatment, the scores on the Y-BOCS Obsessions and Compulsions subscales dropped to 8 and 7, respectively. Manuel still had excessive concerns about good and evil and some

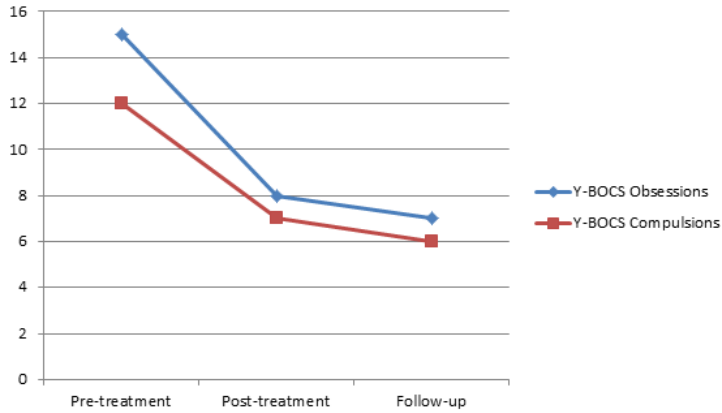

Figure 1. **Results on Y-BOCS Obsessions and Compulsions subscales at pretreatment, posttreatment, and follow-up.**

checking compulsions (e.g., checking that he did not hurt anybody). The scores on OCI-R subscales decreased to 7 in Obsessions, 2 in Checking, and 0 in Neutralization. Table 2 shows decreases on ratings of some feared situations from pretreatment to posttreatment. Regarding depressive and anxiety symptoms, scores dropped into the nonclinical range of 10 and 12, respectively. Manuel reported that he felt happier and hopeful.

Six-month follow-up

At 6 months posttreatment, Manuel and his parents attended a follow-up assessment and booster session. Gains observed at posttreatment were maintained. He acknowledged that some obsessions had appeared (e.g., "I did not behave well,", "my parents are getting older") but that he could control them adequately without performing compulsive behaviors. Figure 1 shows the evolution of Y-BOCS Obsessions and Compulsions scores across assessments.

After assessment, goals achieved in several dimensions (obsessions, compulsions, autonomy, expectations, and family rela-

tionships) were reviewed. Finally, Manuel's therapist motivated all family members to keep working on the gains made to increase maintenance. Manuel and his therapist agreed to have a follow-up visit every 2 months.

Conclusions

Knowledge learned from case

The case presented in this article has illustrated that when obsessive thoughts have a cultural basis and are inserted into the values system of the individual, it may be necessary to integrate evidence-based treatment (CBT) strategies to modify learned roles and attitudes that could challenge a patient's engagement in exposure. Family members have a role of particular importance because they are transmitters of social and cultural values. Concretely in this case, high levels of religiosity and morality exhibited by family members during Manuel's childhood influenced his beliefs about good and evil. These beliefs made Manuel experience his thoughts and behaviors as immoral or sinful when he became an adolescent. Therefore, learning history and cultural backgrounds should be considered when addressing some cases of OCD.

Impact on field

Individual characteristics and unique manifestations of symptomatology may constitute important barriers in the treatment of OCD. In this sense, and according to previous research, individualized evidence-based interventions (Wu & Storch, 2016) and inclusion of techniques from other treatment approaches (Ellard, Fairholme, Boisseau, Farchione, & Barlow, 2010) may be strategies to increase the potential efficacy of CBT in particular cases. Therefore, once the overall efficacy of CBT for OCD has been established, research exploring the complicated factors and solutions for individual cases is necessary for effective clinical practice.

References

Abramowitz, J. S. (2001). Treatment of scrupulous obsessions and compulsions using exposure and response prevention: A case report. *Cognitive and Behavioral Practice*, *8*, 79–85.

Abramowitz, J. S., & Jacoby, R. J. (2014). Scrupulosity: A cognitive-behavioral analysis and implications for treatment. *Journal of Obsessive-Compulsive and Related Disorders*, *3*, 140–149.

American Psychiatric Association. (2000*). Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

Asnaani, A., Kaczkurkin, A. N., Alpert, E., McLean, C. P., Simpson, H. B., & Foa, E. B. (2017). The effect of treatment on quality of life and functioning in OCD. *Comprehensive Psychiatry*, *73*, 7–14.

Beck, A. T., & Steer, R. A. (1990). *Manual for the Beck Anxiety Inventory*. San Antonio, TX: Psychological Corporation.

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Beck Depression Inventory-II*. San Antonio, TX: Psychological Corporation.

Belloch, A., Cabedo, E., Morillo, C., Lucero, M., & Carrió, C (2003). Development of an instrument to assess dysfunctional beliefs in the obsessive-compulsive disorder: Preliminary results of the Obsessive Beliefs Inventory. *International Journal of Clinical and Health Psychology, 3,* 235–250.

Di Nardo, P. A., Brown, T. A., & Barlow, D. H. (1994). *Anxiety Disorders Interview Schedule for* DSM-IV*: Lifetime Version (ADIS-IV-L)*. New York, NY: Oxford University Press.

Ellard, K. K., Fairholme, C. P., Boisseau, C. L., Farchione, T. J., & Barlow, D. H. (2010). Unified protocol for the transdiagnostic treatment of emotional disorders: Protocol development and initial outcome data. *Cognitive and Behavioral Practice, 17*, 88–101.

Foa, E. B., Huppert, J. D., Leiberg, S., Langner, R., Kichic, R., Hajcak, G., & Salkovskis, P. M. (2002). The Obsessive-Compulsive Inventory: Development and validation of a short version. *Psychological Assessment, 14*, 485–496.

Fullana, M. A., Tortella-Feliu, M., Caseras, X., Andión, O., Torrubia, R., & Mataix-Cols, C. (2005). Psychometric properties of Spanish version of the Obsessive-Compulsive Inventory-Revised in a non-clinical sample. *Journal of Anxiety Disorders, 19*, 893–903.

Goodman, W. K., Price, L. H., Rasmussen, S. A., Mazure, C., Fleischmann, R. L., Hill, C. L., . . . Charney, D. S. (1989). The Yale–Brown Obsessive-Compulsive Scale: I. Development, use, and reliability. *Archives of General Psychiatry, 46,* 1006–1011.

Himle, J. A., Chatters, L. M., Taylor, R. J., & Nguyen, A. (2013). The relationship between obsessive-compulsive disorder and religious faith: Clinical characteristics and implications for treatment. *Spirituality in Clinical Practice*, *1*, 53–70.

Malti, T., Eisenberg, N., Kim, H., & Buchmann, M. (2013). Developmental trajectories of sympathy, moral emotion attributions, and moral reasoning: The role of parental support. *Social Development*, *22*, 773–793.

Öst, L. G., Havnen, A., Hansen, B., & Kvale, G. (2015). Cognitive behavioral treatments of obsessive-compulsive disorder. A systematic review and meta-analysis of studies published 1993–2014. *Clinical Psychology Review*, *40*, 156–169.

Rachman, S., & Shafran, R. (1999). Cognitive distortions: Thought–action fusion. *Clinical Psychology & Psychotherapy*, *6*, 80–85.

Rosa-Alcázar, A. I., Sánchez-Meca, J., Gómez-Conesa, A., & Marín-Martínez, F. (2008). Psychological treatment of obsessive-compulsive disorder: A meta-analysis. *Clinical Psychology Review, 28*, 1310–1325.

Salkovskis, P. M. (1999). Understanding and treating obsessive-compulsive disorder. *Behaviour Research and Therapy*, *37*, S29–S52.

Salkovskis, P., Shafran, R., Rachman, S., & Freeston, M. H. (1999). Multiple pathways to inflated responsibility beliefs in obsessional problems: Possible origins and implications for therapy and research. *Behaviour Research and Therapy*, *37*, 1055–1072.

Sanz, J., García-Vera, M. P., & Fortún, M. (2012). El "Inventario de ansiedad de Beck" (BAI): Propiedades psicométricas de la versión española en pacientes con trastornos psicológicos [The Beck Anxiety Inventory (BAI): Psychometric properties of the Spanish version in patients with psychological disorders]. *Psicología Conductual, 20*, 563–583.

Sanz, J., & Vazquez, C. (2011). *Adaptación española del Inventario para Depresión de Beck-II (BDI-II). Manual* [Spanish adaptation of the Beck Depression Inventory (BDI-II). Manual]. Madrid, Spain: Pearson.

Siev, J., & Cohen, A. B. (2007). Is thought–action fusion related to religiosity? Differences between Christians and Jews. *Behaviour Research and Therapy*, *45*, 829–837.

Sociological Research Center. (2014). *Opiniones y actitudes sobre la familia* [Opinions and attitudes about the family]. Estudio nº 3032. Retrieved from http://www.cis.es/cis/export/sites/default/-Archivos/Marginales/3020_3039/3032/es3032mar.pdf

Sociological Research Center. (2018). *Barómetro de Abril 2018* [Barometer for April 2018]. Estudio nº 3210. Retrieved from http://www.cis.es/cis/export/sites/default/Archivos/Marginales/3200_3219/3207/es3207mar.pdf

Williams, A. D., Lau, G., & Grisham, J. R. (2013). Thought–action fusion as a mediator of religiosity and obsessive-compulsive symptoms. *Journal of Behavior Therapy and Experimental Psychiatry*, *44*, 207–212.

Williams, M. T., Chapman, L. K., Simms, J. V., & Tellawi, G. (2017). Cross-cultural phenomenology of obsessive-compulsive disorder. In J. Abramowitz, D. McKay, & E. A. Storch (Eds.), *The Wiley handbook of obsessive compulsive disorders. Volume I* (pp. 56–74). Hoboken, NJ: Wiley.

Williams, M. T., Mier-Chairez, J., & Peña, A. (2017). Tools for treating obsessive-compulsive disorder among Latinos. In L. T. Benuto (Ed.), *Toolkit for counseling Spanish-speaking clients* (pp. 139–171). Cham, Switzerland: Springer.

Wu, M. S., & Storch, E. A. (2016). Personalizing cognitive-behavioral treatment for pediatric obsessive-compulsive disorder. *Expert Review of Precision Medicine and Drug Development, 1*, 397–405.